United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: January 9 - January 13, 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 (ICFMR) 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 review, 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, Interdisciplinary Team (IDT) 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.

Substantial Compliance Ratings and Progress

Across the state's 13 facilities, there was variability in the progress being made by each facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation, of the parties who crafted the Settlement Agreement was for there to be systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report for detail regarding the facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity; some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, provision item L.1 addresses the total system of the provision of medical care at the facility. Contrast this with provision item T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the

provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

First, once again, the monitoring team wishes to 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 again extremely supportive of the monitoring team's activities throughout the week of the onsite review. The Settlement Agreement Clerk, Bertha Macias-Muno, did an excellent job filling in for the Settlement Agreement Coordinator during the week of the onsite review. Further, the monitoring team appreciated the opportunity to have met with family members of some of the individuals at EPSSLC.

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. Further, many positive interactions were observed between staff and the individuals at EPSSLC during the many hours of observation conducted by the monitoring team, including early morning, afternoon, evening, and late night in the homes and day programs. 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, below are comments on a few general topics regarding service operations at the facility and this monitoring report.

- Attention to Settlement Agreement: Facility staff and management were very aware of the Settlement Agreement. There was frequent reference to Settlement Agreement provision and provision items, often by provision item letter and number.

- Management stability: Although there were some changes in personnel, overall there appeared to more stability in the management and clinical staff positions.

- Integration of clinical services: Numerous efforts to this end were observed by the monitoring team.

- Habilitation and nursing: The facility addressed the concerns raised during the previous review regarding the overall quality of habilitation services and the quality of the facility's emergency medical equipment.

- Facility self-assessment: EPSSLC wrote its self-assessment following new guidelines from DADS. As indicated in each of the sections of the report below, this was a good first step. Overall, the new format should help guide the facility in moving forward and to help managers and clinicians develop the ways in which they assess the quality and depth of the activities in which they and their staff engage to meet the many items of each of the provisions of the Settlement Agreement.

- ISP terminology: DADS and the SSLCs changed the wording of many documents, meetings, and processes to Individual Support Plan (ISP). This was a change from the previous Personal Support Plan (PSP). Also, the Personal Support Team (PST) name was changed to the Interdisciplinary Team (IDT). This report uses the new terminology and refers to all documents with the new terminology.

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

- Between 7/1/11 and 12/21/11, 39 restraints occurred. Of these, 21 were programmatic restraints, 18 were emergency restraints, and 32 were personal hold restraints. None were mechanical restraints, and 5 were chemical restraints. A total of 9 individuals were the subject of restraints. One individual accounted for 21 (54%) of the restraint incidents.
- These data, however, did not accurately reflect all restraints. For example, two physical restraints for Individual #13, and chemical restraints for Individual #51 and Individual #85, were not included on the list of all restraints. In addition, the monitoring team found that some mechanical restraints that were being used to address self-injurious behavior were incorrectly classified as medical restraints, therefore, were not being addressed in behavior support plans.
- Actions taken to address restraint usage since the last review were:
    - All restraints were being reviewed in the daily unit meetings.
    - New training was developed for restraint monitors.
    - The facility began statewide Section C audit tool.
    - Restraint audits were being completed monthly.
    - A "Do Not Restrain List" was developed.

- Even so, issues identified during the previous monitoring visit continued to be areas of concern regarding the documentation, monitoring, and review of restraints.

Abuse, Neglect, and Incident Management

- Investigations of 37 allegation of abuse, neglect, or exploitation were conducted by DFPS at the facility from 7/1/11 through 11/30/11. Of these 37 allegations, 13 (35%) were confirmed allegations of neglect, one was confirmed physical abuse, 18 (49%) were unconfirmed allegations, and five (14%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect. There were an additional 27 serious incidents at the facility that did not involve allegations of abuse or neglect investigated by the facility.
- Some positive steps taken to address incident management included:
    - Creation of a database to track disciplinary action related to allegations.
    - Revision of the employee abuse, neglect, and exploitation competency test.
    - Use of the new state office Avatar system for documenting investigations.
    - Inservice for all QDDPs.
    - Revising the discovered injury investigation process.
    - The DADS Section D Monitoring Tool was implemented.
    - Improvements were made in the documentation of activities taken during the investigation process.
- The facility needs to:
    - Create a database that accurately identifies all unusual incidents.
    - Ensure all staff know reporting procedures for unusual incidents.
    - Ensure investigation files include documentation of follow-up to all recommendations and concerns.
    - Ensure IDTs are adequately addressing all incidents and putting necessary protections in place.
    - Ensure that the facility audit system accurately identifies areas of needed improvement.
- DFPS investigations did not always provide a clear basis for findings in cases in the sample. The facility had requested a review of findings in two cases to further clarify investigation results.

Quality Assurance

- There was progress towards the development of a QA program, including the appointment of a new QA director. Further, the facility director was highly involved in and supportive of QA activities.
- There were no facility-specific QA policies. Once the state policy is disseminated, the QA director should determine if a facility-specific policy would be helpful. The monitoring team believes it would be.
- A QA plan was needed, that is, a combination of a narrative description of the overall QA program at the facility and the QA matrix. The QA director created a spreadsheet that was more than 25 pages long. Instead, this should be made into separate, though corresponding documents.

- The QA director created an impressive set of data summaries and graphs. He should ensure that the DADS central office QA coordinator is in agreement with this style of graphing because it was different than that seen at other SSLCs. Furthermore, a great deal of time was devoted to the statewide Settlement Agreement self-monitoring tools. There are next steps that should be taken regarding their content, implementation, and the determination of priority items.
- A monthly QA report was completed by the QA director. It was used as a handout during QAQI Council meetings. The QA report should also be presentable as a stand alone document/report for the many people who may be interested in the content, but do not attend the meeting.
- The QAQI Council meeting was the best one yet observed at EPSSLC because it included a structured agenda, data were presented and reviewed, and there was relatively good participation from attendees. More discussion should occur when presenters bring up concerns and when they talk about decisions that are based on their data.
- The facility attended to the need for corrective actions. The QA director should work with state office on the criterion for determining what does, and what does not, require a corrective action plan.

<u>Integrated Protections, Services, Treatment, and Support</u>

- DADS recently initiated a thorough review of the ISP process and hired a set of consultants to help the SSLCs move forward in ISP development. EPSSLC received assistance from the consultants very recently and had begun implementation of the new ISP process only as of 1/1/12. As a result, only two ISPs had been developed since training had occurred. These two ISPs, however, showed significant improvement in including supports and services in a manner that would guide staff implementing plans.
- Three annual IDT meetings were observed by the monitoring team. In these meetings, the QDDPs were attempting to ensure that all necessary information was covered during the IDT meeting. Meetings attended were lengthy and somewhat fragmented in discussing risks and supports, however, teams engaged in better integrated discussion in the meetings observed than during the previous onsite reviews.
- There was minimal progress being made on developing plans that would lead to a more meaningful day for individuals. IDTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want.
- The facility continued to need to complete more thorough assessments to determine what services were meaningful to each individual and what supports were needed for each individual to fully participate in those services.
- Quality assurance activities with regards to ISPs were in the initial stages of development. While continued progress was found, assessments were still not completed or updated as needed, key members of the team were

not present at annual meetings, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- EPSSLC had done a considerable amount of work since the last onsite review. The facility director had taken a very active role in the activities related to this provision item. This was an important step because achieving substantial compliance with this provision will require that numerous actions occur across multiple disciplines.
- EPSSLC staff were very eager to discuss integration and provide evidence that this was occurring. This enthusiasm was one signal that staff understood the importance of integration even if they were not certain of how to go about achieving it. They also understood that much work needed to be done in this area.
- The monitoring team saw evidence of integration in many areas. It was also evident that several disciplines were not integrating well with other areas and will require a change in the approach of providing services.
- 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.
- The facility will need additional guidance from state office and the monitoring team was informed that additional guidance and a policy are forthcoming.

At-Risk Individuals

- Some positive steps EPSSLC had taken included:
    - Use of the statewide audit tool to assess compliance.
    - Established a schedule for the IDT to meet quarterly review to review risk assessments and action plans.
    - Implemented new training requirements for all staff
    - Incidents that might indicate a change of status for individuals were being reviewed in the daily unit meeting.
    - A database to track changes in status had been created.
    - IDTs were referring individuals to the PNMT and BSC.
- IDTs were consistently completing assessments prior to the IDT meeting or updating assessments as needed. Teams could not adequately discuss risk factors without current, accurate assessments in place. Staff were not adequately trained on monitoring risk indicators and providing necessary supports.

Psychiatric Care and Services

- More than half of the individuals received psychopharmacologic intervention (78 of the 130, 60%). There was a laudable effort placed into the improvement of the clinic process, especially regarding psychiatric documentation.
- There were a limited number (16) of evaluations completed in Appendix B format. The current practice of assigning diagnoses without review of detailed diagnostic criteria did not meet generally accepted professional standards of care. In addition, there were discrepancies in psychiatric diagnoses across different disciplines' evaluations (e.g., physician's annual medical review, ISP, PBSP). More work needs to be done regarding justification and case formulation for specific diagnoses as well as the indications for psychotropic medications. It will be important for collaboration to occur between psychology and psychiatry in case formulation, in the joint determination of target symptoms and descriptors or definitions of the target symptoms, and the use of objective rating scales when appropriate.
- The monitoring team observed three separate psychiatric clinics, and one neuro-psychiatry clinic. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QDDP, direct care staff, and the individual).
- A review of psychiatric documentation (specifically quarterly medication reviews) for 17 individuals revealed that in 100% of the documentation reviewed, MOSES and DISCUS were completed appropriately, results were included in the documentation, and results were reviewed as part of the clinical decision making process.
- There were no specific treatment plans for psychotropic medication that contained the components required by provision item J13. Records reviewed revealed multiple examples of medication adjustments performed concurrently or rapidly with no time for review of behavioral data to determine the appropriateness of the dosage change.

Psychological Care and Services

- In the last six months, there was progress in the initiation of external peer review, initiation of the collection of Interobserver agreement, graphing of data in intervals necessary to better make treatment decisions, and improvements in functional assessments. In addition, there was development of new documentation to increase the likelihood that consent for all PBSPs is obtained.
- Some specific activities that the facility is encouraged to focus on over the next six months are to track interobserver agreement results, establish target levels, and ensure that staff achieve those levels, and collect data reliability, track staff performance, establish target levels, and ensure that staff achieve those levels. Other areas for focus are to track individual staff treatment integrity levels, establish target levels, and ensure that staff

achieve those levels, improve behavioral graphs by minimizing the number of data paths, ensure that internal peer review/behavior support committee meetings occur weekly, and meeting minutes are maintained, and ensure that external peer review occurs monthly and that meeting minutes are maintained.

Medical Care

- The facility made progress in the provision of medical care. The medical director and APRN continued to work collaboratively to provide care for approximately 130 individuals. Each weekday morning, a daily unit team meeting was held. While this meeting served as a good source of information, the format did not allow the types of discussions that are most beneficial for a daily clinical medical meeting.
- A contract with a local neurologist was secured to increase the hours of neurology services and allow for greater integration of neurology and psychiatry. The medical director reported that an agreement had been reached with the local health sciences center to complete gynecological exams on all females, although documentation indicated that discussions were ongoing.
- Databases were established to track preventive care, such as breast, colorectal, and cervical cancer screenings. The number of individuals receiving colorectal and breast cancer screenings increased. There was still an outstanding need for females to have appropriate gynecological evaluations and exams.
- External reviews were completed and data were generated. The medical director used this information to provide feedback to the medical staff. Mortality reviews were completed and recommendations were generated.
- A medical quality program had not been established, but several actions occurred that would contribute and fold into a quality program. There were no new facility-specific policies or procedures developed within the medical department. A new Preventive Care Flowsheet was implemented and it contained guidelines for some preventive care. The state issued guidelines had not been implemented at the facility.

Nursing Care

- Several positive changes occurred in the nursing department. Steps were taken by the department to address several of the serious health and safety problems that were identified six months ago. For example, competency based training in physical assessment, documentation, and dysphagia was provided to nurses; emergency equipment was obtained, cleaned, organized, and regularly checked; a Campus RN Supervisor assumed the Hospital Liaison's duties; staff utilization and deployment policies were revised to help reduce unscheduled absence and promote continuity of care; and corrective action plans to address identified problems in care were developed and partially implemented.
- There continued, however, to be problems with the completion of ongoing and comprehensive quarterly assessments and development of care plans that adequately addressed individuals' health problems and needs.

- There continued to be a pattern of problems in nursing practice. On a number of occasions, nurses failed to deliver nursing care in accordance with accepted standards of practice, and they carried out improper interventions as though they were standard operating procedure. These findings were consistent with the facility's QA data, which revealed that the majority of 12 compliance scores across the monitoring tools associated with nursing ranged from the mid 40s to the mid 70s, with an average score of 51%.
- Despite the problems that were evident, the newly appointed CNE (and former NOO) was aware of the challenges that lay ahead, but was nonetheless encouraged by the signs of progress and positive change, and she embraced her appointment with renewed energy and optimism.

Pharmacy Services and Safe Medication Practices

- Continued progress was noted. The pharmacy continued to complete prospective reviews of new medication orders, communicated with prescribers, and documented outcomes. The use of multiple reporting forms was consolidated, such that one form was used to report all communication.
- A new drug regimen review policy was implemented that outlined the process. It provided timelines for completion and review of documents by clinical pharmacists and medical providers. The clinical pharmacist completed QDRRs in a timely manner and provided good clinical information for use by medical providers.
- Medical providers responded to the recommendations of the clinical pharmacists. With some exceptions, it could usually be determined that the medical providers wrote orders and took other appropriate actions after agreeing with the pharmacists.
- Significant improvement was noted in the completion of the MOSES and DISCUS evaluations. The psychiatrist reviewed the findings and documented conclusions in almost every evaluation completed after July 2011. Email correspondence appeared to indicate that the nursing department had some difficulty related to completing and forwarding the evaluations to the psychiatrist.
- The frequency of ADR reporting increased and there was evidence that the ADRs were discussed and followed-up. One noteworthy finding was that ADRs were usually detected by the clinical pharmacist during routine reviews.
- A new DUE policy was implemented and DUEs continued to be performed on a monthly basis. The evaluations were quality reviews and could be even more helpful with additional work in this area.
- The ongoing efforts in safe medication practices resulted in numerous changes that decreased the number of medication omissions. The system was not capturing all errors, some of which were significant events, based on the duration and the number of individuals involved.

Physical and Nutritional Management

- There had been a tremendous amount of concentrated and organized effort to address the elements of this provision. This was accomplished, in part, through the Immediate Action Plan developed soon after the previous monitoring team review. It included a facility-wide mealtime monitoring that involved all staff including clinical staff from all departments, administrative support staff, and the facility director. Susan Acosta, DPT, had assumed a formal leadership and was well prepared, accessible, and available during this onsite review.
- There was a fully-constituted PNMT, including a full time nurse. They had met consistently with purpose and structure. They had conducted assessments and developed action plans in conjunction with the IDTs. A meeting observed during this review showed some improvement since the last review, but continued to need experience with the PNMT process for refinement.
- Mealtimes and snacks were observed. Improvements were noted related to texture and liquid consistency errors and general implementation of the plans. It was observed, however, that during snack times for individuals, that dining plans or PNMPs were not consistently out. Staff stood to present fluids and when asked about what position they should be in, some knew they should be seated, but could not because there were no chairs or stools. One of the homes observed for lunch and dinner was 513 where significant issues in that home had been noted during each of the previous visits. This time, there was only one issue observed during the evening meal.
- Staff required prompts from the techs and PNMPCs to reposition individuals before, during, and outside meals, and this was not always done appropriately or effectively. On the positive side, the PNMPCs appeared to be more active and confident in their roles. A significant amount of training had occurred for them over the last six months. Monitoring had been done extensively during the last six months. It was of concern, though, that the home supervisors, backups, PNMPCs and Hab techs may not have had sufficient training and practice to become competent to conduct check-offs with direct support staff.

Physical and Occupational Therapy

- There had been a tremendous amount of concentrated and organized effort to address the items of this provision. Staffing levels were improved, though some existing staff had resigned and new staff were just recently hired.
- The assessment process had significantly improved. The content had also improved, though the analysis of findings was issue-specific and in a list format, which did not promote an integrated comprehensive review of all the data presented. Information contained within the assessment report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective IDT should then drive the supports and interventions via the PNMP and other more direct services. There was emerging evidence that the therapists had begun to consider this and include statements in their assessments.

- The measurable outcomes were limited to staff actions rather to promote improvements in functional status or skill acquisition. The OT and PT clinicians appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services. The monitoring team observed a clinical team meeting. This appeared to be a sound practice.
- The PNMPs continued to be reviewed with improvements in many areas. The positioning, transfer, and mobility sections should be more carefully examined. There was a lot of professional jargon, abbreviations, and complex instructions that made it difficult for staff to understand. The plans must reflect instructions in a manner that is easy to understand and follow. The plans should serve as a reference when staff are unsure or want to check instructions. There was a continued need for improved staff attention to the details of proper positioning and alignment in wheelchairs and dining chairs, and compliance with the PNMPs. Attention to personal body mechanics used by staff also continued to need improvement. Review of gait belt use was also indicated. A number of individuals with gait belts did not appear to require them and/or they were not used correctly.
- There had been significant collaboration with program developers regarding the development of SAPs. More collaboration across disciplines will be necessary as the facility sees changes in behavioral supports. For example, with less sedation there will be a greater demand for meaningful and purposeful activities throughout the day. Therapies should play a key role in this process.

Dental Services

- Progress was noted in the provision of dental services. Clinic was operated five days a week. The dentist provided services three days each week. There was no onsite dental director and the lack of a full time dental director may have contributed to a lack of forward movement in some areas.
- Overall, it appeared that individuals received appropriate care to the extent that it could be delivered. The use of general anesthesia started in August 2011 resulting in several individuals undergoing extensive treatment. Other individuals were referred to the community hospital for dental work to be performed under general anesthesia. Individuals received preventive care and emergency care. Very few individuals had restorative work completed. The majority of extractions occurred with the community dentist.
- The clinic itself appeared structured, but the dental program lacked structure. The state-issued dental policy was implemented and staff trained, but no other procedures were formally developed. There were no procedures related to the hygienists' roles in home care, special supports for those at high risk, or suction toothbrushing.
- The percentage of individuals with poor oral hygiene seemed slightly, but not significantly, improved. While the IDTs documented efforts undertaken to improve the oral hygiene of individuals, there was no facility-wide strategy targeted at improving oral health. It was not clear how many individuals had been assessed for the appropriateness of formal desensitization. Five plans had been implemented and most of those were within the

past three months. A few individuals appeared to have long standing needs based on the number of extractions performed.

Communication

- Progress with completion of communication assessments per the Master Plan was reasonable, but had become more limited since November 2011, due to lowered staffing levels. In addition, approximately only half of individuals considered to be highest priority had received a comprehensive assessment.
- Consistency of the implementation of AAC and communication plans continued to be problematic. A significant amount of new training had been initiated via the Immediate Action plan developed from the previous monitoring review. Home staff and PNMPCs had received training related to this area. While this was a great foundation, these staff would not be able to ensure that communication plans were effectively implemented alone.
- Clinical staff had limited time for inserting themselves in the environments and daily routines of individuals, however, this will be key to effective assessments, the selection of meaningful and useful communication supports, the development of communication programs, and to provide modeling of how to be an effective communication partner. 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.

Habilitation, Training, Education, and Skill Acquisition Programs

- 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.
- There were several improvements since the last review. These included improvements to the skill acquisition training sheet/format, integration of other departments in the development of skill acquisition plans, and improved quality of the SAPs.
- The facility should focus on expanding the new SAP format to all SAPs at the facility; consistently graphing SAP data to increase the likelihood that the continuation, modification, or discontinuation of SAPs are the result of data-based decisions; ensuring that the SAPs are implemented with integrity; and initiating new procedures to improve individual engagement

Most Integrated Setting Practices

- Individuals who were on the referral list were placed in the community, more individuals were referred for placement, and the APC engaged in many more activities related to the numerous requirements of this provision. The specific numbers of individuals who were placed, however, was at annual rate of only approximately 6 percent (4 placements in six months, census of 129). Further, only 8 (approximately 5%) of the individuals at the facility were on the active referral list. The list of individuals not being referred solely due to LAR preference contained 58 names (45% of the individuals).
- In two new style ISPs, there was no indication that the professionals' determinations were discussed during the meeting. In an ISP meeting observed, some but not all professionals gave their determinations. The individual, however, was ultimately referred because there were no obstacles identified and IDT members did not have a reason to not refer him.
- In the ISPs, it did not appear that all of the protections, services, and supports for safety and adequate habilitation were included and detailed. The Functional Skills Assessment (FSA) did not appear to be used at all in the preparation of the ISP. Some skill acquisition topics were individualized and appeared functional and meaningful. Other skill acquisition topics appeared to be nonfunctional, if not silly.
- A plan to address identified obstacles via an action plan as a service objective or training objective was not explicitly noted in the ISPs. The APC was beginning to gather data on the obstacles across the facility. He had written an assessment report regarding these obstacles. DADS created a report summarizing obstacles across the state and included the facility's report as an attachment to the report.
- The three CLDPs reviewed by the monitoring team were not developed in a timely manner. Even so, each of the three individuals visited a number of providers and IDTs were thoughtful about choosing a provider. The CLDP meeting observed during this review was much better than the CLDP meeting observed during the previous review. It lasted one hour and 40 minutes (last time it was two and a half hours). Participation was active and most everyone was engaged. The APC focused on comments from each of the clinical disciplines and the identification of essential and nonessential supports.
- Overall, the PMM did a thorough and complete job of post move monitoring. She was thorough, looked at every item (rather than just asking staff to verbally report on them), and interacted extensively with the staff and individuals.
- Community providers continued to be prepared to provide residential and day supports to additional individuals. The monitoring team continued to be impressed by the services provided by Draco Services to all of the individuals who have transitioned from EPSSLC to their day programs and homes.

Consent

- The facility had partnered with the ARC of Texas to obtain advocates for some individuals at the facility. The Human Rights Officer continued to work with families applying for guardianship.
- While the facility maintained a list of individuals needing an LAR, IDTs were not adequately addressing the need for a LAR or advocate. Efforts did not appear to be related to those individuals determined by the facility to have the greatest prioritized need
- The facility had a Human Rights Committee (HRC) in place to review restrictions requested by the IDT. At the HRC meeting observed, committee members engaged in good discussion regarding the need for the proposed restrictions prior to giving approval. The HRC did not, however, address individual's ability to give informed consent in regards for the need for guardianship when reviewing rights assessments.

Recordkeeping Practices

- The active records were consistent in format and content. The facility, however, still struggled with keeping them as organized as they could, and should be. This continued to be due, most likely, many clinical and program staff putting documents in, and taking documents out of, the records. As a result, some documents were frequently in the wrong place in the record and the contents of some sections were out of order.
- Legibility of entries and proper signatures had somewhat improved, but only recently. Efforts were being put into securing the records room, especially in one of the homes where an individual had a history of destroying record books if access was available. The integrated progress notes (IPN) contained many insertions and documents that are not typically expected to be in the IPNs. This included sick call reports, printed emails, printed paragraphs cut and glued in, copies of consultations, and body check inspection forms.
- The individual notebooks had many different staff responsible for adding documents, thinning, and/or moving documents. This likely contributed to the variation in their organization, neatness, and clarity. Consideration should be given to removing any items that do not need to be in the individual notebooks, such as communication books and a PNMP log.
- Master records were created for every individual. They were well organized, neat, and consistent.
- The facility should determine what to do about items that remain missing.
- Unified record quality assurance review audits were done by the URC and were completed in a consistent manner. Errors were noted and tracked. The URC reported that she could only follow-up on one of the five audits to see if corrections were done. This was due to her competing work responsibilities. The facility needs to address this.

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 DADS Policy: Use of Restraints 001 o Restraint Documentation Guidelines for SSLCs dated November 2008 o EPSSLC FY11 Trend Analysis Report o EPSSLC Self-Assessment o EPSSLC Section C Presentation Book o Section C completed restraint audits summaries for June 2011 – October 2011 o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o PMAB Training Curriculum o EPSSLC Restraint Monitor Training Curriculum 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 List of all medical restraints for the past six months o List of all dental restraints for the past six months o EPSSLC "Do Not Restrain" list o List of individuals with desensitization plans o Dental desensitization plans for: • Individual #85, Individual #47, Individual #20, Individual #88, and Individual #63 o Restraint Reduction Committee meeting minutes for past six months o List of all individuals who had a Safety Plan for Crisis Intervention o Training transcripts for 24 EPSSLC employees o Documentation for pretreatment medical sedation for: • Individual #81, Individual #27, Individual #104, Individual #34, Individual #123, Individual #191, Individual #188, Individual #117, Individual #100, and Individual #32 o Positive Behavior Support Plans (PBSPs), Safety Plans, and ISPAs for: • Individual #13, and Individual #37

- A sample of restraint documentation for behavioral intervention including:

Individual	Date/Type P = Physical C = Chemical	Restraint Checklist and Face to Face Assessment	ISP ISPA	PBSP	Safety Plan
#13	7/8/11P	x x	3/14/11 9/7/11 (A) 6/30/11 (A) 6/28/11 (A)	3/4/11	1/11
	7/14/11 P	x x			
	8/2/11 P	x x			
	8/24/11 P	x x			
	8/30/11 P	x x			
	10/24/11 P	x			
#37	8/17/11 P	x x	5/25/11 11/14/11(A) 10/6/11 (A) 9/22/11 (A) 9/13/11 (A)	7/14/11	10/10/11
	9/19/11 P	x x			
	9/19/11 P	x x			
#120	7/13/11 P	x x	1/11/11 11/14/11(A) 10/11/11 (A) 9/13/11 (A) 8/12/11 (A) 6/21/11 (A) 3/3/11 (A) 1/25/10 (A)	2/2/11	
	8/10/11 P	x x			
#161	11/21/11 C	x x	5/12/11	6/8/11	
	11/24/11 C	x x			
	12/3/11 C	x x			

Interviews and Meetings Held:

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

	Observations Conducted: o Observations at residences and day programs o Daily Unit Meeting 1/9/11 o Incident Management Review Team Meeting 1/9/11 and 1/11/11 o Human Rights Committee Meeting 1/11/11 o Annual ISP meetings for Individual #70 and Individual #84
	Facility Self-Assessment: EPSSLC had revised its self-assessment, previously called the POI. It was updated on 12/23/11. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans to reach provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the self-assessment included relevant activities in the "activities engaged in" sections. Self-assessment activities should include activities that are in line with what the monitoring team assesses as indicated in this report. According to the self-assessment, compliance ratings were based on audit findings from October 2011 and November 2011. Information was not specific as to how each area of compliance was assessed. Based on audit summaries and comments on the self-assessment, the facility was aware of problems with documentation, monitoring, and review of restraints. The facility rated itself as being in substantial compliance with items C1, C2, C3, and C6. All other areas were assigned a noncompliance rating. The monitoring team agreed with the facility's self-assessment ratings for C3, C4, C5, C7, and C8, but did not find the facility to be in substantial compliance with C1, C2, and C6. The facility was found to be in substantial compliance with one of eight provision areas, C3, and one of the items of C7 (C7g).
	Summary of Monitor's Assessment: Based on information provided by the facility in a list of all restraints used for crisis intervention, between 7/1/11 and 12/21/11: • 39 restraints occurred • 21 were programmatic restraints • 18 were emergency restraints • 32 were personal hold restraints • 0 were mechanical restraints

	• 5 were chemical restraints • 9 individuals were the subject of restraints It was found that data collected by the facility did not accurately reflect all restraints incidents found documented by the monitoring team. For example, two physical restraints in the sample reviewed for Individual #13 were not included on the facility list of all restraints, and chemical restraints for Individual #51 on 8/21/11 and Individual #85 on 9/16/11 were not on the list. Additionally, during observation at the facility, it was found that some mechanical restraints being used to address self-injurious behavior were classified as medical restraints by the facility and, therefore, were not being addressed in behavior support plans. Individual #13 accounted for 21 (54%) of the restraint incidents. Individual #6 accounted for six (15%) and Individual #120 accounted for four (10%). Individual #161 accounted for three (60%) of the five chemical restraints. Five other individuals were each restrained once during the reporting period. According to the facility, actions taken to address compliance with section C since the last monitoring visit included: • All restraints were being reviewed in the daily unit meetings. • New training was developed for restraint monitors. • The facility began a self-assessment process using the statewide Section C audit tool. • Restraint audits were being completed monthly using the Section C audit tool developed by the state office for a sample of restraints. • A "Do Not Restrain List" was developed. Issues identified during the previous monitoring visit continued to be areas of concern regarding the documentation, monitoring, and review of restraints. Minimal progress had been made towards meeting the requirements of Section C.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral incidents. Sample #C.1 was a random sample of restraints for the four individuals with the greatest number of restraints. The individuals in this sample were Individual #13, Individual #37, Individual #120, and Individual #161. • Individual #13 had the greatest number of restraints, accounting for 21 (54%) of the 39 restraints for crisis intervention in the six months prior to the monitoring visit. • Individual #37 had the second greatest number with six (15%) of the restraints. • Individual #120 had four, accounting for 10% of the total number of restraints. • Individual #161 had three chemical restraints during the reporting period. <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. There were postings throughout the facility reminding staff that prone restraint was not to be used. Based on a review of 14 restraint records for individuals in Sample #C.1 involving four individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> 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 documentation for 14 restraints. The following are the results of this review: • In 13 of the 14 records (93%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. The following description did not indicate an immediate and serious threat. o The restraint checklist for Individual #161 dated 12/3/11 did not describe her behavior prior to a chemical restraint being administered. • For 14 restraint records in the sample, a review was completed of <u>the description of events leading to behavior that resulted in restraint</u>. The checklists reviewed described the individual's behavior prior to the restraint in 12 (86%) instances. Exceptions were for Individual #37 dated 9/19/11 and Individual #161 dated 12/3/11. • Only four (29%) restraint checklists in the sample indicated either what activity	Noncompliance

#	Provision	Assessment of Status	Compliance
		the individual was involved in at the time of the restraint or what was occurring in the environment that might have triggered the behavior leading to restraint. • An example where staff adequately described events leading to the behavior: o The restraint checklist for Individual #13 dated 8/2/11 noted "wanted to get in the supervisor's office and the door was locked." • Some examples where events leading to restraint were not adequately documented included: o In the area for the description of events on the restraint checklist for Individual #37 on 8/17/11, staff documented "yelling, pushing staff, property destruction." o On the restraint checklist for Individual #13 dated 9/19/11 the description of events leading to the behavior noted "was chasing staff with objects and was able to hit staff with stick." Staff did not document in what activity the individual was involved prior to the incident. • In 12 of 14 the records (86%), 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. Exceptions were: o Two chemical restraints for Individual #161 dated 11/21/11 and 12/3/11. 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. Monitoring team observations in the residences indicated that progress had been made on addressing environmental factors contributing to behavioral incidents. Based on observations in day programs, engaging individuals in more individualized and meaningful programming of interest would likely reduce behavioral incidence leading to restraints. During the monitoring visit, the monitoring team found three individuals who were wearing protective equipment (helmet and mittens) for self-injurious behaviors (Individual #12, Individual #107, and Individual #84). The facility was not documenting or monitoring these restraints as required by state policy. IDTs were not addressing alternate strategies to reduce the use of protective equipment. The facility should ensure that these protective restraints are documented, monitored, and reviewed. Plans to	

#	Provision	Assessment of Status	Compliance
		reduce the behavior resulting in restraint should be addressed by the IDT. Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 14 restraints, 14 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> The facility provided a list of medical pretreatment sedation/ medical restraints between 7/2/11 and 11/30/11: • 44 incidents of pretreatment sedation for medical appointments occurred, • 46 incidents of pretreatment sedation for dental appointments occurred. Additionally, a list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there were no medical desensitization plans in place. Five individuals had dental desensitization plans in place. A pretreatment sedation committee had been organized to begin looking at medical pretreatment sedation restraints. The facility indicated that it was in substantial compliance with this provision based on the facility self-assessment. The monitoring team did not agree with this self-rating. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, as well as all interventions attempted prior to restraint. Further, all restraints need to be included in the facility's data. Also, desensitization programs should be developed for those individuals requiring the use of pretreatment sedation for routine medical appointments.	
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 four individuals in Sample #C.1 were reviewed. Of these, two of the individuals had a Safety Plan for Crisis Intervention (SPCI) that gave direction for the use of restraint (Individual #13 and Individual #37). The SPCI for Individual #13 did not give release criteria. Six individuals at the facility had an SPCI in place at the time of the review. A sample of restraint documentation for 11 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. Six of 11 (55%) restraints reviewed indicated that the individual was released immediately when no longer a danger. Restraints in the sample lasted from three minutes to 15 minutes in duration. • The restraint checklist for Individual #13 dated 7/14/11 indicated that he was released after three minutes, but was still agitated, throwing rocks, and banging on windows.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The restraint checklist for Individual #13 dated 8/24/11 and 8/30/11 indicated that he was released according to criteria identified in his SPCI, however, his SPCI did not include criteria for release. • The restraint checklist for Individual #13 dated 10/24/11 did not describe his behavior at the time of release. • The restraint checklist for Individual #37 dated 9/19/11 noted that he was agitated and yelling prior to release. The checklist release code indicated "H" for motion/exercise release after five minutes. • The restraint checklist for Individual #120 dated 7/13/11 indicated that he was released according to his SPCI. He did not have an SPCI in place at the time of the review. SPCIs should include specific behavioral indicators to identify when release from restraint should be attempted based on knowledge about that individual. An attempt should be made to release an individual from restraint as soon as staff determines that he or she does not pose an immediate danger. Staff should document behavior at the time of release on the restraint checklist. The facility was not in substantial compliance with this item. Specific behavioral indicators demonstrating that the individual is no longer a danger are required to be documented, not only the checking of the box on the form.	
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	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-four (100%) had current training in RES0105 Restraint Prevention and Rules. • 22 of the 24 (92%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. • Twenty-four (100%) had completed PMAB training within the past twelve months. • 20 of the 24 (83%) completed PMAB refresher training within 12 months of previous restraint training. The facility self-assessment indicated that the facility was in substantial compliance with	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	restraint techniques; and adequate supervision of any individual in restraint.	training requirements in regards to restraints. A review of a sample of training documentation supported substantial compliance with C3.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 14 restraint records (Sample #C.1), 14 (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. The facility had not developed medical desensitization plans for all individuals who required the use of restraint for routine medical care. According to a list provided to the monitoring team, desensitization programs had been developed for five individuals who needed pretreatment sedation or restraint to have routine dental care completed. A sample of five plans that had been implemented was submitted to the monitoring team for review. Plans were individualized for each person. The facility had created a "Do Not Restrain" list. There were 16 individuals at the facility that had been identified for placement on this list for which physical restraints would be contraindicated due to medical or physical conditions. There was no evidence that any individuals on the list had been restrained in the past six months. IDTs should discuss the need for restraints during medical and dental procedures, and individual-specific treatments or strategies (such as, but not limited to desensitization plans) should be developed to try to reduce or eliminate the need for restraint. The facility was not in compliance with this provision.	Noncompliance
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	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 14 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 12 out of 14 incidents of restraint (86%), there was assessment by a restraint monitor. The exceptions were restraints involving Individual #13 on 10/24/11 and Individual #161 dated 12/3/11. • In the 10 instances of restraint where there was a face-to-face assessment form completed, the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Exceptions were: o Individual #37 dated 9/19/11 and Individual #120 dated 7/13/11 did not indicate time of assessment by a restraint monitor.	Noncompliance

#	Provision	Assessment of Status	Compliance
	status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Based on a review of 14 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 five (36%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #13 dated 7/8/11, 7/14/11, 8/2/11, 8/30/11, and 10/24/11 o Individual #120 dated 8/10/11 o Individual #37 dated 9/19/11 o Individual #161 dated 11/21/11 and 11/24/11 (monitoring was not documented every 15 minutes as required by state policy for a chemical restraint) A sample of restraints used for medical pretreatment sedation was reviewed for compliance with monitoring requirements. Restraint documentation did not indicate that the physician had specified the schedule and type of monitoring required. It was difficult to determine if vital signs and mental status were monitored consistently because restraint checklists did not indicated the time or duration of medical appointments. The facility remained out of compliance with this provision. Monitoring and post restraint review should be conducted and documented as required by state policy. In the case of medical restraint, the physician should specify the schedule and type of monitoring that should occur.	
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	The facility self-assessment indicated that the following actions had been taken to address compliance with this provision: • Restraint checklists were reviewed in the daily unit meeting for completion. • Restraint monitors and nurses were trained on restraint requirements. • A system was implemented to ensure one-to-one supervision was occurring for medical restraints. A sample of 14 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 six (43%), continuous one-to-one supervision was indicated as having been provided, including Individual #161 dated 11/21/11 and 11/24/11, Individual #13 dated 8/24/11 and 8/30/11, Individual #37 dated 8/17/11, and Individual #120 dated 8/10/11. • In 14 (100%), the date and time restraint was begun were indicated.	Noncompliance

#	Provision	Assessment of Status	Compliance
	restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	• In 11 (79%), the location of the restraint was indicated. Exceptions included restraints for Individual #13 dated 7/14/11, Individual #37 dated 8/17/11, and Individual #161 dated 12/3/11. • In 12 (86%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Only four (29%) indicated what events were occurring that might have led to the behavior (see section C1). • In 13 (93%), the specific reasons for the use of the restraint were indicated. The exception was the restraint for Individual #161 dated 12/3/11. • In 14 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 14 (100%), the names of staff who applied/administered the restraint was recorded. • In 14 (100%) of 14 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 11 (100%) of 11 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 13 (93%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded. The exception was the restraint for Individual #13 dated 11/24/11. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 15 minutes in duration. In a sample of 14 records (Sample #C.1), restraint debriefing forms had been completed for 12 (86%). The exceptions were a chemical restraint for Individual #161 dated 12/3/11 and a physical restraint for Individual #13 dated 10/24/11. A sample of 10 restraint checklists for individuals receiving medical pretreatment sedation was reviewed to ensure one-to-one supervision was provided. Only one checklist (Individual #104) in the sample indicated that one-to-one supervision was provided. The facility was conducting monthly audits of restraint documentation for compliance with this provision. The facility's self-assessment indicated that the facility was not in compliance with section C6. Additional staff training is needed on completing the restraint checklists. The facility was not yet in substantial compliance with the requirements of this provision item.	

#	Provision	Assessment of Status	Compliance
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, two individuals were placed in restraint more than three times in a rolling 30-day period. Both of these individuals (i.e., Individual #13 and Individual #37) were reviewed (100%) to determine if the requirements of the Settlement Agreement were met. PBSPs, safety plans, and individual support plan addendums (ISPAs) that occurred as a result of more than three restraints in a rolling 30-day period were requested. ISPA minutes following more than three restraints in 30 days were only available for Individual #37. ISPA minutes for Individual #13 were provided to the monitoring team, however, none represented meetings to specifically address more than three restraints in 30 days. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. Only one individual (i.e., Individual #37) had ISPA meetings following more than three restraints in a rolling 30-day period. The monitoring team, however, was encouraged to see that Individual #37's ISPA meeting minutes appeared to be organized around the specific issues listed below. As discussed below, however, the comprehensiveness of the minutes needs to be improved. Finally, EPSSLC needs to document that each individual's PBSP has been implemented with integrity. Individual #37's ISPA of 9/26/11 reflected a discussion of his adaptive skills and biological factors. Additionally, the ISPA indicated that the team hypothesized that psychosocial issues are affecting his target behaviors that resulted in restraint. The ISPA minutes did not, however, reflect a plan (e.g., referral for individual therapy, referral to psychiatry) to address these psychosocial issues. All ISPAs should reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors, and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	Noncompliance
	(b) review possibly contributing environmental conditions;	Individual #37's ISPA reflected a discussion of the lack of staff attention as a possible contributing environmental factor to his dangerous behavior that provokes restraint. No suggestions, however, for increasing staff attention to prevent the future probability of restraint were documented in Individual #37's ISPA minutes.	Noncompliance

#	Provision	Assessment of Status	Compliance
		All ISPAs 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.	
	(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 ISPA following more than three restraints in 30 days did not document a discussion of antecedent conditions that may increase the probability of dangerous behavior that provoked 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 the future probability of the dangerous behavior.	Noncompliance
	(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 #37's ISPAs documented a discussion of staff attention as likely maintaining the dangerous behavior that provokes restraint. The ISPA minutes did not, however, reflect an action (e.g., increase staff attention for appropriate behaviors, etc.) to address this potential source of motivation for the target behavior that provokes restraint.	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	Both of the individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Two (100%) were based on the individual's strengths. • One (50%) of the PBSPs reviewed (Individual #37 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). • Both of the PBSPs reviewed (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint. • Both PBSPs (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. One of the two PBSPs (50%) to weaken or reduce the behaviors that provoked restraint, however, were determined to be incomplete (i.e., Individual #37) because it 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	represents the results: • In both of the Safety Plans reviewed (100%), the type of restraint authorized was delineated. • In one (Individual #37) of the four safety plans reviewed (25%), the maximum duration of restraint authorized was specified. • In all (100%), the designated approved restraint situation was specified. • In all of the safety plans reviewed (100%), the criteria for terminating the use of the restraint were specified	
	(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%), were 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 one (i.e., Individual #13) of the individuals reviewed, the PBSP was 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.	Restraint incidents were reviewed daily in the Daily Unit meetings. Restraint incidents were also referred to the IDT for follow-up. See C7 for comments on review by the IDT. A sample of Face-to-Face Debriefing and Review Forms related to incidents of non-medical restraint was reviewed by the monitoring team. The review form had an area for signature indicating review by the unit director. • Only seven (50%) restraints in the sample indicated review of the restraint by the unit director. Of those four, only two were completed within three days of the restraint (Individual #161 dated 11/21/11 and Individual #37 dated 9/19/11). • There was no indication that this review resulted in recommendations or additional staff training when warranted The facility did not adhere to restraint monitoring and review requirements for all protective mechanical restraints used for self-injurious behaviors because some of these restraints were classified as medical restraint (see C1). The facility should ensure that these protective restraints are documented, monitored, and reviewed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 application or documentation.	

Recommendations:

1. The facility needs to ensure all restraints are documented and included in data collected and resulting trend reports in order to ensure adequate review has been completed (C1, C8) .
2. 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 (C1) .
3. The facility should ensure that protective restraints are documented, monitored, and reviewed. When applicable, plans to reduce the behavior resulting in restraint should be addressed by the IDT (C1).
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. SPCIs should specify specific behavioral indicators to identify when release from restraint should be attempted (C2, C4).
6. IDTs 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 (C2, C4).
7. Monitoring and post restraint review should be conducted and documented as required by state policy (C5).
8. 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).
9. Continue to monitor restraints and retrain staff as necessary (C8).
10. Complete all of the requirements for provision item C7 (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 Section D Presentation Book o EPSSLC Self-Assessment updated 12/23/11 o DADS Policy: Incident Management #002.2,dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o MH&MR Investigations Handbook Commencement Policy Effective 8/1/11 o Information used to educate individuals and their LAR on identifying and reporting unusual incidents o Incident Management Committee meeting minutes for each Monday of the past six months o Human Rights Committee meeting minutes for the past six months o Three most recent five-day status reports o Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired in the past two months (19) o List of staff who failed to report abuse, neglect, or exploitation o List of reporters that are known to be an individual or LAR o Training and background checks for the last three employees hired o Training transcripts for facility investigators (4) o Training transcripts for DFPS investigators assigned to complete investigations at EPSSLC (4) 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 ISPs for Individual #23, Individual #78, Individual #46, Individual #32, Individual #83, Individual #35, Individual #114, Individual #93, Individual #55, and Individual #20 o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, BSP and ISPA related to the last three incidents of peer-to-peer aggression o List of all serious injuries for the past six months o List of all injuries for the past six months o List of all A/N/E allegations since 7/1/11 including case disposition o List of all investigations completed by the facility since 7/1/11 o List of all confirmed allegations of abuse and neglect o List of employees reassigned due to ANE allegations

- A sample of completed audits summaries for abuse and neglect concerns or unusual incidents
- A sample of completed Discovered Injury Investigations for Individual #12 and Individual #72.
- A sample of 23 injury reports for Individual #32
- Documentation from the following completed investigations including follow-up:

Sample D.1	**Allegation**	**Disposition**	**Date/Time of APS Notification**	**Initial Contact**	**Date Completed**
#40836258 UIR #035	Neglect (2) Physical Abuse (1)	Confirmed Referred back Referred back	12/11/11 11:39 am	12/11/11 4:21 pm	12/21/11
#40835380 UIR #034	Neglect	Confirmed	12/11/11 4:41 am	12/11/11 5:26 pm	12/20/11
#40830318 UIR #033	Neglect (4)	Unconfirmed (3) Confirmed (1)	12/9/11 10:38 pm	12/11/11 5:30 pm	12/29/11
#40652943 UIR #030	Neglect (3)	Unconfirmed (3)	11/21/11 5:10 pm	11/23/11 10:52 am	12/1/11
#40637319 UIR #028	Neglect	Unconfirmed	11/19/11 3:35 pm	11/20/11 5:30 pm	11/25/11
#40610636 UIR #027	Neglect (2) Physical Abuse (2)	Confirmed (2) Confirmed Inconclusive	11/17/11 7:31 am	11/8/11 9:45 am	11/26/11
#40381997 UIR #019	Neglect (1) Physical Abuse (2)	Confirmed (1) Unconfirmed (2)	10/22/11 10:05 pm	10/22/11 10:25 pm	10/27/11
#40302986 UIR #015	Neglect	Unconfirmed	10/7/11 7:28 pm	10/7/11 8:02 pm	11/9/11 Methodological Review
#40302511 UIR #014	Neglect	Unconfirmed	10/6/11 1:18 pm	10/7/11 12:07 pm	10/11/11
#40289869 No UIR	Neglect	Confirmed	9/27/11 2:07 pm	9/27/11 4:08 pm	10/13/11
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of DFPS Referral**	**Began Investigation**	**Closed Investigation**
#40637319 UIR #028	Neglect	Unconfirmed Administrative Referral	11/20/11		
#40578140 UIR #025	Physical Abuse	Unconfirmed Administrative Referral	11/17/11		

#40518117 UIR #022	Neglect	Administrative Referral	11/8/11		
Sample D.3	**Type of Incident**	**Date/Time of Incident**	**Director Notification**		
#013	Serious Injury P-T-P Aggression	10/1/11 2:45 pm	10/1/11 3:00 pm		
#017	Serious Injury	10/13/11 5:40 pm	10/14/11 6:30 pm		
#018	Serious Injury	10/13/11 12:45 pm	10/14/11 5:00 pm		
#029	Serious Injury	11/20/11 5:45 pm	11/20/11 6:00 pm		
#036	Serious Injury	12/13/11 3:01 pm	12/13/11 3:15 pm		
#039	Serious Injury	12/20/11 4:45 pm	12/20/11 5:15 pm		
#041	Choking	1/2/12 2:25 pm	1/2/12 2:45 pm		

Interviews and Meetings Held:

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

Observations Conducted:

- Observations at residences and day programs
- Daily Unit Meeting 1/9/11
- Incident Management Review Team Meeting 1/9/11 and 1/11/11
- Human Rights Committee Meeting 1/11/11
- Annual ISP meetings for Individual #70 and Individual #84

Facility Self-Assessment:

EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement.

	For the self-assessment, there were areas to describe the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. For a majority of the provisions in Section D, in both the area to describe the results of self-assessment and self-rating, the IMC restated the requirements of the Settlement Agreement without offering enough information to show what sample or criteria were used to base ratings. For example, for D3c, the result of self-assessment statement was "All investigations are coordinated not to interfere with investigations being conducted by law enforcement." The substantial compliance self-rating was justified by the statement, "Based on the findings from this self-assessment, this provision is in substantial compliance because all investigations are coordinated with any investigations complete by law enforcement agencies..." He did not specify what investigations were reviewed or how cooperation was determined. Findings of the facility self-audit conflicted with findings in a number of sections. For example, in D3i, the IMC noted that all cases requiring disciplinary or programmatic action were reviewed for completion. As noted in this report, the monitoring team reviewed a sample of cases for compliance with this provision and found examples where adequate follow-up was not documented. According to the facility self-assessment, all provision items for Section D were in substantial compliance and no problems were noted. It did not appear that the facility had taken adequate steps to identify any areas of concern. To take this process forward, the monitoring team recommends that the IMC review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the IMC to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. The facility self-rated itself as being in substantial compliance with all provision items in section D. The monitoring team found that 13 out of 22 areas of section D were in substantial compliance. The monitoring team found the facility not to be in compliance with D1, D2a, D2e, D3g, D3i, and D4 based on the samples reviewed.

Summary of Monitor's Assessment:

According to information provided to the monitoring team, DFPS confirmed 1 allegation of physical abuse and 13 allegations of neglect from 7/1/11 through 11/30/11.

DFPS investigated a total of 37 allegation of abuse, neglect, or exploitation at the facility. This included 11 allegations of physical abuse, one allegations of emotional/verbal abuse, and 25 allegations of neglect. In addition to the 14 confirmations, 18 (49%) were unconfirmed allegations, and 5 (14%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect.

A list of all serious incidents investigated by the facility during the previous six months was requested by the monitoring team. The facility provided a summary of incidents from 7/1/11 through 12/31/11. In this six month period, there were an additional 27 serious incidents at the facility that did not involve allegations of abuse or neglect investigated by the facility.

Incident Type	Total
Serious Injury- Determined Cause	15
Peer to Peer Aggression w/ Serious Injury	3
Choking	2
Unauthorized Departure	1
Death	2
Suicide Threat	1
Other	3

The facility had taken steps to address concerns related to incident management at the facility. Some positive steps taken to address the provision items of section D included:

- Creating a database to maintain and track disciplinary action related to allegations of abuse, neglect, and exploitation.
- Revision of the employee abuse, neglect, and exploitation competency test.
- The facility began using the new state office Avatar system for documenting investigations.
- Inservice for all QDDPs on providing information and educating LARs, family members, and individuals on identifying and reporting unusual incidents, including abuse and neglect.
- Revising the discovered injury investigation process.
- The DADS Section D Monitoring Tool was implemented.
- Improvements were made in the documentation of activities taken during the investigation process.

As noted below in the findings for section D, it was not apparent that some of these steps had adequately addressed concerns noted in previous monitoring reports. The facility needs to focus next on:

- Creating a database that accurately identifies all unusual incidents.
- Ensuring all staff know reporting procedures for unusual incidents.

	• Ensuring investigation files include documentation of follow-up to all recommendations and concerns. • Ensuring IDTs are adequately addressing all incidents and putting necessary protections in place. • Ensuring that the facility audit system accurately identifies areas of needed improvement. DFPS investigations did not always provide a clear basis for findings in cases in the sample. The facility had requested a review of findings in two cases to further clarify investigation results.

#	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, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. 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. • Employees at EPSSLC were required to sign a form titled Acknowledgement of Responsibility for Reporting Abuse/Neglect Incident(s) form during pre-service training and every 12 months thereafter. o Completed forms were requested by the monitoring team for a random sample of 24 employees. All (100%) had signed a form acknowledging responsibility to report abuse and neglect within the past 12 months. o Additionally, employees were required to sign an acknowledgement of zero tolerance for abuse, neglect, exploitation and obligations for reporting form. Signed forms were provided for all employees hired within the past two months. The facility provided a copy of the signed acknowledgement for 19 new employees. • 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Documentation of disciplinary action was reviewed for five cases in which DFPS substantiated an allegation of abuse or neglect and the AP was known. In three (60%) out of five cases, disciplinary action was documented, though not necessarily in the investigation file. • In DFPS case #40505699, allegations of neglect were confirmed on three employees. The case was closed on 11/14/11. Two APs were terminated on 11/28/11 and one was issued a written warning on 11/30/11. • In DFPS case #40518117, the AP was terminated on 11/28/11 after DFPS returned a confirmed neglect allegation on 11/15/11. • Disciplinary action was not documented in DFPS case #40836528, completed 12/21/11 and DFPS case #40289869, completed 10/15/11. • In DFPS case #408353380, completed 12/20/11, an employee received a written warning on 1/3/12 following a confirmed allegation of neglect. For cases where disciplinary action was documented, it appeared that the facility was taking a position of "no tolerance" for abuse and neglect. The facility will need to ensure evidence of disciplinary action taken is included in each investigation file. The facility reported that no evidence had been found that an employee had failed to report abuse or neglect since the last monitoring visit. • In DFPS case #40289869, an allegation of neglect was reported 23 days after the incident occurred. DFPS found a breach of supervision contributing to an unauthorized departure from campus. The facility investigator investigated the incident on the date of occurrence, but did not report suspected neglect to DFPS, even though video surveillance did not substantiate witness testimony. Signatures on the UIR completed by the facility indicated that the assistant director of programs, facility investigator, and unit manager all reviewed the incident report, but did not report the incident to DFPS. The IMC and facility director failed to review the incident report. • In DFPS case #40578140, a video surveillance monitor reported suspected abuse to the facility investigator, rather than directly to DFPS. The facility investigator reported the suspected abuse and reminded the monitor to report directly to DFPS. • In DFPS case #40836258, significant bruising to the individual's thighs in the shape of handprints was discovered on 12/10/11 at 6:35 pm. According to the UIR, the facility investigator was not notified until 8:00 am on 12/11/11. The DFPS investigation indicated that DFPS was not notified until 10:39 am on 12/11/11.	

#	Provision	Assessment of Status	Compliance
		The facility was not in substantial compliance with this provision. The facility will need to ensure that all incidents of suspected abuse or neglect are reported to DFPS for investigation immediately. When the facility discovers that allegations have not been reported, recommendations should be included in the UIR to address issues identified in regards to reporting allegations.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to DADS Incident Management Policy 002.3, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. With regard to other serious incidents, the state policy addressing Incident Management required that all unusual incidents be reported to the facility director or designee within one hour of witnessing or learning of the incident. This included, but was not limited to: • Allegations of abuse, neglect, or exploitation, • Choking incidents • Death or life-threatening illness/injury • Encounter with law enforcement • Serious injury • Sexual incidents • Suicide threats • Theft by staff, and • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This 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 37 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last monitoring visit. From these 37 allegations, there were: • 11 allegations of physical abuse, o 1 was substantiated,	Noncompliance

#	Provision	Assessment of Status	Compliance
		o 9 were unsubstantiated, and o 1 was referred back to the facility for investigation. • 1 allegation of emotional/verbal abuse, o 1 was unsubstantiated • 25 allegations of neglect, o 13 were substantiated, o 8 were unsubstantiated, and o 4 were referred back to the facility for investigation. According to a list provided to the monitoring team, the facility investigators conducted investigations for 27 additional serious incidents since the previous monitoring visit. From all investigations since 7/1/11 reported by the facility, 20 investigations were selected for review. The 20 comprised three samples of investigations: • Sample #D.1 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 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 not reportable to DFPS. Based on a review of the 10 investigative reports included in Sample #D.1: • Eight of 10 (80 %) reports in the sample indicated that DFPS was notified within one hour of the incident or discovery of the incident. Two instances of late reporting were identified: o In DFPS case #40836258, injuries were discovered on 12/10/11 at 6:35 pm. According to the UIR, the facility investigator was not notified until 8:00 am on 12/11/11. The DFPS investigation indicated that DFPS was not notified until 10:39 am on 12/11/11. o DFPS case #40289869 was not reported by the facility to DFPS at the time of the incident though video evidence showed a breach in level of supervision. An anonymous caller reported the incident three weeks later. • Ten (100%) indicated, the facility director or designee was notified within one hour by DFPS. • Four of four (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • Two of 10 (20%) indicated that the state office was notified as required. Cases that included documentation of state office notification were DFPS #40381997	

#	Provision	Assessment of Status	Compliance
		and DFPS #40302511. In reviewing Sample D.3 (serious incidents), documentation indicated: • In seven of seven (100%) were reported immediately (within one hour) to the facility director/designee. o UIR #4462 sexual incident o UIR #110 serious injury o UIR #4604 sexual incident • Documentation of state office notification was only found in two of seven (29%) UIRs. Missing notifications included: o UIR #12-018 serious injury o UIR #12-041 choking incident o UIR #12-039 serious injury o UIR #12-036 serious injury o UIR #12-029 serious injury • DADS Regulatory was notified in one of one (100%) case that required notification. The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents in the sample. This form was adequate for recording information on the incident, follow-up, and review. A standardized UIR which contained information about notifications was included in: • 9 out of 10 (90%) investigation files in Sample #D.1. The exception was for DFPS #40289869. A UIR was completed on the original incident that led to an allegation of neglect, but one was not completed in regards to the investigation of the allegation. • 10 of 10 (100%) investigation files in Sample #D.2 and Sample #D.3. Fourteen serious injuries occurring since 7/1/11 were reviewed to determine if serious injuries were reported for investigation. • According to a list of all investigations completed by the facility, all serious injuries had been investigated. • Of the five serious injuries reviewed in Sample #D.3, all were reported to the facility director within one hour of determination of a serious injury. 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 19 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form.	

#	Provision	Assessment of Status	Compliance
		Based on an interview of six staff responsible for the provision of supports to individuals, five (83%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. One staff person interviewed was clearly nervous talking to the reviewer and could only state that he would notify his supervisor. As noted in D1, in one of the investigations in the sample, the facility investigator did not report an instance of possible neglect. In another investigation in the sample, the video surveillance monitor reported suspected physical abuse to the facility investigator rather than directly to DFPS. The facility was not in substantial compliance with the reporting requirements of this provision. The facility needs to document all required notifications in the investigation file and ensure all incidents involving suspected abuse and neglect are reported to DFPS immediately.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The facility did have a system in place for assuring that alleged perpetrators were removed from regular duty until notification was made by the facility Incident Management Coordinator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Based on a review of 10 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. The monitoring team was provided with a log of employees who had been reassigned since 7/1/11. The log included the applicable investigation case number, the date of the incident and the date the employee was returned to work or in some cases discharged. In 10 out of 10 cases (100%) where the AP was known, there was no evidence that the employee was returned to client contact prior to the completion of the investigation or when the employee posed no risk to individuals. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 10 investigation files in Sample D.1, 10 (100%) UIRs documented additional protections implemented following the incident. For example, • In DFPS case #40300917, the UIR indicated that a physical assessment was completed by a nurse, a preliminary investigation was started by the facility investigator, photos were taken of the injury, APs were placed in non client contact positions, and video surveillance was reviewed. • For UIR #12-001, in regards to an unauthorized departure, the Critical Incident Team was notified to organize a search, family was notified, the administrator-	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		on-duty called area hospitals and businesses, and missing person flyers were distributed. When the individual was found, a physical and emotional assessment was completed and the individual was placed on one-to-one supervision. The standardized UIR form had recently been revised by the State Office. All investigations were completed using the new UIR format. Description of corrective actions taken was much more detailed on these reports. The facility was in substantial compliance with this provision.	
	(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. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 22 (92%) of 24 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 24 (100%) employees had completed competency-based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 6 (25%) of the 24 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with six direct support staff in various homes and day programs: • Five (83%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. One staff reported that he would tell his supervisor if he suspected abuse or neglect. He was clearly nervous during the interview. After a few prompts, he did state that he would call "the state." Based on current training, the facility remained in substantial compliance with this provision, however, the facility needs to ensure that training is completed in a timely manner.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All	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 19 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	the sample had signed this form. 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. A sample of 10 DFPS reports included three examples where employees failed to report abuse. The failure to report was addressed in two (67%) of three cases. See D1 for a summary of cases that were not immediately reported for DFPS for investigation. The facility was in substantial compliance with this item. In order to send a clear message to all employees that abuse and neglect will not be tolerated, the facility needs to ensure that all incidents of failing to report by employees are addressed and that corrective action is immediate and appropriate.	
	(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. The monitoring team cited the facility for not including documentation that information on reporting abuse and neglect had been shared with individuals and their LARs during the last review. The facility self-assessment indicated that steps had been taken to correct this deficiency. • QDDPs were retrained on the process of including this information in ISPs. • Informational brochures on identifying and reporting abuse and neglect were mailed to 100% of all LARs and correspondents. A sample of 10 ISPs developed after 9/7/11 was reviewed for compliance with this provision. The sample included ISPs for Individual #23, Individual #78, Individual #46, Individual #32, Individual #83, Individual #35, Individual #114, Individual #93, Individual #55, and Individual #20. • Only one (10%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. In informal interviews with individuals during the review week, all individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. There was at least one example in the sample of an individual's	Noncompliance

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		family reporting abuse or neglect directly to DFPS. The facility provided a list of six investigations since 7/1/11 where the individual or LAR reported an allegation of abuse or neglect to DFPS. The facility remained out of compliance with this item. QDDPs continue to need to be reminded to include documentation in ISPs regarding the sharing of information on recognizing and reporting abuse, neglect, and exploitation.	
	(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. There was a human rights officer at the facility. Information was posted around campus identifying the rights officer with her name, picture, and contact information. The rights officer was known by individuals at the facility and was actively involved in meetings regarding abuse, neglect, and rights issues. Campus Administrators monitored and reviewed postings in each living unit and day program and were instructed to replace missing posters as necessary.	Substantial Compliance
	(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 10 allegation investigations completed by DFPS (Sample #D.1), DFPS had notified law enforcement and OIG of the allegation in five (100%) when appropriate.	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	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.	Substantial Compliance

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	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.	The facility was asked for a list of staff who alleged that they have been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. The facility reported zero cases where fear of retaliation was reported. Based on a review of investigation records (Sample #D.1), there was one concern noted related to potential retaliation for reporting. In DFPS case #40652943, the incident was not immediately reported by staff witnessing the incident. One witness told the investigator that another witness told her if they reported this, they would get into trouble, so they better not say anything. She further stated that one staff member made a gesture of her throat being cut, as if to say their heads would be cut off. This witness was a temporary contracted worker and had not attended training on reporting abuse and neglect. It was evident based on the sample reviewed, staff routinely report incidents when abuse or neglect was suspected. The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment. The facility needs to ensure all reports of fear of retaliation are addressed in investigation recommendations.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to the facility self-assessment, the following measures had been implemented to address this provision. • All individual's records were reviewed once every six months to ensure that all serious injuries and unusual incidents were reported and investigated. • Serious, repeated, or suspicious injuries discovered during record reviews were reviewed at the daily Incident Management Review Team meeting. • The facility had implemented a discovered injury internal investigation process. Sample #D.3 included investigations completed on a sample of serious injuries. All seven (100%) of the investigations were thorough and completed using a standardized UIR. Appropriate recommendations were made for follow-up action in each case. The monitoring team observed daily IMRT meetings held the week of the onsite review. All injuries were reviewed and discussed by the team. Serious injuries, suspicious injuries, and trends of injuries were investigated further and recommendations were made by the team for follow-up. The facility had initiated a review process for non-serious discovered injuries. This appeared to be an effective process for ensuring injuries were adequately investigated. The new review process included investigating discovered injuries that met the following	Substantial Compliance

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		criteria or at the discretion of the incident management department: • Discovered during or following 1:1 LOS • Repeated injuries • Suspicious injuries (or those lacking reasonable explanation of probable cause • Discovered injuries to vulnerable areas • Injuries determined by nursing to be suspicious or lacking reasonable explanation of probable cause The review process included reviewing information gathered regarding the injury and making recommendations for preventative action or reporting the injury to DFPS when applicable. As noted in D2a, an additional sample of serious client injury were reviewed for serious injuries occurring in the past six months to determine if injuries were reported for investigation. According to a list of all investigations completed by the facility, all serious injuries in the sample had been investigated. Based on observations and the sample of documentation reviewed, the facility's audit process was adequate for ensuring that injuries or trends of injuries were reported for investigation.	
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	DFPS reported its investigators were 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 conducting investigations and working with people with developmental disabilities. Four DFPS investigators were assigned to complete investigations at EPSSLC. The training records for DFPS investigators were reviewed with the following results: • Four investigators (100%) had completed the requirements for investigations	Substantial Compliance

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	retardation, and who are not within the direct line of supervision of the alleged perpetrator.	training. • Four DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. EPSSLC had four employees designated to complete investigations. The training records for those designated to complete investigations were reviewed with the following results: • Four (100%) facility investigators had completed CIT0100 Comprehensive Investigator Training or CSI 0100 Conducting Serious Incident Investigations. • Four (100%) had completed UNU0100 Unusual Incidents within the past 12 months. • Four (100%) had completed Root Cause Analysis according to training transcripts reviewed. • Four (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Trained investigators were now completing all investigations at the facility. Additionally, facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility was in substantial compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that facility staff had failed to cooperate with investigators in any of the cases. The facility was in substantial compliance.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found:	Substantial Compliance

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		• Of the 10 investigations completed by DFPS (Sample #D.1), four had been referred to law enforcement agencies. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. 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.3): • There was no indication that evidence was not safeguarded during any of the investigations. The facility remained 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 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.	DFPS had implemented a new commencement policy effective 8/1/11. Mandates in the new policy were described in the MH & MR Investigations Handbook published on 10/1/11. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations noted the date and time of initial contact with the alleged victim. o This contact did not occur within 24 hours in two of 10 (20%) investigations. This included DFPS cases #40830318, and #40652943. o Ten (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. For the two where initial contact was not made with the alleged victim, this included gathering other documentary evidence and making initial contact with the facility. Although this meets DFPS guidelines for investigation commencement, an immediate interview with the alleged victim is the best way to ensure that the individual is able to relay accurate information to aid in the investigation. • Eight of 10 (80%) were completed within 10 calendar days of the incident. o An extension was filed in both cases that were not completed within 10 calendar days.	Substantial Compliance

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		o In DFPS case #40830318, additional allegations were added to the original allegations, so further investigation was necessary. • All 10 (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 seven of the 10 DFPS investigations reviewed (70%), concerns or recommendations for corrective action were included. Six of those cases resulted in Administrative Referrals. Concerns were appropriate based on evidence gathered during the investigation in six cases. The exception was: o An administrative referral was submitted to the facility to address concerns in DFPS case #40836258. Justification for the referral was not clear. The investigator stated that the allegation of physical abuse was being referred back because there was no evidence to support that the injuries were caused by excessive force by a staff member. This statement would infer that DFPS investigated the allegation and did not substantiate it. The next paragraph stated that the allegation of physical abuse did not meet the definition of abuse, so it was being referred back. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3 : • Seven of seven (100%) of the UIRs reviewed indicated when the investigation commenced. All investigations in the sample commenced within 24 hours of the incident. • Seven of seven (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Six of seven (86%) investigations included recommendations for corrective action. Overall, recommendations appropriately addressed findings in the investigation. The adequacy of these recommendations is discussed further in D2i. o UIR #12-039 did not include recommendations for follow-up. The investigator did not note that all staff present reported that they did not see the fall resulting in a serious injury. The individual's PNMP required "hand held to contact guard assistance to supervision when ambulating." Although this did not clearly direct staff in knowing what type of assistance to provide, all would require staff assistance. The facility was found to be in substantial compliance with investigation commencement and conclusion timelines. DFPS needs to ensure that initial contact with the alleged victim is conducted as soon as possible to prevent the loss in critical evidence in the case.	

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	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	DADS 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.3) 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: • For the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following: o In 10 (100%), each serious incident or allegations of wrongdoing; o In 10 (100%), the name(s) of all witnesses; o In 10 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 10 (100%), the names of all persons interviewed during the investigation; o In 10 (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 10 (100%), all documents reviewed during the investigation; o In 10 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS investigations now included a statement indicating that previous investigations were reviewed and either found relevant or not relevant to the case. ▪ DFPS Case #40289869 indicated that there was no prior case history for any of the principals in the case. It was a neglect allegation involving Individual #39. A previous allegation of neglect was reported to DFPS on 7/12/11. o In 10 (100%), the investigator's findings; and o In 10 (100%), the investigator's reasons for his/her conclusions. Contents of the report of investigations were not sufficient in two (20%) of 10 cases to provide a clear basis for its conclusion: • In DFPS investigation #40835380, the investigator confirmed an allegation of neglect based on video evidence that the AP physically restrained an individual, not allowing him to get off the couch using a restraint method that was not approved by the state. By definition, this should have been a confirmed physical	Substantial Compliance

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		abuse allegation rather than neglect. Chapter 711 of the TAC defines physical abuse in part by "the use of chemical or bodily restraints on a person served not in compliance with federal and state laws and regulations." • In DFPS case #40836258, the investigator failed to fully investigate the cause of significant bruises on her thigh to rule out physical abuse. According to one witness statement, the victim had bruises that "resembled an upward hand print on both thighs." The witness further noted that at the time the bruises were discovered, she placed the victim's hands over the bruises and it did not appear that she could have caused the bruises herself due to the angle of the bruising. There was no further investigation into the cause of the bruises. At the time of the monitoring visit, the IMC did report that the facility was requesting a methodological review of the case. <u>Facility Investigations</u> The following summarizes the results of the review of seven facility investigations included in sample #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In seven (100%), each serious incident or allegations of wrongdoing; o In seven (100%), the name(s) of all witnesses; o In seven (100%), the name(s) of all alleged victims and perpetrators when known; o In seven (100%), the names of all persons interviewed during the investigation; o In seven (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 seven (100%), all documents reviewed during the investigation; o In seven (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. o In seven (100%), the investigator's findings; and o In seven (100%), the investigator's reasons for his/her conclusions. As noted, two of the DFPS investigations in the sample did not seem to support the findings by DFPS. The facility did request a review of findings in one of the cases. The facility was in substantial compliance with this item.	
	(g) Require that the written report, together with any other	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were	Noncompliance

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	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.	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 10 DFPS investigations included in Sample #D.1: • In 10 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. It was not clear that this review ensured that the investigation was thorough and complete and that the report was accurate, complete, and coherent. Deficiencies or areas of further inquiry in the investigation and/or report were not addressed promptly. For example, o DFPS case #40610636 documented OIG notification and an attempt to interview the witness on 11/14/11. The incident did not occur until 11/17/11. o As noted in D3f, the allegation of neglect in DFPS case #40835380 should have been an allegation of physical abuse. o In DFPS case #40836258, the investigator failed to fully investigate the cause of significant bruises on her thigh to rule out physical abuse. UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Samples #D.1, • Seven (70%) DFPS investigations were reviewed by both the facility director, and IMC following completion. Exceptions were DFPS cases #4038199, #40637319, and #40289869. o Only two (20%) UIRs from Sample #D.1 were signed off on by the facility director and IMC within five days of receipt of the completed investigation from DFPS. This included DFPS case #40302986, and #40302511. o A methodological review was requested for two investigations in the sample following review of the completed report. o For Sample #D.2, one of three (33%) documented prompt review and approval of the investigation following the facility completion date. The IMC and facility director did not review and approve the completed investigation within five days in DFPS case #40637319 or #40578140. Two IMRT meetings were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings. These meetings were led by the facility director and attended by the IMC. Additional investigations were reviewed for this requirement below in regards to	

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		investigations completed by the facility. <u>Facility Investigations</u> • In seven of seven (100%) UIRs from sample #D.2 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. • Six of seven (86%) of the reviews by the IMC were completed within five days of the completion date. The exception was UIR #12-017. Seven were signed by the director, but only two (29%) indicated the date that the director reviewed the UIR. Investigation documentation should indicate that all DFPS investigations are reviewed promptly by DFPS and the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent. The facility was not in substantial compliance with this provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A uniform UIR was completed for 19 out of 20 (95%) unusual incidents in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in a sample of 10 investigations. Seven investigations in Sample D.1 included confirmed allegations of abuse or neglect. Two were confirmed on unknown perpetrators. Of the five cases where the perpetrator(s) were identified, only one case included documentation of disciplinary action taken. A list provided by the facility indicated that disciplinary action had been taken in at least some of the cases, but documentation was not included in the investigation file for DFPS cases #40836258, #40610636, #40835380, and #40289869. In 10 of 13 DFPS cases reviewed from Sample #D.1 and Sample #D.2, DFPS documented additional concerns or recommendations. In three of those 10 cases (30%), the facility investigation file did not include documentation that concerns or recommendations were addressed. Examples found where documentation of programmatic action was not adequate included: • In DFPS case #40830318, a concern was referred back to the facility regarding attributing bruising found to self-injurious behavior with no documentation of self injurious behavior occurring. The investigation documentation did not indicate that this concern had been addressed. • In DFPS case #40610636, a referral was made back to the facility regarding	Noncompliance

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		video evidence that staff were not following appropriate guidance techniques as written in the PNMP. There was no evidence that this was addressed with staff. • In DFPS case #40381997, a concern was noted by the DFPS investigator regarding the lack of documentation of injuries. There was no indication that this concern was addressed by the facility. Recommendations for programmatic actions were made in six of seven cases reviewed for facility investigations in Sample #D.3. Two of six cases (33%) did not document adequate follow-up to address concerns noted by the investigator. • UIR #12-018 was a serious injury involving Individual #61. The investigation file included an email from the IMC requesting documentation of follow-up action taken by the IDT. It was recommended that the team look at repairing/replacing the individual's helmet and seek a neurological consultation. There was no documentation that this had occurred. • UIR #12-029 was a serious injury related to a fall involving Individual #32. Recommendations were made for an assessment by the neurologist and habilitation therapy. There was no documentation that adequate follow-up by the team occurred to develop an action plan to reduce his risk of falls. UIR #12-036 was the investigation of a second fall resulting in a serious injury. At that time, the investigator requested that the IDT meet to discuss a trend of injuries (34 documented injuries). There was documentation that he was referred to the PNMT for review of injuries and risks. The PNMT noted that there was "not an adequate action plan to minimize his risk of falls." The facility needs to ensure that appropriate follow-up action is completed and documented. The facility was not in substantial compliance with this item.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Files requested during the monitoring visit were readily available for review at the time of request. 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.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to	The facility had a system in place to collect 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,	Noncompliance

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	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.	• Individuals directly involved, • Location of incident, • Date and time of incident, • Cause(s) of incident, and • Outcome of investigation. The latest trend reports available at the time of the review in January 2012 were for the month of November 2011. The facility was unable to review data in a timely manner to ensure that trends were addressed expeditiously because data were not compiled on a monthly basis. Data provided to the monitoring team were not consistent in the numbers of incidents reported in trend reports. For example, the facility provided a document of all abuse and neglect allegations reported to DFPS from July 2011 through November 2011. This document indicated there had been 23 allegations reported. The November 2011 Trend Report showed 33 allegations for the same time period. 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 gather accurate data and frequently evaluate how data can best be used to evaluate that progress and take action to reduce the number of incidents and injuries. Greater emphasis should be placed on actions that can and should be taken to address incidents and injuries. The facility needs to review various data collected in regards to incidents and investigations at the facility and ensure trend reports include accurate data. The facility was not in substantial compliance with this provision item.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living	Substantial Compliance

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	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.	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 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. Background checks were conducted on new employees prior to orientation and 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. According to information provided to the monitoring team, for FYI 11, criminal background checks were submitted for 770 applicants. There were a total of 21 applicants who failed the background check in the hiring process and therefore were not hired. No employees had dismissed due to results of background checks since the last review. 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. • Signed acknowledgement forms were submitted for 24 of 24 employees (100%). The facility remained in substantial compliance with this provision.	

Recommendations:

1. The facility will need to ensure evidence of disciplinary action taken is included in each investigation file (D1).

2. The facility needs to document all required notifications in the investigation file and ensure all incidents involving suspected abuse and neglect are reported to DFPS immediately (D1, D2a).

3. The facility needs to ensure that required training is completed in a timely manner (D2c).

4. In order to send a clear message to all employees that abuse and neglect will not be tolerated, the facility needs to ensure that all incidents of failing to report by employees is addressed and that corrective action is immediate and appropriate (D2d).

5. QDDPs continue to need to be reminded to include documentation in ISPs regarding the sharing of information on recognizing and reporting abuse, neglect, and exploitation (D2e).

6. The facility needs to ensure all reports of fear of retaliation for reporting abuse or neglect are addressed in investigation recommendations (D2h).

7. Investigation documentation should indicate that all investigations are reviewed promptly by the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent (D3g).

8. The facility needs to ensure that appropriate follow-up action is completed and documented in investigation files (D3i).

9. Data 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 if data is accurate and how data can best be used to evaluate that progress (D4).

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 o EPSSLC policy lists, dated 10/31/11 o List of typical meetings that occurred at EPSSLC o EPSSLC Self-Assessment, 12/23/11 o EPSSLC Action Plans, 12/28/11 o EPSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/9/12 o EPSSLC DADS regulatory review reports, through 8/30/11 o QA department meeting notes, August 2011 through November 2011 (three meetings) o EPSSLC Quality Assurance Plan/matrix, undated, but most likely December 2011 o List of QA managed databases • Sample front pages of seven of these databases o Set of blank tools used by QA department staff (four) o Data charted and graphed, three tools (meal engagement, meal monitoring, emergency equipment) o Statewide trend analysis document, four sections, 8/31/11 o Set of data for completed statewide/facility self-assessment tools, including tabled and graphed data, for all tools, 1/1/11 through 12/9/11 o EPSSLC QA Reports, monthly, September 2011 through January 2012 (but not November 2011) • Additional QA management report for January 2012 o QAQI Council charter, and charters for two other committees o QAQI Council agenda and meeting minutes from July 2011 through December 2011 (8 meetings) o Integration meeting minutes, 12/5/11 o DADS EPSSLC family satisfaction survey online, cumulative reports September 2011 through November 2011, 47 participants o Self-advocacy monthly meeting minutes and Aktion committee minutes, monthly September 2011 through January 2012 <u>Interviews and Meetings Held</u>: o Victor Quiroz, Director of Quality Assurance, Lori Powell, QA Director, Denton SSLC o Jaime Monardes, Facility Director <u>Observations Conducted</u>: o QAQI Council meeting, 1/11/12 o Integration Meeting, 1/9/12

	o Self-advocacy meeting, 1/12/12 o Monthly QA statewide scan call, 1/10/12
	Facility Self-Assessment EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document, separate from another document that listed all of the action plans for each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. The QA director did a good job in this, his first attempt at completing this type of self-assessment activity. Overall, however, in the "activities engaged in" sections, he listed activities the QA department, and the operational and service departments, engaged in <u>to conduct</u> quality assurance-related activities, rather than activities the QA director engaged in <u>to assess</u> whether the QA department was in substantial compliance with the requirements of each provision item. Determining how to assess the quality assurance provision items is a challenging task. Consider that much of what the QA department does is to help the departments self-assess their own performance (and to make changes, corrective actions, etc.). This task requires a subtle distinction be made. That is, the task is for the QA director is to determine how to self-assess his department's activities in supporting self-assessment activities of departments, collecting data, analyzing data, etc. Item #5 in the "activities engaged in" list for E1 probably came the closest to doing this. The monitoring team recommends that the QA director review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the QA director to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." He also should work with the DADS central office QA coordinator and other QA directors on this task. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the QA director and believes that the facility was proceeding in the right direction. The facility self-rated itself as being in noncompliance with all five of the provision items of section E. The monitoring team agreed.

	Summary of Monitor's Assessment: EPSSLC made progress towards achieving substantial compliance in many of the key areas of this provision. Much activity had occurred since the previous onsite review, most notably, the appointment of a new QA director. The facility director was highly involved in and supportive of QA activities. There were no facility-specific QA policies. Once the state policy is disseminated, the QA director should determine if a policy specific to EPSSLC would be helpful in supporting the implementation of the state policy. The monitoring team believes it would be. The QA director needed to develop a QA plan: a combination of a narrative description of the overall QA program at the facility and the QA matrix. He created a spreadsheet that was more than 25 pages long (and that used a very small font size). Instead, this should be made into separate, though corresponding documents. For the first document, only a list/inventory of the data is needed. The second document should list those data that are managed (e.g., trended, graphed, analyzed) by the QA department and include the detailed information about how these data are collected and managed. This is referred to as the QA matrix. Across the facility, a great deal of time was devoted to the implementation of the statewide Settlement Agreement provision self-monitoring tools. There are some important next steps in the use of the statewide tools that should be taken regarding their content, implementation, and the determination of priority items. The QA director created an impressive set of data summaries and graphs for the Settlement Agreement provisions for which there was a statewide self-monitoring tool (i.e., all but E, G, H, and L). He should ensure that the DADS central office QA coordinator is in agreement with this style of graphing because it was different than that seen at other SSLCs. A monthly QA report was being completed by the QA director. The QA report at EPSSLC was used as a handout for QAQI Council to use during QAQI Council meeting. The QA report should also be presentable as a stand alone document/report for the many people who may be interested in the content, but do not attend the meeting. The QAQI Council meeting was the best one yet observed at EPSSLC because it included a structured agenda, data were presented and reviewed, and there was relatively good participation from attendees. More discussion should occur when presenters bring up concerns and when they talk about decisions that are based on their data. EPSSLC attended to the need for corrective actions. The facility should work with state office on the criterion for determining what does, and what does not, require a corrective action plan. The intention of this provision item is not for there to be a corrective action plan for every activity that every department engages in to correct some aspect of its operation or service provision.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	EPSSLC made progress towards achieving substantial compliance. Continued improvement was evident in many of the key areas of this provision: QA data matrix list, QA data collection, QA report, QAQI Council, and the implementation of corrective actions. Much activity had occurred since the previous onsite review, most notably, the appointment of a new QA director. <u>Policies and General QA Planning</u> This state policy, #003: Quality Enhancement, dated 11/13/09, was still being extensively revised. A draft of the new policy was disseminated a number of months prior to this onsite review. Finalization, dissemination, and implementation are the next needed steps in this aspect of quality assurance statewide. There were no facility-specific QA policies. Once the state policy is disseminated, the QA director should determine if a policy specific to EPSSLC would be helpful in supporting the implementation of the state policy. The monitoring team believes it would be. Facility-specific policy will need to go through the DADS process for review. When the new state and facility-specific policies are finalized, training for senior management and department heads should occur. Below are comments from the monitoring team regarding EPSSLC's status with some of the important component steps in the development of a QA program. The monitoring team had the opportunity to discuss these at length with the QA director. These component steps were listed in the previous monitoring report. Detail is again provided below in hopes that it will be helpful to the QA department. 1. Create a listing/inventory 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 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	Noncompliance

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		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, the FSPI, and any other types of data that DADS central office may determine necessary for submission to state office. EPSSLC Status: The QA director made a lot of progress on this activity. Please see the comments below under "Quality Assurance Plan." 2. Determine which of these data are to be submitted to the QA department for tracking and trending (and to be part of the QA matrix). EPSSLC Status: The QA department also made progress on this activity. See comments below under "Quality Assurance Plan." The monitoring team and the QA director discussed the goal of the QA matrix, that is, that the QA matrix should indicate all the data that the QA department will track, trend, and comment upon. Separation of the matrix from the overall listing of data (item #1 immediately above) will help the QA department in making this matrix and the QA plan functional and relevant. 3. Determine which of these data are to be included in the QA report. EPSSLC Status: A monthly QA report was now being completed (see E2 below). 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. EPSSLC Status: Data were being presented to QAQI Council. 5. Create and manage corrective actions based upon the data collected and direction from the QAQI Council. EPSSLC Status: Corrective actions were being recorded in the QA report. Although work needed to be done, this was an improvement since the last onsite review (see E2 below). QA Department Victor Quiroz was appointed as the QA director since the time of the last onsite review. He had worked in the QA department and was promoted to the director position. This was the third QA director at EPSSLC since the monitoring team began its reviews. As a result, the QA program had not developed or progressed much over the past two years. This fortunately had now changed and the monitoring team noted progress in many areas of the QA program. Moreover, the QA director was receiving support and mentoring from the Denton SSLC QA director. She was present during the first part of the week of the onsite review. This appeared to be a good working relationship that will likely benefit both facilities.	

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		The QA director was just beginning to hold regular meetings with his departmental staff. The monitoring team recommends that these meetings be used for the professional development of QA staff (e.g., training), not only for the making of announcements. The facility director was highly involved in and supportive of QA activities. This also bodes well for continued progress to occur in the QA program at EPSSLC. <u>Quality Assurance Plan</u> The QA director created a spreadsheet that was more than 25 pages long (and that used a very small font size). As a result, the document was extremely lengthy and cumbersome. After much review and discussion, the monitoring team came to understand that there were four parts to this spreadsheet: • A list of tools to monitor each of the provisions of the Settlement Agreement. This was a list of the statewide self-monitoring tools plus two other tools (one for provision N and one for provision S). • A list of data that the QAQI Council wanted to see. This was called Key Indicators. There were 14. • A list of data that the QA staff collected themselves, or that the QA department received from various departments. There were 47 items. • A list for each operational and service department of the types of data collected by the department. There were 19 departments with lists ranging from one item (psychiatry) to 25 items (pharmacy). Moreover, for each item in each of these four parts, the QA director included multiple columns that indicated the tool, sample, frequency, reviewers, criterion for a CAP, etc. Instead, the monitoring team recommends that this lengthy spreadsheet be made into separate, though corresponding documents. • For the first document, the monitoring team recommends that the QA director put his data into the format outlined in #1 above. This should only be a list/inventory of the data, that is, it does not require all of the columns of additional information that were included in the current spreadsheet. • The second document should list those data that are managed (e.g., trended, graphed, analyzed) by the QA department. This is referred to as the QA matrix. This includes more detail regarding each piece of data, such as what was being reported in the additional columns. Many items from the list/inventory would also be included on this list. Thus, this second document should include: o The statewide self-monitoring tools. o Other tools used by the departments, only if they are going to be	

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		submitted to QA (and many might be, especially if they are going to be included in the QA report). o The items called Key Indicators (i.e., data QAQI Council wants to see). o The QA director maintained about a dozen databases. These need to be included in this part of the QA matrix, too. o Any data the QA department collected itself by doing observations, record reviews, etc. The QA director already had most of this information. The monitoring team remains amenable to other ways of organizing these sets of data. The goal, and the purpose of the above recommendation, is to make it more accessible to those who will be using these lists. In addition, the QA director needed to develop a QA plan: a combination of a narrative description of the overall QA program at the facility and the QA matrix. It might include a one or two page overall description of how QA is conducted at EPSSLC; a description of the comprehensive inventory listing of all data that are collected across the facility; a description of the QA matrix and how those data are managed, reviewed, trended, and analyzed by the QA department; the role of the QA director's databases; and the overall expectation and process for data analysis and corrective action management. The QA matrix would be attached to this description, thereby, creating the QA plan. <u>QA Activities and Indicators</u> QA staff collected data for areas that QA was responsible for monitoring, completed statewide self-assessment tools primarily to assess interobserver agreement, and participated on various committees and in meetings. Across the facility, a great deal of time was devoted to the implementation of the statewide Settlement Agreement provision self-monitoring tools. There are some important next steps in the use of the statewide tools. • First, is to update the content of the statewide tools so that they are relevant and valid. Facility managers and clinicians would likely welcome the opportunity to participate in making suggestions for additions, deletions, and re-wording of items in each tool. • Second, consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. • Third, some items may be more important than others. These should be indicated. • Fourth, the overall process of self-assessment was updated at EPSSLC. These tools should be one of many components of the self-assessment procedures used	

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		by each of the departments. As discussed in previous reviews, a variety of satisfaction measures are important for a comprehensive QA program. Family and LAR satisfaction information was collected over the three-month period September 2011 through November 2011 from 47 respondents via an online system of near 70 questions. This was a very good rate of response. The APC was responsible for these data. He summarized the results in a four-page report and presented it during the QAQI Council. There was, however, no discussion from QAQI Council regarding any response to the results or follow-up to any of the concerns raised (though, overall, the findings were positive). With surveys, such as this, it is important to review and consider action for any dissatisfaction that is identified. Moreover, assessing family satisfaction might be done in other ways, such as choosing a sample of family members to call on the phone each quarter. During the onsite review, the monitoring team met with a small group of family members who had a number of concerns. Facility management was aware of their concerns. In addition, as noted in previous monitoring reports, satisfaction measures should also be obtained for (a) individuals living at the facility, (b) staff, and (c) others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. The self-advocacy committee might provide one way to gather information related to individual's satisfaction.	
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 continued to develop the QAQI Council. Overall, to meet the requirements of this provision item, EPSSLC needs to (a) analyze data regularly, and (b) act upon the findings of the analysis. <u>QA Data Management and Analysis</u> EPSSLC made progress in this area. The QA director was adept at creating tables, spreadsheets, and graphs. He created a number of graphic summaries: • Statewide self-monitoring tools for each provision of the Settlement Agreement. o The QA director created an impressive set of data summaries and graphs. He was consistent in presentation style, too. Data summaries and graphs were maintained for the Settlement Agreement provisions for which there was a statewide self-monitoring tool (i.e., all but E, G, H, and L). There was a spreadsheet showing the data in table format and a set of five graphs for every tool: ▪ overall score per month with successive months connected by a	Noncompliance

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		line graph; this was a good way to present these data ▪ A graph showing only those tool items that scored below 70%. These were connected by a line graph, but a bar graph would be more appropriate. ▪ A single bar showing the average score for all administrations of the tool since its initiation. This is probably not needed. ▪ A graph showing only those items for which interobserver agreement was scored at less than 70% agreement. This was good information. ▪ A single bar showing the average score all inter-observer agreement checks done by the QA department since its initiation. This was not very useful information. Perhaps a graph showing the trending of IOA over time, or the overall percentage of IOA for the current month, would be more interesting to the reader. o This presentation of data graphs for the statewide self-monitoring tools was different than that done at the other SSLCs. The monitoring team spoke at length with the QA director and reviewed these graphs in detail in the weeks following the onsite review. The monitoring team was satisfied with this presentation, however, recommends that the QA director do two things before the next onsite review: ▪ Get approval from the DADS central office QA coordinator to continue in this manner. If the QA coordinator is in agreement, the QA director should continue. If the QA coordinator directs the QA director to proceed differently, he should follow that direction. ▪ Ensure that the QAQI Council members fully comprehend these graphs, find them useful in analyzing and understanding their department's performance, and use them to generate corrective actions. • Four key indicators (meal monitoring, meal engagement, emergency equipment, ISP packet audit). o Graphic presentations were easy to understand. • Trend analysis: statewide standardized report. o No additional summary of data was done. Some of these data could be used when presenting the corresponding provision at QAQI Council. If trend analysis data are to be in the QA report and QAQI Council meeting, the four trend analysis topics should be presented along with their corresponding Settlement Agreement provisions (i.e., sections C and D). • QA director's databases: data not reviewed by monitoring team.	

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		In addition, 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 QA matrix). These data will also need to be summarized and trended (e.g., graphed). Not all of these graphs need to be created by the QA department. It is possible for the facility to set 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. <u>QA Report</u> A monthly QA report was now being completed by the QA director. This was another area of progress. The report contained two major sections: one for each provision of the Settlement Agreement that was to be reviewed during that month's QAQI Council meeting, and one for data on seven of the key indicators. Each Settlement Agreement section contained the spreadsheet table data and page of graphs described above. In addition, for almost all of the sections, the department head wrote a few paragraphs providing additional detail and analyzing of the data. This was good to see. Also in addition, all related action plans were included. This was lengthy and detracted from the report. The monitoring team recommends that it be removed or done in a briefer way. The QA director should format the report contents in a way that makes it more readable (e.g., size and placement of graphs, removal of action plan boxes). For the key indicators, three included data with no description or analysis. One, for the family survey, included the four-page report, but there was no discussion, and for three, three the statewide standardized trend analysis was attached rather than a summary of these data. Some comments regarding the QA report: • The QA report at EPSSLC was used as a handout for QAQI Council to use during QAQI Council meeting. This was good, but in addition, the QA report should be presentable as a stand alone document/report for the many people who may be interested in the content, but do not attend the meeting. • The department heads might consider the presentation of additional relevant data along with the statewide self-monitoring tool data. If the purpose of the QA report is to present the status of progress in each provision, data in addition to the statewide self-monitoring tools will be relevant. It may be that the data from	

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		the activities described in the self-assessment for each provision can be included in the report. • Because each provision only comes up once per quarter, the QA director and the facility director should consider including data on all provisions in the report every month, even though not all of the provisions will be reviewed at QAQI Council every month. As the QA director continues to develop the QA report, he should • Work with state office to ensure he is progressing in a way consistent with the standards set and expected by state office and the soon-to-be-issued state policy on quality assurance • Determine whether and how action plans, corrective actions, and/or CAPs should be incorporated (or separated) from the QA report. <u>QAQI Council</u> The QAQI Council at EPSSLC had its own operating document called the charter. This was a good idea and helped to set the occasion for members to understand their roles. The QAQI Council met twice per month since the last onsite review. One meeting each month was to discuss general items; the other meeting was a more formal review of data. The monitoring team reviewed the minutes from each meeting and attended a "data" QAQI Council meeting during the week of the onsite review. The meeting followed the QA Report, as noted immediately above. Below are the monitoring team's comments: • This was the best QAQI Council meeting observed yet at EPSSLC because it included a structured agenda, data were presented and reviewed, and there was relatively good participation from attendees. • On a few occasions, the presenter raised good points regarding what the data were telling him or her (e.g., pharmacist regarding relevance of data for two items on her checklist tool, habilitation director regarding key data items for mealtimes), however, neither the participants or the facility director took the opportunity to expand on these good observations that specifically used data. The facility director should look for, and foster, these types of comments and observations. • Similarly, data were presented, but there should next be more analysis, interpretation, commentary, and discussion of the presented data. • There was good discussion regarding how to proceed with the somewhat-concluded mealtime monitoring and observation project in which all administrators participated. This activity appeared to have served a number of	

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		good purposes: mealtimes were reviewed more frequently, and administrators and other clinical staff who didn't typically observe or interact with individuals (e.g., pharmacy staff) got to do so, to the betterment of everyone. • Comments regarding challenges should receive more discussion. For example, the director of food services said that so many individuals had special food preparation needs that it was becoming difficult to ensure that the food service staff did all of them correctly. This was directly related to obtaining and maintaining good outcomes in the above mealtime monitoring and observation project and should be explored further. <u>Corrective Actions</u> EPSSLC attended to the need for corrective actions. This was evident at the QAQI Council meeting, in reviews of various documents throughout the week of the onsite review, and in the comments made by many department heads during the onsite review. In other words, the monitoring team heard and saw frequent reference to corrective action plans, corrective actions, and data. That was good. The QA department reported that there were 44 corrective action plans across 17 different departments. In addition, department heads indicated that they were developing other corrective action plans. CAPs were not, however, managed or tracked in an organized manner yet. They were inserted into the QA report. QAQI Council, however, did not discuss these CAPs in a meaningful way during the meeting. The department head presented his or her section during the meeting and said that he or she had listed the corrective action plans, but the QAQI Council didn't comment, other than a benign "OK." Further, it seemed that CAPs were based on findings from the statewide self-monitoring tools. This was good, however, CAPs can be drawn from any data from any area of operation or service provision at the facility. To move forward towards substantial compliance regarding CAPs for this provision item, as well as provision items E3, E4, and E5, the facility needs to do the following: • Work with state office on the criterion for determining what does, and what does not, require a corrective action plan. The intention of this provision item is not for there to be a corrective action plan for every activity that every department engages in to correct some aspect of its operation or service provision. o The monitoring team recommends that state office (with perhaps with the participation of all of the facilities so that this can be consistent across all of the SSLCs) develop and provide detailed, specific direction	

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		to the SSLCs so that there is: ▪ a criterion, or set of criteria, for determining if a corrective action requires a corrective action plan. ▪ guidance on the types of activities that should have a corrective action plan ▪ a way for state office to provide some feedback to the facilities regarding their set of corrective action plans. This might be for a limited time period, such as six months or a year. Once this is determined, the facility can then appropriately track each CAP as required by this provision item and provision items E3, E4, and E5.	
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. Revise facility-specific policies after the state policy is approved and disseminated (E1).
2. Provide training to management and clinical staff on QA and on the new state and facility policies (E1).
3. Separate the lengthy spreadsheet into two documents, one that is a listing/inventory of data collected, and the other that shows the data being managed, trended, reviewed, etc. by the QA department (i.e., the QA matrix) (E1).
4. Write a QA plan, the QA matrix should be included in the QA plan (E1).
5. Include professional development activities for QA staff during the QA staff meetings (E1).
6. Along with state office guidance, determine how to best use the statewide self-monitoring tools and whether/how to update their content (E1).

7. Include a range of satisfaction measures in the QA program (e.g., individuals, staff, and related community businesses), in addition to family satisfaction measures. Follow-up on family dissatisfaction (E1, E2).

8. Review data graphing system with DADS central office QA coordinator (E2).

9. Modify QA report format, especially regarding the inclusion of action plans; ensure the report is not too lengthy for adequate review by QAQI Council members (E2).

10. Consider doing a full QA report every month, even though QAQI Council will not review all portions of it during the QAQI Council meeting. In this way, data will be available more regularly (i.e., monthly) (E2).

11. Ensure QAQI Council thoroughly discusses data and topics as they are brought up by department heads (E2).

12. Determine what actions do and what actions do not require a corrective action plan (E2).

13. 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: Individual Support Planning Curriculum o DADS Policy #004: Individual Support Plan Process o DADS Procedure: Personal Focus Assessment dated 9/7/11 o EPSSLC ISP-Risk Review Competency Based Training o EPSSLC Self-Assessment o EPSSLC Section F Presentation Book o Section F Audit Summary o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, Quarterly Reviews for the following Individuals: • Individual #65, Individual #32, Individual #89, Individual #78, Individual #46, Individual #83, Individual #23, Individual #35, Individual #20, Individual #93, Individual #114, Individual #55, Individual #118, Individual #178, Individual #72, Individual #45, and Individual #59 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Mario Gutierrez, Incident Management Coordinator o Gloria Loya, Human Rights Officer o Valerie Grigg, Director of Behavioral Services o Aurora Ramos, QDDP o Nora Padilla, QDDP Observations Conducted: o Observations at residences and day programs o Daily Unit Meeting 1/9/11 o Incident Management Review Team Meeting 1/9/11 and 1/11/11 o Human Rights Committee Meeting 1/11/11 o Annual ISP meetings for Individual #70 and Individual #84
	Facility Self-Assessment: EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. 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. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the QDDP Coordinator included relevant activities in the "activities engaged in" sections. Activities were a list of corrective measures or actions that had been taken to meet compliance and actions taken to assess compliance. The list of activities engaged in by the facility was not as comprehensive as activities reviewed by the monitoring team to assess compliance. For example, for F1b, the self-assessment noted that the facility had implemented a tracking database to track IDT attendance. The monitoring team reviewed what supports and services were needed by the individual to determine who would be a relevant team member, then additionally, looked at whether or not team members came to the meeting with information needed to participate in an informed discussion. To take this process forward, the monitoring team recommends that the QDDP Coordinator review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the QDDP Coordinator to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the QDDP Coordinator. This was positive progress. The facility assigned a noncompliance rating to all items in section F. Though progress had been made in regards to meeting substantial compliance with section F, the monitoring team agreed with these self-ratings.
	Summary of Monitor's Assessment: DADS had recently initiated a thorough review of the ISP process and hired a set of consultants to help the SSLCs move forward in ISP development and the meeting of this provision's requirements. Comments are more generalized for section F in this report in light of the fact that EPSSLC had received technical assistance from consultants 11/30/11 before fully implementing the person centered planning process. The facility had begun implementation of the new ISP process as of 1/1/12. As a result, only two ISPs had been developed since training had occurred. These two ISPs showed significant improvement in including

	supports and services in a manner that would guide staff implementing plans. Three of the four annual IDT meetings scheduled during the review week were observed by the monitoring team. In meetings observed, the QDDPs were attempting to ensure that all necessary information was covered during the IDT meeting. Meetings attended were lengthy and somewhat fragmented in discussing risks and supports, however, teams engaged in better integrated discussion in the meetings observed than during the previous onsite reviews. There was minimal progress being made on developing plans that would lead to a more meaningful day for individuals. IDTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want. 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. Quality assurance activities with regards to ISPs were in the initial stages of development. The facility had begun to use state developed audit tools to review both meeting facilitation and the ISP development process. 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 IDT. The ISPs that were reviewed were chosen from among the most recently developed ISPs. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and IDTs had been responsible for the development of the plans. As noted throughout section F, while the monitoring team did see continued progress in this area with the new style ISPs, assessments were still not completed or updated as needed, key members of the team were not present at annual meetings, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.

#	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 developing, monitoring, and revising treatments, services, and supports.	QDDPs were responsible for facilitating IDT meetings at the facility. The QDDPs were also responsible for ensuring that team members were developing, monitoring, and revising treatments, services, and supports. According to the facility self-assessment, 75% of all QDDPs had attended facilitation skills training. QDDPs were at varying stages in learning to competently facilitate meetings that encouraged integrated discussion adequate for developing appropriate supports. The QDDP Coordinator was attending a sample of IDT meetings and evaluating the QDDP's facilitation skills using the Q Construction QMRP Facilitation Skills Performance Tool. Additionally, DADS had hired a team of consultants who were providing classroom training, coaching, and mentoring to the IDTs on facilitation skills and ISP development. The consultants had recently provided technical assistance to EPSSLC. While onsite, the monitoring team observed three of the four ISP meetings held. Meetings observed during the monitoring visit confirmed that QDDPs were facilitating ISP meetings. A sample of eight IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. At all annual meetings, there was a QDDP present. The facility's self-assessment indicated noncompliance with this requirement. While progress had been made in towards meeting substantial compliance, the monitoring team agreed with that assessment. It will be important for the QDDPs to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify. DADS reported that it was continuing to work on describing and defining the aspects of facilitation that should be demonstrated by the QDDPs.	Noncompliance
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals	A sample of attendance sheets was reviewed with the following results in terms of appropriate team representation at annual IDT meetings. The sample included ISPs for the following individuals: Individual #32, Individual #65, Individual #89, Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	#114, Individual #35, Individual #78, Individual #23, and Individual #20. Five (63%) of eight indicated that the individual attended the meeting; • The exceptions were Individual #35, Individual #78, and Individual #20. Four of the individuals in the sample had a guardian. Three (75%) of four participated at the annual IDT. • Exceptions included Individual #214, Individual #66, Individual #265, and Individual #321. The monitoring team does not expect that all individuals or their LARs will want to attend their IDT meetings. When individuals are not present for meetings, the QDDP 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. When individuals consistently refuse to attend meetings, the team should look at what factors contributed to the refusal to attend and brainstorm ways to encourage participation. A review of eight signature sheets for participation of relevant team members at the annual IDT meeting indicated that three (38%) of the meetings were held with <u>all</u> relevant staff in attendance. There was no documentation included in any of the IDTs that would indicate input was given prior to the meeting by staff that were unable to attend the meeting. All relevant staff were in attendance at the two most recent ISP meetings in the sample (Individual #89, Individual #65). Some examples where team participation was not found to be adequate include: • A review of the attendance sheet for Individual #32 indicated that neither he nor his guardian attended his annual IDT meeting. Additionally, psychiatric staff, vocational staff, direct support staff, his dietician, and habilitation therapy staff were not present. Professional staff should have been in attendance to contribute their expertise in developing appropriate supports to address his identified risks and ensure adequate programming was in place. Direct support staff often know the individual the best and can contribute information regarding preferences, support needs, and any changes in functioning status. • Individual #114 was on a modified diet for aspiration risk and his ISP noted that he had very limited communication. His dietician and SLP did not attend his annual IDT meeting. His PCP did not attend the meeting, though he had complex health care needs and was at risk in a number of areas. • The SLP and dietician did not attend the annual ISP for Individual #35. The expertise of both of these team members would have contributed to overall planning in regards to his supports and programming.	

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		While all relevant disciplines were in attendance at the IDT meeting observed the week of the review for Individual #70, team members did not come prepared with accurate information to adequately assess his risks and develop supports based on his current health status. For example, results of his last MBS were not available and the team was not clear on whether or not his liquids were required to be thickened. Without this information, the team could not adequately address his risk for aspiration. Team members not only need to be present at the meeting, they need the most recent assessment information available to make informed decisions. The facility found similar findings regarding the lack of attendance by key staff members in the self-audit of the ISP process. The absence of key members was a significant barrier to integration in the development of ISPs. 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. The facility had recently implemented the use of a database to track attendance at IDT meetings for relevant team members. IDTs were determining who needed to be present at the annual IDT meeting during the third quarterly review meeting based on the results of the PFA. These processes were new, but should have a positive impact on meeting participation. The self-assessment indicated that the facility was not yet in compliance with requirements for integrated team participation. The monitoring team agreed.	
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.	Steps the facility had taken to improve the assessment process used for planning included: • Use of a database to track the submission of assessments prior to annual IDT meetings had begun. • Change of status for individuals was being identified in the daily unit meetings. • Monitoring effectiveness of identification of change of status during the unit team meeting. The monitoring team found the quality and timeliness of some assessments continued to be an area of needed improvement. In order for adequate protections, supports, and services to be included in an individual's ISP, 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	Noncompliance

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		assessments, section R regarding communication assessments, and section T regarding most integrated setting practices). 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 ISPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual ISP. The PFA format had been revised 9/7/11. The facility self-assessment indicated that the PFAs were completed at the third quarterly meeting prior to the annual IDT meeting. PFAs reviewed in the sample, however, did not support this. Some PFAs were completed just a few days prior to the annual IDT meeting. For example, the PFA was completed for Individual #114 on 11/1/11. His annual IDT meeting was held on 11/4/11. The PFA for Individual #65 was completed on 11/27/11. His annual IDT meeting was held 12/2/11. In two cases, (Individual #55 and Individual #46), the PFA was completed after the annual IDT meeting. The list of preferences developed from the PFA process was reviewed for eight individuals. Teams were at varying stages in developing a list of priorities and preferences that could be used for planning. Overall, there had been significant improvements in identifying individual's preferences. The two new style ISPs in the sample included a much more individualized list of preferences and priorities. Information gathered from the PFA was discussed in the IDT meetings observed. Each QDDP reviewed the individual's list of preferences and members of the team engaged in discussion on how these might be supported. Teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. Consideration of outcomes was limited based on activities available at the facility. Outcomes should be considered that might lead to greater exposure to the community. The facility was using the Functional Skills Assessment (FSA) to assess each individual's functional skills. The FSA will not be beneficial to teams if it becomes a rote checklist to be completed annually. Staff completing the assessment will need to put thought into information gathered from the assessment and make recommendations that will assist the team in planning. FSAs had been completed for Individual #18, Individual #65, Individual #89, Individual #23, Individual #20, Individual #114, Individual #35, Individual #78, Individual #55, Individual #93 and Individual #83. None of the FSA assessments in this sample included specific recommendations for training. Staff were completing the checklist, but not developing individualized recommendations from	

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		assessment results. Some examples where adequate assessments were not completed for the individual prior to the annual IDT meeting, or updated in response to significant changes included: • As noted above, not all PFAs were completed in advance of the annual IDT meeting to allow all disciplines to review the assessment prior to the meeting. • Individual #18's ISP noted that the IDT was unable to conduct a risk review at the time of his annual IDT meeting because all disciplines had not completed the risk review form at the time of the meeting. • For Individual #35, his vocational assessment, bathing assessment, and individual travel assessment were completed the same day as the annual IDT meeting. • For Individual #83, her annual physical exam and parts of the FSA were completed after the annual IDT meeting. Her vocational assessment was completed two days prior to the annual meeting. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Assessments should result in recommendations for support needs when applicable. The facility was not in compliance with this item.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	ISPs included a summary of assessment information and recommendations, but, it was not evident that assessments were completed prior to the annual IDT meeting (as noted in F1c), were adequate to address needs, or were revised as individual's needs changed. In order to gain substantial compliance with F1d, an adequate assessment process will have to be in place. QDDPs were still at varying stages in integrating information from assessments into a meaningful plan that identified supports in relation to the individual's preferences and needs. None of the plans in the sample offered clear guidance to direct support staff on all supports needed by the individual throughout the day. There were still some plans in the sample where QDDPs were "cutting and pasting" information from assessments into the narrative section of the plan without any additional discussion of how direct care staff should support the individual throughout the day. Further, the use of clinical terms throughout some ISPs likely made it difficult for direct support staff to understand how assessment recommendations should be implemented. For example, Individual #45's PNMP stated that she would ambulate inside the cottage with hand held assistance or gait belt for assistance ranging from contact guard assistance to supervision (staff awareness) for safety. The plan did not describe when each of these methods should be used, leaving it up to direct support staff to try to determine the appropriate support.	Noncompliance

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		This terminology was found in multiple plans throughout the facility. This practice was noted in the last monitor's report. Examples of ISPs where supports were difficult to understand included: • The narrative portion of the ISP for Individual #35 included a "cut and paste" summary of current assessments. Again, there was the use of clinical jargon throughout the ISP. For example, the speech/audiological section of the ISP began with, "A) consultative SLP services that probe ability to learn two new signs should be carried out to determine the degree of stimulability at this point in his communication development. This would be measureable in regard to the frequency of use of the two new signs. B) Introduction and application of Alternative Communication is the form of increased usage of the Strategies for Optimal Communication should also be carried out. (See the section below which includes these Alternative forms of extra-linguistic communication). The visual modality with physical prompting are the best modalities." The ISP included additional information regarding the provision of supports, however, the inclusion of unnecessary information made the plan difficult to read and understand. • The ISP for Individual #46 noted that she was at high risk for aspiration. Her ISP stated that she "demonstrates severe decrease labial/lingual strength/coordination/ROM with inability to produce a consistent and adequate labial seal. Pharyngeal triggering is severely delayed which can cause her airway to be unprotected for long periods of time this creating a high potential for aspiration/penetration." Staff were then instructed to follow her positioning guidelines. An easier to read and follow guide for providing supports might have simply stated that she has difficulty swallowing which may lead to aspiration, so staff should ensure that she only receives pureed foods while in an upright seated position as instructed in her PNMP. The two ISPs developed in the new format offered much clearer directions for providing supports and services based on assessment recommendations. This was good to see. It was not evident in the sample reviewed that assessments were always used to revise protections and supports, as necessary. For example, Individual #32 was rated as medium risk for falls according to his risk assessment (his ISP stated high risk for falls). A risk action plan was implemented to prevent injury from falls on 8/23/11 that simply stated "continue being monitored by habilitation." He had a fall on 11/20/11 that resulted in a serious injury. There was no indication that the team revised his action plan or put additional supports or protections in place following the fall. He fell again on 12/13/11 sustaining another serious injury. At that time, the team met and put additional supports and protections in place. It was not apparent that adequate supports	

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		were in place prior to the two serious injuries occurring. The facility was not yet in compliance with this item. QDDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and information from assessments is used to develop plans that integrate all supports and services needed by the individual. Plans should be clear and easy to follow for all non-clinical staff responsible for providing daily supports.	
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).	DADS Policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual ISP meeting, at minimum. The facility's self-assessment indicated that ISPs continued to address community integration via action plans and learning objectives. As noted below, the monitoring team did not find this process adequate. A sample of 10 ISPs was reviewed for indication that individuals and/or their LARs were offered information regarding community placement, as required. This included the ISPs for Individual #32, Individual #114, Individual #78, Individual #23, Individual #35, Individual #46, Individual #20, Individual #89, Individual #93, and Individual #18. In 10 (100%) this discussion took place at the annual IDT meeting. As evidenced by the summary below, this discussion, however, was not always adequate (also see section T of this report). • For Individual #32, the team did not indicate that there were barriers or obstacles to living in a less restrictive environment with appropriate supports. He had been institutionalized for 40 years and did not appear to understand community living option information presented to him. The team agreed that he should visit homes in the community. Action plans were not developed with timelines and enough detail to ensure that this would occur. Other outcomes were not developed to provide him with meaningful exposure to life in the community. • The ISP for Individual #114 stated that he did not have the capacity to understand community living options and had limited exposure to the community. The team agreed that, with appropriate supports in place, he could live in the community. The team concluded that optimal placement at the time of his IDT meeting was EPSSLC due to his lack of community awareness. Action plans were not developed to provide greater exposure to the community or move forward with exploring alternate placement in the community. • Individual #78's ISP indicated that EPSSLC was the most integrated setting for	Noncompliance

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		her since she needed "specialized sensory therapy that isn't provided in the community." Her OT/PT assessment indicated that she had a sensory SAP, but did not provide any details on implementation. It was not referenced in her ISP or included in her SAPs provided for review. Her ISP further noted that she did not understand the living options discussion, though she enjoyed being in the community. She had an outcome that stated that she liked to go out in the community and would benefit from be able to identify a women's restroom sign and a wheelchair accessible vehicle. Both of these outcomes were to be implemented in the classroom by identifying pictures. Since was non-ambulatory and required one-to-one assistance for mobility in the community, it was not clear why these outcomes would be a priority for her in the community. These outcomes did not provide any greater level of community integration or community awareness. • The ISP for Individual #20 indicated that she needed to "gradually start acquiring community awareness." The team recommended an outcome to identify a stop sign. It was not clear why this was selected as a priority for community awareness because she did not drive and required contact guard assistance when walking. • The ISP for Individual #18 included a good discussion regarding barriers to community placement. It was noted that he often displayed self-injurious behaviors when going into the community because he was fearful of trips to the doctor. His IDT recommended incorporating pictures of homes, doctor clinics, parks, stores, and libraries into his communication dictionary, so that staff could show him where he was going before he went into the community. This strategy, however, was not integrated into his SAPs regarding community awareness. He also had an outcome to recognize a wheelchair accessible vehicle from a selection of pictures. Again, this would not be a priority for him when accessing the community. In the discussions at the IDT meetings observed by the monitoring team, the community living options discussion was much more in-depth and meaningful. MRAs present at the meetings observed were much more knowledgeable regarding community options and could adequately address questions by team members. QDDPs involved other team members in an integrated discussion regarding the most appropriate placement. This discussion, however, did not lead to the development of meaningful outcomes. There were some common themes among the discussion and determination of optimal living placement in the ISPs reviewed: • Teams were not able to determine the preferences of individuals due to lack of exposure to other living options or inability to communicate choices and	

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		preferences. • Community integration and employment was not adequately addressed in any of the ISPs reviewed or at any of the IDT meetings observed. • Measurable action plans with reasonable timelines for completion were not developed when IDTs agreed that placement in a least restrictive environment would be an appropriate consideration. • Outcomes addressing community awareness were not based on priorities identified by the team and were not functional in the community. IDTs need to give consideration to the following: • The primary focus of all IDTs should be to provide training and supports that would allow each individual to live in the most integrated setting possible. • Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility when these are identified as barriers to living in a less restrictive setting. • Team members need to be provided with updated training on services and supports that are now available in the community. Plans included limited opportunities for community based training. No plans included opportunities to develop relationships and gain membership in the community. Although the facility reported that some training was occurring in the community, it was not evident in ISP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. There was not progress towards ensuring opportunities for community integration in the two newest ISPs in the sample. The ISP for Individual #89 included an outcome for community awareness that was written to take place in the classroom setting rather than the community. He had an SAP to identify the picture of a bus from a set of different pictures of vehicles. Similarly, Individual #65 had community awareness outcomes to identify the men's restroom sign from a set of pictures of various signs. Another outcome stated that he would identify a picture of an item that he could purchase from a worksheet. Both of these outcomes would have been more functional if implemented in the community. He did have an additional outcome to hand the cashier his money at his favorite restaurant. This was a good example of a functional community outcome. 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. This provision is discussed in detail later in this report with respect to the facility's progress in addressing section T.	

#	Provision	Assessment of Status	Compliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The self-assessment indicated that while the facility was not yet in substantial compliance with this provision, reviews had demonstrated an improvement in the integration of both preferences and learning objectives. The monitoring team agreed with this assessment. The ISPs in the sample continued to include a list of the individual's preferences and interests. For individuals in the sample, this list was used as the basis for outcome development. Limited exposure to new activities, however, meant that this list was often limited. In order to meet compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences. ISPs reviewed were reflective of the lack of options and programming. While some plans included opportunities to take trips to the community, as well as minimal training opportunities in the community, no plans 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. Some examples are noted above in F1e. The facility was not in compliance with this item.	Noncompliance
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies	The facility had taken steps to address this provision: • Program developers completed training and began using the Murdoch system to develop outcomes and action steps. • Program developers were providing training to other disciplines in developing	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	SAPs based on recommendations from action plans. Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. ISPs in the sample reviewed did not consistently specify individualized, observable, and/or measurable goals and objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs. Outcomes were not written to address all preferences and were not written in a way that progress or lack of progress could be consistently measured. Specific behavioral indicators should be identified to determine successful implementation. For example: • Individual #23 had an outcome to learn to make choices in relation to personal activities. Action steps included participating in leisure activities of his choice, being provided the opportunity to participate in recreational activities, and participating in the activities of his choice offered by the blue group. An SAP had been developed for the outcome and staff were documenting progress. It was not clear what would constitute a successful trial for this outcome. The SAP stated when he "responds to training." He had an action step in his ISP that stated "participate in a BSP to learn to develop better social skills." His BSP did not address social skills. His Risk Assessment indicated that he was at risk in a number of areas including choking, aspiration, and respiratory compromise. His risk action plan was not integrated into his ISP and did not include measurable strategies to address his risk. • Individual #46 had an SAP to address tooth brushing and visiting other areas of the facility. The SAP described actions that would be taken by the DSP. Progress was not measured by her participation, but instead by the DSP's implementation of the plan. There was no indication what would be considered successful completion of the outcome. Her outcome for participating in a leisure activity also did not indicate what would be considered a successful attempt. Outcomes from her risk action plans were not incorporated into the ISP and did not include measurable criteria. 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 F1e and T1b for additional comments related to this requirement.	
	3. Integrates all protections, services and supports, treatment plans, clinical care	As noted in F1d, recommendations for assessments were not integrated into supports for individuals. PNM, healthcare management plans, and dining plans were not submitted as part of any of the ISPs in the document request. These plans should be attached to the	Noncompliance

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	plans, and other interventions provided for the individual;	ISP and considered an integral part of the plan. The facility self-assessment process found that assessments were not always submitted 10 days prior to the annual IDT meeting and in some cases, not submitted until after the meeting, so integration of all plans was not possible. When developing the ISP 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. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, ISPs described the timeframes for completion and the staff responsible. Methods for implementation were not always adequate, as is discussed in further detail in section S below. Professional or supervisory staff were often designated as the responsible person in action plans. Direct support staff's role was not specified when they typically played a key role in monitoring healthcare needs and providing daily support. The ISP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in ISPs. For example, Individual #45's risk action plan included supports to reduce her risk of choking, aspiration, dental, cardiovascular disease, constipation, gastrointestinal issues, osteoporosis, seizures, infections, falls, fluid imbalance, urinary tract infections, and circulatory issues. Neither her risk action plan nor ISP offered DSP clear instructions on monitoring her risk and providing adequate supports. A new skill acquisition plan format was recently implemented. See Section S for further comments regarding this new process. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The role of direct support staff in implementing plans should be clearly documented in the ISP.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional	The facility had made little progress towards compliance with this item. As noted throughout the report, plans did not always adequately address supports needed by the individual to achieve the outcomes. Minimal functional learning opportunities were included in the ISPs 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	Noncompliance

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	at the Facility and in community settings; and	needs. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. Few training opportunities were offered in a natural setting, such as the home or community. There were constraints on training opportunities because individuals were living at a facility rather than in the community. For instance, individuals did not participate in meal preparation and service. They did not bank in the community or go to the pharmacy to get their medication. They did not have routine access to stores, libraries, and other facilities. They were not able to choose, join, or regularly participate in group and social activities such as church, art, and gym classes. As noted in other provision items, there were numerous examples of outcomes in the sample, where individuals were sitting at tables in the classroom identifying things in the community in pictures rather than going out in the community. This type of training was observed in the day program during the review week. It appeared to have little meaning or interest to individuals involved in training. Interventions, strategies and supports did not adequately address individual's needs and many were not practical and functional at the facility and/or in community settings.	
	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.	ISPs identified the person responsible for implementing service and training objectives and the frequency of implementation. ISPs also included a column to note where information should be recorded. A person was assigned to collect data, but it was not clear what happened with the information gathered from this process in terms of making changes when an outcome was completed or when there was no progress made. Training program/data collection sheets were generated for training objectives. This form included what data would be collected, the frequency of data collection, who would collect data, and who would monitor data. As noted in F2a1, it was not always evident what would determine a successful attempt in data collected. For example, the SAP for Individual #78 indicated that the DSP was to brush her teeth after meals. Data were collected indicating on some days 0 for no response and other days "1" for physical prompts. Both responses were counted as a positive response when calculating percentages for progress. In October 2011, her overall progress was calculated at 0% with data collected showing 0 each day. In November 2011, she had five trials marked with 0 and 25 trials marked with 1. Her overall progress was calculated at 100% for November 2011. It was not evident that team members were using data collected to drive planning in regards to necessary supports. This was particularly true in regards to risk discussions.	Noncompliance

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		Data that should have been reviewed by the team included test/laboratory results, skill acquisition goal data, injury and incident data, data related to nursing care plans (weight, number of seizures, hospitalizations, etc.), behavioral data, and response to medications. See section I for additional comments regarding adequately identifying risks. 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, sections L and M for the collection and review of medical and nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	
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 item 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. Please refer to these sections of the report regarding the coordination of services as well as section G regarding the coordination and integration of clinical services. As noted in F1b and F1c, representation from all relevant disciplines was not evident during planning meetings and adequate assessments were not completed prior to the annual meetings. The monitoring team found a lack of coordinated supports and services throughout the facility. IDTs will need to work together to develop ISPs that coordinate all services and supports. The facility did not have a process to ensure coordination of all components of the ISP.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The facility self-assessment indicated that active treatment monitoring by various disciplines revealed that DSPs were not fully competent and aware of how to carry out the ISP. The facility self-assessment indicated a 40% compliance rate with this requirement. Monitoring and interviews with DSPs found that all DSPs were not aware of where to find the ISP or risk action plans for individuals whom they supported. Interviews by the monitoring team throughout the residential and day programs resulted in the same findings. Staff interviewed were not familiar with BSPs, PNMPs, healthcare plans, and risk action plans. Some staff interviewed could not describe risks and interventions needed by individuals that they were assigned to support. For example, a number of individuals were walking around wearing gait belts during observation without staff assistance. When asked what type of assistance the individual needed, staff gave conflicting answers. For some of these individuals, PNM plans were not clear in describing supports or listed a string of alternatives that required staff to determine	Noncompliance

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		what type of support was needed in each situation. Records in some homes were not easily accessible to staff. A sample of individual records was reviewed in various homes at the facility. Current ISPs were not available in five of 39 (13%) of the records, indicating that support staff did not have information necessary to fully implement ISPs. This was noted to be a problem during the last monitoring visit. Although, this was a sizeable improvement from the last monitoring visit, there were still a significant number of plans not available to staff providing supports. As noted in F1d, plans still contained clinical jargon where assessment information was just cut and pasted into the plan. It was difficult for staff to determine how to carry out necessary supports. Many health and therapy related outcomes did not assign responsibility to direct support staff that would need to carry out the plan. As noted in F2a4, plans did not offer a clear guide on who would be responsible for plan implementation. As a direct support professional, it would be difficult to read the ISPs as written and determine what supports should be provided for an individual during the course of a 24-hour day. Lack of integration of plans contributed to this confusion. Many separate plans existed that were not integrated into the one comprehensive plan. As the state continues to provide technical assistance in plan development, a strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary	The facility self-assessment indicated that section F audits found problems in the consistent review and revision of plans as needed. A review of records indicated that the IDT routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues, however, it was not evident that teams were aggressively addressing regression, lack of progress, and risk factors by implementing appropriate protections and supports, and revising plans as necessary. An example of this was given in F1d, where Individual #32's team did not address a series of falls until a second serious injury occurred. At the annual ISP meeting for Individual #70, there was a lengthy discussion regarding his risk for weight loss and aspiration. Team members did not have the results of his MBS available. He had experienced a significant weight loss, but team members were not sure if the scale was accurate. This was not addressed prior to the meeting. It was not evident that the team had met to develop an aggressive plan prior to the annual IDT meeting.	Noncompliance

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	team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	QDDPs completed quarterly reviews. The quarterly review form included a section to note progress or regression on all service and training objectives monthly, and a place for QDDPs to comment quarterly on the progress or lack of progress. It was not evident that this process was thorough enough to adequately assess the progress and efficacy of the related interventions. Examples of findings: • The quarterly review for Individual #78 dated 1/11/12 offered little information on her progress or response to the implementation of outcomes. She had an outcome that stated, "DSP will brush her teeth." In October 2011, data indicated 0% successful trials. It was not clear if this meant that he teeth were not brushed or data were not collected. Similarly, her data collection sheet for her toileting outcomes included a mix of 0, 1, and 2 responses. All were counted as successful trials. The QDDP did not comment on progress. Progress noted on her outcome to purchase a drink from the vending machine showed 0% progress for the first two months of the quarter and 1% progress for the third month. The QDDP comment noted that she had not shown progress. The data sheets indicated that she had refused to participate. Her refusals were not addressed. She had a medical appointment for on 11/1/11 and a vision exam on 12/5/11 and a neurological consultation. The QDDP did not comment on the outcome or any follow-up needed. • The quarterly review dated 10/3/11 for Individual #178 indicated that he had a sleep study for apnea on 9/2/11. No results or recommendations were noted. His quarterly review did not include implementation dates. His January 2012 quarterly review included a good summary of interventions and discussion of risks in response to changes in status. • The quarterly review of services for June 2011 through August 2011 for Individual #191 was not completed until 10/13/11. He was discharged from the hospital on 9/7/11. The quarterly review did not indicate that his risk assessment was updated or recommendations and supports were discussed following his hospitalization. Monthly and quarterly reviews should address the lack of implementation, lack of progress, or need for revised supports. Follow-up on issues occurring during the quarter should be documented. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QDDPs need to keep in mind that ISPs 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	

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		in any area. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues.	
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, QDDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document. • A review of training transcripts for 24 employees indicated that 24 (100%) had completed the new training on ISP 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 was aware of deficits in the implementation of the ISP and was providing additional training to direct support staff. The facility's self-assessment indicated noncompliance with this requirement. The monitoring team agreed with that assessment.	Noncompliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a	Of ISPs in the sample reviewed, all (100%) had been developed within the past 365 days. The facility self-assessment showed a 78% compliance rate with this requirement based on ISPs audited 8/1/11 through 10/31/11. As noted in F2c, a sample of 39 plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 13% of the plans in the sample were not current. This is concerning for a number of reasons. The ISP 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. As noted in F2d and other areas of this report, plans were not always revised when	Noncompliance

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	written extension.	supports were no longer effective or applicable. The facility was rated as being out of compliance with this provision item.	
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 ISPs to ensure the development of a comprehensive ISP that addressed all services and supports. The facility had generated a report from data collected from observations and document reviews using the statewide audit tool for section F. Compliance scores from the self-audit were between 30% and 100% for the various requirements included in section F. Overall compliance for section F requirements was 71% with a lower than 70% score for 13 areas. Quality enhancement activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had made significant progress in this area. They had just begun to analyze findings and develop corrective action plans. Reports identifying problem areas were being presented to the QAQI council and to the ADOP for further follow-up. An effective quality assurance system for monitoring ISPs was not fully in place at the facility.	Noncompliance

Recommendations:

1. Team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year (F1).

2. It will be important for the QDDPs to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify (F1a).

3. When individuals are not present for meetings, the QDDP 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. When individuals consistently refuse to attend meetings, the team should look at what factors contribute to the refusal to attend and brainstorm ways to encourage participation (F1b).

4. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community (F1c).

5. A description of each person's day along with needed supports identified by assessment should be included in ISPs. All supports and services should be integrated into one comprehensive plan (F1d).

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

7. Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility (F1e).

8. IDTs should review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual (F1e).

9. IDTs will need to identify each person's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

10. Meaningful supports and services should be put into place to encourage individuals to try new things in the community. The IDTs should develop action steps that will facilitate community participation while learning skills needed in the community (F2a1).

11. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Specific behavioral indicators should be identified to determine successful attempts at outcomes. (F2a2)

12. IDTs 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 (F2a3).

13. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The ISP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in ISPs (F2a4, F2c).

14. IDTs should develop outcomes that are practical and functional at the facility and in community settings (F2a5).

15. Outcomes should identify the data to be collected and/or documentation to be maintained, the frequency of data collection, the person(s) responsible for the data collection, and the person(s) responsible for the data review (F2a6).

16. Ensure plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation (F2c).

17. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues (F2d).

18. Develop a process to revise ISPs when there is lack of progress towards ISP outcomes or when outcomes are completed or no longer appropriate outside of schedule quarterly review meetings. Review and revise plans when there has been regression or a change in status that would necessitate a change in supports. Ensure that staff are retrained on providing supports when plans are revised (F2d, F2e, F2f).

19. Develop an effective quality assurance system for monitoring ISPs (F2g).

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 EPSSLC Organizational o List of typical meetings that occurred at EPSSLC o EPSSLC Self-Assessment o EPSSLC Action Plan o EPSSLC Sections G and H Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team o Review of records listed in other sections of this report Interviews and Meetings Held: o Jaime Monardes, Facility Director o Ascension Mena, M.D., Medical Director o Lilani Muthali, MD, DADS Medical Services Coordinator o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report
	Facility Self-Assessment: The facility's plan for moving towards substantial compliance was outlined in two separate documents, the Self-Assessment and the Action Plan. For each provision item, the self-assessment listed (1) activities engaged in to conduct the self-assessment, (2) results of the self-assessment and (3) the self-rating, substantial compliance or noncompliance. The self-assessment listed the following activities engaged in: (1) reviewed monthly meetings, such as pretreatment sedation, (2) attended unit meetings, (3) reviewed neurology and neurology-psychiatry clinic schedule, (4) conducted observations of psychiatry clinic, (5) reviewed the process for development of SAPs, and (5) reviewed medical provider compliance audits. Results showed that individualized strategies to minimize sedation were insufficient, medical representation at unit meeting was previously lacking, neurology services were insufficient, collaboration between psychiatry and psychology was lacking, and integration in SAP development was lacking

	The Action Plan provided a series of action steps that aligned with the results of the assessment findings. The monitoring team recommends that the medical director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report and recommendations included throughout the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. The facility found itself noncompliant with both provision items. The monitoring team agreed with this assessment.
	Summary of Monitor's Assessment: EPSSLC had done a considerable amount of work since the last onsite review. The facility director had taken a very active role in the activities related to this provision item. This was an important step as achieving substantial compliance with this provision will require that numerous actions occur across multiple disciplines. EPSSLC staff were very eager to discuss integration and provide evidence that this was occurring. This enthusiasm was one signal that staff understood the importance of integration even if they were not certain of how to go about achieving it. They also understood that much work needed to be done in this area. The monitoring team saw evidence of integration in many areas. It was also evident that several disciplines were not integrating well with other areas and will require a substantial change in the approach of providing services. The facility will need additional guidance from state office and the monitoring team was informed that additional guidance and a policy are forthcoming.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they	EPSSLC continued its efforts towards achieving compliance with the Settlement Agreement. Recognizing the importance of integration of clinical services, state office issued a directive that required the facility director to serve as the lead person for this provision. The facility director had taken a lead role in supporting the medical director with this provision item. This was an important step given the facility wide requirements for this provision and the importance of coordinating services. <u>Monitoring team examples</u>: Throughout the week of the review, many staff were eager to explain and demonstrate how they integrated clinical services. The monitoring team observed evidence of integration in many instances:	Noncompliance

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	need.	• The facility conducted a daily unit meeting that was chaired by one of the unit directors and attended by the medical director, nurse managers, all available QDDPs, and representatives from pharmacy, psychology, and habilitation. The meeting covered a variety of topics, including environmental concerns, client injuries, and medical issues, including hospitalizations. The format of the meeting did not allow for the appropriate discussions of clinical issues. • Each month there was a neurology-psychiatry clinic. During this clinic, individuals with both a psychiatric disorder and seizure disorder were evaluated and recommendations made for treatment. The clinic attended by the monitoring team was an excellent example of how clinical services worked with non-clinical services, such as residential, to help the individuals achieve good outcomes. • Integration between psychology and psychiatry was not particularly evident. A first step in achieving this goal was having the two department leads participate in weekly meetings so that relevant issues could be discussed. The facility director, psychology, and psychiatry leads visited a sister SSLC to learn more about the roles of psychology and psychiatry, and how to foster integration. Moreover, a psychology technician was moved to the psychiatry department to serve as a bridge between the two disciplines. • The offices of the psychologists were also recently moved into the cottages to make them more accessible to the teams. • The medical director met with the clinical pharmacists and nurse manager to review 180-day orders on all individuals. Through this process, the pill burden of many individuals was decreased. • Pretreatment sedation was discussed during a multidisciplinary meeting that occurred each month. The pharmacy director presented each case to the group. The treating physician or dentist requesting the medication provided health related data. The psychiatrist discussed the impact of the drugs. The group made a final decision with regards to medication use. The monitoring team observed that during this meeting there was a real collaboration among the participants and found that the QDDP brought to the meeting some very valuable information about family supports that could be used or in an effort to decrease the use of sedation. • A database was being developed that would allow tracking of attendance for all disciplines. • There was increased collaboration in writing the SAPS. The program developers were receiving input from habilitation. The goal was to train the habilitation staff in SAP development. • The hospital liaison nurse visited those individuals who were hospitalized and conducted face to face assessments. The hospital liaison report included the	

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		results of the assessments, a review of recommendations from non-facility clinicians, and an evaluation of the individual's response to treatment. This information was shared during the daily unit team meetings. Notwithstanding a series of enormous efforts towards integration of clinical services at EPSSLC, the monitoring team noted several areas that were worthy of attention and improvement: • A weekly integration meeting was conducted. This meeting appeared to serve as a forum for transferring information and making announcements. It lacked true discussion of how each discipline achieved integration and what more needed to be done. • The PNMT did not usually receive referrals from the IDTs for individuals who would benefit from assessment and supports from the team. The PNMT self-initiated assessment of individuals with a change in status, such as hospitalizations and pneumonia. • The ISPs of several individuals failed to integrate their health needs and risks and ensure that they received the clinical services they needed. Individual #89 experienced many problems, including behavioral changes and anorexia. These changes were noted in his record by the direct care professionals for several weeks, but went received little attention in his annual ISP. • The area of desensitization was clearly lacking integration and the disconnect between the various disciplines was leading to delays in this important process. The assessment, development, implementation, and follow-up of strategies, interventions, and desensitization plans were almost always seen as a function of psychology, and that should not be the case. • There was a lack of collaboration and integration in the provision of suction toothbrushing. This was intended to be collaboration between nursing and dental clinic, but clearly that was not the case. The provision of suction toothbrushing was seen as a nursing function resulting in little follow-up regarding the response to treatment. • The process of reviewing medication errors and implementing corrective actions required greater input and participation by the medical director.	
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	The medical director developed a tracking log for all consultations. It included the date of appointment and status, such as completed or re-scheduled. Medical providers were expected to review and address the consults within five business days. The medical staff had been inserviced on these requirements. The medical director indicated that when a consult returned, the medical provider made a note on the consult, initialed, and dated it. Following this, an entry was made in the	Noncompliance

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	whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	IPN. When a change in the plan of care occurred, the issue was referred to the IDT. The medical director indicated that during the conduct of IDT meetings, he was often able to review consults, acknowledge them in the IPN, and write orders. Record audits showed that documentation related to consults and consult recommendations did not always occur. The facility's self-assessment documented that the November 2011 external medical provider audit showed 16.7% compliance score. The DADS medical director had drafted a G2 procedure that was to be disseminated to all medical directors. As discussed in G1, the hospital liaison nurse provided valuable information regarding the status of individuals that were hospitalized. This was filed in the active record.	

Recommendations:

1. Clinical services should conduct a separate morning meeting to allow for more detailed discussions of health care and behavioral issues. This can reasonably be accomplished within 30 minutes provided there is a standardized format (G1).
2. The collaborative efforts between the psychiatry and psychology leads should be modeled for the larger groups (G1).
3. Implement the G1 and G2 policies when issued by state office (G1, G2).
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 (G1).
5. Consider the inclusion of a statement regarding the integration of clinical services in each individual's ISP document (G1).
6. All medical providers should be re-informed of the requirements to address consultant recommendations in the IPN. This should be monitored closely and perhaps monthly until notable improvement is demonstrated (G2).
7. Address the items above in G1 that were considered in need of improvement (G1).

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 EPSSLC Organizational Charts o List of typical meetings that occurred at EPSSLC o EPSSLC Self-Assessment o EPSSLC Action Plan o EPSSLC Sections G and H Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team o Review of records listed in other sections of this report Interviews and Meetings Held: o Jaime Monardes, Facility Director o Ascension Mena, M.D., Medical Director o Lilani Muthali, MD, DADS Medical Services Coordinator o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report
	Facility Self-Assessment: The facility's plan for moving towards substantial compliance was outlined in two separate documents, the Self-Assessment and the Action Plan. For each provision item, the self-assessment listed (1) activities engaged in to conduct the self-assessment, (2) results of the self-assessment and (3) the self-rating, substantial compliance or noncompliance. The Self-Assessment listed numerous activities engaged in to conduct the self-assessment. The activities included review of policy and procedure, attendance and observation of meetings, and review of audit data The Action Plan provided a series of steps targeted at correcting the deficiencies noted in the results of the Self-Assessment.

	Summary of Monitor's Assessment: Incremental progress was noted in this area. The facility director had taken the lead role in supporting the medical director with regards to activities related to this provision. Again, this was important due to the multiple disciplines that are involved with this provision. Overall, provision H relates to the management and assessment of the facility's many discipline specific assessments. A draft state policy was disseminated. Although it was not yet completed, it provided some detailed guidance to the facility regarding provision H. 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.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	There was no specific policy to guide this provision, but progress was noted in a number of areas. The facility director described how an individual's change in status was captured in the unit team meeting. During the meeting, a number of issues were discussed including hospitalizations and behavioral incidents. The medical staff, QDDPs, psychologists and other clinicians were in attendance. If a problem met the criteria for change in status, the QDDP followed the risk process which required the IDT convene, conduct a risk assessment, and develop an action plan within five days. This was followed up in subsequent meetings and noted in the minutes. A database captured all of this information, per team and per incident. The medical director reported several initiatives indicating that assessments occurred regularly and in response to a change in status: • The most recent medical audit showed 76% compliance with essential elements of care. • Preventive Care Flowsheets were all implemented by the end of December 2011. • Respiratory assessments were completed and medication regimens adjusted. <u>Monitoring Team Examples</u> Throughout the conduct of the review, the monitoring team had the opportunity to evaluate routine assessments as well as assessments that were completed in response to a change in health status and noted the following: • There was improvement in timely completion of Annual Medical Summaries. There were several records that reflected a lack of an adequate plan of care for	Noncompliance

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		active medical problems. The most recent summaries, however, appeared to address that issue by outlining a specific plan for each active problem. Preventive Care Flowsheets were found in all records, but were usually not accurate and indicated "no history" for many elements of care. The facility had yet to implement the requirement to complete Quarterly Medical Summaries. • Record audits indicated several instances in which abnormal labs were not addressed in a timely manner, and consultant recommendations were not acknowledged or followed-up. • Respiratory assessments were noted in several records, but these assessments seemed cursory, were often incomplete, and usually indicated that no respiratory intervention was needed. This was noted even for individuals with significant respiratory issues, such as Individual #191. • The nursing department often failed to ensure that emergent changes in individuals' health status were identified, assessed, and addressed in a timely manner. For example, in December 2011, Individual #89's FNP and psychiatrist noted that he had suffered a significant unplanned 12-pound weight loss, increased paranoia, aggression, insomnia, and left groin adenopathy. He was diagnosed with anorexia and prescribed an appetite stimulant. He was prescribed new medications, changes in existing medications, and an abdominal ultrasound. During this period of significant change, there were only three nurses' notes documented in his record and there was no evidence of follow-up to any of these nurses' notes and these significant changes in Individual #89. • Psychiatry clinic was providing quarterly medication reviews that were timely up until June of 2011. Also, the facility was behind with regard to Appendix B evaluations. The psychiatrist was not participating in all the IDT meetings and will need to attend to discuss risks relative to polypharmacy and the effect of specific psychotropic medications on other health conditions. • Initial psychological assessments and annual psychological assessments were not consistently completed. Functional assessments were not completed for the majority of individuals with PBSPs. • For habilitation services, a new assessment format had been implemented and was in improvement in format and content. While there was evidence of discipline specific assessments based on a change in status, such as hospitalizations, these were not comprehensive in nature. • Since the prior review, EPSSLC's direct care staff members received training on recognizing the signs and symptoms of significant changes in individuals' health status. The direct care staff members appeared to have benefitted from the training and a review of 20 sample individuals' records revealed that, since the prior review, they were more likely to consistently notify the individuals' nurses in a timely manner of significant changes in the individuals' health status and	

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		needs.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	There was no policy in place to require or guide the activities required to meet this provision item. EPSSLC was not tracking or monitoring this requirement. The medical director reported that a training module was developed. The training was not completed at the time of the review. The monitoring team noted the following with regards to this provision item: • The majority of the medical documentation utilized appropriate ICD-9 nomenclature. • For psychiatric diagnoses, there was low compliance with this requirement. During the visit, the monitor suggested that the physician review the diagnostic criteria for certain conditions in an effort to improve diagnostics. Over the course of the visit, the monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. • Nursing assessments consistently failed to accurately reference complete lists of the individuals' active medical problems. This problem appeared to be related to nurses who used prior, sometimes incorrect assessments as templates for current assessments and failed to carefully review, correct and accurately complete the new, current assessment. • The majority of nursing assessments failed to result in a complete or accurate list of nursing diagnoses, in accordance with NANDA.	Noncompliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The facility director reported that 100% of individuals had risk assessments completed and placed in the records. Moreover, according to the self-assessment, treatments and interventions were timely based on a review of 100% of individual problem lists. Meeting compliance with this provision item required that the facility provided timely and appropriate treatments and interventions based on assessments and diagnoses and had evidence that this was occurring. In order to effectively measure if this occurred, the facility needed to conduct periodic assessments of these clinical activities using an audit tool that outlined the clinical outcomes. The monitoring team looked for evidence of this through activities such as observations, interviews, and record audits and noted the following: • The facility completed a number of audits, such as the medical provider audits to determine compliance with this provision item. There was, however, not one specific item that addressed this provision item. Even so, during these record reviews, there were examples of failure to provide adequate follow-up of labs, diagnostics, and consults. • For psychiatric services, this remained a challenge due to differing diagnoses in	Noncompliance

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		various areas, such as the psychiatric evaluation and the behavioral support plan. • There was one initial psychological assessment available for review and it was timely and clinically appropriate.	
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. The facility and state, however, should be sure to address clinical indicators for all areas of clinical practice, not only in medical care and nursing services. This final version of the policy had not been issued by the state and the facility there was no facility specific policy or draft policy to guide this process. According to the self-assessment, the new clinical pathways and their use in guiding care were reviewed. Based on discussions with the medical director and a review of current medical policies and procedures, the clinical pathways had yet to be formally implemented, although they may have been used in practice by clinicians. The monitoring team noted the following through a series of document and record reviews: • With regards to habilitation services, there was insufficient discussion of the efficacy of interventions and supports in the annual assessments. This did not permit appropriate justification to continue, change or discontinue interventions and supports. • IOA and treatment integrity were not consistently collected and tracked across the facility. With the development of clinical guidelines, the medical director must take the next steps of selecting valid and reliable clinical indicators and determining the desired outcomes. It would be reasonable to consider that this would be standardized across the state and throughout all facilities. With regards to provision H, the facility will need to remain mindful that all clinical areas need to be addressed.	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	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 ISP process. A change in status was addressed as discussed in H1. At the time of	Noncompliance

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	individuals.	the onsite review, the overall health status of each individual was monitored through a series of assessments that included annual medical assessments and comprehensive nursing assessments. Quarterly pharmacy assessments were also completed. Additional oversights, such as the adverse drug reporting system, contributed to the monitoring of health status. The DUEs completed by the clinical pharmacists contributed to monitoring of health status as individual-specific information was reviewed. When an acute medical problem was identified, the physician was notified. Acute problems that were not urgent were managed in the medical clinic. The draft common elements policy outlined expectations for development of a health status monitoring system, which included a number of clinical indicators. Additional clinical indicators need to be developed. The clinical guidelines issued by state office should provide several. Again, clinical indicators will need to be developed across all disciplines and not just medical, nursing, and psychology. With establishment of a comprehensive set of clinical indicators, the facility will need to determine how to effectively measure and capture if outcomes are being achieved. This will likely require some revision of the audit tools currently used.	
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.	This provision item, like many others in provision H, represents a mechanism of auditing how the facility is performing. The most critical issue is to develop protocols, practices, and standards that are consistent with professional standards. Several guidelines have been issued by state office. The next step will be the development of indicators and outcomes as discussed in H5. The facility can then determine if outcomes are met. If outcomes are not met, the expectation would be to change the interventions until an acceptable outcome is achieved.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance. State policy was in draft.	Noncompliance

Recommendations:

1. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H (H1, H7).

2. Ensure that all clinical services are addressed by the facility, not only medical activities (H1-H7).

3. Medical guidelines and protocols should be formally implemented. Indicators and outcomes should be clarified and all clinics trained on the guidelines and expectations. This action, the development of clinical guidelines, will need to occur for all clinical disciplines (H1-H7).

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 (H1-H7).

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 (H1-H6).

6. Problems cited in this report above in sections H1 – H6 should be addressed (H1-H6).

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 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 EPSSLC Self-Assessment for Section I o Risk ratings and date risk assessment was completed for all individuals at the facility o List of serious injuries for the past six months o List of individuals with the greatest number of injuries o List of individuals seen in the ER since 1/1/11 o List of individuals hospitalized since 1/1/11 o List of individuals with pneumonia incidents in the past 12 months o List of individuals with choking incident since the last review o List of individuals diagnosed with pica o List of individuals who have been treated for pain, including chronic and acute o List of individuals considered missing or absent without leave 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 5/1/11 o ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #45, Individual #59, Individual #72, Individual #20, Individual #55, Individual #114, Individual #23, Individual #83, Individual #18, Individual #35, and Individual #46, <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Mario Gutierrez, Incident Management Coordinator o Mike Reed, Facility Investigator o Gloria Loya, Human Rights Officer o Valerie Grigg, Director of Behavioral Services o Aurora Ramos, QDDP o Nora Padilla, QDDP

	Observations Conducted: o Observations at residences and day programs o Daily Unit Meeting 1/9/11 o Incident Management Review Team Meeting 1/9/11 and 1/11/11 o Human Rights Committee Meeting 1/11/11 o Annual ISP meetings for Individual #70 and Individual #84
	Facility Self-Assessment: EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. A list of activities engaged in to determine compliance was included in the APC. The facility and the monitoring team had taken similar steps to assess compliance with each provision item. For example, for provision I1, the facility not only looked to see if risk ratings had been assigned for all individuals, but additionally looked to see if assessments were completed and available to facilitate accurate determination of risks. For compliance with I3, the self-assessment audit not only looked for documentation that risk plans were in place, but also audited whether or not they were accessible to staff. Findings from both reviews were also similar. 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.
	Summary of Monitor's Assessment: Some positive steps EPSSLC had taken towards compliance with this provision included: • The facility began using the statewide section I audit tool to assess compliance. • The facility had established a schedule for the IDT to meet quarterly review to review risk assessments and action plans. • The facility had implemented new training requirements for all staff to include: o At Risk Competency Based Training o Preventing Aspiration o Observing and Reporting Clinical Indicators o PNMP-Speech/Dysphagia

	• Incidents that might indicate a change of status for individuals were being reviewed in the daily unit meeting. • A database to track changes in status had been created. • IDTs were referring individuals to the PNMT and BSC who were at risk, not stable, and whom the IDT required assistance in developing a plan. • Teams were beginning to analyze assessment findings, integrate recommendations, and propose an action plan with measureable goals and outcomes within five working days of the identified significant change of risk status. While significant progress had been made on meeting compliance through an initial attempt to ensure all individuals had been assessed and action plans were in place to address risks, the facility was not yet in compliance with the three provisions in Section I. The facility self-assessment showed similar findings. As noted in section F, the monitoring team did not find that IDTs were consistently completing assessments prior to the IDT meeting or updating assessments as needed. Teams could not adequately discuss risk factors without current, accurate assessments in place. Staff were not adequately trained on monitoring risk indicators and providing necessary supports. 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 state policy, At Risk Individuals 006.1, required IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT 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 when appropriate. A list of indicators for each of 21 risk areas had been identified by the 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. Observation of annual IDT meetings scheduled the week of the review showed that IDTs were still experimenting with how to integrate the new risk identification process with the new ISP development process. QDDPs 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 onsite reviews. Although, teams were beginning to engage in more in-depth discussions regarding health indicators, there was still a strong reliance on guidelines developed by the state that did not take into consideration integrated risk factors. Clinical indicators were not always available at meetings and, therefore, not always considered when determining health	Noncompliance

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		risk ratings. The facility captured data in a number of ways that should have been useful to identify risks for particular individuals, but it was not evident that the data were being used to identify risks. The monitoring team observed the IDT for Individual #70. The team did not have data or health indicators necessary to thoroughly evaluate his risks. It was noted that he was significantly underweight and had numerous other health risks that needed to be considered regarding mealtime supports, including risk for aspiration, dehydration, constipation, and GERD. The team was not sure whether or not he was on thickened liquids, and did not have the results of his latest swallow study. There was discussion over whether or not his weights were accurate. His dietician was not available to answer questions about his current diet and approved supplements. Rather than developing an integrated plan to address all risks, the team focused on developing a plan to address his weight loss first. A sample of ISPs and the facility risk rating list were reviewed to determine if risks were being properly identified and addressed by IDTs. IDTs were holding much better discussions regarding risk and assessments were more accurate. The following are some examples where risks were not appropriately identified in documents reviewed. ▪ The IDT rated Individual #59 at medium risk for falls. According to assessments, he was a high risk for falls. He had uncontrolled seizures. His PNMP noted that he needed a helmet and gait belt with one- to two-person assistance when ambulating. He had three falls in the past year, one in which he sustained a serious injury. He was also rated at medium risk for GERD, though his last EGD showed erosive esophagitis, erosive gastritis, and a hiatal hernia. He had nine episodes of emesis during the past year. ▪ Individual #178 was rated as medium risk for skin integrity. He was non-ambulatory, obese, incontinent, had diabetes, a history of diaper rash, and a history of wounds to his hands and feet. Staff needed to be aware that his risk for skin breakdown was high. His skin integrity should be carefully monitored and appropriate supports should be in place to reduce his risk. ▪ Individual #72 was rated as being at medium risk for falls. The team did not rate his risk for injuries. He was blind and required one-to-one supervision when ambulating. He was high risk for challenging behaviors which included tilting his wheelchair over when agitated. DSPs reported that he is often unsteady. Although EPSSLC's implementation of the new/approved health risk assessment tool/processes had improved since the prior review, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. The review of 20 sample individuals' records (listed in section M) revealed that four of the 20 individuals' records failed to have a risk assessment and risk action	

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		plan filed in their record at the time of the review. Also, across the 20 sample individual records reviewed, it appeared as though changes in behavior were much more likely to trigger an ISPA and review of risk than changes in health. During an observation of one ISP meeting, the RN case manager appeared to be prepared to discuss the individuals health risks, but often failed to voice an opinion or contribute to the discussion and the determination of the level of risk by way of voluntarily offering relevant health information, such as health status data summaries, outcomes of planned nursing interventions to achieve the individual's health goals. Additional examples are listed in section M5. For both short and long range planning, the teams will need to: • Frequently gather and analyze data regarding health indicators (changes in medication, results from lab work, engagement levels, mobility, etc.) • Consider and discuss the interrelatedness of risk factors in an interdisciplinary fashion. • Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical. • 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. • Monitor progress towards outcomes and share information with all team members frequently so that plans can be revised if progress is not being made or regression occurs. The facility's self-assessment indicated that the facility had given itself a noncompliance rating for this provision. The facility was not yet in compliance with this provision item. 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	The At Risk policy required that when an individual was identified at high risk, or if referred by the IDT, 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 IDT within 14 working days of the completion of the plan, or sooner if indicated by risk status. In the sample reviewed, it was evident that teams were making referrals to the PNMT for review and recommendations. As noted throughout this report, it was still not evident that adequate plans were being	Noncompliance

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	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.	developed to address identified risk or that all risks were appropriately identified by the IDT. The facility will have to have a system in place to accurately identify risks before achieving substantial compliance with I2. The facility self-assessment process found that prior to 11/15/11, there was no system in place to track changes in health or behavioral status. A system was implemented to identify changes in status at the morning unit meeting and a change in status database was created. Observation of the morning unit meeting confirmed that this was occurring. It was too soon to evaluate the effectiveness of this process. The IDTs of several individuals who were suffered significant changes in their health status and needs failed to conduct interdisciplinary assessments of the individuals' needs of services and supports and develop plans to meet those needs. One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. The facility was not yet in compliance with this provision item.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. A majority of the ISPs that were reviewed included general 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 IDT in response to risk categories identified by the team. According to data provided to the monitoring team, a plan was in place to address all risks for those individuals designated as high risk or medium risk in any area. However, as noted in I1, accurate risk ratings were not necessarily being assigned, so adequate plans were not in place for all individuals. As noted above, four of the 20 individuals' records that were reviewed in section M failed to have a risk assessment and, if appropriate, a risk action plan filed in their record. This was a significant problem because these four individuals had many health needs and risks, which required assessment, planning, evaluation of outcomes, and consistent monitoring to ensure their health and safety.	Noncompliance

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		None of the plans in the sample included clinical indicators to be monitored to accurately determine the adequacy of the plan for all action steps. For example, the Risk Action Plan for Individual #72 had a number of action steps addressing his risk including "monitor bowels." The plan did not indicate what clinical indicators should be present to warrant an assessment or what assessment results would require additional follow-up. Similarly, he had another action step that stated, "refer to neurologist as needed." The plan did not indicate what clinical criteria would determine "as needed." Individual #114 was appropriately identified as being at risk for constipation. His risk action plan indicated that staff needed to monitor his fluid intake. His risk action plan and his ISP did not indicate how often staff should encourage fluid intake or what specific supports might be needed to ensure appropriate hydration. Risk action plans were not always updated in response to a change in status. For example, Individual #72 was hospitalized for hyponatremia on 11/22/11. The IDT met to begin the assessment process on 12/1/11 and reevaluated his risks levels. According to an ISPA documenting the discussion, the team raised his risk level for fluid imbalance and skin integrity and recommended further assessment. There was no documentation that the team met again following assessment or that his risk action plan was updated to address these risks. Additionally, plans were not always integrated into ISPs or conflicted with action plans in ISPs. For example, • Individual #45's risk action plan noted that she had diabetes and was on an ADA diet. Her ISP noted that she was on a high fiber diet. There was no reference to diabetes or an ADA diet. Her ISP stated that she used a gait belt to ambulate around her home. Her action risk plan did not mention the gait belt. • Individual #93 was rated as high risk for polypharmacy. Her ISP stated, "see risk action plan." The risk action plan noted that DSP should report to nursing staff any side effects of medication. The risk action plan did not include side effects to be monitored. It will be necessary for the facility to have a system in place that accurately identifies risk prior to achieving substantial compliance with I3 requirements. As noted throughout this report, intervention plans often did not provide enough information for direct support staff to consistently implement support or were not carried out as written, therefore, individuals remained at risk. See additional comments throughout this report regarding the monitoring of healthcare risks. The facility self-assessment indicated that the facility was not in compliance with	

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		this provision. The monitoring team agrees with that assessment.	

Recommendations:

1. Ensure assessments are completed prior to annual IDT meetings and results are available for team members to review (I1).
2. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).
3. The facility needs to ensure that present risk assignments are reviewed for accuracy (I1).
4. 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 (I1).
5. The facility needs to ensure that adequate plans are in place to address all risks (I1).
6. The facility needs to ensure that all staff are trained on plans to minimize and monitor risks (I1).
7. All health issues should be addressed in ISPs 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 (I1, I2, I3).
8. Monitor progress towards outcomes and share information with all team members frequently so that plans can be revised if progress is not being made or regression occurs.
9. Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical (I1).
10. Ensure IDTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).
11. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).
12. Implement a monitoring system to ensure that direct support staff have ISPs and other plans readily available at all times to provide necessary supports to each individual in the home (I2 and I3).
13. Frequently gather and analyze data regarding health indicators, such as changes in medication, results from lab work, engagement levels, and mobility (I1).

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 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 IDT 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 Five examples of dental desensitization plans o Auditing/monitoring data and/or reports addressing the pretreatment sedation medication. o A description of any current process by which individuals receiving pretreatment sedation were 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 ISP 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 was monitoring this condition, and the date and result of the most recent monitoring scale utilized o Documentation of inservice 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; Trazodone; 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 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; Individual Support Plan, and ISP 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 refused to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attended or might attend, including any information that is routinely collected concerning the Psychiatrists' attendance at the IDT, ISP, ISPA, and BSP meetings o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that related to the role of psychiatrists o A list of all psychiatrists including board status; with indication who was designated as the facility's lead psychiatrist o CVs of all psychiatrists who worked 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 inservice 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 had a diagnosis of seizure disorder o For the past six months, minutes from the committee that addressed 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 newly prescribed 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 were 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 receiving psychotropic medication o Name of every individual assigned to psychiatry clinic who 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 Comprehensive psychiatric evaluations per Appendix B for the following individuals: • Individual #8, Individual #104, Individual #191, Individual #51, Individual #133, Individual #23, Individual #39, Individual #83, Individual #73, and Individual #13 o Documentation of psychiatry attendance at ISP, ISPA, BSP, or IDT meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months o Section J presentation book <u>Documents Requested Onsite:</u> o All data presented, doctor's orders, and physician's documentation for neuro-psychiatry clinic 1/10/12 regarding Individual #3 and Individual #32. o All data presented, doctor's orders, and physician's documentation for psychiatry clinic 1/10/12 regarding Individual #20 and Individual #129, o Curriculum vitae of Alfredo Lujan, M.D. (consulting neurologist) o Documentation regarding the ISP meeting for Individual #108 o All data presented, doctor's orders, and Dr. Chavez-Rice's documentation for psychiatry clinic 1/11/12 regarding Individual #58 and Individual #112 o All data presented, doctor's orders, and Dr. Chavez-Rice's documentation for psychiatry clinic 1/12/12 regarding Individual #8 o Sample information from dental clinic regarding pretreatment sedation o Minutes of the pharmacy meeting dated 1/12/12 o Copies of the last three months of log regarding collaboration between psychiatry and primary care. o These documents: • Identifying data sheet • Annual Medical Summary and Physical Exam (Health Data) • 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)
- ISP and ISP addendums/reviews/annual (for the past six months)
- Behavioral Support Plan
- Annual Nursing Assessment
- For the following individuals:
    - Individual #161, Individual #13, Individual #56, Individual #61, Individual #2, Individual #8, Individual #108, Individual #112, Individual #134, Individual #157, Individual #37, Individual #78, Individual #83, Individual #188, Individual #120, Individual #47, Individual #51

Interviews and Meetings Held:

- Eugenio Chavez-Rice M.D. facility lead psychiatrist with Nohemi Ostos and Becky Torres, L.V.N., psychiatry clinic staff
- Mary Ann Clark, R.N., Chief Nursing Executive
- Ascension Mena, M.D., Medical Director
- Amista Salcido, Pharm.D., Pharmacy Director with Giovanna Villagran, Pharm.D.
- Valerie Grigg, M.A., BCBA, Director of Behavioral Services with George Zukotynski, Ph.D., BCBA-D.
- Howard Pray, D.D.S., facility dentist with Jennifer Pacheco, RDH
- Nohemi Ostos, C.P.T. with Kathleen Torres, L.V.N.
- Alfredo Lujan, M.D., consulting neurologist

Observations Conducted:

- Observation of three psychiatry clinics including the following individuals:
    - Individual #20, Individual #129, Individual #58, Individual #8 and Individual #112,
- Observation of ISPA meeting for Individual #108.
- Observation of Neuro-Psych clinic regarding Individual #3 and Individual #32.
- Observation of pharmacy meeting including pretreatment sedation meeting
- Observation of individuals in two facility homes.
- Meeting with family member of Individual #112
- Psychiatry/Psychology weekly meeting
- Daily unit meeting 1/13/12

Facility Self-Assessment

EPSSLC had made revisions to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement.

For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment

	activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an improvement in the facility self-assessment process. Overall, the lead psychiatrist included relevant activities in the "activities engaged in" sections. He should, however, include activities that are in line with what the monitoring team assesses as indicated in this report. For example, for J14, the self-assessment stated that this provision item was in substantial compliance because the "psychiatrist has adopted a new Informed Consent Form." While a new form had been developed, there was no corresponding policy and procedure regarding the use of this form, and the form had not been implemented at the facility. The monitoring team would require policy and procedure as well as the implementation of the process and an assessment of the clinical utility of the process and subsequent documentation. To take this process forward, the monitoring team recommends that the lead psychiatrist review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should allow the lead psychiatrist to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the lead psychiatrist and believes that the facility was proceeding in the right direction. This was a good first step. The facility self-rated itself as being in substantial compliance with nine provision items: J1, J2, J3, J7, J9, J11, J12, J14, and J15. The monitoring team agreed with three of these J1, J12, and J15.
	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 12 of the items in this provision of the Settlement Agreement. More than half of the individuals received psychopharmacologic intervention (78 of the 130, 60%). There was a laudable effort placed into the improvement of the clinic process, especially regarding psychiatric documentation. There were a limited number (16) of evaluations completed in Appendix B format. The current practice of assigning diagnoses without review of detailed diagnostic criteria did not meet generally accepted professional standards of care. In addition, there were discrepancies in psychiatric diagnoses across different disciplines' evaluations (e.g., physician's annual medical review, ISP, PBSP). More work needs to be done regarding justification and case formulation for specific diagnoses as well as the indications for psychotropic medications. It will be important for collaboration to occur between psychology and psychiatry in case formulation, in the joint determination of target symptoms and descriptors or definitions

	of the target symptoms, and the use of objective rating scales when appropriate. The monitoring team observed three separate psychiatric clinics, and one neuro-psychiatry clinic. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QDDP, direct care staff, and the individual). A review of psychiatric documentation (specifically quarterly medication reviews) for 17 individuals revealed that in 100% of the documentation reviewed, MOSES and DISCUS were completed appropriately, results were included in the documentation, and results were reviewed as part of the clinical decision making process. There were no specific treatment plans for psychotropic medication that contained the components required by provision item J13. Records reviewed revealed multiple examples of medication adjustments performed concurrently or rapidly with no time for review of behavioral data to determine the appropriateness of the dosage change. Nevertheless, there were several areas where the facility was able to achieve substantial compliance ratings (e.g., J15, J12), 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.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications</u> 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. Psychiatry staffing, administrative support, and the determination of required FTEs are addressed below in section J5. <u>Experience</u> 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 14 additional months of experience, having started his current job 11/1/10. <u>Monitoring Team's Compliance Rating</u> Based on the qualifications of the FTE psychiatrist at EPSSLC this item was rated as being	Substantial Compliance

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		in 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.	<u>Number of Individuals Evaluated</u> At EPSSLC, 78 of the 130 individuals (60%) received psychopharmacologic intervention at the time of this onsite review. There were a limited number (16) of evaluations completed in Appendix B format (discussed in J6). There were concerns regarding the limited psychiatric resources (addressed in J5) expressed by the psychiatry team as one of the factors resulting in the insufficient number of completed evaluations. <u>Evaluation and Diagnosis Procedures</u> Via the monitoring team's observation of three psychiatry clinics during the monitoring review, it was apparent that the team members attending the visit were well-meaning and interested in the treatment of the individual. In some cases, however, it was disappointing that staff did not know valuable information regarding the individual. • For example, Individual #58 was reviewed at psychiatry clinic due to a Reiss Screen performed for behavioral changes suspicious of psychiatric problems. o The psychiatrist, performing the initial interview, was attempting to communicate with the individual, who, although nonverbal, did appear to have some understanding of verbal communication. Although she had reportedly resided at EPSSLC since 1981, staff at clinic were unable to state if her preferred language was English or Spanish. o This individual was experiencing crying spells, grabbing at her throat, drooling, and mouthing objects. Staff said that these episodes were due to "frustration." The team discussed at length a possible diagnosis of depression. Ultimately, the monitoring team suggested GERD as a possible etiology. It turned out that this individual was being treated with Carafate, however, it was being dosed inappropriately after meals (as opposed to prior to meals). Following lengthy discussion, it was decided that the individual would be referred to medical clinic for a review of both the status of the GERD diagnosis and treatment. This example was illustrative of the team examining other possible etiologies of the individual's behavioral challenges prior to determining that the challenging behaviors were solely related to a mental illness. It should be noted that the monitoring team participated heavily in the discussion, specifically with regard to queries regarding the possible contribution that GERD related symptoms made to the individual's difficulties. What was also concerning was the suggestion by psychiatry that this individual met criteria for an autistic spectrum disorder. This individual, although nonverbal, was interacting with team members, handing her ball back and forth,	Noncompliance

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		and playing interactively with staff. The monitoring team suggested that the psychiatrist and the team review the diagnostic criteria for autistic spectrum disorders, and suggested that this individual's challenges may be due to a genetic syndrome (because this individual had a physical appearance suspicious for this type of disorder). Following a review of the diagnostic criteria for autistic spectrum disorders, the team was in agreement. Unfortunately, there were no resources at the facility for genetic testing to determine the suspected genetic syndrome. • In a second example, Individual #20 was also presented to psychiatry clinic due to a Reiss Screen performed for behavioral changes suspicious for psychiatric problems. o This individual was nonverbal and exhibited signs and symptoms consistent with an autistic spectrum disorder (e.g., impaired social interaction, nonverbal, self-stimulation, hand flapping). The staff participating in psychiatric clinic were focused on a diagnosis of Asperger's disorder. At the insistence of the monitoring team, the diagnostic manual was reviewed and the psychiatrist realized that, because the individual was nonverbal, this diagnosis was inappropriate. It was strongly recommended to the psychiatrist and the team participating in psychiatry clinic that they review the diagnostic criteria when making a diagnosis for an individual. This observation raised concern with regard to appropriate diagnoses for <u>all</u> individuals. The documentation generated as a result of this psychiatric clinic was reviewed. The specific diagnostic criteria that this individual exhibited that were reviewed with the monitoring team were not reflected in the documentation. In addition, although, there was a laudable effort placed into the improvement of the clinic process regarding psychiatric documentation, the monitoring team had difficulty determining the current diagnoses due to discrepancy in psychiatric diagnoses across different disciplines' evaluations (e.g., physician's annual medical review, ISP, PBSP). It was recognized that some of the challenges to providing care in the facility were out of the psychiatrists' control (e.g., lack of reliable data). The current practice of assigning diagnoses without review of detailed diagnostic criteria does not meet generally accepted professional standards of care. For further information regarding these issues, please see J8 and J13 below.	

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		Clinical Justification In order to improve documentation about evaluating and diagnosing individuals in a clinically justifiable manner, recently, the psychiatric staff designed a new form called the "quarterly psychiatric medication review." The monitoring team encouraged the lead psychiatrist to develop psychiatry policy and procedure to instruct the IDT about expectations of material to be presented in the psychiatry clinics per the new format. These changes represented progress, but the implementation of the proposed plan should be a formal facility-wide process. Tracking Diagnoses and Updates Due to the facility not having an updated database to track these elements, the IDT and monitoring team were not able to determine details of diagnostics or revision of diagnostics. Given the IDT type clinical encounter now utilized for psychiatry clinic, the monitoring team would expect more cohesion in the documentation, however, as illustrated in this report, this was not the case (see J9 for an example). There was no facility specific policy and procedure outlining the function of psychiatry clinic at the facility. A facility-specific policy and procedure might help with development of a system to ensure appropriate documentation and clinical consistency across disciplines. Monitoring Team's Compliance Rating Based on the early stage of development for the psychiatrists to document delivery of care (i.e., new quarterly psychiatric medication review), and the lack of completion of evaluations to ensure that no individual received psychotropic medication without having been diagnosed in a clinically justifiable manner (i.e., incompletion of the majority of Appendix B evaluations), this item was rated as being in noncompliance. The facility self-assessment had rated this item in substantial compliance, indicating that 100% of the individuals prescribed psychotropic medications had a clinically justifiable diagnosis. Record review revealed a paucity of completed Appendix B evaluations and unacceptable gaps of time between quarterly medication reviews. As such, the monitoring team did not concur with the facility self-assessment.	
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	Treatment Program/Psychiatric Diagnosis Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. While all individuals prescribed medication had diagnoses noted in the record, there were instances noted where the diagnosis provided by psychiatry differed from that included in the behavior support plan (BSP). The monitoring team reviewed the active positive behavior support plan (PBSP), sometimes referred to as a behavior support plan (BSP) in the sample of 17 records reviewed. All 17 individuals prescribed medication had a PBSP on file. The content of	Noncompliance

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	of staff, and effective immediately, psychotropic medications shall not be used as punishment.	the PBSPs is reviewed in section K of this report. It was notable the BSP documents sometimes did not include a signature from the treating psychiatrist, yet medication regimen, medication side effects, and medication changes were described in detail in the BSP. Although it was good to see this information in the BSP, it must be developed in consultation or collaboration with the individual's prescribing psychiatrist, and appropriately included in the comprehensive psychiatric assessment/quarterly psychiatric reviews. It will be imperative that psychiatry and psychology formulate a cohesive diagnostic summary for each individual. The absence of this process resulted in difficulties for the individuals. For example, in the record of Individual #120, the BSP dated 2/2/11 indicated diagnoses of Disruptive Behavior Disorder and Severe Mental Retardation. Psychiatric diagnoses per the quarterly psychiatric medication review dated 12/27/11 revealed diagnoses including Intermittent Explosive Disorder, mood disorder due to status post meningitis causing orbitofrontal disconnection syndrome. Psychiatric documentation revealed documentation of concerns regarding this individual's mood symptoms and indicated that "he had been diagnosed wrongly with disruptive behavior disorder and his treatment was geared to that instead of a mood disorder…have reassessed his medications and started him on Tegretol for impulsivity and mood stabilization, increased his Paxil for depressive features." As psychiatric documentation prior to this date was not provided for review, it was not possible to determine when the diagnoses changed because, in the document, the current diagnoses included a mood disorder. Review of the log entitled "Individuals Prescribed Psychotropic Medication," which included dates when individuals were evaluated by psychiatry, did not include any contact dates for this individual. What was not clear was if the IDT was aware of the shift in treatment focus and need to adjust the BSP to address and assess for mood symptoms that were apparently contributing to this individual's behavioral challenges. In this particular example, because behavioral supports were not addressing mood, it was apparent that medications consisting of Tegretol, Paxil, and Clonazepam were being utilized in the absence of appropriate treatment supports. For further discussion regarding the issue of discordant diagnoses (i.e., differing diagnoses between psychiatry and psychology), please see J11. Also, as noted in J9 below, PBSP documents reviewed for this monitoring period did not adequately identify non-pharmacological interventions outside of specific PBSP behavior supports. Therefore, it must be considered that some psychotropic medications were being used in lieu of, and perhaps as a substitute for, a treatment program. For instance, individuals require active engagement during the day. In walking around the facility during the daytime and early evening, the monitoring team noted individuals	

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		often milling about, not engaged in activities. This lack of engagement must be addressed because it can lead to increased behavioral challenges including, but not limited to, self-injurious behavior, self-stimulatory behavior, and exacerbations of mood disorders. There was, however, no indication that psychotropic medications were being used as punishment or for the convenience of staff. While all individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the justification and case formulation for specific diagnoses as well as the indications for psychotropic medications prescribed to address the diagnoses in the record. For further discussion regarding this issue, please see the discussion below in sections J8 and J13. It will be important for collaboration to occur between psychology and psychiatry in case formulation, and in the joint determination of target symptoms and descriptors or definitions of the target symptoms, as well as the use of objective rating scales normed for the developmentally disabled population. It will be imperative that psychiatry and psychology staff meet to formulate a cohesive diagnostic summary inclusive of behavioral data and in the process generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and to discuss strategies to reduce the use of emergency medications. It is also imperative that this information is documented in the individual's record in a timely manner. <u>Emergency use of Psychotropic Medications</u> The facility self-assessment did not provide any data regarding the emergency use of psychotropic medications. 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 SIB/agitation/aggression had remained relatively stable, as there were eight instances of emergency psychotropic medication utilization between 6/5/11 and 11/24/11 compared to 10 incidents in the previous six months. For the current review period, there were eight instances involving four individuals. Individual #161 received emergency psychotropic medication on five different occasions. As was discussed with psychiatric and primary care staff during the monitoring visit, there was concern on the part of the monitoring team regarding the multiple medications utilized for each chemical restraint episode. For example, this individual received a total of Haldol 5 mg on 10/6/11. On two subsequent occasions, 11/21/11 and 11/24/11, she was prescribed Haldol 5 mg, Ativan 2 mg and Phenobarbital 65 mg (the dosage of Phenobarbital was increased to 130 mg during the second November 2011 episode). Phenobarbital has no indications for use with regard to psychiatric illness and, therefore, would be utilized in this case simply for sedative properties. Documentation revealed	

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		that this individual experienced little benefit as a result of the chemical restraint or during subsequent chemical restraint episodes dated 11/21/11 and 11/24/11. A review of this individual's record revealed that, per the psychiatric evaluation dated 10/21/11, the psychiatrist documented "much of her behaviors are caused by a combination of neuropsychiatric disorders…we believe that pharmacological interventions will help to stabilize this individual but it will be the behavioral interventions which will maintain remission and continued improvement." Review of this individual's BSP dated 6/8/11 did not reveal any updated information regarding alterations to the plan to address increasing behavioral challenges. IDT meetings were documented subsequent to each chemical restraint episode, however, other than alterations to the medication regimen in an attempt to address symptoms, there was no notation of behavioral interventions or non-pharmacological treatment other than one to one level of supervision. <u>Monitoring Team's Compliance Rating</u> Although the facility self-rated this item in substantial compliance, following discussion with facility staff, it was understood that due to the paucity of non-pharmacological interventions, and the apparent over reliance on psychotropic medication, this provision would remain in noncompliance.	
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.	<u>Extent of Pretreatment Sedation</u> There was a listing of individuals who received pretreatment sedation for either medical or dental clinic. This listing indicated 48 individuals received pretreatment sedation for dental clinic and 37 individuals received pretreatment sedation for medical clinic, with a total number of 85 individuals receiving sedation. It was not possible to determine if the individuals designated as receiving dental pretreatment sedation were the same individuals ultimately referred for TIVA. Of the 85 individuals listed receiving pretreatment sedation for either medical or dental treatment, 58 (68%) were enrolled in psychiatry clinic. The document provided to the monitoring team did not provide the information required for tabulating the extent of TIVA. Per interviews conducted during the monitoring review, TIVA began at the facility in August 2011. There were approximately six sessions conducted with approximately 20 patients receiving TIVA. In summary, in order to evaluate the extent of pretreatment sedation utilized at EPSSLC, the calculation should include one comprehensive list of individuals who have received pretreatment sedation medication <u>or</u> TIVA for medical or dental procedures that includes: individual's name, designation of whether it was medical or dental pretreatment sedation, date the pretreatment sedation was administered, name, dosage,	Noncompliance

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		and route of the medication, and date of ISP that documents review to minimize the need for the use of pretreatment sedation medication. <u>Interdisciplinary Coordination</u> Interviews with the dental department staff, psychology, pharmacy, primary care, and psychiatry, as well as observation of the Pretreatment Sedation meeting and documentation from the IDT mini-staffing regarding Pretreatment Sedation, indicated that the facility had a good process for review of medication regimens prior to the administration of pretreatment sedation. The individual cases were reviewed via the IDT and then presented during the monthly pharmacy meeting for a review of the current medication regimen in comparison to the planned additional medication. During this meeting, adjustments to the individual's existing regimen could be made in an effort to reduce the duplication of medications administered. For example, individuals scheduled for pretreatment sedation may require a reduction in dosage of scheduled benzodiazepines in order to avoid over-medication. This process was observed during the previous and current monitoring visits. <u>Desensitization Protocols and Other Strategies</u> A list of all individuals with medical/dental desensitization plans and date of implementation were requested. The monitoring team was provided with a copy of an email dated 12/12/11 indicating that five dental desensitization plans had been implemented. Discussions with facility staff revealed some level of frustration with desensitization plans, as the responsibility for this process was "all falling on psychology." The monitoring team discussed with facility staff that what was first necessary was a process to triage those individuals who would be immediately amenable to desensitization, and then an individualized assessment of the individual's abilities and where that individual would start desensitization on a continuum. For example, some individuals may be able to come to dental clinic and sit in the dental chair. Others may need to start with desensitization with regard to basic dental hygiene. What was needed was the development of individualized strategies and interventions that occurred according to a process inclusive of IDT involvement in the development of the protocol. The facility should understand that the goal of this provision item is that there be treatments or strategies to minimize or eliminate the need for pretreatment sedation. That is, formal desensitization programs may not be necessary for all individuals (though certainly will be necessary for some individuals). Processes have been developed at other DADS facilities (e.g., LSSLC) that may serve as a model. <u>Monitoring After Pretreatment Sedation</u> A review of provided documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented	

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		assessment of the individual and vital signs. Monitoring Team's Compliance Rating This item will remain in noncompliance because further effort must be made with respect to the development of desensitization protocols and/or other individualized treatments or strategies. Plans must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the 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.	Psychiatry Staffing More than 50% of the census (a total of 78 individuals) received psychopharmacologic intervention requiring psychiatric services at EPSSLC as of 1/11/12. At the time of this monitoring review, there was one FTE board certified psychiatrist, designated as the lead psychiatrist, providing services at the facility. This psychiatrist was scheduled to work 40 hours per week and was available after hours via telephone consultation. Administrative Support Psychiatry clinic staff included a Rehab Therapy Tech III and a Psychiatric LVN III. These staff members were invaluable with regard to organizing and structuring psychiatry clinic so as to make the most out of the scarce psychiatry resources. Psychiatry clinic staff admitted to "multitasking." It was apparent during the monitoring visit that these staff members were working hard, but due to the level of need, were struggling to provide services. Determination of Required FTEs EPSSLC psychiatric staff calculated the required FTEs for improved provision of care and coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology, as being a minimum of 1.5 FTE prescribing psychiatric practitioners. The lead psychiatrist indicated the number of hours for the conduct of the psychiatry clinic were developed to take into account not only clinical responsibility, but also documentation of delivered care, such as quarterly reviews, Appendix B comprehensive evaluations, and required meeting time (e.g., physician's meetings, behavior support planning, emergency ISP attendance, discussions with nursing staff, call responsibility, participation in polypharmacy meetings). The facility had one FTE prescribing psychiatric practitioner at the time of the site visit. Overall, EPSSLC had done an adequate job in assessing the amount of psychiatric FTEs required and it was reported that a search for additional psychiatry contract providers had begun. As noted elsewhere in this report, there were delays in completion of quarterly psychiatric medication reviews. These were opined to be due to a lack of staff and staff absences in the intervening period since the last monitoring report. For further information regarding this issue, please see the discussion under J13, J12, and J9.	Noncompliance

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		Monitoring Team's Compliance Rating Due to the lack of sufficient psychiatric resources to provide the services required, this provision remained in noncompliance.	
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.	Appendix B Evaluations Completed EPSSLC psychiatry staff reported a total of 16 individuals had psychiatric evaluations performed according to Appendix B. Given that 78 individuals received treatment via psychiatry clinic, 80% of the individuals still required a comprehensive psychiatric assessment. At the time of the last monitoring visit, only three initial psychiatric evaluations had been completed for the individuals enrolled in psychiatric clinic. A document submitted prior to the onsite review listed 16 individuals that had a psychiatric assessment completed per Appendix B, with dates of assessment from 4/28/11-1/6/12. During the previous monitoring review, the monitoring team was provided with a schedule for completion of Appendix B evaluations where 77 individuals participating in psychiatry clinic were scheduled for a comprehensive psychiatric evaluation, with the last individual scheduled 4/2/12. Given challenges with psychiatry clinic and scarce resources, this schedule was ambitious and not feasible. A sample of Appendix B style evaluations were reviewed for the following 10 individuals: Individual #8, Individual #104, Individual #191, Individual #51, Individual #133, Individual #23, Individual #39, Individual #83, Individual #73, and Individual #13. While the evaluations followed the format for the Appendix B outline, there were areas in need of improvement. In general, the relevant history was provided. There was extensive documentation of the psychotropic medication history. In all examples, there was documentation of multiple medication changes over the past year. For further information regarding this topic, please see J13. It was difficult, in the absence of a clear and explicit case formulation, to determine the appropriateness of the diagnosis. For example, in the Appendix B evaluation of Individual #51, the history of present illness noted "aggression towards peers…urinate in public…severe SIB…tantrums…genital fondling, rectal digging…Zyprexa began causing severe weight gain…was discontinued…after two months…extremely agitated…SIB…appeared to be hallucinating…added the diagnosis of Pervasive Developmental Disorder, autistic type…he fulfills the criteria per DSM-IV." … "until he was seven months his developmental milestones were normal…walk at…13 months…never really spoke…at seven months…prolonged high fevers and rash…age of two years…meningitis with sequelae…"	Noncompliance

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		Further review of the document did not reveal a review of the symptoms or behaviors that this individual was experiencing that led to the specific diagnosis. There was no case formulation tying together the information provided from the various disciplines. Moreover, this document included information that was taken directly from the ISP document. Per the documentation, "after several psychiatric clinic IDTs we came to the conclusion that [individual] suffered from (1) Pervasive Developmental Disorder, (2) psychotic disorder, not otherwise specified, and (3) Impulse control disorder, not otherwise specified." This was the extent of the diagnostic review. All Appendix B evaluations included information regarding the integrated treatment plan that was taken directly from the ISP document. While this is useful, what is required is a case formulation that reviews information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. This should inform treatment recommendations, both from a pharmacological and non-pharmacological perspective. For further information regarding case formulations, see J8. In addition, instruction in the treatment recommendations must include non-pharmacologic intervention and pharmacologic intervention as summarized in Appendix B. The psychiatrist must guide the IDT in a detailed fashion about intention of each medication and what to monitor in order to determine medication efficacy in an evidence-based manner. This is an area that would be amenable to quality assurance or peer review monitoring. <u>Monitoring Team's Compliance Rating</u> The data indicated an average of two comprehensive assessments, as described in Appendix B were completed per month. The monitoring team reviewed this rate with determined it would take approximately two and a half years to complete the remainder of the Appendix B evaluations, without any additional admissions to the facility. Given the number of comprehensive psychiatric assessments outstanding, this provision will remain in noncompliance. In addition, the completed Appendix B evaluations reviewed would benefit from critical review via a peer review process or quality assurance monitoring.	

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J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Reiss Screen Upon Admission</u> The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at EPSSLC, only for those who did not have a current psychiatric assessment. The data presented to the monitoring team for this provision were unreliable. • The facility had two new admissions for the previous six months with both of these individuals being administered a Reiss screen (based on information provided to the monitoring team). o Individual #134 was reportedly screened within two weeks of admission. Per documentation, this individual was followed in psychiatry clinic; however, a review of his record did not reveal any psychiatry documentation. Additional documentation received via a spreadsheet of all Reiss Screens completed within the past 12 months indicated that this individual's Reiss Screen results indicated "no need for further assessment." Further review of this individual's record did not reveal any medication prescription or behavioral challenges that would have required psychiatric intervention. It was noted that there may have been a typographical error in documentation. o Individual #133 was screened approximately four months following admission. Fortunately, this individual received a comprehensive psychiatric evaluation within 19 days of admission. Per documentation, this individual was followed in psychiatry clinic. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> This was a difficult item to assess because there were three different sources of information provided (one in the Section J presentation book, and two via documents submitted prior to the onsite review). Three data sources provided different/conflicting information. Per documentation reviewed of a listing of individuals residing at the facility who were not currently receiving treatment via psychiatry clinic there were 72 individuals who would be appropriate for Reiss screening (the sum of the difference between the number of individuals currently participating in psychiatry clinic and the total number of individuals housed on campus). Of these, 32 individuals had documented completed screens. Of the 32 individuals who had completed Reiss screening, five individuals were referred to psychiatry clinic. Further, nine individuals known to psychiatry clinic and to the monitoring team from previous monitoring reviews/reports were reportedly screened 12/9/11. There was no notation of the rationale for the screen or an indication as to what change in status had occurred that resulted in the screening. Per information obtained via psychiatry clinic, there were 28 Reiss screens performed where no further assessment was needed. In an additional 12 instances, the individual	Noncompliance

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		was currently being seen in psychiatry clinic (it was not possible to determine from the data if these individuals entered into psychiatry clinic as the result of the screening). Nine individuals were referred to psychiatry clinic following screens occurring 12/2/11 through 12/9/11 and were scheduled to be seen 12/21/11 through 1/11/12. The documentation indicted that two individuals received Reiss screening due to a change in status. Given the data provided, it was difficult to determine which individuals were previously psychiatry clinic patients, which were referred and entered the clinic following a routine Reiss Screen, and which were screened due to a change in behavior or circumstance and then entered the clinic. What was noted during the monitoring review was that psychiatry reviewed all completed screens. Also good to see was that during the onsite review, two individuals with no history of treatment in psychiatry clinic who had positive screens were presented for their initial psychiatric evaluation. <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> Individuals that were referred for an evaluation due to the "score equated high" on the screen were either already enrolled in psychiatry clinic or, per the log document, were referred to psychiatry via the QDDP. Discussions with psychiatry clinic staff revealed that they were attempting to formalize the process by which individuals are referred to psychiatry clinic. This process must be formalized in policy and procedure <u>Monitoring Team's Compliance Rating</u> Given the challenges with the unreliable data presentation and individuals not being screened upon admission, this provision remained in noncompliance.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	<u>Policy and Procedure</u> The SSLC statewide policy and procedure dated 8/30/11 for psychiatry services had a title of "Integrated Care" summarizing that each state center must "develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation." There were, however, no specific procedural elements denoted for the IDT to follow, therefore, there were no written documents to guide the development and implementation of such a system to address this provision. The facility did not have facility specific policy and procedure regarding psychiatry in effect. <u>Interdisciplinary Collaboration Efforts</u> The monitoring team observed three separate psychiatric clinics, and one Neuro-Psychiatry clinic. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the	Noncompliance

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		disciplines (psychiatry, psychology, nursing, QDDP, direct care staff, and the individual). There were challenges noted with the receipt of information from psychology with regard to behavioral assessments and the determination of behavioral antecedents. One area of integration that required attention was regarding the use of data. Both psychiatry and psychology staff voiced concern regarding the accuracy of the choice of clinical indicators for the individual. It was also notable that graphs of data presented to the physician did not, but should, 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). 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. For further discussion regarding the graphing and presentation of data, please see section K of this report. Medication decisions made during clinic observations conducted during this onsite review were based on lengthy (minimum 40 minute) observations/interactions with the individuals, as well as the review of information provided during the time of the clinic. In the three clinic observations, the psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them, and discussed the plan, if any, for changes to the medication regimen. As stated repeatedly in this report, there was an IDT process within the psychiatry clinic with representatives from various disciplines participating in the clinical encounter. While this was a positive development, as noted in the examples above, there was a need for improvement both in combined assessment and case formulation, as well as improvements in the review of specific diagnostic criteria, for each diagnosis such that this process would comport with generally accepted professional standards of care. A review of the psychological and psychiatric documentation for 17 individual records 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. This type of collaboration should be evident in psychiatry clinic, the psychiatric treatment plan, psychiatric assessments, the ISP process, the PBSP process, and, hopefully, with other interventions and disciplines (e.g., speech and language, OT/PT, medical). Case formulation should provide information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. There was minimal discussion during the	

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		psychiatric clinics regarding results of objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions. As noted in J9 below, depending on what document was reviewed, there were varied diagnoses. Interviews conducted during this monitoring review revealed that combined case assessments and formulations had been inconsistently occurring since the last review. There was however, the more integration between psychiatry and psychology, specifically the attempts by psychiatry to attend some ISP meetings, opportunities for interaction during psychiatry clinic with the psychologist and other disciplines, as well as the weekly meeting between the lead psychiatrist and the director of psychology. Additionally, there were noted attempts to increase integration with primary care. This was evidenced by the log book maintained by psychiatry clinic staff with regard to consultation and collaboration between psychiatry and primary care. <u>Integration of treatment efforts between psychology and psychiatry</u> There were noted attempts by both psychiatry and psychology leadership to improve and integrate treatment efforts. This was noted via the weekly integration meeting attended by the lead psychiatrist, psychiatric clinic staff, and the director of psychology. This meeting was observed during the monitoring review, and the improvement of communication between leadership was apparent over prior monitoring visits. There remained challenges with regard to collaborative case formulation and diagnostic concordance between documentation generated by psychiatry and psychology. <u>Coordination of behavioral and pharmacological treatments</u> As noted in J13 below, there was cause for concern with regard to medication regimen alterations in the absence of data review to determine the effect of a specific medication change on the individual's symptoms or behaviors. As discussed with the psychiatric clinic team during the monitoring visit, the generally accepted professional standard of care is to change medication dosages slowly while simultaneously reviewing the data regarding identified target symptoms. In this manner, the psychiatrist can make data driven decisions with regard to medications, and the team can determine the need to increase or alter behavioral supports to address symptoms. This type of treatment coordination was not evident in the psychiatric clinics observed, nor in the clinical documentation reviewed. <u>Monitoring Team's Compliance Rating</u> Due to the lack of documentation of combined assessment and case formulation, this provision remained in noncompliance.	

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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.	<u>Psychiatry Participation in BSP and other IDT activities</u> Per interviews with the psychiatry staff, the prescribing psychiatric practitioner did not routinely attend meetings regarding behavioral support planning for individuals assigned to his caseload, and he and other psychiatry staff were not consistently involved in the development of the plans. During psychiatry clinic, the psychiatrist was noted to ask pertinent questions regarding behavioral challenges, how these were being addressed via the BSP, questioning the function of specific behaviors, and focusing on the non-pharmacological interventions (or the lack thereof) utilized in a particular individual's case. The psychiatrist stated a willingness to become formally involved, but indicated that a lack of clinical time and requirements of attendance at other meetings would likely make 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. It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. There was, however, stability with regard to the psychiatrists' participation in IDT meetings. There were 34 examples of psychiatry participation in the IDT process between the dates of 7/3/11 and 11/23/11 (this was a similar number to that reported during the prior monitoring period). What was notable was the constellation of staff present at psychiatry clinic, such that this clinic encounter would also qualify as an IDT gathering. <u>Treatment via Behavioral, Pharmacology, or other Interventions</u> The following example highlighted the continued problems of poor communication amongst the team members and, therefore, the existence of an inadequate development of the treatment plan by the IDT. • The BSP for Individual #108 was reviewed. In addition, the monitoring team had the opportunity to attend an IDT meeting for this individual. During the meeting, it was discussed that this individual had not made progress with regard to programming due to her refusal to participate. Unfortunately, the individual's BSP had not been revised to address the issue of refusal. During the IDT meeting, the team discussed consideration of a short time period with smaller, achievable goals rather than global goal setting. It was also discussed that this	Noncompliance

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		individual (with a diagnosis per the BSP dated October 2011of Major Depressive Disorder, recurrent; Panic Disorder; Generalized Anxiety Disorder) had experienced a reported regression in her activities of daily living (poor oral hygiene and decreased interest in leisure activities). A review of the psychiatric summary for the quarterly review meeting dated 1/6/12 revealed that the diagnoses included Impulse Control Disorder, not otherwise specified, and Profound Mental Retardation. Given the differing diagnoses reported per psychiatry and psychology, with a history of a diagnosis of a depressive disorder in an individual with a regression of abilities, it was apparent that a re-evaluation of her treatment program was required. It was also notable that the BSP indicated a history of treatment with antidepressant medication, and the most recent psychiatric documentation did not include an antidepressant in the medication regimen (current medications were noted as Haldol Decanoate, Zolpidem, and Lorazepam). Per a review of the Individuals Prescribed Psychotropic Medication spreadsheet that included dates of clinical contact with psychiatry, this individual was last seen for a quarterly psychotropic medication review 7/11/11. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> The psychiatrist was aware that the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports, were not necessarily chosen due to the identified psychiatric diagnosis. The psychiatrist attempted to give feedback to the IDT during the psychiatry clinic, specifically with regard to the need for improved non-pharmacological interventions. The psychiatrist was noted during clinic to routinely check the individual's BSP to determine what non-pharmacological interventions were suggested. Unfortunately, it was apparent from discussions with the team that these interventions were either not occurring or occurring on such a sporadic basis as to be ineffective. • For example, Individual #129 was referred to psychiatry clinic following a positive Reiss screen. Reportedly, he had experienced increased tantrum behavior, SIB, hostility, and aggression. This individual was not currently prescribed psychotropic medication and the psychiatrist was reluctant to prescribe medications, opining that the behaviors could be addressed via the BSP. The individual's IDT documentation regarding his likes was reviewed, and it indicated that he enjoyed being outside. The record was reviewed to determine when he last engaged in activity that he enjoyed. The record was reviewed back to 11/27/11 and there was no noted documentation. It was reported by staff that active engagement was not documented in the record. It was decided to refer this individual to program development in an attempt to increase his daily activities and involvement.	

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		Monitoring Team's Compliance Rating To meet the requirements of this provision item, there needs to be an indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. As stated in other sections of this report regarding provision J, psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological. Therefore, this provision item was rated as being in noncompliance.	
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.	Policy and Procedure A review of DADS policy and procedure entitled "Psychiatry Services," dated 8/30/11, noted that state center responsibilities included that the psychiatrist "must solicit input from and discuss with the [IDT] any proposed treatment with psychotropic medication…must determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of the psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications." Quality of Risk-Benefit Analysis Per staff interview and record review, there had been some change with regard to this practice, specifically with regard to increased consultation and collaboration with the primary care physician. Psychiatry clinic staff had begun keeping a detailed log of consultations between psychiatry and primary care. A current review of the records of 17 individuals at the facility who were prescribed various psychotropic medications revealed variability in the quality of the specific risk/benefit analysis with regard to treatment with medication as required by this provision item. For example, the Initial Psychiatric Evaluation regarding Individual #8 dated 10/17/11 indicated, "the risks and benefits of the…plan have been reviewed by the [Interdisciplinary Team]…this approach has the highest potential for improving quality of life." The document then goes on to review each prescribed medication and include documentation of potential side effects associated with each. Although it was good to see that there was an attempt to review each medication's side effects, this was not an exhaustive list, and did not address all major side effects (for example, side effects associated with Seroquel did not include cataracts, Tardive Dyskinesia). Specific risks were not addressed in the document. The facility shared a revised quarterly psychiatric medication review document, the completion of which may address some of these issues. 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	Noncompliance

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		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 comprehensive manner in which psychiatry clinic was conducted during the review (inclusive of thorough interviews and team discussion), the elements necessary to this documentation appeared to be readily available. The goal is to transfer this discussion into a cogent document. 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. <u>Observation of Psychiatric Clinic</u> During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed some of the laboratory findings with the IDT, but did not thoroughly outline findings in the form of a risk/benefit analysis. The structure of the new quarterly psychiatry form developed at EPSSLC, however, may facilitate this process in the future. The development of the risk/benefit analysis was undertaken during psychiatry clinic. The team should consider reviewing this type of information together via a projector/screen and typing the information <u>during</u> the clinic process. The QDDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the IDT currently participating in psychiatry clinic, access to equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time will be necessary to set up the shell of the document. The monitoring team is available to facilitate further discussion in regards to this recommendation, if requested. The 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 also compares the former to likely outcomes and/or risks associated with reasonable alternative strategies.	

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		Human Rights Committee Activities A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). The following example of Individual #108, presented to HRC Committee 10/19/11 showed the results of insufficient documentation by the psychiatric physician regarding an individualized specific risk/benefit analysis, yet even so, it was approved by the HRC. • Adderall 5 mg in the morning and Trazodone 200 mg at bedtime were presented. The justification for the medication included information that the individual was not sleeping well, however, the presentation did not state the potential for this medication to further disrupt sleep patterns. At the same time, Trazodone 100 mg was started for "insomnia," Ambien was discontinued, and Saphris was tapered. • At the next clinic encounter, 11/16/11, behavioral challenges including aggression, agitation, SIB, refusal to eat and poor sleep were noted. These behaviors were attributed to the discontinuation of Haldol Decanoate. Documentation did not indicate that the physician considered stimulant medication as a potential etiology for these behaviors. Medication orders of this date discontinued Trazodone and Adderall XR, started Haldol Decanoate 200 mg IM every two weeks, and Ambien 10 mg at bedtime. • The medications prescribed on 11/16/11 were presented to HRC on 11/23/11. The documentation provided indicated that this individual continued to experience insomnia, such that Ambien was necessary, and that Haldol Decanoate was needed due to "uncooperative, disrobing…removing her shoes, and refusing any kind of redirection." The documentation revealed "no questions/concerns from any members of the committee." There was no notation of the HRC questioning the multiple medication regimen changes and the potential for side effects from the previous medication regimen. For additional discussion regarding multiple medication changes please see J13. Monitoring Team's Compliance Rating 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. The input of the psychiatrist and various disciplines must occur and be documented in order for the facility to meet the requirements of this provision item.	

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J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Facility-Level Review System 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. Review of Polypharmacy Data Documentation presented during the polypharmacy oversight committee meeting 1/12/12 was reviewed. Per these data: • The total number of individuals residing at the facility prescribed antipsychotic medication had decreased from 56 in December 2010 to 49 in December 2011. • The total number of individuals who met criteria for antipsychotic polypharmacy had decreased from six in December 2010 to three in December 2011. • The average number of psychoactive medications prescribed for any individual who received psychotropic medication had been reduced from 3.67 in December 2010 to 3.31 in December 2011. A review of the active psychoactive medication list by drug class revealed that there were three individuals meeting criteria for intraclass polypharmacy for antipsychotic medications, three individuals with intraclass polypharmacy for antidepressant medications, two individuals with intraclass polypharmacy for benzodiazepines, one individual with intraclass polypharmacy for sedative medication (inclusive of Zolpidem and Trazodone), and eight individuals with intraclass polypharmacy under miscellaneous (inclusive of medications such as Benztropine, Lithium, Guanfacine, Propranolol, Guanfacine). This was a total of 17 individuals. There were an additional 39 individuals with intraclass polypharmacy for seizure medications. A review of the pharmacy quarterly drug regimen documents located in 17 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 51 individuals who met criteria for psychotropic medication polypharmacy.	Noncompliance

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		There were 49 individuals prescribed antipsychotic medications at the facility (a decrease from 50 individuals the previous monitoring review). Of these: • Three individuals were prescribed two antipsychotics (reduced from five during the previous monitoring review) • None were prescribed three antipsychotics (reduced from one during the previous monitoring review). Regarding other classes of medication: • A total of 38 individuals were prescribed antidepressant medications (an increase from 35 during the previous monitoring review): o Of these, two were prescribed two antidepressant medications (a decrease from three in the last monitoring period). • There were 56 individuals prescribed anxiolytic medications (a decrease from 57 in the previous monitoring period). o Of these, two were prescribed two anxiolytic medications (a decrease from three in the previous monitoring period). • Six individuals were prescribed stimulant medication (an increase from six during the previous monitoring period). o There was no polypharmacy noted in this class. • 14 individuals were prescribed sedative medication (a decrease from 15 during the previous monitoring period) o There was one individual prescribed two sedative medications (no change from the previous monitoring period). Of the total of 106 individuals prescribed psychotropic medication from any class in the month of December 2011: • A total of 56 individuals were prescribed two or more psychotropic medications from the same class. The majority of these individuals (39) were prescribed two or more antiepileptic medications. In none of these cases, was the medication being used in the absence of a seizure disorder. Therefore, all 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. It was also noted during the facility level review meeting that this forum should be the place for a lively discussion regarding reviews of the	

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		justification for polypharmacy derived during psychiatry clinic. This element was missing in the facility level review process observed by the monitoring team, as well as documented in meeting minutes. <u>Review of Polypharmacy Justifications</u> Documentation regarding polypharmacy in the record of Individual #61 (treated with two antipsychotic medications) dated 7/27/11 stated "while we have her on antipsychotic polypharmacy she has been the only way she improved on it but will discuss further need for it [sic]. BSP was recently updated and will continue following it. We believe that patients schizophrenia will be controlled [illegible word] these antipsychotic medications rather than behavioral interventions. The symptoms/medication correlation is Zyprexa, Seroquel XR – psychosis. Will return to lover level of Seroquel that she responded to in the past. Cogentin – EPS." Per a review of the log regarding her contact with the psychiatrist, this individual was seen on rounds 8/3/11. There was, however, no documentation of this contact in the integrated progress notes, nor was a psychiatry clinic note located (this may have been a copy error). Regardless, this individual was last seen in psychiatry clinic 7/27/11, indicating that she was overdue for quarterly psychotropic medication review. Documentation regarding polypharmacy in the record of Individual #78 (treated with two antidepressant medications) revealed the most recent psychiatric medication review was performed 7/1/11. This was confirmed via a review of the log regarding individual's contact with the psychiatrist, which documented no clinic visits with psychiatry since that time (there was a risk review documented 8/5/11). Given this time lapse, this individual was overdue for quarterly psychiatry clinic. Per the polypharmacy review, this individual was prescribed Fluoxetine and Amitriptyline. The last psychiatric documentation 7/1/11 did not note treatment with Amitriptyline. Review of the drug regimen profile revealed that this medication (apparently not prescribed by psychiatry) was prescribed for migraine prophylaxis as of 1/21/11. This individual was prescribed Fluoxetine at the 7/1/11 clinical encounter due to "patient has continued with aggression, agitation and SIB behaviors since the sensory plan has not been implemented and reportedly will take some more time, so will try pharmacological intervention…believe that she has some orbitofrontal and frontotemporal disconnection due to anoxia neonatorum and possible [illegible word] convulsions. We will adopt an individual Rx plan with SSRI, anticonvulsant and benzodiazepine." Unfortunately, at this time, the pharmacological treatment review did not include the information regarding psychotropic medications prescribed by other practitioners for non-mental health indications.	

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		Monitoring Team's Compliance Rating The facility had made strides with regard to this provision item, however, given the ongoing challenges noted above with regard to documentation regarding the rationale for polypharmacy in the individual records where polypharmacy was present, the lapse in timely review of medication justification, as well as the need for improvement with regard to the critical review of polypharmacy justification via the facility level review, this provision was rated 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.	Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) In response to the document request for a spreadsheet of individuals who have been evaluated with MOSES and DISCUS scores, the facility provided a notation indicating, "currently spreadsheets are available from each RN case manager indicating dates of completion for both…scores…are not included. Efforts are underway to revise these spreadsheets to include the scores." No spreadsheets were provided in response to the document request, as such it was not possible to determine completion rates or timeliness of the administration of these side effect screening items. Per documentation received from psychiatry, the clinic staff had attempted to create a database inclusive of this information, however, this was challenging with regard to data collection. Per interviews with facility staff, there were plans to institute a tracking system similar to that piloted at Lufkin SSLC. Nevertheless, the monitoring team's review of 17 records revealed that, for this sample, the assessment tools were being administered within the appropriate time frames. Training A review of documentation provided regarding inservice training for nursing case managers revealed that training had been completed during the month of September 2011 for 14 of the 24 staff members requiring it. In four instances, it was noted that training was pending. Of the remaining six nursing case managers, two received training in May 2011, three received training in 2008, and for one staff member training was reportedly not applicable. Quality of Completion of Side Effect Rating Scales In regard to the quality of the completion of the assessments, it appeared that for the set of scales reviewed (10 examples of each assessment tool), all were completed appropriately and included the signature of the psychiatrist. A review of psychiatric documentation (specifically quarterly medication reviews) for 17 individuals revealed that in 100% 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 this information was included in the more	Substantial Compliance

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		recent documentation. Furthermore, 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. This indicated that when the individuals were seen in clinic, the documentation was reviewed and utilized. A review of the log of the individuals prescribed psychotropic medication, however, revealed that, out of 78 individuals participating in psychiatry clinic, 14 had been seen in psychiatry clinic during the last quarter of 2011. Where there were contacts documented for Neuro-Psychiatric clinic and/or Rounds, this was indicative of a delay in quarterly psychotropic medication review by the psychiatrist. The accuracy of these data was questionable, as evidenced in the example of log documentation of Individual #8 that his last contact with psychiatry clinic was 8/24/11, however, an initial psychiatric evaluation dated 10/17/11 was provided for review. Fourteen individuals were noted to have the diagnosis of tardive dyskinesia (TD). Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Medication reduction or the absence of the antipsychotic or metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. <u>Monitoring Team's Compliance Rating</u> Given that the required nursing inservice training had been provided to the majority of staff, and the improvements in the consistency of the documented review of these assessment tools as well as their use in clinical decision making, this provision will be rated in substantial compliance. There was an issue that must be addressed with regard to the time lag between quarterly psychotropic medication review.	
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	<u>Policy and Procedure</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," dated 8/20/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b., the policy directly quoted the language in this provision. There was, however, no facility specific policy and procedure in effect regarding this requirement. Per interviews with the facility psychiatrist and psychiatry clinic staff, a new quarterly medication review format had been devised. This format was inclusive of prompts to ensure compliance with the requirements of this provision (e.g., current DM-IV psychiatric diagnosis, current medications, relevant medical/laboratory	Noncompliance

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	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.	findings, mental status examination/behaviors, behavioral pharmacological treatment hypothesis, psychiatric/psychological case formulation, diagnostic justification according to DSM-IV, psychotropic medication treatment plan; rationale for polypharmacy; relevant drug/drug interactions; risk/benefit analysis, medication response, time for response, current side effects, BSP assessment, criteria for improvement, medication/symptoms correlations, behavioral versus pharmacological intervention assessment). Reportedly, there were five quarterly medication reviews completed according to this newly developed format. Unfortunately, none were submitted to the monitoring team for review. <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 17 individuals, there were no specific treatment plans for psychotropic medication that contained the components required by this provision item. If done correctly, however, the psychiatrist's initial and follow-up evaluations can address the components of a psychiatric treatment plan in the assessment and recommendation sections. A review of documentation did note inclusion of the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or 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 not consistently outlined in the records. As noted above, the implementation of the newly developed quarterly medication review format may be beneficial. <u>Psychiatric Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was some psychiatry participation in the ISP process. As one full time psychiatrist staffed the facility, the schedule did not allow for their consistent attendance or participation in the ISP process. A review of the documentation revealed 34 examples of psychiatry participation in the ISP process between the dates of 7/3/11 and 11/23/11. Given the manner of the data request, it was not possible to determine what percentage of the total number of meetings the psychiatrist attended. In an effort to utilize staff resources most effectively, the facility created an IDT meeting during psychiatry clinic, and could consider incorporating IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry	

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		clinic, the integration of the IDT into psychiatry clinic may allow for improvements in overall team cohesion, information sharing, collaborative case conceptualization, and management. <u>Psychiatry Clinic</u> 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, three psychiatry clinics (for a total of five individuals) were observed. In all but one instance, the individual was present for at least a portion of clinic (Individual #112 presented to clinic, however, as his LAR requested to meet privately with the team, he returned to his home after a brief time). 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 some cases, the data were not up to date, and in the other cases, data were not appropriately graphed. Several team discussions regarding the accuracy of the data were observed during the monitoring review. All staff interviewed expressed skepticism regarding the validity of data. Interviews revealed plans to increase training for direct care staff with regard to data documentation. In addition, timelines for medication dosage changes or stressful life events were not included in the data graphs. This made data based decision making difficult for the psychiatrist, as medication changes and other events that may affect behavior or psychiatric symptoms were not noted. Improvements were noted regarding exchange of pertinent information during some of the psychiatric clinics, however, the data predominantly focused on behavioral presentation (i.e., agitation, self-injurious behavior, or aggression towards others). This information, although relevant, was insufficient if the goal was to implement an evidence-based approach in evaluating medication efficacy associated with a psychiatric disorder. 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, in discussion with staff, and per an observation of one of the meetings, it was apparent that some improvements had occurred.	

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		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. Full implementation of the newly developed format for quarterly medication reviews may assist in this regard. <u>Medication Management and Changes</u> 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. This was often not the case at EPSSLC and thereby did not demonstrate generally accepted professional standard of care and practice in psychiatric medication management practices. Records reviewed revealed multiple examples of medication adjustments performed concurrently or rapidly with no time for review of behavioral data to determine the appropriateness of the dosage change. Below are three. Individual #83 was seen in psychiatry clinic on 11/16/11. The only documentation located from this encounter was a brief integrated progress note. The note indicated, "patient seen and examined during Psychiatric Clinic [IDT] because hyperactivity and insomnia…has been insomniac for the past four to five nights and has had breakthrough hypomania. Patient decompensating due to insomnia." There was no documented review of data or of other contributing factors to this individual's difficulties. There was also no documentation noted from the IDT with regard to this issue. Physician's orders on this date included "Increase Clonazepam to 2 mg in the morning, 2 mg pm and 4 mg at bedtime (the time for pm dosing was not indicated); Ambien 10 mg at bedtime, Decrease Amantadine to 100 mg twice daily for seven days then to 100 mg in the morning for five days, then 100 mg every other day for one week then stop." Laboratory examinations, including a complete metabolic profile, lithium level, and thyroid profile were also requested. • The subsequent psychiatry visit was dated 12/2/11. At this visit, it was documented, that "staff states that patient appears to have less behavioral disturbances. From 10/24 to 10/30 no recorded behaviors…still having episodic agitation with sudden shouting, hyperactivity, agitation which last until staff changes her environment." There was no documented review of sleep data, and documentation of sleep data was not located in the records reviewed. At this visit, medication changes including "change Ambien 10 mg at bedtime to Ambien	

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		CR 12.5 mg at bedtime, Start Trazodone 100 mg at bedtime for insomnia." There was no documentation of review of the laboratory examinations ordered 11/16/11, and record of these was not included in the documents available for review. • This individual was next seen on 1/3/12, at which time "decompensation with insomnia and agitation during menses" was documented via a brief note located in the integrated progress notes. There was no notation of laboratory review, however, a diagnosis of rule out menses-related dysphoria was documented, and Aldactone 50 mg twice daily was prescribed for edema. There was no notation of the slowly increased behavioral challenges that had been noted in the two previous clinical notes, nor was there any review of behavioral data noted. In addition, this individual was also prescribed Lithium, and there must be concern with regard to increasing Lithium levels when prescribing a diuretic to an individual who is also prescribed Lithium. This potential negative medication interaction was not noted in the documentation. • This individual was next seen 1/5/12. Per the clinic documentation "seen due to constant manic type behaviors…aggressive…sleeping poorly…not responding to pharmacological interventions." At this encounter, again, there was no notation of a review of the previously requested laboratory examinations. Medication including Haldol 5 mg at bedtime was started. In addition, this individuals Clonazepam dosage was shifted to total dosage of 8 mg at bedtime. On 1/6/12, a physician's order indicated, "discontinue Haldol." There was no corresponding documentation regarding this order. Individual #112 experienced multiple adjustments to his medication regimen. On 8/29/11, Saphris 10 mg twice daily was tapered over the course of three weeks. This rapid taper does not allow for an adequate review of data to determine if behavioral challenges or target symptoms exacerbated as a result of this taper. • There was documentation in the integrated progress notes regarding this regimen change. On the same date, the dosage of Lithium was reduced from a total of 1200 mg daily to a total of 600 mg daily. Laboratory examinations dated 8/26/11 revealed a Lithium level of 1.18 (.6-1.2). These results were initialed by the psychiatrist and the box indicating "no action needed" was checked. The dosage was reduced. A subsequent Lithium level dated 9/19/11 revealed a Lithium level of 0.57 (.6-1.20). No dosage adjustment was made. • On 10/19/11, Ativan 2 mg in the morning was discontinued. Also on this date, Amantadine 100 mg twice daily was tapered to discontinuation over the course of three weeks. Rapid discontinuation of Ativan is not advisable because this medication can be associated with a detoxification reaction. Per a review of the 180-day medication orders, this medication was started 4/28/11, indicating that	

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		it should be tapered prior to discontinuation. Rapid discontinuations of benzodiazepines, such as Ativan, are outside the generally accepted standard of professional care. Review of the psychiatrist's integrated progress note authored 10/19/11 revealed that there was no documentation regarding the rationale for the discontinuation of either of these agents. The only reference to medication was "it appears that the behavioral management supersedes the psychopharmacological interventions, but psychology will monitor this and present results on next [IDT]." Given this documentation, it was not possible to determine what symptoms or behavioral data psychology was to monitor. • On 11/21/11, Clomipramine was increased to 300 mg at bedtime. An integrated progress note dated the same date was reviewed. Per this document, "continues with OCD…during wiping after BM…even when he hasn't been having BM…continues…hanging head and states he does so because of fear of tripping." The assessment concluded, "unresolved OC behaviors…psychology will coordinate behavioral interventions on OC behaviors in BSP." Clomipramine was increased per the physician's orders. This document did not note a review of relevant behavioral data to determine the extent of the increase in compulsive behaviors. It also did not address the presence or absence of other stressors that may have increased this individual's anxiety resulting in increased compulsions. In the case of Individual #108, there were multiple rapid alterations to the medication regimen. There was no psychiatric clinical documentation provided for review (it was noted that this may have been a copy error). On 7/8/11, Thorazine 100 mg was discontinued. There was no documentation noted in the integrated progress notes from psychiatry. It was not possible to determine the rationale for this regimen change. • On 10/17/11, Saphris 10 mg was tapered over the course of one week. Ambien was discontinued, Adderall 5 mg in the morning was added, and Trazodone 200 mg at bedtime was added. The rapid taper of Saphris did not allow for a review of the data to determine if this taper resulted in increased behavioral challenges, however, it would not be possible to determine if behavior problems increased due to the taper of Saphris, or as a result of side effects due to Adderall or Trazodone. Per an integrated progress note authored 10/17/11, this individual suffered "chronic insomnia probably due to sleep apnea and behavioral disturbances…patient had responded too much to Adderall XR 30 mg but with a lower dose she might improve…refuses meds frequently and not responding to Saphris or Ambien." There was no documentation of the consideration that behavioral challenges could be the result of poor sleep. There was no documentation of the review of the sleep data or other behavioral data. For individuals with sleep disturbances, stimulant medications are ill advised because they have the potential side effect of further reducing sleep. (Please	

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		note that the integrated progress note indicated "Start Adderall XR 10 mg in the morning and Trazodone 100 mg at bedtime, this was in contrast to the actual orders documented above). • On 11/16/11 an integrated progress note from psychiatry reported "break through aggression, agitation, lying on the floor and SIB…since we discontinued Haldol Decanoate patients behavior has deteriorated back to aggressive, agitated, SIB, doesn't want to do anything, refuses to eat and is not sleeping." Physician's orders from this date included discontinue Trazodone and Adderall XR (per prior orders the patient was prescribed Adderall), Ambien 10 mg at bedtime (despite the previous progress note that the individual did not respond to Ambien), and Haldol Decanoate 200 mg IM every two weeks. There was no documentation of review of behavioral data, or acknowledgement that treatment with a stimulant medication could have resulted in the agitation, lack of sleep, and reduced appetite. In addition, the prescribed starting dosage of Haldol Decanoate far exceeded the FDA recommended maximum dosage for initiation of therapy of 100 mg. • On 11/30/11 this individual was seen in Neuro-Psychiatry clinic. It was documented that this individual had a history of seizure activity (last reported seizure 7/07) and due to side effects associated with the Depakote (the current anti-epileptic medication), Trileptal 300 mg twice daily was prescribed. There was notation that this case was discussed with the psychiatrist, but no notation regarding the recent prescription of Haldol, which has a side effect of reducing the seizure threshold. The above case examples illustrated the problems that occur when multiple medication dosage and regimen changes are made in the absence of data review. In this case, it was not possible to determine if any pharmacological interventions were beneficial, and it was not possible to determine if initial medication levels or other medical issues were contributing to this individual's difficulty. It was also impossible to determine if behavioral data supported the medication alterations or if behavioral supports were appropriately utilized. <u>Monitoring Team's Compliance Rating</u> A review of a sample of 17 records revealed varying quality in documentation for the psychiatric reviews. Additionally, the data delivery must be improved to allow for data driven decision making with regard to psychotropic medication. Given the noted deficiencies, the facility remained in noncompliance for this item.	

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J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure Per DADS policy and procedure "Psychiatry Services" dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." 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 reportedly remained in effect at the time of this monitoring review. Per an interview with the facility psychiatrist, the process of informed consent was in the process of revision. An updated consent form had been developed, and there were plans to draft a policy and procedure regarding the use of the new form. Per a review of the proposed form, there was some room for improvement as, for example, it did not include a space for the signature of the staff member responsible for obtaining consent (per generally accepted practices, this must be the prescribing practitioner). It also did not include space to log attempts to contact the LAR in order to obtain verbal consent via telephone. Subjecting the proposed draft form to critical review by peers and DADS administrative staff is recommended. Further, as suggested in previous monitoring reports, 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. Current Practices 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, plan, and notation regarding family notification; or a signed checklist to ensure that specific information was addressed via the informed consent process. In two instances (Oxcarbazepine for Individual #72 and Trazodone for Individual #108), both forms were provided. Documentation of seven consents for psychotropic medication for four individuals was reviewed (Individual #72, Individual #108, Individual #161, Individual #32). 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 examples, the nurse case manager. This current facility practice was not consistent with generally accepted professional	Noncompliance

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		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. Monitoring Team's Compliance Rating This provision remained in noncompliance due to the inadequate informed consent practices noted above.	
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.	Policy and Procedure Per DADS policy, Psychiatry Services dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when the medications are prescribed to treat both seizures and a mental health disorder." There was no facility-specific policy and procedure in effect for the purpose of guiding the clinical relationship or communication between physicians and the neurologist. Individuals with Seizure Disorder Enrolled in Psychiatry Clinic A list of individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder included 44 individuals. At the time of the previous review, there were 46 individuals listed that required neuropsychiatric intervention to coordinate the use of medications 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 (four hours) weekly. This schedule remained, however, now the last Tuesday of every month was designated as "Neuro-Psychiatry" clinic. The facility had contracted with a new neurologist, who had been present in clinic for the past three months. Records provided revealed that of the 44 individuals identified above, 29 were seen in the previous six months. There were a total of five individuals who had not seen neurology in the previous year. Documentation from Neuro-Psychiatry clinic was reviewed. There was notation of collaboration between the neurologist and the psychiatrist in each of the eight examples reviewed. Additionally, the monitoring team observed Neuro-Psychiatry clinic. During the observation, two clinical encounters occurred. There was rich discussion and noted collaboration between the physicians. The collaboration was limited, however, due to the lack of data available to the physicians for review. The following case example will be utilized to illustrate the limitations: • Individual #32 declined to come to clinic, refusing to come out of the van. To	Substantial Compliance

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		their credit, both physicians went into the parking lot, attempting to engage him to come to clinic. When he declined, they observed him in his location, and then returned to meet with the IDT in order to develop a treatment plan. They both requested information regarding reports that the individual had experienced some falls, which they hypothesized, may have been related to seizure activity. Unfortunately, there was no documentation of the character of these events, making it impossible to determine. Per an interview with the neurologist, improvements in the documentation of suspected seizure activity was necessary. <u>Adequacy of Current Neurology Resources</u> Given the current monthly "Neuro-Psychiatry" clinic, with approximately four individuals seen in each clinic, and a total of 44 individuals currently requiring "Neuro-Psychiatry" consultation each individual would be seen approximately once per year in the combined clinic. As the physicians continue organizing and participating in this clinical consultation, they will need to determine 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 44 individuals currently prescribed both seizure and psychotropic medications). <u>Monitoring Team's Compliance Rating</u> While the increased neurology consultation hours and the designated Neuro-Psychiatry clinic were improvements, this clinic will need to demonstrate consistency in occurrence and documentation. Additionally, facility staff will need training with regard to documentation of possible seizure activity. The facility could consider a facility-specific policy and procedure addressing the organization/participation and documentation requirements for Neuro-Psychiatry clinic.	

Recommendations:

1. Develop case formulations in collaboration with psychology 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, J13, J9, J8, J6).

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

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

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

6. Review the current data collection process for tabulating individuals receiving pretreatment sedation inclusive of TIVA (J4).

7. Develop a process for the assessment, creation, and implementation of desensitization plans and/or other treatments or strategies 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. Review the data collection and presentation regarding the completion of the Reiss Screen in order to ensure consistency and clarity (J7).

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

15. 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).

16. Develop combined assessment and case formulations for individuals (J8).

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

18. Identify non-pharmacological interventions for individuals that are included in the BSP, such that the least intrusive and most positive interventions can be utilized (J3, J9).

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

20. Psychiatry should be the primary author and reviewer of risk/benefit analysis for the prescription of psychotropic medications. 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).

21. 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).

22. Ensure a lively discussion via the facility level review of polypharmacy justification (J11).

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

24. Complete nursing inservice training regarding MOSES and DISCUS (J12).

25. Ensure that individuals are seen quarterly for psychiatric medication review (J12, J13, J9, J5)

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

27. 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).

28. Review the target behavioral data for each individual to determine if appropriate data are being collected. In order for the data to be usable, it should be graphed with medication information (i.e., start/stop dates of medication, and dosage adjustments) included (J13, J8).

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

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

31. Individualize the process for informed consent (J14).

32. Review proposed informed consent forms. Subject them to critical peer review during the development process.

33. Develop facility-specific policy and procedure regarding informed consent.

34. Consult with DADS administration regarding the possibility of a statewide policy and procedure for Informed Consent (J14).

35. Determine the adequacy of neurological consultative resources (J15).

36. Improve documentation of suspected seizure activity. Training for staff may be necessary (J15).

37. 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:** <u>Documents Reviewed</u>: o Positive Behavior Support Plans (PBSPs) for: • Individual #37 (10/3/11), Individual #13 (8/24/11), Individual #102 (10/28/11), Individual #99 (10/19/11) Individual #67 (10/10/11), Individual #17 (8/18/11), Individual #32 (10/26/11), Individual #114 (12/15/11), Individual #18(12/7/11), Individual #7 (10/19/11), Individual #76 (8/31/11), Individual #74 (11/30/11) o Functional Assessments for: • Individual #13 (8/2/11), Individual #51 (9/26/11), Individual #39 (12/9/11), Individual #133 (10/12/11), Individual #127 (9/30/11), Individual #32 (9/16/11), Individual #104 (8/30/11), Individual #72 (9/30/11), Individual #119 (8/6/11), Individual #74 (12/1/11) o Annual Psychological updates for: • Individual #155 (10/25/11), Individual #161, (6/13/11), Individual #59 (10/17/11), Individual #56 (10/18/11), Individual #18 (9/19/11), Individual #57 (9/1/11); Individual #8 (11/20/11), Individual #5 (10/29/11), Individual #17 (7/11/11), Individual #100 (11/20/11) o Full Psychological Assessment for: • Individual #133 (8/16/11) o Section K Presentation Book, undated o El Paso Plan self-assessment, dated 12/23/11 o A list of all individuals with psychological assessments, undated o A list of all individuals receiving counseling/psychotherapy, undated o Circles Counseling Plan for: • Individual #37 (6/16/11) • Individual #191 (12/5/11) • Individual #88 (10/25/11) o Anger Management Counseling Plan for: • Individual #61 (11/11/11) o Individual/Group Therapy Progress notes for: • Individual #37 (10/6/11, 11/2/11, 11/15/11, 12/2/11) • Individual #191 (12/6/11) • Individual #61 (11/18/11) • Individual #88 (10/25/11, 11/3/11) • Individual #13 (8/3/11, 8/10/11, 8/31/11, 9/21/11, 9/29/11, 10/12/11) o A list of all individuals who have a Positive Behavior Support Plan (PBSP), undated o Teaching Behavior Support Plan/Working Plans, undated

	o IOA data for: • Individual #104, 12/5/11, 12/6/11, 12/7/11, 12/8/11, 12/9/11 • Individual #39, 11/28/11, 11/29/11, 11/30/11, 12/1/11, 12/2/11 • Individual #191, 12/5/11, 12/6/11, 12/7/11, 12/8/11, 12/9/11 o A list of all training conducted on PBSPs, undated o A list of all psychology department staff, undated <u>Interviews and Meetings Held</u>: o Valerie Grigg, Director of Behavioral Services o Carmon Molina, Associate Psychologist o Marisela Franco, Associate Psychologist o Mary Webb-Tafoya, Associate Psychologist <u>Observations Conducted</u>: o Psychiatry Clinic Rounds: • Staff Present: Eugenio Chavez-Rice, Psychiatrist; Giovanna Villagran, Clinical Pharmacist; Maria Viteta, RN; Nohemi Ostos, Psychiatric Technician; Kathleen Torres; Elsa Mendoza Duarte, Associate Psychologist; Tracy Bustillos-Urbina, DCP; Christina Sanchez, QDDP • Individual Presented: Individual #58 o Psychiatry Clinic Rounds: • Staff Present: Eugenio Chavez-Rice, Psychiatrist; Aurora Ramos, QDDP; Alex Euzaragga, QDDP; Marisela Franco, Associate Psychologist; Giovanna Villagran, Clinical Pharmacist; Neda Daniels, RN case manager; Heather Rodriquez, Physical Therapist; Bahola Puentes Polo, Speech Language Pathologist • Individual Presented: Individual #112 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, Rosina Duran, Psychology Assistant • Individual Presented: Individual #84 o Behavior Support Committee meeting • Staff present: Valerie Grigg, Director of Behavioral Services; Carmen Molina, Associate Psychologist; Marisela Franco, Associate Psychologist; Mary Webb-Tafoya, Associate Psychologist; Maya Deslongchamps, Behavior Analyst Intern; Lorene Lopez, QDDP; E. Melinda Blystone, RN case manager; Guadalupe Azzam, Program Developer; Gracie Galaviz, Job Developer; Rosa Montes, DCPII; Bahola Puentes Polo, Speech Language Pathologist • Individual Discussed: Individual #73 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 self-assessment, dated 12/23/11. EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. The self-assessment included a section for activities engaged in to conduct the self-assessment. For most provision items, however, this section appeared to include a description of activities the facility engaged in to achieve compliance with this provision item. For example, in K4, under the heading activities the facility engaged in to conduct the self-assessment, the director of psychology included "Graphs for cottages have been converted to daily data points for target behaviors and replacement behaviors to allow for more sensitive data analysis. Monthly progress notes include the daily data graphs." The organization of the new self-assessment appeared to be an improvement over the previous POI, however, the facility needs to do a better job of implementing this new tool. EPSSLC's self-assessment indicated substantial compliance for items K2 and K13, 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 except for item 13, which was rated as being in noncompliance. The action plans 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 short-term (i.e., six month) goals. The specific provision items that the monitoring team suggests that the facility focus on in the next six months have been summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: In the last six months, there was been progress in the following areas: • Initiation of external peer review (K3) • Initiation of the collection of Interobserver agreement (K4, K10) • Graphing of data in intervals necessary to better make treatment decisions (K4) • Improvements in functional assessments (K5)

	• Development of new documentation to increase the likelihood that consent for all PBSPs is obtained (K9) Some specific activities toward compliance with this provision of the settlement agreement that the facility is encouraged to focus on over the next six months are: • Track interobserver agreement results, establish target levels, and ensure that staff achieve those levels (K4, K10) • Collect data reliability, track staff performance, establish target levels, and ensure that staff achieve those levels (K4) • Track individual staff treatment integrity levels, establish target levels, and ensure that staff achieve those levels (K11) • Improve behavioral graphs by minimizing the number of data paths (K4, K10) • Ensure that internal peer review/behavior support committee meetings occur weekly, and meeting minutes are maintained (K3) • Ensure that external peer review occurs monthly and that meeting minutes are maintained (K3)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because the psychologists at EPSSLC were not demonstrably competent in applied behavior analysis (ABA) as evidenced by the absence of professional certification, and the lack of consistent quality of the positive behavior support plans (see K9). At the time of the onsite review, four of the five psychologists that wrote positive behavior support plans (PBSPs) were enrolled in course work toward becoming board certified behavior analysts (BCBA). The remaining psychologist had completed BCBA coursework and was waiting to take the national examination. Additionally, the director of psychology was certified as a behavior analyst, and was providing supervision to the psychologists enrolled in BCBA 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 developed a spreadsheet to track each psychologist's BCBA training and credentials.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology	The facility continued to be in substantial compliance with this item. The director of psychology had a master's degree, was a BCBA, and had more than five years of experience working with individuals with intellectual disabilities.	Substantial Compliance

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	who is responsible for maintaining a consistent level of psychological care throughout the Facility.	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.	
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 utilized an internal peer based system to review positive behavior support plans (PBSPs). Additionally, the facility had recently begun external peer review. At the time of the onsite review, however, these meetings had not consistently occurred. Therefore, this item was rated as being in noncompliance. The internal peer review meetings at EPSSLC reviewed PBSPs that required annual review. The internal peer review meeting observed by the monitoring team consisted of all the department's psychologists, and included a productive discussion of potentially important modifications to Individual #84's PBSP. The Behavior Support Committee (BSC) meeting consisted of interdisciplinary members, and provided an opportunity for psychologists to present cases that were not progressing as expected. During the Behavior Support Committee meeting observed by the monitoring team, Individual #73's PBSP was reviewed. There was active discussion and several examples of staff sharing strategies and suggestions to better identify the variables affecting Individual #73's undesired behaviors. Review of minutes from internal peer review and BSC meetings indicated that these meetings did not consistently occur weekly. It is recommended that internal peer review/BSC meetings be scheduled and occur weekly. Additionally, at the time of the onsite review, the external peer review meetings had just begun, and there was no evidence that they occurred monthly. It is recommended that external peer review meetings occur monthly. Operating procedures for both internal and external peer review committees will also need to be established, prior to achieving substantial compliance for this item.	Noncompliance
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	There were some improvements in this provision item since the last onsite review. In order to achieve substantial compliance, however, the facility needs to expand and track interobserver agreement (IOA), implement and track data collection reliability, begin graphing replacement behaviors, simplify graphs, and ensure that all individuals with PBSPs have monthly progress notes. At the time of the onsite review, the facility was conducting hourly data collection (i.e., target behaviors) in all residential and day programming sites. Additionally, direct care professionals (DCPs) were required to record a zero or a line (or an explanation of why	Noncompliance

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	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.	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. The requirement of a recording (i.e., either indicating the frequency of the target behavior, or a zero/line indicating that the target behavior did not occur) in each interval of the data sheet also allowed the psychologists to review data sheets and determine if DCPs were recording data in the intervals specified. As in the last report, the monitoring team did its own data collection reliability in each residence by sampling individual data books, 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 continued to be disappointing: • The target behaviors for only three (two data sheets in cottage 509, and one of two in Dorm B) of 13 data sheets (23%) reviewed were completed up to the previous hour. This was better than the percentage of completed data sheets reported in the last review (i.e., 12%), but still very low. • Most disturbing was finding that two data sheets (in cottage 512, and cottage 506) where the data were already filled out until 10 pm, however, the observations were at approximately 7 pm and 8 pm of the same day. This was consistent with the last review when one data sheet contained data for the entire shift, before the shift ended. These observations indicated that DCPs were not consistently recording target behaviors, and support the concerns of several psychologists who reported to the monitoring team that they did not have confidence in the reliability of their data. This was a serious problem because if the DCPs are not accurately recording data, the psychologists cannot evaluate the effects of their interventions. It is recommended that the facility initiate its own data collection reliability for all target and replacement behaviors collected in each residence and day/vocational site. Finally, specific reliability goals should be established, and staff retrained or data systems modified, if scores fall below those goals. One reason that data collection reliability was poor could be that the individual notebooks (which contain data sheets) were not consistently available to DCPs. For example, the data books were kept in a locked room in cottage 506. Additionally, a DCP in that cottage told the monitoring team that they were not allowed to bring the individual books into the community, even when individuals were on a community outing.	

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		The replacement behavior data were substantially better. • Eight of 11 data sheets sampled (73%) were complete. This, however, represented a slight decrease in the percentage of replacement data sheets completed reported in the last review (i.e., 88%). An area where the facility improved since the last review was the beginning of the development of inter-observer agreement (IOA) measures. At the time of the onsite review, the facility had collected IOA on six individuals. As discussed in the last report, the addition of data collection reliability described above (which assesses whether data are recorded), along with IOA data (which assesses if multiple people agree that a target or replacement behavior occurred) represent the most direct methods for assessing and improving the integrity of collected data. Now, the facility needs to establish specific IOA and data collection goals, and arrange to provide staff with performance feedback to achieve and maintain those goals. Because the systems necessary to track and increase data collection reliability, IOA, and treatment integrity (see K11) require the cooperation of departments other than psychology (e.g., DCPs, unit directors) and require the development of new tools (e.g., tracking systems), it is suggested that the facility pilot the tracking of these behavioral systems in one or two homes. This will allow the facility to work out the logistical challenges, and better assess the additional resources that will be necessary to implement it across the all homes and day/vocational sites. As indicated in the last report, EPSSLC had improved the graphing of target behaviors. For example, in a psychiatric clinic meeting observed by the monitoring team, Individual #112's target behaviors were graphed in weekly intervals making it possible for the psychiatrist to make a data-based decision concerning the continuation of his medication. None of the graphs encountered during the onsite review or document review, however, included replacement behaviors. It is recommended that the facility graph both target and replacement behaviors. Additionally, graphed data were not consistently present in the Behavior Support Committee meeting and peer review meeting observed by the monitoring team (see K3). It is recommended that graphed data (including both target and replacement behaviors) be consistently presented at all treatment review meetings, so that data based decisions can be made. Although improved, the monitoring team believes that the graphs at EPSSLC could be easier for staff to interpret (and therefore use) by utilizing a more simplified presentation. At the time of the onsite review, the majority of graphs reviewed utilized multiple data paths (e.g., Individual #37's graph included seven data paths, and Individual #99's contained nine separate data paths) resulting in graphs that were confusing to understand, which would potentially discourage their use. One reason there were so many data paths on each graph was that each individual's medications were graphed along with his or her target behaviors. It is recommended that only target and	

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		replacement behaviors be included in each graph. The effects of medication changes (and other potentially important environmental events such as moves to different residences) could be displayed by the use of phase lines or arrows, thereby allowing the reader to quickly evaluate the effectiveness of these changes on each individual's behavior. 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 #114's PBSP was modified in November of 2011 following an increase in aggressive behavior. • Individual #37's PBSP indicated that his plan had been modified in August 2011 and October 2011. • Individual #13's PBSPs was modified seven times in the last year. Nevertheless, progress of the most severe behavior problems (i.e., physical aggression and SIB) indicated that four of six individual's severe target behaviors were either unchanged (Individual #18 and Individual #102) and occurring at high rates (relative to levels established as objectives), or getting worse (Individual #99, and Individual #32), with no indication of a systematic action to address the lack of progress. 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, initiation of a functional assessment) had occurred if an individual was not making expected progress. 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. Finally the director of psychology indicated that not all individuals at EPSSLC had updated progress notes. It is recommended that all individuals with PBSPs have current monthly progress notes.	
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	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological and functional assessments for each individual, and the lack of comprehensiveness of some of those assessments. <u>Psychological Assessments</u> The director of psychology reported that not all individuals at the facility had initial psychological assessments. One initial psychological assessment was completed in the last six months. The monitoring team found that assessment (i.e., Individual #133) to be complete and include an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and	Noncompliance

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	that may require intervention.	assessment of medical status. All individuals at EPSSLC should have an initial (full) psychological assessment. <u>Functional Assessments</u> As noted in the last report, the director of psychology had indicated that not all individuals with a PBSP had a functional assessment. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors. A list of all functional assessments completed in the last six months indicated that 10 were completed since the last review. All 10 of those functional assessments (100%) were reviewed to assess compliance with this provision item. As discussed in the last report, the functional assessments included all of the components commonly identified as necessary for an effective functional assessment. As discussed below, the quality of some of these components, however, was insufficient for the functional assessments to be as effective as they could be. Ideally all functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect procedures helped to understand why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. All 10 of the functional assessments reviewed included acceptable indirect procedures. In six (i.e., Individual #127, Individual #133, Individual #39, Individual #119, Individual #32, and Individual #13) of the 10 functional assessments reviewed (60%), direct observation procedures were rated as complete. This represented an improvement in the number of complete direct assessment procedures compared to the July 2010 review (the last review in which functional assessments were available for review) when no direct procedures were judged to be acceptable. An example of a complete direct observation was: • Individual #39's functional assessment included several dates and times of observations, and the occurrence of target behaviors, antecedents, and consequences. Four of the 10 functional assessments reviewed, however, did not clearly include direct observations. For example: • Individual #74's functional assessment consisted of direct observations, but the target behavior did not occur, so the assessment did not provide any additional	

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		information about relevant antecedent or consequent events affecting the target behavior. • Individual #104's functional assessment included observations of his undesired behavior, but did not include any potential antecedents or consequences of the behavior. The functional assessment concluded that Individual #104's target behavior was maintained by negative reinforcement, but it is not clear how that conclusion was related to the direct observations described. Direct and repeated observations of target behaviors in the natural environment are an important component of an effective functional assessment. All functional assessments should attempt to include direct observations of target behaviors and provide additional information about the antecedents and consequences affecting the target behavior. The accuracy and usefulness of these direct observations is greatly enhanced by recording the relevant antecedents, behaviors, and consequences as they occur. One potentially effective way to collect direct functional assessment data is to use ABC (i.e., the systematic collection of both antecedent and consequent behavior) data. In order to be useful, however, ABC data need to be collected for a duration long enough to observe several examples of the of the target behavior, and sufficiently repeated so that patterns of antecedents and consequences could be identified. All 10 of the functional assessments reviewed (100%) identified potential antecedents and consequences of undesired behavior that would likely be useful for developing effective PBSPs for reducing undesired behaviors. When comprehensive functional assessments are conducted, there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. All 10 of the functional assessments reviewed (100%) included a concise summary statement. There was no evidence during this review that functional assessments at EPSSLC were reviewed and modified when an individual did not meet treatment expectations. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment (with a maximum of one year between reviews). Six (i.e., Individual #127, Individual #133, Individual #39, Individual #119, Individual #32, and Individual #13) of the 10 functional assessments reviewed (60%) were evaluated to be comprehensive and clear.	

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		The monitoring team was pleased with the progress EPSSLC was making in the quality of functional assessments. It is recommended that the facility now develop a plan to ensure that all individuals with a PBSP have a current functional assessment.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The one initial (full) psychological assessment available for review was complete (K5) and current. Since only one initial psychological assessment was available for review, however, this provision item was rated as being in noncompliance.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	In addition to the initial or full psychological assessment, an annual psychological 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. 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. A list of annual assessments indicated that they were not completed for 38 individuals at EPSSLC. Additionally, the list indicated that four annual assessments (i.e., Individual #23, Individual #111, Individual #123, and Individual #47) were more than 12 months old. All individuals at EPSSLC should have annual assessments. The monitoring team reviewed 10 annual psychological assessments completed in the last six months to assess their comprehensiveness. • All 10 psychological updates (100%) contained a standardized assessment of intellectual and adaptive ability, and a review of personal history. • Eight (80%) contained a review of behavioral/psychiatric status. • Two of 10 psychological updates (20%) contained a review of medical status. In order to achieve compliance with this item of the Settlement Agreement, all psychological updates will need to contain all of the components described in K5. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of one recent admission to the facility in the last six months indicated that this component of this provision item was in substantial compliance.	Noncompliance

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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, however, some more work is needed before this provision item can be considered to be in substantial compliance. Psychological assessments, ISPs, 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, ISP, or PBSP. At the time of this onsite review, five individuals participated in counseling/psychotherapy. Treatment plans for four of these individuals (80%), and progress notes for all five individuals (100%) were reviewed to determine progress with this provision item. 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). The treatment plans and progress notes reviewed included the following: • A plan of service • Goals and measurable objectives • Documentation reflecting evidence-based practices • Services included in progress notes • Qualified staff (i.e., psychologists with a degree in counseling) providing the services • 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 treatment plans reviewed, however, did not consistently include a process to generalize skills learned to living, work, leisure, and other settings. An example of a plan to generalize skills was: • Individual #88's 11/3/11 progress note stated that Individual #88 used the techniques discussed in therapy to maintain personal space when asking her QDDP to make a phone call. None of the progress notes for three of the five individuals' progress notes reviewed, however, indicated any plan or measure of generalization of learned skills to living, work, leisure, settings. It is recommended that the facility add a plan to generalize skills learned for all individuals receiving psychological services, other than PBSPs, provided at EPSSLC.	Noncompliance

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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 did not appear to be based on functional assessment results. The facility's self-assessment and the director of psychology indicated that not all PBSPs had current consent and approvals. The facility recently developed additional documentation to address this issue. All PBSPs should have current approvals and consent. A list of individuals with PBSPs provided to the monitoring team indicated that 97 individuals had PBSPs at EPSSLC, however, 33 of these were more than one year old. Each individual's PBSP should be revised annually. Twelve PBSPs were reviewed to evaluate substantial compliance with this provision item. All PBSPs reviewed included descriptions of target behaviors, however, three (Individual #17, Individual #37, and Individual #74) of these were not operational (25%). This was the same percentage of target behaviors that were rated as not operationally defined in the last review (i.e., July 2011). Examples of definitions that were not operational are highlighted below: • Individual #17's PBSP defined agitation as "… facial features indicating (Individual #17) is obviously upset, but with no perceivable reason." This definition required the reader to infer if Individual #17 was indeed upset with no reason. • Individual #37's PBSP defined property destruction as "… intentionally destroying objects…" This definition also required the reader to infer if Individual #37 did indeed have an intention to destroy items. An operational definition should not require DCPs to infer an individual's intentions, or determine if someone has a reason to be upset. An operational definition should only include observable behavior. An example of a well written operational definition was: • Individual #114's target behavior of aggression was defined as "…hitting, kicking, pushing, or biting others." All PBSPs should include operational definitions of target behaviors. All 12 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but six (i.e., Individual #17, Individual #67, Individual #102, Individual #18, Individual #114, and Individual #37) of these (50%) identified antecedents and/or consequences that did not appear to be consistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening undesired behavior. This is the same percentage of PBSPs reviewed last time (i.e., July	Noncompliance

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		2011) that was judged to be inconsistent with the stated function. An example of a consequent intervention not related to the hypothesized function was: • Individual #17's PBSP hypothesized that his undesired target behaviors may have been maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). His PBSP, however, included offering him a change of environment following the occurrence of undesired behavior. If avoiding undesired activities was reinforcing for Individual #17, then this intervention would likely increase the likelihood of his targeted behavior. Ideally after the targeted behavior occurred, Individual #17 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of his undesired behavior is such that it is dangerous to maintain him in the activity, then the PBSP should specify his return to the activity when he is calm, and again encourage him to escape or avoid the demand by using desired forms of communication. The PBSP needs to clearly state that removal of the undesired activity should be avoided whenever possible, because it encourages future undesired behavior. 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 #32's PBSP hypothesized that his physical aggression functioned primarily to gain staff attention. Antecedent interventions included telling him he is doing a good job when he was exhibiting socially appropriate behavior, and encouraging him (i.e., by providing attention) to shake hands as a way to obtain others attention. His intervention following aggression included avoiding making eye contact and minimizing attention until the aggression had stopped. 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 12 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 the reinforcer for alternative behavior is practical. The monitoring team found that in four (i.e., Individual #17, Individual #74, Individual #114, and Individual #13) of the 12 (33%) PBSPs reviewed, replacement behaviors that could be functional were not functional. This represents a decrease from the last report, when 100% of all replacement behaviors that could be functional were functional. An example of a replacement behavior that was not functional was:	

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		• Individual #17's PBSP hypothesized that his undesired behaviors were maintained by negative reinforcement. His replacement behaviors were walking and manipulating objects. These behaviors may be important for Individual #17 to acquire, however, they do not appear to be functional. An example of a functional replacement behavior would include teaching/reinforcing another way to escape or avoid unpleasant activities, such as asking for a break. In eight of the PBSPs reviewed, the replacement behaviors appeared to be behaviors that staff needed to do, rather than skills the individual needed to acquire. For example • Individual #102's replacement behavior was for staff to encourage him to use his verbal skills to request the things he wanted. In contrast, in four of the PBSPs reviewed, functional replacement behaviors appeared to require the acquisition of a new skill. For example: • Individual #67's replacement behavior consisted of teaching her to answer yes or no, and point to what she wants. It is recommended that replacement behaviors that require the acquisition of new behaviors include skill acquisition plans (SAPs) for training. Moreover, these plans should be included into the current methodology, data system (when appropriate), and schedule of implementation for other SAPs 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 #32, Individual #99, Individual #7, and Individual #76) of the 12 PBSPs reviewed (33%) represented an example of a complete plan that contained operational definitions of target behaviors, functional replacement behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented a slight decrease over the last review when 50% of the PBSPs reviewed were judged to be acceptable.	
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	The monitoring team was encouraged by the initiation of the collection of IOA measures at EPSSLC. At the time of the onsite review, the facility was collecting IOA for six individuals. These data, however, were not tracked or monitored. In order to achieve substantial compliance with this provision item, a system to regularly assess, track, and maintain minimum levels of agreement of PBSP data (i.e., IOA) across the entire facility will need to be demonstrated (see K4). Target behaviors were consistently graphed monthly at EPSSLC. As discussed in K4, the	Noncompliance

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	efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	quality and usefulness of many of these graphs had improved, however, it is recommended that they be simplified by indicating event changes (e.g., medication changes) with phase lines rather than multiple data paths (see K4). The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path. Replacement behaviors were not, however, consistently graphed. All individuals should have replacement/alternative behavior graphs (See K4).	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	Although the facility recently began the collection of treatment integrity as part of its staff training of PBSPs (see K12), at the time of the onsite review, these data were only collected on 20% of the staff and only following a change in the PBSP. This provision item was rated as being in noncompliance because treatment integrity was not consistently collected and tracked across the entire facility. As discussed in the last report, EPSSLC implemented a PBSP review sheet to ensure that plans were written at a level that was understandable to DCPs. This process will likely result in more practical and useful PBSPs that are more likely to be implemented with integrity by DCPs. The only way to ensure that PBSPs are implemented with integrity, however, is to regularly collect treatment integrity data. In order to achieve substantial compliance with this provision item, integrity data should be collected for all PBSPs. Additionally, treatment integrity data should be tracked and reviewed regularly, and minimal acceptable integrity measures established and maintained.	Noncompliance
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.	The psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. The trainings were reported to be conducted by psychologists and psychology assistants prior to PBSP implementation, and whenever plans changed. Additionally, the facility has added a competency based staff-training component. Although improving, more work in this area is needed to achieve substantial compliance with this item. The monitoring team could not observe any staff training of PBSPs because none were scheduled during the onsite review. The monitoring team will observe and comment on the strengths and weaknesses of the current training procedures during subsequent onsite reviews. There was no system in place to ensure that all staff (including relief staff) implementing PBSPs had been trained. Additionally, there was no systematic way to identify all of the staff who required remedial training. In order to meet the requirements of this provision item, the facility will need to present documentation that every staff assigned to work with an individual has been trained (including a competency based component) in the	Noncompliance

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		implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter. Additionally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, EPSSLC had a census of 129 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. Ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).
2. Meeting minutes should reflect that internal BSC/peer review meetings occur weekly (K3).
3. Meeting minutes should reflect that external peer review meetings occur monthly (K3).
4. Operating procedures for both internal and external peer review committees need to be established (K3).
5. The facility should initiate data collection reliability for all target and replacement behaviors. Additionally, specific reliability goals should be established, and staff retrained or data systems modified, if scores fall below those goals (K4).
6. Establish specific IOA and data collection goals, and arrange to provide staff with performance feedback to achieve and maintain those goals (K4, K10).
7. The facility should graph both target and replacement behaviors (K4).
8. Ensure that graphs are designed to most clearly demonstrate the effect of environmental events on target and replacement behaviors (K4).
9. It is recommended that graphed data be consistently presented at all treatment review meetings so that data based decisions can be made (K4).
10. All individuals with PBSPs should have current monthly progress notes (K4).
11. All individuals should have an initial (full) psychological assessment (K5).

12. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors (K5)

13. All functional assessments should include direct observations that include target behaviors and provide additional information about the antecedents and consequences affecting the target behavior (K5).

14. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment (with a maximum of one year between reviews) (K5).

15. Ensure that all individuals have annual psychological updates that contain all of the components described in K5 (K7).

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

17. The facility should ensure that all service/treatment plan reflects how learned skills will be generalized outside the clinical environment for all psychological services offered (K8).

18. All PBSPs should have current approvals and consent (K9).

19. Each Individual's PBSP should be revised annually (K9).

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

21. 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).

22. It is recommended that replacement behaviors that require the acquisition of new behaviors include skill acquisition plans (SAPs) for training (K9).

23. 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 (K11).

24. The facility needs to provide documentation that all staff assigned to work with an individual have been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter. This training should include a competency-based component. Additionally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP (K12).

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 Preventive Health Care Guidelines, 8/30/11 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 #044.2: Emergency Response, 9/7/11 o DADS Policy #003: Quality Enhancement, 11/13/09 o Presentation Book for Section L o Self-Assessment for Section L o Action Plan for Section L o EPSSLC Organizational Charts o EPSSLC Policy and Procedure: Medical Emergency Response, 2/17/11, Rev 10/3/11 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 Listing, Individuals with seizure disorder o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 40 with dates of last mammogram o Listing, Females over age 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders o Listing, Individuals hospitalized and sent to emergency department o Report of external medical reviews conducted in August and November 2011 o Medical caseload data o Mortality Review Documents 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 ISPs, and ISP addendums for the following individuals: • Individual #52, Individual #31, Individual #92, Individual #161, Individual #73, Individual #122, Individual #3, Individual #104, Individual #191, Individual #100 o Components of the active integrated record- annual medical summary, preventive care flowsheets, active problem list, consults, quarterly medical summary, labs, immunization records, most recent

	QDRR and MAR, and ISP for the following individuals: • Individual #124, Individual #352, Individual #309, Individual #330, Individual #69, o Neurology Notes for the following individuals: • Individual #83, Individual #172, Individual #24 Individual #122, Individual #115, Individual #100, Individual #3, Individual #61, Individual #95, Individual #9 <u>Interviews and Meetings Held</u>: o Ascension Mena, MD, MS, Medical Director o Eugenio Chavez-Rice, MD, Psychiatrist o Denise Jones, APRN, FNP o Ramesh Komaragiri, MD, Contract Physician o William Hand, MD, Contract Physician o May Ann Clark, RN, Acting Chief Nurse Executive o Elaine Lichter, RN, Quality Enhancement Nurse o Cynthia Diaz, RN, Nurse Manager <u>Observations Conducted</u>: o Daily Unit Team Meeting o Medical staff meetings o Neurology-Psychiatry Clinic o Medical Clinic o Clinical Death Review Meeting
	Facility Self-Assessment: The facility's plan for moving towards substantial compliance was outlined in two separate documents, the Self-Assessment and the Action Plan. For each provision item, the self-assessment listed (1) activities engaged in to conduct the self-assessment, (2) results of the self-assessment, and (3) the self-rating, substantial compliance or noncompliance. The activities engaged in that were listed consisted primarily of a series of actions that were taken to help achieve compliance. Various reviews were also listed along with the findings of the reviews. The Action Plan, which covered only provision L1, consisted of two steps. One was to hire a second physician and the other was to develop a tracking form for code blues. The monitoring team recommends that the medical director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps.

	The facility found itself noncompliant with all provision items. The monitoring team agreed with this assessment.
	Summary of Monitor's Assessment: The facility made progress in the provision of medical care. The medical director and APRN continued to work collaboratively to provide care for approximately 130 individuals. Each weekday morning, a daily unit team meeting was held. Participants included the medical director, pharmacy director, nursing, and other clinical and administrative staff. While this meeting served as a good source of information, the format did not allow the types of discussions that are most beneficial for a daily clinical meeting. A contract with a local neurologist was secured to increase the hours of neurology services and allow for greater integration of neurology and psychiatry. The medical director reported that an agreement had been reached with the local health sciences center to complete gynecological exams on all females, although documentation indicated that discussions were ongoing. Databases were established to track preventive care, such as breast, colorectal, and cervical cancer screenings. The number of individuals receiving colorectal and breast cancer screenings increased. There was still an outstanding need for females to have appropriate gynecological evaluations and exams. External reviews were completed and data were generated. The medical director used this information to provide feedback to the medical staff. Mortality reviews were completed and recommendations were generated. A medical quality program had not been established, but several actions occurred that would contribute and fold into a quality program. There were no new facility-specific policies or procedures developed within the medical department. A new Preventive Care Flowsheet was implemented and it contained guidelines for some preventive care. The state issued guidelines had not been implemented at the facility. Data and information management presented a challenge for completion of this review. For example, the presentation book included the monitoring report and recommendations from the 2010 baseline visit although the cover page was correctly dated July 2011. The original document request was submitted with a response of "none" for several categories even when it was obvious, as in the case of individuals with a diagnosis of GERD, that this was incorrect.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	**Overview** The medical staff was comprised of a fulltime medical director and a full time advanced practice registered nurse. Two contract physicians provided part time services. One saw individuals in the medical clinic two days a week. The other worked 10 – 20 hours each month completing tasks, such as case reviews. In August 2011, a full time contract respiratory therapist began providing services. There was one full time psychiatrist. The facility conducted onsite neurology, dental, and psychiatry clinics. A new contract was secured for neurology services in October 2011. Clinic was conducted every Tuesday with the last Tuesday of each month dedicated to a joint neurology-psychiatry clinic. Individuals who required hospitalization were admitted to University Medical Center. X-rays were also done at the medical center. Digital images were available on the internet within one hour. EKGs were done at the facility. There was no cardiology over-reading, but the medical director had discussed this possibility with two local cardiologists. The facility had recently contracted with a new local company to provide laboratory services. During the July 2011 review, the collaborative practice agreement for the family nurse practitioner was reviewed. This agreement was executed with the physician who provided occasional weekend coverage and not with the facility's medical director. The current agreement was signed by the nurse practitioner on 3/11/11. The medical director's signature was not dated. It should be noted that the medical director was not employed at EPSSLC in March 2011. **General Medical Care and Documentation** <u>Annual Medical Assessments</u> Current AMAs were found in all but one of the records contained in the sample. The assessments provided some good information. One important change noted in recent assessment was that problems were linked to a plan of care. <u>Active Problem List</u> Active problem lists were found in all records of the sample. They were not updated as problems arose and resolved. <u>Integrated Progress Notes</u> Medical providers documented in the integrated progress notes. The notes were usually timed, dated, and signed. Most notes were done in SOAP format. Legibility of some notes was poor.	Noncompliance

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		Quarterly Medical Summaries The medical staff did not complete quarterly medical summaries. Physician Orders Physician orders were usually signed and dated. Every record contained in the sample contained physician orders that had multiple untimed entries. There were numerous medication orders that required clarification due to incorrect routes and formulations. Consultation Referrals There was significant improvement in the completion of the consultation forms. The forms usually included relevant information and advised the consultant of the specific problem that required consultation. **Routine and Preventive Care** Routine and preventive services were available to all individuals supported by the facility. Vision and hearing screenings were provided with high rates of compliance. Documentation indicated that the core adult vaccinations were usually administered to individuals. Documentation of varicella and zoster vaccinations was inconsistent. Breast cancer, colorectal cancer, and prostate cancer screenings were all completed with high rates of compliance. This was a significant and important improvement for the facility. The Preventive Care Flowsheet was implemented in October 2011. All of the records reviewed contained this document. At the time of the onsite review, many of these documents appeared to have been quickly implemented, as they contained "no history" for numerous entries. This was observed even when information, such as immunizations and screenings, were found in the record. The "no history" entry was corrected in some records. The PCFS provided cues for performing some testing, such as visual exams and cancer screenings. Many of the guidelines provided on the flowsheet differed from the preventive health care guidelines issued by state office in August 2011. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below.	

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		Vaccinations • 9 of 10 (90%) individuals received the pneumococcal, influenza and hepatitis B vaccinations • 1 of 10 (10%) individuals had unclear documentation of administration Screenings • 8 of 10 (80%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing Prostate Cancer Screening • 1 of 4 males met criteria for PSA testing • 1 of 1 (100%) males had appropriate PSA testing A list of males greater than 50 was provided. The ages ranged from 50 – 73. The list contained 25 individuals: • 21 of 25 (84%) males had PSA results documented within the past year • 4 of 25 (16%) males had no results or results dated more than 12 months prior to the review Breast Cancer Screening • 4 of 6 females met criteria for breast cancer screening • 4 of 4 (100%) females had current breast cancer screenings A list of females age 40 and older, date of last mammogram, and reasons for noncompliance was provided. The list contained 44 individuals. Thirty-seven names were legible. • 36 of 37 (97%) females completed breast cancer screening • 1 of 37 (3%) females had refusal documented Cervical Cancer Screening • 6 of 6 females met criteria for cervical cancer screening • 2 of 6 (33%) females completed cervical cancer screening within the past two years A list of all females age 18 and older was provided. The list contained the names of 56 females, the date of the last pap smear, and explanations for lack of testing: • 4 of 56 (7%) females had documentation of cervical cancer screening between the years 2009 and 2011 • 52 of 56 (93%) females had no documentation of cervical cancer screening o 51 of 52 (98%) females did not complete cervical cancer screening due	

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		to "refusal." o 1 of 52 (2%) females was post-hysterectomy The issue of refusal was discussed with the medical director who indicated that the lack of pap smears was primarily due to a lack of services. This problem was being addressed. <u>Colorectal Cancer Screening</u> • 3 of 10 individuals met criteria for colorectal cancer screening • 2 of 3 (67%) individuals had undergone colonoscopy for colorectal cancer screening A list of individuals, age 50 and older, was provided. The list contained 50 individuals. Forty-seven individuals were aged 50 and older. • 38 of 47 (81%) individuals had completed colonoscopies within the last 10 years • 7 of 47 (15%) individuals had pending GI referrals • 1 of 47 individuals (2%) did not complete colonoscopy due to refusal of guardian • 1 of 47 individuals (2%) completed a colonoscopy in 2000 **Medical Management** The facility had not localized the state issued preventive care policies and clinical guidelines. Although approved in August 2011, they were not included in the medical services policy manual. The medical director reported that he had developed audit tools for osteoporosis care, diabetes mellitus, and pneumonia based on state issued guidelines. The diabetes care audit tool was submitted for review. The management of individuals with diabetes mellitus, osteoporosis and pneumonia is discussed below. <u>Diabetes Mellitus</u> The monitoring team requested a list of all individuals with the diagnosis of diabetes. The original document request indicated "none." The list provided during the onsite review contained the names of six individuals. The monitoring team requested documents for five individuals. One individual did not appear to have a diagnosis of diabetes. Four records were reviewed for compliance with standards set by the American Diabetes Association: (1) glycemic control (HbA1c<7), (2) monitoring for diabetic nephropathy	

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		(3) annual eye examinations, and (4) administration of yearly influenza vaccination: • 4 of 4 (100%) individuals had adequate glycemic control • 3 of 4 (60%) individuals had urine microalbumin documented • 2 of 4 (50%) individuals had eye examinations in 2011 • 4 of 4 (100%) individuals received the yearly influenza examination It was identified through pharmacy documents that Individual #58 and Individual #113 were diagnosed with diabetes. They were not included in the diabetes listing. The medical director should review data to ensure that all individuals with the diagnosis of diabetes mellitus are captured and their treatment monitored. <u>Osteoporosis</u> A list of 91 individuals with the diagnosis of osteoporosis or osteopenia was provided. Individual #191, Individual #73, and Individual #3 were diagnosed with osteoporosis or osteopenia, but were not included in the list. The medications for all individuals were provided as separate documents in drug order reports for each drug. No further analysis of these data was performed. The following information was obtained from the review of the record sample: • 10 of 10 (100%) individuals had BMD documented • 7 of 10 (70%) individuals were diagnosed with osteopenia o 7 of 7 (100%) individuals had vitamin D levels documented and received appropriate supplementation o 7 of 7 (100%) individuals received calcium supplementation o 3 of 7 (43%) individuals received treatment with Prolia • 2 of 10 (20%) individuals were diagnosed with osteoporosis o 2 of 2 (100%) individuals had vitamin D levels documented and received appropriate supplementation with calcium and vitamin D o 1 of 2 (50%) individuals received treatment with Prolia • 1 of 10 (10%) individuals had normal bone density <u>Pneumonia</u> The facility provided multiple sets of data related to pneumonia. The original document requested listed two individuals with a diagnosis of pneumonia. The monitoring team requested additional information and, during the onsite review, was provided with a list that included five individuals. The infection control nurse typically tracked information related to pneumonia. That position had been vacant for several months. The medical director reported that the facility did not have many issues with pneumonia. He believed that many individuals who returned from the hospital with a diagnosis of pneumonia were incorrectly diagnosed. There was no standardized review	

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		of pneumonia or suspected pneumonia to ensure that the diagnosis was correct or to differentiate aspiration pneumonia from non-aspiration pneumonia. Individual #52 had a diagnosis of respiratory congestion pneumonia versus congestive heart failure. Clarification of this diagnosis was essential in order to provide the appropriate medical care and supports. <u>Oral Contraceptive Use</u> Eight females were identified who received oral contraceptives for menstrual suppression or dysmenorrhea: • 3 of 8 (38%) females were age 40 or greater • 2 of 8 (25%) females were age 35 -39 • 3 of 8 (38%) females were age 30 – 34 • 6 of 8 (75%) females had a diagnosis of seizure disorder o 2 of 6 (33%) had intractable seizure disorder • 2 of 8 (25%) had documented GYN exams The facility completed a DUE on the use of oral contraceptives. While the DUE (discussed in section N7) achieved its objectives, it was clear that the individuals did not have an appropriate risk assessment completed for the use of oral contraceptives. The CDC provides guidance on medical conditions and personal characteristics that may impact decisions related to oral contraceptive use, including, but not limited to (1) age, (2) smoking history, (3) weight, and (4) history of cardiovascular disease, hypertension, deep vein thrombosis, gynecological disorders, and epilepsy. **Do Not Resuscitate** The facility submitted a list of three persons with current DNR orders. The active records of two individuals were reviewed. Individual #161 had a DNR order implemented on 6/20/11 due to a history of bilateral pulmonary emboli and deep vein thrombosis. A review of the active records indicated that the IDT agreed with the decision. There was no documentation, in the records provided, by the physician regarding the rationale for the decision. A cardiology consult dated, 6/16/11, indicated that anticoagulation should be reconsidered, provided there were no absolute contraindications. Furthermore, the cardiologist documented "I think the patient has the option of IVC filter placement to prevent further DVT." The records did not provide any details related to a discussion of why this recommendation was rejected. Individual #34 had a DNR order implemented on 8/5/11. The reason for the DNR order	

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		was reported as a history of congenital heart disease, Eisenmenger's syndrome, and dermatofibrosarcoma. Individual #52 had a DNR signed on 6/23/11 due to a history of "respiratory congestion pneumonia vs. CHF." Records indicated that the IDT met on 6/20/11 and agreed that the individual would maintain DNR status. A new DNR was signed on 6/23/11. A cardiology consult dated 8/12/11 stated that there was no objective evidence of valvular disease or systolic dysfunction. No clinical evidence of CHF was present. The individual was discharged from cardiology. There was no pulmonary consultation and no sleep studies to support the diagnosis of sleep apnea. There was no note available in the records that indicated why the medical staff agreed with the continued DNR. The facility must review the process by which DNRs are being implemented and continued. Individual #52 and Individual #161 did not appear to have a terminal diagnosis. Moreover, there was no documentation of discussion and consideration of potential alternative and/or additional treatment modalities. **Seizure Management** Neurology clinic occurred every Tuesday from 8 am to 12 pm. The last Tuesday of each month was dedicated to a joint neurology-psychiatry clinic. A list of all individuals with the diagnosis of seizure disorder was submitted. Eighty-four individuals were listed. Thirteen percent of individuals received no AEDs. Forty percent received monotherapy, while 38% received two AEDs. Ten percent of the individuals received the older and more toxic AEDs. The clinic notes for 10 individuals were reviewed along with all neurology clinic notes included in the record sample. The consults completed over the last two months were extremely difficult to read due to the legibility of the handwriting. The clinic notes reviewed were brief and often lacked data essential in the management of seizure disorder, such as drug dosages, severity of seizures, date of last seizure, adverse effects of drugs, results for drug monitoring, and the impact of seizure disorder and AEDs on the quality of life. None of the notes provided recommendations related to calcium and vitamin D supplementation, screening for osteoporosis, and monitoring for drug side complications. Side effect monitoring tools, such as the MOSES and DISCUS evaluations, were not utilized in the evaluations. The monitoring team attended the neurology-psychiatry clinic. Individual #89 was reviewed for the first time. Participants included the psychiatrist, neurologist, pharmacy director, RN case manager, and the QDDP. The primary medical provider and psychologist did not attend clinic. The individual did not attend clinic. There was a discussion about going to see the individual, but it was decided that this would be done	

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		at the next evaluation. The psychiatrist read the relevant history. Labs, diagnostics, and consults were reviewed. There was a good discussion among the disciplines, about the behavioral issues and how this was impacted by the neurological condition and medications. This appeared to be an effective approach in medical management. Since this was the initial evaluation, the examination of the individual, however, should not have been postponed. Overall, individuals appeared to receive adequate care for the management of seizure disorder. The neurologist providing services had changed several times over the past year. Recent changes increased the number of hours, allowed for all individuals with a VNS to have the device checked, and improved integration of neurology and psychiatry. Even so, there were a number of individuals with refractory seizure disorder. Those individuals should be referred to a local epilepsy center for evaluation.	
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> External medical reviewers, from sister SSLCs, conducted medical reviews in August 2011 and November 2011. The monitoring team reviewed the flowchart "SSLC External Medical Quality Assurance Process" and discussed the process with the medical director. As outlined in the chart, a five percent sample of records (seven 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. The QA Department generated action plans based on data generated by the audits. Reports from the August 2011 visit were not provided, but overall compliance was reported in the self-assessment. Compliance data from both reviews indicated an increase in the percentage of essential items in compliance from August 2011 to November 2011. In response to the August 2011 audit, the medical director provided a follow-up, dated 10/4/11, on action plans. The following problems were addressed: • The Preventive Care Flow Sheets were not included in any records. • Tobacco use was not documented in any records. • External consults lacked information for consultant. • Consult findings were not included in IPN. • X-ray and lab results were not included in IPN. • Physician orders were lacking some signatures, times and indications.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Many of the annual medical assessments were not up to date. • The DRR profile did not include a stop date on all medications The audit findings and corrective action plans resulting from the November 2011 audit were reviewed with the medical director. Although there was overall improvement, the data indicated less than 70% compliance with the following requirements: • The APL was updated with each new problem or as problems were resolved. • Medication orders for acute conditions included indications and durations for all meds prescribed. • Responses to significant abnormal lab values were documented in the IPN. • Progress notes and orders were signed, dated and timed. • Pertinent medical history is included in communication with consultant. • Consultant recommendations were addressed in the IPN within five business days after the consultation recommendations are received. The QA department generated a total of 58 action plans related to the November 2011 review. Follow-up reports documented that all of 56 plans reviewed by QA were satisfactorily completed. Two action plans had not been reviewed by the QA department. The medical director provided an inservice for the medical staff in September 2011, which included a review of the requirements stated above. <u>Mortality Reviews</u> There were four deaths in 2011. The average age at the time of death was 51 years. There were two deaths since the last onsite review. One occurred in November 2011 and the other in late December 2011. With regards to the first death, both the clinical and administrative death reviews occurred in a timely manner. Documents related to the death were reviewed by the monitoring team. There was participation in the clinical death review by a local community physician who also served as the medical director of a local Medicaid HMO. The transcript of the proceeding was provided. The external reviewer, although not familiar with the SSLC systems, appeared to have done a detailed review of the case and offered some very salient recommendations regarding care. Most of these recommendations appeared to have been discussed in the administrative death review that occurred on 12/14/11. A corrective action plan was developed based on the recommendations generated. Several of the corrective actions were completed at the time of the onsite review. The monitoring team attended the clinical death review conducted during the onsite review. The meeting was attended by the facility director, state office medical services	

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		coordinator, medical director, acting CNE, QA Nurse, and the medical staff. The clinical review was provided by the contract physician who had completed record reviews. It was evident that additional information related to the individual's history and treatment was needed. The meeting participants posed numerous questions. After a lengthy discussion of the case, the state office medical services coordinator requested that additional records and information be obtained prior to completion of the review.	
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 medical director reported that no medical quality program, other than the external reviews, had been developed. Nonetheless, several actions had occurred that would contribute to the framework of a medical quality program: • An internal audit tool was developed by the medical director based on clinical guidelines completed by state office. • Internal audits were going to be completed by a contract physician with infectious diseases training. Areas that were targeted for review included UTIs, pneumonia and antibiotic use. • Databases for tracking preventive care, diabetes, and osteoporosis were developed. • A "Do Not Restrain List" was generated. • A consultation tracking log was implemented. In most instances, it was not clear exactly how existing information was utilized. There was not an analysis of data to indicate good or bad provision of services. The monitoring team noted the following: • The facility did not have any data analysis to show how outcomes had changed over time. While no aggregate data were available during the last review, facility data and record audits indicated improvement in areas, such as breast and colorectal cancer screening. Similarly, data related to cervical cancer screening indicated no improvement occurred in providing services to females. Although it was reported in July 2011 that this would occur, the service had not been secured at the time of the onsite review. • A list of individuals with the diagnosis of diabetes was maintained. Although the accuracy of the data was questioned, record audits revealed that some individuals were lacking some elements of care. • A consult-tracking log was maintained. It contained data on consult appointments. It did not contain some key data, such as the length of time it took to actually obtain the consult. • The facility needed to better define clinical outcomes. The number of individuals diagnosed with pneumonia was not clear.	Noncompliance

#	Provision	Assessment of Status	Compliance
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The medical department had not developed any new policies or procedures. The medical director presented the Preventive Care Flowsheet as evidence of clinical guidelines. As previously discussed, this document was not consistent with state issued clinical guidelines. Those guidelines had not been formally implemented at the facility. The medical director will need to update the PCFS so that it is consistent with state issued guidelines. Additionally he will need to localize the policies, procedures and guidelines issued by state office.	Noncompliance

Recommendations:

1. The collaborative agreement between the advanced practice registered nurse and medical director should be completed in accordance with state guidelines. The current agreement was signed prior to the medical director's employment at EPSSLC (L1).

2. The medical director must ensure that all state issued policies are implemented and that facility-specific policies are also developed and implemented (L1).

3. Active Problem Lists should be updated in an ongoing manner. This includes updating as problems arise and/or resolve (L1).

4. The medical staff should be inserviced on all elements of proper documentation. This includes the requirement to make IPN entries in SOAP format in a legible manner, provide legible signatures, and titles and write complete physician orders (L1).

5. The medical director must develop a template for completion of Quarterly Medical Summaries (L1).

6. All of the Preventive Care Flowsheets in the records should be updated to reflect current and accurate information (L1).

7. The template for the Preventive Care Flowsheet should be reviewed and the standards for providing care should be updated to reflect state issued policy (L1).

8. The medical director should review data related to vaccinations to ensure that varicella and zoster vaccinations are provided in accordance with CDC guidelines. The PCFS and vaccination records should be updated (L1).

9. Gynecological evaluations must be completed on females in accordance with state issued guidelines (L1).

10. The medical director should review available data and ensure that the list of persons with the diagnosis of diabetes is accurate. Once this is done, the diabetes flowsheet should be completed for each individual to ensure that care is consistent with ADA guidelines (L1).

11. A facility-specific policy related to osteoporosis management should be developed (L1).

12. Data related to pneumonia should be reviewed to ensure that all individuals with a diagnosis of pneumonia receive appropriate treatment. Specifically, those with a history of aspiration should be reviewed to ensure that appropriate supports are in place (L1).

13. Consideration should be given to development of a checklist to review every case of pneumonia. The checklist would attempt to better define an individual's risk and determine the likelihood of an aspiration event. The monitoring team also suggests that the facility develop a process to ensure that every episode of pneumonia is captured. This may involve a monthly review of multiple data sets, such as a list of all individuals who received antibiotics for the diagnosis of pneumonia. This is necessary because not all individuals with a diagnosis of pneumonia are hospitalized or sent to the emergency department (L1).

14. The infection control nurse position should be filled as quickly as possible (L1).

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

16. Consideration should be given to dictating the neurology clinic notes to improve legibility and produce notes that are usable for the entire IDT. The medical director should also consider development of a template to ensure that key seizure management data are captured in the consultations, including but not limited to: drug dosages, severity of seizures, date of last seizure, adverse effects of drugs, results for drug monitoring, results of the MOSES and DISCUS evaluations, and the impact of seizure disorder and AEDs on the quality of life. When appropriate, there should also be clear documentation of the discussion of discontinuing drugs for individuals who have been seizure free for five or more years (L1).

17. Individuals with refractory seizure disorder should be referred to a local epilepsy center for evaluation by an epileptologist (L1).

18. The external medical reviews should be revised to include process and outcome indicators (L2).

19. The medical director should ensure that all information is available for the physician completing the clinical death reviews (L2).

20. The medical director should work with the state office medical services coordinator to develop a medical quality program. (L3, L4).

21. State issued policies, procedures, and guidelines must be implemented and localized (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:** Documents Reviewed: 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 ISP, 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 nursing discharge summary for the last five individuals who transitioned to the community o The agenda for new staff orientation o The curricula for new staff orientation, including training materials used o The schedule for ongoing inservice staff training o The curricula for ongoing inservice 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 provided 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, 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 List of individuals who were recommended for suction tooth-brushing 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 Schedule of medication pass times for all units o QA Death Reviews for Nursing for Individual #97 o Nursing Daily Assignments and Required Tasks for 1/9 – 1/14/12 o Competency evaluations and test scores for 10 randomly selected nurses o Nursing Education Handbook o 2011 Infection Control Reference Manual for SSLCs o Hospital Liaison reports for Individual #107, Individual #115, and Individual #191 o EPSSLC Self-Assessment (12/23/11) o EPSSLC Action Plan (12/28/11) o EPSSLC Nursing Corrective Action Plans of 7/28/11, 8/4/11 o EPSSLC Nursing Corrective Action Plan Addendum (8/3/11) o Employee Immunization Action Plan o EPSSLC Nursing Department Corrective Action Plan in response to Infection Control/Emergency Equipment Report by DADS (11/7/11) o EPSSLC Meeting Schedule updated 12/12/11 o Records and MARs/TARs of: • Individual #13, Individual #32, Individual #39, Individual #76, Individual #115, Individual #9, Individual #34, Individual #83, Individual #126, Individual #31, Individual #55, Individual #89, Individual #128, Individual #103, Individual #44, Individual #92, Individual #49, Individual #189, Individual #25, and Individual #90 <u>Interviews and Meetings Held</u>: o Opening meeting on EPSSLC progress since 7/11 review o Acting CNE/Nurse Operations Officer, Mary Ann Clark, RN o Quality Enhancement Nurse, Elaine Lichter o Pharmacy Director, Amista Salcido, Pharm.D. o Nurse Manager, Cynthia Diaz, RN o Nurse Manager, Veronica Bahner, RN

	o Campus RN Supervisor/Hospital Liaison, Martha Manriquez, RN o Medical Director, Dr. Mena o PNMT Nurse, Michael Terry, with Susan Acosta, Acting Director of Habilitation Therapy and Karen Hardwick, DADS Habilitation Services Coordinator o Meeting with staff responsible for the at-risk identification and management process <u>Observations Conducted</u>: o Visited individuals residing in Dorms A, B, and C, and Cottages 506, 507, 508, 509, 510, and 513 o Emergency medical equipment in Dorms A, B, and C, and Cottages 506, 507, 508, 509, 510, 511, 512, and 513 o Medication administration in Dorms A, B, and Cottages 512 and 513 o Enteral administration of medications and/or feedings in Dorm A, B, and Cottage 513 o Annual ISP meeting for Individual #92 o 1/9/12 Clinical Death Review o 1/10/12 Medication Error Committee o 1/12/12 Unit Meeting
	Facility Self-Assessment: EPSSLC submitted a self-assessment and an action plan, which were updated 12/23/11 and 12/28/11, respectively. Across the provision items of Section M, the findings of the self-assessment revealed that all provision items were rated as noncompliant. The monitoring team was in agreement with these self-ratings, but not necessarily for the same reasons put forward by the section lead of Section M. For example, it was not the case that the monitoring team assigned a rating of noncompliance because findings revealed that EPSSLC's performance failed to achieve 100% compliance. Rather, across the provisions of Section M, the monitoring team assigned ratings of noncompliance because of EPSSLC's significant and substantial pattern of failure to provide nursing care that resulted in prompt reporting and adequate response to identified changes in individuals' health status, complete assessments of individuals' nursing care needs, development and timely implementation of nursing interventions to address individuals' health care needs, establishment and implementation of nursing assessment and reporting protocols sufficient to address individuals' health needs and clinical indicators of risk, and administration of medications in accordance with current, accepted standards of care. The action plan developed by EPSSLC for Section M appeared to target the achievement of short-range goals, such as obtaining adequate numbers of trained, competent nursing staff members and securing important information vis a vis monitoring tools. It appeared as though once these short-range goals were obtained, appropriate corrective action plans that would expectantly address problems and barriers to achieve the provisions of the Settlement Agreement would be developed. However, as of the monitoring review, almost half of the action steps to achieve these short-range goals had

	not been completed. In addition, several of the steps, such as filling the position of Infection Control Nurse and implementing various inservice training sessions and monitoring of state guidelines and protocols by the Nurse Educator, which were reported, "Complete," were actually incomplete because the nurses had recently reneged/resigned the positions. During the onsite review, the presentation book was reviewed. Essentially, the presentation book was a hard copy of the electronic data submitted and reviewed by the monitoring team in preparation for the onsite monitoring review.
	Summary of Monitor's Assessment: Since the prior review, with the immediate and consistent support of EPSSLC administration and the State Nursing Services Coordinator, Valerie Kipfer, several positive changes occurred in the Nursing Department at EPSSLC. Steps were taken by the department to address several of the serious health and safety problems that were identified six months ago. For example, competency based training in physical assessment, documentation, and dysphagia was provided to nurses; emergency equipment was obtained, cleaned, organized, and regularly checked; a Campus RN Supervisor assumed the Hospital Liaison's duties and almost immediately became a value-added nursing staff member; staff utilization and deployment policies were revised to help reduce unscheduled absence and promote continuity of care; and corrective action plans to address identified problems in care were developed and partially implemented. All of the aforementioned actions were taken during the preceding months when the Nurse Operations Officer (NOO), who was the acting Chief Nurse Executive (CNE), carried and shared all of the roles and responsibilities of nursing leadership with the help of two Nurse Managers. Notwithstanding these significant accomplishments, as of this review, the absence of nursing leadership remained largely unchanged, and, to a degree, it was further weakened by the absence of an Infection Control Nurse. Thus, the review of documents submitted and onsite activities continued to reveal many problems across the provision items of Section M. For example, as described below in detail, there continued to be problems with the completion of ongoing and comprehensive quarterly assessments and development of care plans that adequately addressed individuals' health problems and needs. There continued to be a pattern of problems in nursing practice. On a number of occasions, nurses failed to deliver nursing care in accordance with accepted standards of practice, and they carried out improper interventions as though they were standard operating procedure. These findings were consistent with the facility's QA data, which revealed that the majority of 12 compliance scores across the monitoring tools associated with nursing ranged from the mid 40s to the mid 70s, with an average score of 51% compliance with the Settlement Agreement and Health Care Guidelines. Despite the problems that were evident across the Nursing Department, the newly appointed CNE (and former NOO) plainly acknowledged that she was aware of the challenges that lay ahead, but was

	nonetheless encouraged by the signs of progress and positive change, and she embraced her appointment with renewed energy and optimism.

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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.	As noted in all prior monitoring reviews, EPSSLC continued to articulate a commitment to improve performance and achieve compliance with this provision item of the Settlement Agreement. Since the prior monitoring review, although EPSSLC reported that it had made several changes in staffing patterns and deployment of nurses, hired a Nurse Hospital Liaison, analyzed QA data, and developed corrective actions to address problems, 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 individuals' 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, 10 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. In addition, there were apparent steps taken to correct the problem of absence of records on the dorms and cottages for extended periods of time throughout the day and early evening shifts, which was noted during the prior review. Records were usually present and available, and when/if records were not present, they were usually signed out to the clinic. In addition, the records provided to the monitoring team for review were significantly more complete and organized than what was submitted during the prior review. For example, only one of the 20 sample individuals' records reviewed contained record notes that pertained to another individual. Notwithstanding the positive findings regarding record organization and availability, there continued to be problems with content and legibility of nurses' notes and signatures, incomplete signatures, such as nurses' signing only their first name and the first initial of their last name, failure to note the time of the entry in the IPNs, notes out of sequence, erroneous entries written over and not properly designated as errors, and, although requested by the monitoring team, no hospital records were provided for the sample individuals who were hospitalized. 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	Noncompliance

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		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. For example: • Re: the assessment of Individual #34's change in respiratory status – "Little bit of rhonchi [noted.]" • Re: the assessment of Individual #83's insomnia – "She sleeps just a few hours at night." • Re: the nature and impact of Individual #126's significant, unplanned weight loss – "[It] triggered a number of weight notification forms." • Re: the nurse's professional opinion of the most integrated setting for Individual #189 – "He would probably do alright." The Nursing Department's action plan related to provision M1 indicated that, since the prior monitoring review, two LVNs and an RN were added to the evening shift to provide additional support for the delivery of nursing care during the late afternoon and evening hours. Also, a Nurse Hospital Liaison was hired in September 2011, and policies and protocols relevant to this position were developed and implemented. However, 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 appropriately recording follow-up to resolution. Also, there continued to be a number of occasions when the first reference to a significant change in an individual's health status was documented by the individual's physician and/or clinic nurse 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, as noted in the prior review, there continued to be delays in the assessment, treatment, and follow-up of individuals' health needs and risks. The following detailed examples, which were typical for all 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. • Individual #90 was a 62-year-old man with multiple behavioral and physical health needs and risks. Individual #90 received daily doses of multiple psychotropic medications, as well as other medications, to treat his conditions.	

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		Many of his medications had significant and well-documented side effects, such as lack of coordination, postural hypotension, dizziness, tremors, etc. Individual #90's record contained numerous documents indicating that his clinical professionals, non-clinical professionals, and direct care staff members were aware of his high health risks, which included falls, fractures, and untoward side effects of his medications. In addition, Individual #90 had HMPs and Risk Action Plans that defined many of his health needs and risks and prescribed interventions to address them. By all accounts, Individual #90's plans indicated that he was an individual who was becoming weaker, more unsteady, and prone to "losing his balance immediately." o On 11/19/11, at approximately noontime, Individual #90's direct care staff member called his nurse and reported that he "had an emergency." Upon the nurse's arrival to Individual #90's cottage, Individual #90 was observed standing in the bathroom with his direct care staff member, who was holding wipes to the back of his head to stop the bleeding. Individual #90's direct care staff member reported that he/she had found Individual #90 on the floor. Individual #90's nurse called 911, and he was transferred to the hospital where he was diagnosed with a fractured cervical spine (C7) and possible NMS (neuroleptic malignant syndrome) – a life-threatening untoward reaction to neuroleptic/antipsychotic medication and some non-neuroleptic agents. o During the three-week period prior to this serious untoward incident, Individual #90's direct care staff members' observation notes were peppered with entries such as "[He] was unsteady throughout the shift," "[He] attempted to drop to the floor," "[He] was crying," "[He] refused to walk," "[He] appear to be unsteady that's why he was transferred to the wheelchair," "[He] appears to lose his balance," "[He] still appears unsteady," etc. Notwithstanding Individual #90's well-documented problems and risks, his multiple plans that called for close monitoring and supervision, and his direct care staff members' almost daily reports indicative of significant decline in his health status and functioning, during the three weeks preceding Individual #90's serious incident, there were only <u>three</u> nurses' notes entered in his record. The first note relayed Individual #90's direct care staff member's report that he was refusing to walk (11/1/11), the second note indicated that his direct care staff member reported finding a bruise on his lower lip (11/3/11), and the third note referenced that a "body check" was done in response to an allegation of suspected abuse/neglect (11/7/11). o There was no evidence that Individual #90's nurses conducted adequate and appropriate follow-up assessments or evaluations of the aforementioned changes in Individual #90's health. Rather, the very	

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		next entry in Individual #90's IPNs was his nurse's 11/19/11 report that his direct care staff member found him on the floor bleeding from the back of his head. o As of the monitoring review, Individual #90 remained hospitalized, and, in addition to his fracture and other injuries, he has suffered multiple complications during his hospitalization, including pneumonia, bacteremia, skin breakdown, and deep vein thrombosis. • On 10/1/11, at 4:30pm, Individual #39's direct care staff member reported to his nurse that another individual bit Individual #39. According to Individual #39's nurse, he suffered a human bite with broken skin on the left side of his upper back. Although Individual #39's physician ordered wound care and oral antibiotic, there was no evidence of a follow-up assessment of Individual #39's wound, no evidence of monitoring for signs/symptoms of infection, and no evidence of an investigation of Individual #39's and the other individual's infectious disease histories until three days later when Individual #39 was re-evaluated at the medical clinic. At this time, Individual #39's physician noted that Individual #39 had received all of his hepatitis vaccines, but recommended, "Check to see if Td booster given." o There was no evidence of follow-up to Individual #39's physician's recommendation. Of note, the monitoring team's review of Individual #39's record revealed that his last Td vaccination occurred on 2/10/03. For a number of reasons, this would have been extremely important information for Individual #39's nurse to have provided to his physician, especially because of the new recommendations on who should get just a tetanus shot (e.g., anyone who has an injury or wound that could possibly cause tetanus who has not had a vaccine in the past five years) versus a vaccination against tetanus, diphtheria, and pertussis (e.g., all adults under age 65 who never received a TDaP vaccine). • On 9/13/11, Individual #76's direct care staff member reported to his nurse that the was "sleepy." On the basis of an incomplete assessment, Individual #76's nurse agreed that he was "sleepy" and noted that he/she would "continue to monitor [Individual #76's] LOC [level of consciousness]." After several hours passed, Individual #76's nurse again noted that he was "Still in bed...Slept all am...Unsteady gait noted...DCS fed client - ate 20% of lunch...Remains sleepy." Again, based upon an incomplete assessment of a significant change in Individual #76's health status, his nurse concluded his/her assessment with one word – "Sleepy," and planned to "Refer [Individual #76] to the clinic for evaluation via wheelchair for unsteady gait." o Later this same day, Individual #76's physician evaluated him and diagnosed him with mild dehydration and ordered that he receive more	

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		fluids (water) over the next 24 hours – with meals and between meals – with another follow-up visit to the clinic for possible intravenous hydration. There was no evidence of follow-up assessment and close monitoring by Individual #76's nurses for symptoms of the progression and complications of dehydration, such as electrolyte imbalance, loss of consciousness, etc. On 9/14/11, Individual #76's physician evaluated him again, noted that his oral mucous was still slightly dry, and ordered strict monitoring of his intake and output and a fluid intake of two liters of fluid a day. o Notwithstanding the continued presence of significant change in Individual #76's health status and potential for life-threatening complications, again, there was no evidence of follow-up assessment and close monitoring by his nurses until his episode of dehydration was resolved. • Overall, Individual #9's nurses failed to carry out at least one physician's order and failed to provide adequate, ongoing assessment, intervention, and evaluation of the changes in Individual #9's health, such as pain, change in appetite, meal refusals, alteration in food/fluid intake, which occurred subsequent to her tooth extraction and led to complications, such as constipation and impaction. o On 12/22/11, Individual #9 underwent tooth extraction with general anesthesia. Over the next several days, her record notes indicated that she complained of pain, ate only small amounts of food, vomited undigested food, and received a Dulcolax suppository on 12/24/11 for "no documented BM past 3 days." Over the next two days, there was no evidence of follow-up by Individual #9's nurses. Thus, on 12/26/11, Individual #9's nurse again described her as refusing meals and complaining of pain. Similarly, there was no evidence of follow-up to this report until the next day when yet another nurse noted that Individual #9 was "positive for impaction and that she had received a suppository with results pending." At this time, in addition to the suppository, Individual #9's physician ordered Fleet mineral oil enemas, every day for three days, and an x-ray of her abdomen. According to a review of Individual #9's IPNs, over the next three days, Individual #9 received daily Fleet mineral oil enemas, and every day, her nurses' noted "results pending." o However, there was no evidence of Individual #9's nurses' follow-up to the enemas, which normally produce results within 2 to 15 minutes. In addition, there was no evidence that Individual #9's nurses implemented her physician's order for a KUB x-ray. Of note, several days later, on 1/3/12, Individual #9's physician re-ordered the KUB x-ray, the order was carried out, and radiologist reported that Individual	

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		#9 suffered "gas-filled loops of small bowel and constipation with fecal loading of her ascending, transverse, and proximal half of her descending colon." Although Individual #9's physician ordered her to received daily Dulcolax suppositories for the next 7 days to treat her constipation, from 1/4/12-1/8/12, there were no nurses' notes filed in Individual #9's record, and there was no evidence of the implementation and outcomes of the prescribed medical treatment to address her significant change in health status. <u>Regarding numerous individuals</u> A critically important aspect of ensuring adequate, appropriate, and timely response to significant changes in individuals' health status was ensuring that physicians were promptly notified of their health care problems. At EPSSLC, individuals' physicians were notified of changes in individuals' health by way of "Sick Call Reports." A review of the 20 sample individuals' records revealed that occasionally Sick Call Reports were complete, but usually they were incomplete or not documented at all. There were also "Clinic Evaluation Requests" inconsistently filed in some individuals' records. Although they seemed to reference the same questions as the Sick Call Reports, it was unclear whether or not they were a newly implemented form, an outdated form, or a specific nurse's rendition of the form. Whatever the reason, they too were incomplete or not documented prior to the individual's visit to the medical clinic. Thus, written communications with and notifications of the individuals' physician of changes in individuals' health were not consistently documented and/or sufficient to readily identify changes in status. Another important aspect of ensuring adequate, appropriate, and timely response to significant changes in individuals' health status occurred during medical emergencies and was evidenced by the presence and availability of functioning emergency medical equipment. A review of the state of affairs of medical emergency equipment at EPSSLC revealed significant improvement of the serious problems noted during the prior review. For example, the medical emergency equipment for Dorms A, B, and C were stored in one central location. Across all cottages, medical emergency equipment was clean, organized and stored on carts in the record rooms. All cottages had suction machines, and oxygen was available. There was evidence that daily checks of emergency equipment were usually done, but only two of the eight cottages had logs with daily checks that were complete for the period of 1/1-1/9/12. Notwithstanding these positive findings, there were three problems noted in this area. One problem was that the doors to record rooms on the cottages where emergency medical equipment was stored had signs that stated that the doors were to be kept locked at all times. Although it was reported that direct care staff members should have	

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		keys to the record rooms, it was unclear whether or not immediate access to emergency medical equipment would be delayed by their storage in locked rooms. The second problem was that although the facility's 7/28/11 Corrective Action Plan, which stipulated that the "additional emergency equipment needed will be ordered by 8/5/11, [and] purchased equipment will be cleaned and checked upon receipt and will be place on the homes/units," indicated that this step was "Completed," as of the review, four of the seven AEDs were not in place on cottages 507, 510, 515, and the Systems building nurses' station as planned because, according to the Director of Risk Management, the facility was "waiting for the cabinets to be finished by the Maintenance Department for installation of the AEDs." The third problem was that, at the time of the review, Item #4 of the facility's 7/28/11 Corrective Action Plan, which pertained to the provision of a "set of back-up emergency equipment," required clarification of its expectations by the state's Nursing Services Coordinator, Valerie Kipfer. According to Ms. Kipfer, "The intent of #4 was that there would always be an additional set of equipment available in the event that emergency equipment brought to a drill or actual code is not available or malfunctions by ensuring that a backup set of emergency equipment is brought to each and every drill or actual code. Specific areas are assigned to respond as 'backup equipment providers' to each drill or code... The intent of the action step was not that a specific set of emergency equipment was designated solely as the facility backup set of equipment, but that there would always be a backup set of equipment available at every drill or actual code." Although Ms. Kipfer's explanation and her expectations for the availability and use of emergency medical equipment were indeed clear, the facility's interpretation, and, thus their application of the intent of this particular item of the corrective action plan, varied according to department. For example, the Director of Risk Management interpreted Item #4 to mean that EPSSLC's backup emergency equipment "...will be cottage 508's emergency equipment station and will act as the backup for all other cottages. Cottage 512 can also act as back for all cottages. In the systems building, A dorm will act as backup for B dorm and C dorm and vice versa (sic)." According to the CNE, the Nursing Department had "...additional supplies and equipment stored on campus at all times that they could readily assemble another set of emergency equipment if required...At any given time, with the supplies stocked on campus, there is always more than enough equipment to assemble several backup sets if required." Of concern to the monitoring team was that the various interpretations of Item #4 might prevent EPSSLC from fulfilling and meeting the spirit and intent of the item, which clearly indicated that malfunctioning and missing emergency medical equipment, would be replaced without delay.	

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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. As noted in prior reports, nurses continued to document by exception, which meant that they only documented episodic events, findings, etc. that were, in their opinion, abnormal. The generally accepted practice guidelines, which usually guide and direct clinical professionals who prefer to use this style of documentation, referenced the use of "care pathways," "protocols," and "templates" to support the process of documentation by exception in health care. Further, this type of documentation, which was focused on detecting, assessing, and analyzing variances, heavily relied upon the experience, knowledge, education and training, and ability of clinical professionals to differentiate normal versus abnormal findings. At EPSSLC, RNs and LVNs alike, were documenting IPNs by exception without the support of care pathways and templates for IPNs. Of note, since the prior monitoring review, the EPSSLC RNs completed a statewide physical assessment course, which undoubtedly helped improve their knowledge and training in identifying and evaluating variance in health status indicators. Also, the state's Nursing Services Coordinator recently developed pocketsize "protocols" for nurses to help them in their performance of assessment, documentation, and reporting to physicians and other clinical professionals their findings related to several, frequently occurring health problems, such as vomiting, infection, etc. It was reported that soon, all SSLC nurses would have access to these tools. Nonetheless, documentation by exception, as implemented by EPSSLC nurses, was fraught with problems. The review of 20 sample individuals' records revealed that nursing assessments, especially those that occurred as indicated by the individual's health status and apart from the regularly scheduled annual and quarterly reviews, substantially failed to meet the provisions of the Settlement Agreement and Health Care Guidelines. As a result, a rating of noncompliance was given to this provision item.	Noncompliance

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		The facility's self-assessment of their performance in this area ranged from 76% compliance, as measured by the QA Department, to 80% compliance, as measured by the Nursing Department. However, the monitoring review of the 20 sample individuals revealed that all nursing assessments reviewed 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 failed to consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This continued to be 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. The significant discrepancies between the facility's self-assessments of their compliance and the findings of the monitoring review were of concern, because the bases for the facility's relatively positive findings were not evident throughout the conduct of the monitoring review of this provision item. In addition, the facility's self-assessments of its compliance across the other aspects of nursing care, which provided the foundation upon which complete, accurate, and comprehensive nursing assessments were developed, scored relatively low, with an average score of 51% compliance. Across the entire sample of individuals reviewed, nursing assessments had many of the deficiencies described below. Of note, these deficient practices were also found during prior reviews: • 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 for several sample individuals who resided in the Systems building were blank, • When significant weight changes were revealed in the individuals' records, there were no corresponding evaluations of the nature and impact of the changes on the individuals' health status in their assessments. This problem was most egregious for individuals who suffered significant, unplanned weight loss, but were "still within their desired and/or ideal weight range," • Tertiary care reviews were incomplete, • Individuals' significant histories of chronic and acute conditions, including, but not limited to, respiratory illnesses and infections, heart disease, skin breakdown, medication side effects, etc. were not completely identified and evaluated, • Erroneous information frequently obtained and documented during prior assessments from year(s) prior, were carried over from one quarter to the next	

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		without correction, • Nursing assessments that indicated that individuals' had pain management problems failed to reference an evaluation of the location, intensity, onset, duration, quality, etc. of the individuals' pain, and none explained where, when and how the individuals' communicated their 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 #189 was a 37-year-old man diagnosed with many health problems, needs, and risks. Over the past several months, he from suffered anorexia, constipation, diarrhea, vomiting, and skin breakdown. In addition, Individual #189's parents frequently called his physician to voice their concerns that he was in pain, not voiding as he should, and overusing laxatives, which caused him to have recurrent diarrhea. Despite his many health needs, risks, and parents' concerns regarding his declining health, his 12/30/11 nursing assessment: (1) was missing page three, (2) failed to include any information regarding meal monitoring by his nurse, (3) failed to reference a review of his response to and effectiveness of his medications and treatment, (4) failed to reference his GERD, sensory impairments, poor oral hygiene, and pain history and management, (5) failed to reference an assessment of his abdomen and lower extremities, (6) inaccurately portrayed his genitourinary status as "asymptomatic" and the condition of his upper extremities as "no abnormal findings," and (7) failed to conclude with a list all of his current, active nursing problems/diagnoses. • Individual #39 was a 30-year-old man who, at the time of the monitoring review, did not have a current comprehensive nursing assessment filed in his record. Since Individual #39's most recent, 8/19/11 nursing assessment, he suffered a	

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		human bite with broken skin, significant change in behavior that included increased episodes of aggressive behavior, absconded from EPSSLC, refused to participate in his day program and/or follow staff members' instructions, was diagnosed with a new Axis I diagnosis of intermittent explosive disorder, voiced increased complaints of headache and upset stomach, was diagnosed with asymptomatic bradycardia, fell and suffered a head injury with laceration to left eyebrow, and suffered a choking episode that required his staff member's intervention. In addition to no current comprehensive nursing assessment, Individual #39 failed to have HMPs and ACPs in place to address his ongoing and acute health and safety problems, needs, and risks. • Individual #25 was a 57-year-old woman with many health problems, needs, and risks. Notwithstanding her multiple and complex health problems and her many health needs, a number of sections of her nursing assessments were blank. For example, there was no evidence of meal monitoring by her nurse, and no evidence of her nurses' evaluation of her fractured shoulder, analysis of her nausea/vomiting episodes, review of her risks related to multiple extractions of abscessed teeth, and evaluation of her pain and its management. In addition, at the time of Individual #25's most current nursing assessment (10/31/11), although her nursing assessment indicated that her nurse noted her skin to be "pink, warm, dry, [and with] no alteration in skin integrity," a review of Individual #25's record notes revealed that at the time of the nurse's assessment, Individual #25 was diagnosed with and receiving treatment for vaginal candidiasis and a peri-anal rash. Also, although Individual #25's nursing assessment indicated that her nurse noted "no abnormal findings" of her lower extremities, a review of Individual #25's record notes revealed that at the time of the nurse's assessment, Individual #25's physician was monitoring her lower extremities, which were edematous. These findings raised serious question over whether or not a face-to-face evaluation of Individual #25 had actually occurred.	
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	According to the facility's action plan for this provision item, since the prior review, EPSSLC implemented the state's care plan policy revisions, instructed all RNs on these revisions, analyzed monitoring tools for compliance, developed corrective actions to address problems identified during the compliance monitoring, and completed training to all nurses on care plan development. 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 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,	Noncompliance

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	by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	objectives, and outcomes within a specified timeline of implementation of the interventions. One of the most telling findings of the review of this provision item was that four of the 20 individuals reviewed failed to have any HMPs and/or ACPs filed in their records, and another two individuals had only a page or two of a HMP filed in their records. Thus, for all intents and purposes, at the time of the monitoring review, <u>30% of the sample individuals failed to have some measure of a written nursing care plan filed in their records</u>. The rest of the 14 sample individuals had some, usually only few, of their health needs referenced in Health Management Plans (HMP) and/or Acute Care Plans (ACP). 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). 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 nursing assessments, both regularly scheduled and ongoing assessments, into the HMPs and ACPs, • reference all health risks and actual problems in the HMPs and ACPs, • adequately and appropriately individualize the HMPs and ACPs, and • update the HMPs and ACPs as needed to ensure they addressed all current health needs at all times. Some general comments regarding the 14 sample individuals with care plans were as described below. • Across the 14 sample individuals reviewed, it was curious to find that the "baseline assessment" and "implementation" dates of a number of the individuals' HMPs for chronic conditions were routinely changed to match the date that the most current comprehensive nursing assessment was completed. This practice appeared to take the place of documenting, at least quarterly, the nurses' reviews of the effectiveness of HMPs for chronic conditions. • None of the 14 sample individuals reviewed had HMPs that consistently addressed all of their health care needs, and, when appropriate, ACPs were not consistently prepared in a timely manner, or at all, in response to individuals' acute and/ or emergent health care needs and risks. • Five of the 14 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. • Eleven of the 14 sample individuals had recommendations by their dentist for general anesthesia and dental reports indicative of fair to mostly poor oral	

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		hygiene. As of the monitoring review, none of the 11 individuals had a HMP to address their oral hygiene problems. • Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, there was only one instance where the HMPs was appropriately revised to reflect the most current conditions and intervention strategies. • 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. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #49 was blind and severely hearing impaired. In addition, over the past several months, Individual #49 suffered acute illnesses and injuries. On 11/2/11, she fell and hit the left side of her head, and on 11/15/11, according to Individual #49's direct care staff member, she suffered another head injury when another individual knocked her to the floor while she was standing in her gait trainer. Despite her many health needs and risks, there was only one HMP related to falls/potential for injury, filed in her record. In addition, her sole HMP, which was missing one of three pages, was not developed and implemented until well over a month after her serious injury. The HMP also referenced a "goal" that Individual #49 "will experience less than 3 falls during the next 12 months." This goal was certainly not a desired outcome and should be revised. Indeed, the entire HMP should be revised and individualized to adequately protect Individual #49 and ensure her safety, while maximizing her potential for independence and mobility. • Individual #126 was a 33-year-old woman with multiple behavioral and physical health needs. Also, over the past year, Individual #126's weight decreased from 147 to 103 pounds. Although Individual #126 has many complex health needs, most of them there were not addressed nursing interventions, in accordance with a nursing care plan. There were only two HMPs and one ACP filed in Individual #126's record. The HMPs were related to paralytic ileus and herpes simplex, and the ACP was related to sinusitis. Of note, the HMPs that were present were not individualized to meet Individual #126's specific needs, thus some of the interventions put forward in the plans were not appropriate, and some were not indicated. For example, one of Individual #126's plans stated, "The appropriate intervention is to <u>withhold laxative and allow resumption of normal bowel function</u> (emphasis added)." This intervention was not appropriate, not medically or clinically indicated, and, if implemented,	

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		potentially harmful. • Individual #103 was a 37-year-old woman with many health needs. She was diagnosed with chronic conditions, such as spastic quadriplegia, asthma, pyelonephritis, constipation, GERD, osteopenia, contracted lower extremities, and poor oral hygiene. She also suffered multiple acute health problems. Over the past several months, Individual #103's physician evaluated and treated her for possible respiratory infection, cough and congestion, cerumen impaction, skin rash, vaginal candidiasis, dry skin around mouth, excoriation around her g-tube site, and hyperthermia. Notwithstanding Individual #103's many health problems, needs, and risks, there were no HMPs or ACPs filed in her record.	
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 vacancies across nursing leadership, nurse case managers, and direct care nursing positions continued. As noted in the prior review, it continued to be expected that the nurses who remained in their positions would cover the duties of the vacant positions until nurses were hired to fill the positions. For example, the Acting CNE/Nurse Operations Officer and two Nurse Managers were expected to assume the additional roles/responsibilities of the Nurse Educator, Hospital Liaison (recently filled in September 2011), and Infection Control Nurse (on leave since 8/22/11). Also, it was reported that direct care nurses were still required to cover one to two extra shifts a month to achieve minimum staffing levels. Although the Nursing Department's 10/28/11 Corrective Action Plan Addendum indicated that an evaluation of staffing patterns would occur during August 2011 to October 2011 and that a plan to address adequate staffing on all shifts would be developed, as of the review, the only staffing plan submitted to the monitoring team was the three-line, minimum/maximum EPSSLC Staffing level sheet, which referenced the same minimum/maximum LVN and RN staffing requirements that were reported during the prior review as, "not working anymore." Although there were piecemeal attempts to address the Nursing Department's "nurse staffing/deployment" vis a vis changing a vacant RN case manager position to an RN Supervisor position for the evening shift and "converting and moving" other filled and vacant nursing positions, there was no evidence that a strategy was developed to ensure that there were adequate numbers of nurses present and available across all shifts, in accordance with relevant clinical factors and the presence, severity, and complexity of individuals' current health and medical needs across the facility. Despite the vacancies and turnover in the Nursing Department, since the prior review, several important steps were taken to develop and implement assessment and reporting protocols at the facility. For example, the EPSSLC RNs completed the statewide physical assessment course, all nurses completed the statewide, competency-based documentation training course, and the revised emergency medical equipment	Noncompliance

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		procedures and emergency drill protocols were implemented. However, since the prior review, and most likely related to the continued absence of a Nurse Educator, the acting CNE's plan for the Department of Nursing to meet monthly for education and training sessions was abandoned. Although monthly meetings continued, the only regular attendees were the acting CNE and two Nurse Managers. During these meetings, the acting CNE and two Nurse Managers reviewed the pressing issues and problems of the day and made plans to address barriers to progress toward achieving compliance with the provisions of the Settlement Agreement. A review of their meeting minutes revealed that they often concluded their meetings with the caveat that making progress toward their common goals – improving education and nursing practice and compliance with policies and procedures – was becoming harder due to the ever-increasing demands placed on their time and their difficulty fulfilling multiple roles. They also astutely noted during many of their meetings that, "Infection control monitoring and surveillance and nursing practice compliance monitoring are two areas requiring immediate attention." During the prior review, a significant decline in the development, coordination, implementation and evaluation of the facility's infection control program was noted. Since that time, EPSSLC was months without an Infection Control Nurse, who took leave on 8/22/11, and months without an infection prevention and management program. In response to the monitoring team's request for any EPSSLC policies, procedures, and/or other documents addressing infections, the same set of documents submitted during the prior review – the 2011 Infection Control Reference Manual for SSLCs and 2008 policies/procedures that had not been reviewed/revised in over three years – were resubmitted. On 12/6/11, EPSSLC's Medical Director conducted the first Infection Control Committee meeting since the prior review. The objective of this meeting was "to re-establish ongoing infection control protocols." To his credit, prior to the meeting, the Medical Director examined all individuals' medical records and noted, across the dorms and cottages, the type and frequency of infections that occurred. The Medical Director also worked closely with the Respiratory Therapist to keep track of occurrences of aspiration pneumonia and aspiration related illness with a goal to prevent the occurrence of aspiration pneumonia. The actions taken by the Medical Director, which included the above-mentioned activities, as well as his successful recruitment of an infectious disease medical consultant to the facility, were indeed steps toward resuming an infection control prevention and management program that had lost its foundation. However, a review of	

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		the minutes of the 12/6/11 meeting revealed sobering findings that corroborated the Medical Director's report of months of concern over the decline of the facility's infection control program. For example, the meeting minutes indicated that over the past six months, identifying, reporting, documenting, analyzing, evaluating, and reporting patterns and trends of infections across the facility was not done, antibiograms and other important analyses were not completed as requested by clinical professionals, regular infection control monitoring, surveillance, and "random checks including corrective actions" were not underway, and evidence of ongoing housekeeping inspections, monitoring hand-washing, and tracking individuals and employees exposures to infection diseases were reportedly lost. Over the past six months, the Hospital Liaison and Nurse Educator positions were re-established at the facility. In September 2011, one of the Campus RN Supervisors assumed the additional duties of Hospital Liaison and almost immediately became a value-added member of the Nursing Department. During an interview with the Hospital Liaison, her commitment to advocate on behalf of individuals needs for safety and proactive treatment to protect them from harm during their hospitalizations was evident. She took it upon herself to establish her role with local hospitals and nursing facilities, and she communicated and collaborated with the tertiary care providers and EPSSLC's home managers, case managers, nurse managers, and other clinical professionals. In addition, the EPSSLC Hospital Liaison added something more to what she did – after her visits to hospitalized individuals; she made calls to their family members to let them know how the individuals were doing. A review of three randomly selected individuals' hospitalization reports, however, revealed significant variability in content and quality. For example, there was no evidence of oversight of one of the individuals, who was hospitalized during the period prior to the current Hospital Liaison's tenure. His record revealed one nurse's note that documented his transfer to the hospital and only one unsuccessful attempt to call for a report on the individual's status during his hospitalization. Although the other two individuals who were hospitalized during the current Hospital Liaison's tenure had more evidence of oversight, such as complete Hospital Liaison reports when the Hospital Liaison visited them, the reports of their status and progress varied significantly in content and quality when other EPSSLC nurses covered for the Hospital Liaison. There was no form/format for these reports, which ranged from two sentences to one-page in length, and no consistent gathering of "as much up-to-date information as possible" regarding individuals' responses to their treatment and plans for discharge. Another area where breakdown in the Hospital Liaison's implementation of assessment and reporting protocols occurred was during collaboration with the PNMT during individuals' hospitalizations. According to PNMT meeting minutes and discussion notes,	

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		there were many recommendations for the PNMT RN to be in "constant contact" with the Hospital Liaison so that information would be shared and communicated with the larger PNMT. Breakdown in these processes especially occurred in the realm of discharge planning and coordination of care for individuals when they were discharged from the hospital and readmitted to the facility. During an interview with the PNMT RN it was revealed that although "[communication and collaboration were] a little rough at the beginning, it had improved." Although the Nurse Educator position was re-established, as of the monitoring review, it remained vacant. As noted in the prior review, the absence of a Nurse Educator continued to negatively affect EPSSLC's progress toward achieving compliance with this provision item. Although all EPSSLC RNs attended the state-wide physical assessment competency-based training, program, there was little evidence of ongoing training and education underway to reaffirm, reinforce, and support nurses' retention of what they learned during their attendance at special training sessions. Although as noted in the prior review, the Nurse Education Handbook continued to be available to any and all nursing staff members, there was no evidence that it was regularly used or that its contents were, at least annually, reviewed. There was also no evidence that the two Nurse Managers, who had assumed the Nurse Educator's role/responsibilities during new employee orientation and annual refresher training, were providing ongoing training and education to all EPSSLC staff members and individuals regarding health maintenance and prevention, developing health education strategies, and locating resources for much needed education and training. A review of nine randomly selected nurses education files revealed that the data captured by the former Nurse Educator was no longer maintained and/or available. In addition, although three of the nine nurses were recommended to "review and correct" their performance of neurological assessments, there was no evidence of follow-up to the recommendations. During an interview with the Quality Assurance Nurse, over the past six months, she continued to provide extensive consultation to and collaboration with the Nursing Department. 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 submitted her data/findings to the facility's QA data analyst for analysis and reporting to the Nursing Department In addition, the QA Nurse stepped forward to help the Nursing Department complete its	

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		assigned infection control monitoring reviews, which included the monitoring of the presence, cleanliness, storage, and functioning of emergency medical equipment. A review of these monitoring tools revealed that the QA Nurse, whose findings differed from that of the Risk Management Department, scrupulously checked emergency medical equipment and immediately reported any and all negative findings to the relevant departments for corrective action. Since the prior review, the QA Nurse also completed a clinical death review of nursing care, which was very comprehensive, complete, thoughtful, appropriately critical, and well documented. She highlighted the persistent pattern of problems in nursing assessments, documentation, reporting, and planning processes. The Nursing Department prepared corrective action plans in response to some of the important recommendations put forward in these reports. A review of these plans revealed that some steps were completed, but many were not. Thus, the findings described across the other provisions of section M failed to reveal that consistent positive outcomes occurred as a result of these plans.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	At the time of the monitoring review, EPSSLC had completed the first full year of its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the ISP process. According to the facility's action plan, since the prior review, two actions were "complete" and two actions were "in process" to meet this provision item. Training in clinical indicators of changes in health was provided to direct care staff members and incorporated into the facility's new employee orientation program, and permission to overfill the position of infection control nurse due to the extended leave of the facility's infection control nurse was obtained. Also, activities were in process to analyze infection control monitoring data and develop corrective actions and/or plans to address identified infection control issues. Clearly, the training of direct care staff members in recognizing the signs and symptoms of illness and disease was a step in the direction of helping to ensure that clinical indicators of health risks were promptly identified by direct care staff members and reported to the individuals' clinical professionals. However, according to the facility's self-assessment of its compliance related to infection prevention and management, there were a number of problems still to be addressed in this area (see section M4). During the conduct of the review, the monitoring team attended Individual #92's ISP meeting, which was very well attended by the members of her team, with the exception of the glaring absence of a guardian or LAR (legally authorized representative). According to Individual #92's 1/12/11 ISP, "...it was agreed that [Individual #92] has a	Noncompliance

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		Priority I need for a guardian." Nonetheless, over the past year, no progress was made on this important matter. Thus, absent a guardian/LAR, the discussion of risks versus benefits of various community living options went nowhere, and Individual #92 was "referred to advocacy." Given Individual #92's cognitive capacity and ability to participate in planning her supports and services, the absence of guardian/LAR to facilitate the development of her desired plans and activities was truly unfortunate. The QDDP who chaired the meeting was prepared, organized, and kept the meeting on track. Although the actual assignment of ratings across the specific risk categories was saved until the end of the meeting, relevant discussions related to risk issues occurred throughout the meeting. The QDDP often gave deference to the opinions of Individual #92's clinical professionals regarding the intensity of her health risks, but this did not take away from the process. The conduct of the RN case manager who participated in the ISP meeting continued to need improvement. Although the RN case manager seemed knowledgeable of a number of Individual #92's health needs and risks, he/she often failed to voice an opinion or contribute to the discussion and the determination of the level of risk by way of offering relevant health information, such as health status data summaries, outcomes of planned nursing interventions to achieve Individual #92's health goals, etc. There was also no evidence that the RN case manager had given thought to what aspects of Individual #92's Risk Action Plan required revision prior to the meeting. Thus, once the risk ratings were completed, the review/revision of the Risk Action Plan received little to no attention during the ISP meeting. 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, a review of the 20 sample individuals' records revealed that four of the 20 sample individuals failed to have current risk ratings and, as required for medium and high risks, Risk Action Plans to reduce their risks. Several other individuals' records failed to reveal evidence that ISPAs were convened on behalf of individuals with significant changes in their health/health risks. Thus, there was no evidence that the health risks of a number of individuals were identified and addressed with interventions before the occurrence of adverse events. Also, there continued to be evidence of a number of problems with RN case managers, who (1) failed to demonstrate that they consistently identified and raised health risk problems and brought them to the attention of individuals' IDTs in a timely way such that the likelihood of negative health outcomes were reduced, (2) failed to avail themselves of all accessible pertinent health information and data and fully prepare prior to the IDT meetings, (3) failed to form educated opinions, and 4) failed to serve as the	

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		individual's "health advocate" during the ISP process. Therefore, this provision item was rated as noncompliance. Examples included the following: • Over the past several months, a review of Individual #90's record revealed that he was becoming weaker, more unsteady, refusing to walk, losing his balance immediately, and becoming more impulsive. Notwithstanding Individual #90's well documented failure to positively respond to planned interventions, since 8/18/11, when he was designated at high risk of falls, fractures, and side effects of medications, the action plan to address his high risks remained the same – continue with assistive equipment, continue level of supervision, and continue monitoring. Without evidence of further review by Individual #90's IDT, on 11/9/11, his direct care staff member documented that he was "no longer 1:1 [level of supervision] once asleep." Ten days later, on 11/19/11, Individual #90 was found on the floor bleeding from the back of his head. Individual #90 was transferred to the hospital and diagnosed with a fractured cervical spine and possible neuroleptic malignant syndrome. • Over the past several months, Individual #9, who had a childhood history of severe head injury, suffered several falls with head injuries that required emergency medical treatment. Although Individual #9's IDT met at least twice to review her falls, there was no evidence that she received an assessment of her health risks or that a risk action plan was developed to address her repeated falls and head injuries. This was especially significant for Individual #9 who had multiple health risks, such as ataxia, EPS, seizure disorder, etc., that without a doubt increased her risks of falls and injuries. • Individual #126 was a 33-year-old woman who was hospitalized in September 2011 for treatment of paralytic ileus, which, according to the hospital's clinical professionals, required "clinical correlation" to help determine whether her problem was an infectious or inflammatory condition. There was no evidence that Individual #126's IST met to review and reassess her health risks. This was especially significant because intestinal obstructions can be life threatening and Individual #126 had a number of health problems that could have been associated with or contributed to her intestines not working properly, such chronic constipation, fluid restrictions, and side effects of medications.	
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	Processes related to the administration of medication and the management of the medication administration system at EPSSLC had continued to improve since the previous monitoring review. However, nursing practice had not. As indicated in more detail below, although work still needed to be done to ensure that medications were administered and accounted for in accordance with generally accepted professional	Noncompliance

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	administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	standards of care and the Health Care Guidelines, the facility had taken several steps toward improving their procedures for the administration of medications, in accordance with current, generally accepted standards of care. For example, since the prior review, EPSSLC implemented a revised narcotic accountability form, a Medication Variance policy, and medication observation guidelines. Also, the heads of all disciplines at the facility met to begin working on a plan to incorporate the state's medication administration guidelines into the individuals' PNM plans. Even so, this provision item was rated as being in noncompliance because there continued to be serious problems in this area. The facility's Medication Error Committee identified several of these problems. During the review, observations of medication administration and enteral administration of medications and nutrition were conducted on Dorms A and B and Cottages 512 and 513. Only one of the four observations of nurses' administration of medications, which were delivered via oral and enteral routes, was conducted in accordance with current, accepted standards of practice. As noted in previous reviews, the rest of the observations of medication passes and practices continued to reveal problems with nurses' using inadequate judgment and failing to comply with standards of practice and the Health Care Guidelines, which placed individuals at risk of harm. For example: • A nurse was observed setting up and, sometimes, documenting the individuals' receipt of medications on the Medication Administration Records (MARs) several hours prior to administration. • A nurse was observed signing the MAR for prescribed medications/treatments that he/she did not administer. • Nurses used syringes to quickly push medications and boluses of enteral nutrition quickly into individuals' stomachs and increased their risks of gastrointestinal discomfort and increase gastric residual volume versus allowing individuals to receive their medications and enteral nutrition delivered more slowly and in accordance with standards of practice. For example, during one observation, one individual received two cans of Promote with fiber and water flushes via g-tube in less than five minutes. • Nurses dismantled individuals' adaptive equipment and, in one instance, pushed medications into an individual's mouth via syringe, and held another individual's jaw shut, in what appeared to be attempts to force individuals to accept medications and hurry along the medication administration process. • Nurses mixed multiple crushed pills, contents of opened capsules, and liquid medications altogether into a noxious mixture and assumed the unreasonable expectation that individuals would simply open their mouths and drink the concoctions without a negative response. There was no evidence that nurses	

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		had taken any steps to consult with the pharmacist, physician, nurse manager, etc. to come up with strategies for helping individuals to accept their medications. This was especially significant for those individuals who had well known and well documented difficulty accepting and taking their medications. All told, observations of medication administration by the monitoring team significantly failed to corroborate the facility's self-reported scores of 100% compliance on the Medication Pass Assessment tools and determination that there was no need for immediate corrective actions. The examples referenced above, as well as other practice deficiencies that jeopardized the health and safety of individuals, were carried out in front of nurse supervisors and the monitoring team. On two occasions, in order to prevent potentially dangerous situations from becoming actual harm, the monitoring team requested that the nurse stop what he/she was doing and seek help. 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 individuals' medications. As noted above, 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 12/1/11 - 12/31/11 MARs revealed that 19 of the 20 individuals had missing entries in their MARs, which indicated numerous potential medication errors in the administration of seizure medications, laxatives, psychotropics, calcium/vitamin D, diabetes medications, antihypertensives, eye drops, etc. It was not clear whether, or how, these potential medications errors were reconciled, identified, analyzed, and reported by the Medication Error Committee in their Medication Error Trend reports. Over the past several months, The Medication Error Committee had implemented several steps to decrease medication variance. The Nursing Department began staggered medication administration schedules on Dorm A and Cottage 512, and the Pharmacy Department continued to decrease the frequency of doses and numbers of pills for individuals, where and when appropriate. During the onsite review, the monitoring team attended the 12/13/11 Medication Error Committee Meeting. According to the monthly data and trend analyses presented at the meeting, 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. The results of the Pharmacy Department's November 2011 audit of bulk stock liquids,	

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		however, were striking. The Pharmacy Department's audit revealed that bulk stock liquids, such as laxatives like Clearlax, and ampules of medications to treat respiratory disease, such as albuterol, ipratropium, and budesonide, lasted two to three months longer than they should, when/if they were administered as ordered. For example, the audit showed that 16 individuals potentially missed hundreds of days of daily doses of laxative medications, and six individuals potentially missed almost as many days of daily doses of respiratory medications. Although the Pharmacy and Nursing Departments immediately took action to address these serious findings, it was too late to prevent the negative outcomes for individuals that possibly occurred as a result of their failure to receive medications in accordance with physician's orders. However, the steps taken to convert bulk, stock medications to unit-dose and to permanently assign nurses to particular dorms and cottages were noted, and it was anticipated that further monitoring and auditing would show improvement During the Medication Error Committee Meeting, the following initiatives were put forward for consideration and approval by the Committee: • Continue monthly pharmacy audits and include other bulk, stock, and/or other non-pill form medications, • Consider capturing Category A, prescribing errors, in the Medication Error Trend reports to comply with the state's policy and further improve practice, and • Review, and possibly revise, the current manner in which the severities of the medication errors were determined. As of the monitoring review, the above-referenced initiatives were pending further review by the committee.	

Recommendations:

1. Ensure that unsafe, unacceptable nursing practices associated with medication administration and the delivery medications and nutrition via gastrostomy tubes do not occur at the facility (M6).

2. The facility should consider placing the newly acquired AEDs in their designated locations and continue to 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).

3. The facility should develop a plan to address the absence of a Nurse Educator and Infection Control Nurse (M1-M6).

4. The facility should re-establish its infection prevention and management program (M1, M4, M5).

5. Once vacancies across the Nurse Department are addressed, consider ways in which the Nurse Managers can spend a portion of their day present on the dorms and cottages articulating expectations and overseeing the delivery of nursing care to improve nursing practices across the facility (M1-M6).

6. Involve the Campus RN Supervisors and other direct care RNs in the compliance process. For example, specifically assign the Campus RN Supervisors and direct care RNs a specific job to do to help the Nursing Department improve performance or achieve compliance with a specific provision of Section M (M1-M6).

7. The Nursing Department should complete its analysis of staff and staff deployment and develop a plan that is based on relevant clinical factors and the presence, severity, and complexity of individuals' current health and medical needs across the facility (M1-M6).

8. The Nursing Department should consider affording the Hospital Liaison a place to work that is conducive to completing her job duties. For example, affording her easy access to facility-owned computer and phone and private workspace, such that individuals' private health information is safeguarded (M1, M4, M5).

9. 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).

10. 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).

11. 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).

12. 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).

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.1: Medical Care, 2/16/11 o DADS Policy#011: Pharmacy Services, 10/14/11 o EPSSLC Self –Assessment for Section N o EPSSLC Action Plans for Section N o EPSSLC Organizational Charts o EPSSLC Medication Variances, 9/30/11 o EPSSLC Drug Regimen Reviews, 10/11 o EPSSLC Policy and Procedure: Prospective Review of New Medication Orders, 9/10 o EPSSLC Adverse Drug Reaction Reporting, 11/11 o EPSSLC Drug Utilization Evaluation 10/11 o EPSSLC Policy and Procedure: After Hours Pharmacy Stock, 9/10, rev 10/17/11 o EPSSLC Policy and Procedure: Pharmacy Access After Hours, 9/10, rev 10/11 o EPSSLC Policy and Procedure: Psychiatry Services, 4/26/11 o EPSSLC Lab Matrix, 3/11 o Pharmacy and Therapeutics Committee Meeting Minutes, 7/13/11, 9/8/11, 10/13/11, 11/10/11, 12/15/11, 1/12/11 o Medication Review Committee Meeting Notes, 8/23/11, 9/20/11, 10/26/11, 11/15/11, 12/13/11 o Polypharmacy Oversight Committee Meeting Notes, 7/13/11, 10/13/11, 9/8/11,11/10/11 o Pharmacy Intervention Documentation Forms o Adverse Drug Reactions Reports o Quarterly Drug Regimen Reviews for the following individuals: • Individual #161, Individual #144, Individual #15, Individual #17, Individual #18, Individual #21, Individual #23, Individual #25, Individual #56, Individual #58, Individual #59, Individual #61, Individual #100, Individual #154, Individual #1, Individual #2, Individual #3, Individual #6, Individual #7, Individual #104Individual #105, Individual #112, Individual #67, Individual #71, Individual #72, Individual #73, Individual #113 Individual #114 Individual #191, Individual #117, Individual #28, Individual #31, Individual #40, Individual #125, Individual #127, Individual #118, Individual #122, Individual #49, Individual #92, Individual #93, Individual #52, Individual #54, Individual #129 o DISCUS evaluations for the following individuals: • Individual #155, Individual #60, Individual #99, Individual #100 Individual #2, Individual #3, Individual #102, Individual #103, Individual #104, Individual #108, Individual #111, Individual #66, Individual #157, Individual #71, Individual #72, Individual #73, Individual

	#114, Individual #191, Individual #27, Individual #32, Individual #35, Individual #36, Individual #37, Individual #40, Individual #76, Individual #80, Individual #82, Individual #90, Individual #123, Individual #126, Individual #120, Individual #188, Individual #46, Individual #47, Individual #49, Individual #50, Individual #162, Individual #92, Individual #96, Individual #52, Individual #54, Individual #44, Individual #161, Individual #15, Individual #18, Individual #1, Individual #31, Individual #195, Individual #83 o MOSES evaluations for the following individuals: • Individual #161, Individual #15, Individual #18, Individual #63, Individual #100, Individual #154, Individual #2, Individual #9, Individual #108, Individual #157, Individual #71, Individual #72, Individual #169, Individual #114, Individual #191, Individual #30, Individual #33, Individual #36, Individual #175, Individual #37 Individual #76, Individual #78, Individual #80, Individual #82, Individual #125, Individual #126, Individual #188, Individual #45, Individual #47, Individual #96, Individual #54, Individual #60, Individual #1, Individual #3, Individual #73, Individual #31, Individual #195, Individual #122, Individual #92, Individual #52 <u>Interviews and Meetings Held</u>: o Amista Salcido, Pharm.D., Pharmacy Director o Giovanna Villagran, Pharm.D., Clinical Pharmacist o Ascension Mena, MD, MS, Medical Director o Eugenio Chavez-Rice, MD, Psychiatrist o Howard Pray, DDS, Contract Dentist o Denise Jones, APRN, FNP o May Ann Clark, RN, Acting Chief Nurse Executive o Elaine Lichter, RN, Quality Enhancement Nurse o Cynthia Diaz, RN, Nurse Manager o Meetings with Pharmacy Director and State Office Medical Services Coordinator <u>Observations Conducted</u>: o Pharmacy and Therapeutics Committee Meeting o Medication Error Committee Meeting o Polypharmacy Oversight Committee Meeting o Pretreatment Sedation Meeting o Daily Unit Team Meeting o Pharmacy Department
	Facility Self-Assessment: The Plan of Improvement was replaced with two separate documents, the Self-Assessment and the Action Plan. For each provision item, the self-assessment listed (1) activities engaged in to conduct the self-assessment, (2) results of the self-assessment and (3) the self-rating.

	The activities listed were actually not activities that could be used to determine compliance. Rather, a series of actions taken to help achieve compliance were provided. This included steps, such as revision of policies and procedures, updating of the lab matrix, and completion of quarterly drug regimen reviews. In some instances, this translated into data, such as 100% of policies and procedures were updated or 100% of QDRRs were completed. Future self-assessments could focus on activities similar to those completed by the monitoring team. For example, for provision N2, the facility should document (1) the types of reviews completed to determine that the QDRRs were completed in a timely manner, (2) types of audits done to determine that the QDRRs monitored drug use in accordance with the lab, and (3) audits to determine that physicians complied with requirements for completion of review of the QDRR. The Action Plan for N3 was to monitor metabolic risks associated with the use of the new generation antipsychotics. The plan did not provide any information on how this would be done. The monitoring team used multiple methods to determine if this occurred. The QDRRs were reviewed and individuals who received NGAs were identified. Then, the QDRR report was reviewed to determine if the monitoring for use of the drug was documented. The monitoring team recommends that the pharmacy director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report and the recommendations made throughout the report. This may result in a plan in which the assessment activities provide results that drive the next set of action steps. The facility rated itself in substantial compliance with provisions N1, N2, N3, N4, N5 and N7. The monitoring team rated N2, N4, N5 and N7 as being in substantial compliance.
	Summary of Monitor's Assessment: Continued progress was noted in the provision of pharmacy services. The pharmacy continued to complete prospective reviews of new medication orders, communicated with prescribers, and documented outcomes. The use of multiple reporting forms was consolidated, such that one form was used to report all communication. The change in processes, however, was not codified into policy and procedure. A new drug regimen review policy was implemented that outlined the process. It provided timelines for completion and review of documents by clinical pharmacists and medical providers. The clinical pharmacist completed QDRRs in a timely manner and provided good clinical information for use by medical providers. It was difficult, at times, to get a quick snapshot of compliance with drug monitoring because the report did not always mention the monitoring required for each drug. Even so, the required labs could usually be located in the worksheets or records. Medical providers responded to the recommendations of the clinical pharmacists. With some exceptions, it could usually be determined that the medical providers wrote orders and took other appropriate actions

	after agreeing with the pharmacists. Significant improvement was noted in the completion of the MOSES and DISCUS evaluations. The psychiatrist reviewed the findings and documented conclusions in almost every evaluation completed after July 2011. Email correspondence appeared to indicate that the nursing department had some difficulty related to completing and forwarding the evaluations to the psychiatrist. The frequency of ADR reporting increased and there was evidence that the ADRs were discussed and followed-up. One noteworthy finding was that ADRs were usually detected by the clinical pharmacist during routine reviews. Additional training was being provided, but direct care professionals still had not received training. This was important given the fact that the DCPs have the greatest degree of contact with the individuals. A new DUE policy was implemented and DUEs continued to be performed on a monthly basis. The evaluations were quality reviews and could be even more helpful with additional work in this area. The ongoing efforts in safe medication practices resulted in numerous changes that decreased the number of medication omissions. The system was not capturing all errors, some of which were significant events, based on the duration and the number of individuals involved.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug	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. The pharmacy director reported that when issues were identified, the pharmacist completed a Pharmacy Intervention Documentation Form. This form was used to address allergies, contraindications, drug interactions, incomplete orders and dosing problems. It was divided into three sections. Sections one and three were completed by the pharmacists. The physician completed section two. The monitoring team requested copies of all Pharmacy Intervention Documentation Forms completed since the last onsite review. Documents dated from July 2011 through December 2011 were submitted. A sample of the information contained in those documents is presented in the table below.	Noncompliance

#	Provision	Assessment of Status	Compliance
	literature.		

Individual#	Report Date	Type of Problem	Outcome
18	8/11/11	Drug interaction- Tylenol #3 prescribed; contraindicated with naltrexone	Ibuprofen prescribed
133	7/20/11	Incomplete Rx – Haldol on original med list, but order not written upon return to facility	Haldol not continued based on discharge orders; not dispensed
25	8/3/11	Incomplete order – no indication	Clarified and dispensed
2		Formulation – meds per G-tube; EC cannot be crushed	ASA chewable to be crushed
114	10/21/11	Debrox unavailable	Either write order to hold until avail or use docusate; will hold until available
133	10/25/11	Drug interaction – severe: lisinopril and lithium; clinic nurse contacted and explained increased risk of lithium toxicity; monitor levels decrease lithium dose or consider increasing amlodipine	Lisinopril not dispensed; amlodipine increased
70	11/7/11	Drug interaction- (severe): tetracycline-calcium	Hold calcium for remainder of tetracycline tx duration or separate by 2 hours Outcome not clear (not checked)
123	11/8/11	Duplication – Prilosec 20 mg daily; already receiving 40 mg	Order d/c prescribed 20 mg daily
102	12/5/11	Dosing issues- Megace 80 mg daily prescribed; reported that this was the recommendation of GI	Clarified with GI; 800 mg daily prescribed
161	12/8/11	Dosing issues- Macrodantin dosed BID	Dose changed to QID

These documents indicated that the pharmacists communicated frequently with medical providers and addressed many issues related to medication use. Generally, the forms were completed thoroughly and the pharmacists provided many relevant recommendations. Nonetheless, documentation on the form will require additional work as there were several instances in which the drug involved was not listed and the outcomes were not clear. The pharmacists signed and dated the forms. Current policy required the physician to complete Section 2, but there was no requirement for a physician signature.

#	Provision	Assessment of Status	Compliance
		The pharmacy director also maintained summary data related to clinical interventions. The monitoring team reviewed these data with the pharmacy director and state medical services coordinator. Copies of the third and fourth quarter data were submitted following the onsite review and are presented below:	

Pharmacy Intervention Data 2011		
	3rd QTR (% of total)	4th QTR (% of total)
Interactions	8	16
Incomplete RX	49	37
Dosing Issues	10	6
Duplication	3	7
Formulation	9	15
Lab Monitoring	3	0
Wrong Drug	1.4	1
Total Orders	2408	2546
Total Interventions	141	94

As noted in the table, the majority of the interventions were related to incomplete orders. The pharmacy director reported that the data were provided to the medical director. Pharmacy and Therapeutics Committee meeting minutes did not document any discussion of the intervention data. The medical director provided a memo to the clinic staff, dated 9/29/11, which described several requirements related to documentation, including the requirement to write complete physician orders. There were also several interventions that addressed the wrong dose or route of medications. The monitoring team observed, in the record sample, numerous orders that were incomplete and required clarification. Although these issues were addressed by the pharmacy and corrected, some, but not all, of these issues were prescribing errors (potential variances) and should have been recorded as such. This is discussed further in section N8.

The facility's self-assessment cited that current policies and procedures were working well. The procedures in place were actually not consistent with the approved policy. The pharmacy department implemented the state issued policy on pharmacy operations, but there was no overarching facility-specific policy generated. Several pharmacy policies were revised, but the EPSSLC Policy Prospective Review of Physician Orders, implemented in September 2010 remained in effect and unrevised. This procedure provided guidance on a number of issues, including (1) the prospective drug regimen review, (2) notification of severe drug interactions, and (3) the review of new

#	Provision	Assessment of Status	Compliance
		psychoactive drug orders. The policy required that the pharmacist contact the physician immediately in writing regarding the problem associated with the regimen review and order. For significant severe interactions, the form entitled Pharmacy Notification of Severe Drug Interactions Order was to be forwarded to the physician and respective RN Case Manager. The physician was also required to document the severe interaction in the IPN. Several interventions were documented as severe drug interactions. While the prescriber was notified and action taken, the procedure followed differed from the current written procedure. The monitoring team could not determine if the prescriber documented in the IPN as required. Many of these issues were addressed with recommendations in the July 2011 report. Finally, this provision item required "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… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." The monitoring team discussed this requirement with the pharmacy director and state office medical services coordinator. The pharmacy director stated that this requirement was interpreted as the need for the pharmacist to document that labs were obtained, but they were not necessarily reviewed. 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. That is, the pharmacy and medical departments will need to develop a list of medications that will require documentation of labs prior to dispensing.	
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 facility approved a new policy, Drug Regimen Reviews, in October 2011. The exact implementation date was not included. The policy outlined the process for completion of the QDRRs, specified the timelines for medical providers to review, and outlined the requirements for lab monitoring. The lab matrix provided protocols for monitoring of labs associated with the use of specific drugs or drug classes such as AEDs, psychoactive medications, and thyroid medications. The monitoring team reviewed copies of the QDRRs submitted, as well as the QDRRs included in the record sample listed in Section L. Examples of content of the QDRRs are provided below. For the QDRRs submitted as part of the documents requested, the monitoring team reviewed all documents, including the worksheets. The QDRR report was the only document filed in the active record. For each individual, the monitoring team cited compliance with the requirements stated in the lab matrix as documented on the QDRR by the clinical pharmacist.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Individual #144, 10/25/11 • Prevention – The BMD and vitamin D were documented. Obtaining an annual TSH was recommended, last 8/6/10. • Antihypertensives – The BP and UA were documented. The CBC, CMP, and EKG were not documented. • Antihyperlipidemic agents – The lipid results were documented. LFTs were not documented but included in worksheet. Individual #21, 10/25/11 • Prolia – Vitamin D and BMD were documented. • An inappropriate prn order was noted: ibuprofen indication listed as dysmenorrhea. The individual had no menses since 2010. Individual #58, 10/25/11 • Anti-diabetic agents – The HbA1c was documented and it was elevated. It was documented that the eye exam was past due (last 7/5/10) and that there was no recorded urine microalbumin. • Antihyperlipidemic agents – The lipids were not documented but were included in the worksheet. • Antihypertensive agents – The BPs were documented. The CMP and EKG were not documented. • The recommendation was made to update the active problem list and consider the use of Prolia. Individual #105, 10/25/11 • Antihyperlipidemic agents – The lipids were documented. • Prevention - Vitamin D levels and BMD were documented. The recommendation for use of Prolia was made. Individual #71,10/25/11 • Prevention - Vitamin D and BMD were documented; Prolia candidate • Antihypertensive agents – The BPs were not documented but found on the worksheet. The EKG findings were not documented. • PPIs – Mg was monitored due to long term PPI use. Individual #113, 10/25/11 • Anti-diabetic agents – The Hba1c was documented and elevated. The individual was not on an ACE inhibitor. • Thyroid hormones – The TSH was documented.	

#	Provision	Assessment of Status	Compliance
		• AEDs – Calcium supplementation was recommended due to the use of multiple AEDs. The vitamin D level was documented as decreased. The BMD was monitored Individual #114, 10/25/11 • Prevention Vitamin D – The vitamin D level was not documented. The BMD had increased. • AEDs – The CBZ level was documented. A recommendation to repeat per lab matrix was made since the last was recorded on last 4/11/11. Individual #2, 11/4/11 • Thyroid hormones – The TSH was documented. • Antipsychotics – A baseline prolactin level was recommended. • AEDs – The phenytoin level was 18.6. The recommendation was to monitor for signs and symptoms of toxicity • Prolia - The BMD, Vitamin D and calcium values were not documented • Preventive –Repeat Pneumovax administration was recommended. Individual #72, 11/8/11 • Thyroid hormones – The TSH was documented. • Psychoactive agents- Seroquel- lipids, LFT. Weights not documented, but found on worksheet • Prolia – The BMD was documented. It was noted that individual was not on calcium. Recommended Vitamin D levels due to AED; • Recommend CMP due to oxcarbazepine Individual #7, 11/8/11 • Antihyperlipidemic agents –Lipids were documented, LFTs not documented • Antipsychotics – HbA1c and glucose were not documented. Individual #61, 11/30/11 • Antipsychotics – The glucose, HbA1c, weight and lipids were not documented. • Quetiapine – EKG and eye exam (Seroquel) were not documented. • Thyroid hormones – The TSH was documented. • Antihyperlipidemic agents – It was documented that the last lipids were1/12/11. There were no LFTs documented	

#	Provision	Assessment of Status	Compliance
		Overall, the QDRRs were thorough, well done, and completed in a timely manner. They provided relevant information that was useful in the clinical decision making process. The medical providers documented agreement with all recommendations. For the most part, it appeared that medical providers took actions in response to the recommendations. Nonetheless the monitoring team found some issues with the system and the reviews that must be addressed: • The report did not address every drug for which there was a monitoring parameter included in the lab/procedure matrix. The active record contained only the QDRR report. If the report did not document the monitoring for a drug, the reader did not know that it was completed. The monitoring team was able to determine that labs were done only because worksheets were included or the entire record was reviewed. The user should be able to discern this information by reviewing the report. • The lab/procedure matrix did not include important monitoring parameters, such as the need for eye exams with quetiapine use, nor did it define all parameters associated with metabolic syndrome. With regards to lithium use, the matrix required an annual CMP and UA to assess renal function. It should be noted that serum creatinine can be affected by external factors and remains a less than ideal measurement of GFR. Other diagnostics, such as 24 hour urine sampling, should be considered as an additional measurement of renal function. • There were several guidelines in the lab/procedure matrix, such as cancer screenings, that were not consistent with state issued policy. • The new drug regimen review policy outlined a specific timelines for completion of the reviews by medical providers. Numerous QDRRs submitted did not comply with this requirement. Furthermore, the policy did not include a specific date of implementation but was dated 10/11. The implementation date was needed for numerous reasons inclusive of determining compliance with the procedure.	
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	The facility continued to have monthly Polypharmacy Oversight Committee meetings. This monthly meeting reviewed many areas of polypharmacy, such as AEDs, antipsychotics, and antihypertensives. It also assessed the use of stat medications and chemical restraints. The monitoring team observed the January 2012 meeting. While the use of polypharmacy may have been truly justified, the discussion leading to that conclusion did not occur in the meeting attended. Polypharmacy is discussed in section J. The use of the new generation antipsychotics and the risk of developing metabolic syndrome were monitored through the Quarterly Drug Regimen Reviews. The olanzapine	Noncompliance

#	Provision	Assessment of Status	Compliance
	substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	DUE conducted by the facility highlighted that numerous (71%) individuals had concurrent metabolic/cardiovascular conditions and there were clinical manifestations of hypercholesterolemia in 43% of individuals. Lab monitoring, as guided by the lab matrix, appeared appropriate. As mentioned in section L1, the diabetes listing did not appear to include all individuals with the diagnosis of diabetes. Given the fact that the new generation antipsychotics can worsen existing diabetes, and cause new-onset diabetes and hyperglycemia, the medical director and pharmacy director should work to ensure that all persons with diabetes and glucose intolerance are identified. The lab matrix should be revised to reflect that metabolic syndrome requires monitoring of blood pressure, FBS, central obesity (weight and abdominal girth), triglycerides, and HDL. The QDRR and lab monitoring is discussed above in N2. The QDRRs also noted the anticholinergic burden and benzodiazepine use. Recommendations for decreasing the anticholinergic burden were made on a consistent basis. The use of benzodiazepines and stat medications were reviewed in multiple meetings, such as polypharmacy and P&T.	
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.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. During the prospective pharmacy review, the pharmacist documented the response of the provider on the Clinical Interventions Form. Prospective reviews are discussed in N1 above. Retrospectively, physicians responded to recommendations made by the clinical pharmacists in the QDRRs. In the sample of QRRs reviewed, the medical providers agreed with all recommendations. The monitoring team could not assess physician actions in all instances. Generally, for the record sample provided, there was evidence that the medical providers wrote orders and took other actions in response to the recommendations. The monitoring team noted that QDRRs made repetitive recommendations related to Mg monitoring for PPI use. While the physicians agreed, frequently no action was taken. For Individual #52, the QDRR (10/18/11) recommended decreasing paroxetine from 60 mg to 50 mg. Both the PCP and psychiatrist agreed with the recommendation but no order was written. Routine orders signed in December 2011 continued the dose without change.	Substantial compliance

#	Provision	Assessment of Status	Compliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The monitoring team requested a sample of 60 of the most recent MOSES and DISCUS evaluations. Documents completed prior to July 2011 were eliminated from data calculations. The findings are summarized below: Twenty-three MOSES tools were reviewed for timeliness and completion: • 23 of 23 (100%) were signed and dated by the physician • 22 of 24 (95%) documented no action necessary • 1 of 23 (5%) documented no prescriber review Thirty-eight DISCUS evaluations were reviewed for timelines and completion: • 38 of 38 (100) were signed and dated by physician • 36 of 38 (95%) indicated no TD • 2 of 38 (5%) documented no prescriber conclusion The MOSES evaluation was to be completed every six months while the DISCUS evaluation was required every three months. The psychiatrist assumed responsibility for completion and all were reviewed and signed. This was a significant improvement since the last review. Although the dates on the documents indicated timely completion, the monitoring team was provided a series of emails that indicated that problems existed with this process. There were weekly emails spanning from July 2011 to December 2011, sent by the clinical pharmacist indicating that some MOSES and DISCUS evaluations were outdated. An email from the acting CNE dated 8/24/11 stated that the case managers on Systems had not been trained, resulting in the need for the acting CNE to complete the assessments. Another email from the acting CNE, dated 11/10/11, documented that there would be an attempt to get the evaluations done as soon as possible. <u>Additional Discussion</u> Identification of the development or presence of extrapyramidal symptoms and the potentially irreversible tardive dyskinesia has great clinical significance. The MOSES and DISCUS evaluations should be completed in a timely manner and the information promptly provided to the physicians for review. Moreover, the facility should ensure that assessment for tardive dyskinesia occurs with discontinuation and lowering of drug doses due to the potential for unmasking of symptoms. This information should be made available to the IDTs and consultants such as the neurologist.	Substantial compliance

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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's protocol for reporting ADRs was revised in November 2011. The revision included assurances related to follow-up by the clinical pharmacists and prescribers. Moreover, the revision stated that an intense case analysis would be performed for reported ADRs that resulted in hospitalization. A review of Pharmacy and Therapeutics Committee meeting minutes indicated that ADRs were discussed and followed up during meetings. A total of 56 ADRs were reported in 2011 with the average monthly reporting of four ADRs. The monitoring team attended the Pharmacy and Therapeutics Committee meeting conducted during the onsite review. The ADR discussion included follow-up of several previous ADRs as well as a through discussion of five new ADRS. Individual #120 experienced symptoms of bradycardia and dizziness that resulted in hospital ED evaluation. This ADR did not meet the facility-determined threshold for intense case analysis. The pharmacy director reported that the majority of ADRs were reported as a result of reviews by the clinical pharmacist. These were often discovered during the conduct of the QDRRs or psychiatry clinic. In order to improve reporting and ensure timeliness of reporting, the facility implemented additional training. Starting in December 2011, the pharmacy director began conducting ADR training during new employee orientation for nursing, pharmacy, and physicians. An annual refresher was also now required. The medical director completed training on the new ADR form for the medical clinic staff. Training on the new form had not been completed for nursing and direct care professionals. This was delayed due to discussion on how the form would be completed. A decision was made that completion would be a collaborative effort between medical, nursing and the pharmacy. The unit director and direct care professionals' supervisors would receive training during the nursing supervisor training and they would subsequently be responsible for training direct care professionals. It was also reported that ADRs would be discussed and documents completed in the morning unit meetings attended by the pharmacy, nursing and medical. <u>Additional Discussion</u> The revised ADR policy set hospitalization as the threshold for completion of an intense case analysis. While the monitoring team agreed that ADRs that result in hospitalization should be thoroughly reviewed, the facility must consider lowering the threshold for ICA. The current threshold would not mandate an ICA for a serious ADR that required a prolonged ED stay/evaluation for the individual but did not require hospitalization. A fully implemented ADR reporting and monitoring system mandates that all healthcare professionals and others with extensive contact with the individuals have the ability to	Noncompliance

#	Provision	Assessment of Status	Compliance
		recognize and report adverse drug reactions. The facility must ensure that all medical providers, pharmacists, nurses, respiratory therapists, and direct care professionals receive appropriate training on the recognition of ADRs and the facility's reporting process. Documentation of this training should be maintained.	
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 revised the DUE policy in October 2011. The policy required that one DUE be completed each quarter. The clinical pharmacist completed one DUE each month. The policy provided additional guidance on the DUE process, including the requirement to develop an action plan for identified deficiencies. <u>Prospective DUE - Oral Contraceptives Used For Menstrual Suppression</u> This prospective DUE was presented to the Pharmacy and Therapeutics Committee at the July 2011 meeting. The objective was to identify those individuals who were on menstrual suppression treatment and provide appropriate recommendations for possible alternatives. Eight females received oral contraception, seven of whom had an indication of menstrual suppression. The report indicated that the need for continued use was not clear and additional guidance was needed from gynecology. Follow-up on the recommendation was not noted in subsequent meeting minutes. The use of OCPs is discussed further in L1. <u>Retrospective DUE - Valproic Acid</u> The Valproic Acid DUE was presented at the September 2011 meeting. The DUE was completed in response to five ADR reports associated with valproic acid. Fifteen individuals were identified who received valproic acid. Indications were appropriate for all 15 individuals. Data showed that 53% of individuals had labs that were not drawn or were overdue. There were no elevated valproic acid levels that indicated toxicity. There was no specific plan to address what steps would be taken to ensure that the lab matrix was followed appropriately. <u>Retrospective DUE- Metabolic Side Effects (Olanzapine)</u> This DUE, completed due to several ADRs associated with metabolic side effects, was presented at the October 2011 Pharmacy and Therapeutic Committee meeting. The objective was to identify those individuals at risk for hypercholesterolemia, hyperglycemia, and weight gain, to evaluate current monitoring, and to establish appropriate monitoring parameters to prevent additional adverse drug reactions. Seven individuals received olanzapine. The DUE documented that 1 of 7 (14%) of individuals did not have appropriate HbA1c monitoring. Three of seven (42.9%) of individuals had clinical manifestations of hyperlipidemia. Hyperglycemia was noted in 2 of 7 (28.6%) of individuals. Recommendations included following guidelines of the lab	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		matrix and measurement of waist circumference. Retrospective DUE – Narrow Therapeutic Index (Monitoring Lithium) The lithium DUE was presented in November 2011. It was completed due to the high risk nature of the drug. The objective of the DUE was to ensure proper lithium monitoring to prevent serious adverse events and/or toxicity. It was reported that for the most part, proper lab monitoring was completed. Adherence with the lab matrix protocol was recommended. Additionally, individual specific recommendations were made regarding lithium monitoring. PPIs The PPI DUE was presented and discussed during the Pharmacy and Therapeutics meeting conducted during January 2012 meeting. This was a follow-up DUE. The original was completed in response to the FDA safety announcement related to the risks of low magnesium levels associated with long term PPI use. The lab matrix was updated to reflect the need for periodic monitoring. The DUE documented that PPI use had decreased since April 2011. This was the result of additional GI evaluations that determined many individuals had no indication for continued use. The DUE also showed that Mg levels were documented for only 58% of individuals, however, there was no specific course of action presented to ensure that this would be done. The DUEs were well written and provided good background information on the drugs evaluated. The monitoring team encourages the pharmacy director to ensure that a specific corrective action plan is identified for each DUE when any deficiencies are noted. For example, the lab matrix set the standard for drug lab monitoring, but problems were identified with compliance. A specific action plan, other than "continue to monitor per lab matrix," should have been developed to address the issue. In the case of the OCP DUE, it was noted that continued use of OCPs might not be necessary or appropriate for some individuals. Nonetheless, the individuals continued to receive the medications without further interventions. There was no specific plan other than "guidance is needed from Gyn" and the minutes did not reflect follow-up of that recommendation. The pharmacy director should include in the Pharmacy and Therapeutics minutes a specific plan of action for all deficiencies identified. This should include responsible persons and timelines for completion.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.</td><td>Progress was noted with regards to the reporting of medication errors and corrective actions implemented. The medication data provided to the monitoring team is summarized in the table below.

<table>
<tr><th colspan="7">Medication Variances 2011</th></tr>
<tr><th>Error Type</th><th>July</th><th>August</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>Bin/Omission</td><td>14</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Omission</td><td>65</td><td>71</td><td>44</td><td>29</td><td>35</td><td>36</td></tr>
<tr><td>Wrong Patient</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Wrong Dose</td><td>23</td><td>24</td><td>6</td><td>8</td><td>18</td><td>17</td></tr>
<tr><td>Wrong Drug</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td><td>6</td></tr>
<tr><td>Extra Dose</td><td>1</td><td>2</td><td>2</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Prescribing</td><td>0</td><td></td><td>0</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Other</td><td>3</td><td>2</td><td>1</td><td>10</td><td>6</td><td>3</td></tr>
<tr><td>Total</td><td>107</td><td>99</td><td>53</td><td>49</td><td>60</td><td>56</td></tr>
</table>

Overall, the numbers of medication variances showed a downward trend since January 2011. The multiple checkpoints and reconciliations produced a significant decrease in the number of omissions and bin omissions.

Notwithstanding this notable improvement, the monitoring team recognized that this data might not have been truly representative of the medication errors occurring within the facility. First, there appeared to be an under-reporting of prescribing errors. The pharmacy director reported that prescribing errors were captured in the pharmacy clinical interventions as most were detected in the pharmacy and did not reach the individual. The monitoring team pointed out during the MERC meeting that the state issued a medication variance policy, revised in November 2011, and required reporting of potential errors. Several, but not all of the clinical interventions, were actually potential errors. The MERC minutes dated 8/23/11 stated, “if we look at our current medication error policy, those would go under documentation or prescription errors, even though they are caught early they are considered as errors because they have the potential of becoming med errors.” Clearly, the committee was aware of the requirement.

Second, pharmacy audits, done in recent months, documented issues with several medications. The audit reported in October 2011, and discussed during the MERC meeting attended by the monitoring team, revealed that that PEG solution on average was not being ordered for nearly three months (87 days). The pharmacy director reported that many of these individuals very likely did not receive their medications as prescribed. This finding did not translate into medication errors of omission. This discovery served as a good example of both appropriate and inappropriate responses to a significant event. Due to the seriousness of this finding, the pharmacy department instituted the corrective action of converting from bulk liquids for PEG, Keppra, and Metamucil to unit dose</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		dispensing. As a result of this change, the almost three months of doses were reduced to approximately two doses. It was reported that once individuals were actually receiving the PEG solution as ordered, many required a decrease in the number or amount of medications used to treat constipation. As explained by the pharmacy director, several individuals had doses of constipation medications increased because they were just not receiving all medications as prescribed. Although this was a very significant problem, involving some 19 individuals, there was no additional review of this matter. The clinical outcomes of the individuals had not been adequately assessed and correlated with the failure to administer medications as ordered. Similarly, the November 2011 audit showed that scheduled respiratory treatments with albuterol, ipratropium, and budesonide may not have been administered as ordered. The average shortage was 63 days. Although the MERC minutes of 11/15/11 stated that the managers would investigate, there was no documented follow-up. The monitoring team discussed the need for additional review with the pharmacy director and state medical services coordinator. The facility had not updated the medication variance database to capture of all of the relevant data. The data reviewed and discussed did not include information such as severity levels. The acting CNE reported that the severity level of each variance would be entered in the database in the future. It was reported that no serious medication variances had occurred since the last review and no one had been hospitalized because of a medication error. The medical director, pharmacy director, and chief nurse executive should all have an active role in the medication variance reviews and each should investigate errors that occur within their respective disciplines. The results of the pharmacy audits should have prompted further review by all discipline heads.	

Recommendations:

1. The pharmacy must document all interactions between the pharmacists and the clinicians. The Pharmacy Intervention Form must clearly document the drug involved (N1).

2. The pharmacy director must ensure compliance with the process for managing potential severe drug interactions (N1).

3. The policy Prospective Review of Medication Orders should be revised to reflect the current processes. All policies and procedures should include the specific dates of approval and indicate when the policy becomes effective (N1).

4. 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).

5. The medical director should work with the pharmacy director to develop training for the medical staff related to safe medical practices. This training should focus on the physician's role in the medication use system (N1).

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

7. 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).

8. In order to provide timely, relevant and consistent information regarding the medication regimens of the individuals supported by the facility, the following recommendations should be considered:
    a. The QDRR Report should comment on every medication that is included in the lab matrix. If an individual received a new generation antipsychotic, that drug should be listed and the relevant monitoring documented.
    b. The lab matrix must be revised. Guidelines provided in the matrix should be consistent with state policy.
    c. The lab matrix should include the specific parameters monitored for metabolic syndrome including blood pressure, abdominal girth, HDL, triglycerides, and fasting blood glucose (N2, N3).

9. The clinical pharmacist should continue to monitor for actions related to agreement with recommendations made in QDDR. These data should be provided to the medical director who should take corrective actions when necessary (N4).

10. The medical director and chief nursing executive should work collaboratively to ensure that the MOSES and DISCUS forms are completed and reviewed in a timely manner. The forms should be time stamped upon receipt in the medical services office (N5).

11. All health care professionals and direct care professionals must receive training on detecting and reporting adverse drug reactions. The training should be appropriate for each discipline (N6).

12. The ADR policy should be revised to lower the threshold for the intense case analysis (N6).

13. A corrective action plan should be developed for any deficiencies noted during the conduct of completing DUEs. The actions should be specific, have timelines and identify at the person responsible for the actions. This should be reflected in the Pharmacy and Therapeutics Committee meeting minutes (N7).

14. The pharmacy director must ensure that there is follow-up on corrective actions related to DUEs and document the follow-up in the P&T minutes (N7).

15. The pharmacy director should report all medication errors as specified in the medication variance policy. The policy requires that all medication errors, actual and potential, are reported (N8).

16. The facility should collect and report data consistent with the medication variance policy. The node, type, and severity of index should be

entered (N8).

17. The medical director, chief nurse executive and pharmacy director must ensure that appropriate reviews occur for unusual events even when the facility is unable to document a specific error (N8).

18. The medical director, chief nurse executive and pharmacy director should maintain documentation of errors within their departments. This documentation should include the corrective actions taken to address the variances and the follow-up of the corrective actions. There should be a periodic review of this data in the MERC (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o EPSSLC Client List o PNMT Staff list o PNMT member Resumes/CVs o PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section O-Minimum Common Elements of Physical Nutritional Management o Settlement Agreement Section O: PNM Audit forms submitted o OT/PT/SLP Assessment template o PNMT Assessment template o List of PNMT meetings held since previous review o PNMT meeting minutes and action plans o PNMT Master Calendar o Tracking log of OT/PT assessments completed o Individuals with PNM Needs o List of hospitalizations/ER visits/Infirmary Admissions o PNM Monitoring tool templates o Completed PNMP Monitoring Forms submitted o Dining Plan template o EPSSLC PNMT Process o Lists of individuals with PNMP monitoring tools in the last quarter o PNM Maintenance Log o NEO training curriculum for PNM and check-offs o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Poor Oral Hygiene o Diagnosis of Constipation o Chronic Respiratory Infections o Aspiration/Pneumonia o Individuals with Choking Incidents and related documentation (Individual #120, Individual #39) o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls without injuries o Falls with injuries

	o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals With Decubitus Ulcer During the Past Year o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Orthopedic Devices and Braces o List of competency-based training in the last six months o PNMPs submitted o APEN Evaluations: • Individual #128, Individual #155, Individual #4, Individual #16, Individual #44, Individual #162 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 o PNMP section in Individual Notebooks for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 <u>Interviews and Meetings Held</u>: o Susan Acosta, DPT, Habilitation Therapies Clinical Coordinator o Jessica Cordova, MPT o Eric Herrera, PT o Jennifer Ochoa-Evers, OTR o Heather Rodriguez, MPT

	o Rocio Alvarenga, OTR o Sandra Moreno, PTA o Frank Diaz DeLeon, COTA o Donna Rice RD/LD o Karin De La Fuente, MS, CCC/SLP o Michael Terry, PNMT Nurse o PNMT members o PNMP Coordinators o Various supervisors and direct support staff o PNMT meeting o Clinical meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs
	Facility Self-Assessment: EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as a document separate from the action plans for each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Most of these actions, however, described more of what occurred during the last six months rather than a description of activities to conduct a self-assessment. In some cases, though, more appropriately, the self-assessment activities provided an analysis of the effectiveness of the actions taken. Moving forward, consideration should be given to the areas reviewed by the monitoring team and presenting evidence of actions and progress in those. The audit tools currently in use, and also others in development, will be key indicators of status toward compliance. An analysis of the findings with a discussion of what was working, what was not, and what was needed in the next phase would assist the facility in the ongoing review of the overall strategic plan and to keep a steady pace toward the achievement of compliance. The development of the overall strategic action plan should link to this self-assessment. The Presentation Books in O, P, and R were extensive and provided a tremendous amount of information related to the actions taken, accomplishments, and work products. Even though continued work was needed, the

	monitoring team wants to acknowledge the tremendous efforts of the PNMT and Habilitation Therapies toward compliance with this section. This was an excellent effort. The facility self-rated itself as not in substantial compliance with all of the eight provision items of section O. Actions taken were extensive and have created a sound foundation from which substantial compliance may be achieved with continued perseverance.
	Summary of Monitor's Assessment: There was a tremendous amount of positive change and forward progress across this provision. Susan Acosta, DPT, had assumed a formal leadership role as the Clinical Coordinator. She was well prepared, accessible, and available during this onsite review. She provided the monitoring team with a first-hand account of what they had accomplished since the previous review. She was intimately familiar with the documents requested by the monitoring team, the Presentation books, actions taken, and results. The PNMT and Habilitation Department had completed a tremendous amount of productive activities focused toward achieving compliance with sections O, P, and R of the Settlement Agreement. Each and every staff member, as well as, the facility as a whole is commended for this excellent effort. With regard to section O specifically, there was a fully-constituted PNMT, including a full time nurse. They had met consistently with purpose and structure. They had conducted assessments and developed action plans in conjunction with the IDTs. A meeting observed during this review showed some improvement since the last review, but continued to need experience with the PNMT process for refinement. There was a new system of assigning Levels of Involvement. The majority of individuals reviewed by the team were identified to be Level 3, the lowest level of intervention and support provided by the team. Only two comprehensive assessments had been completed. Significant supports must be considered to ensure that the team members become better skilled in their assessment of individuals and in the development of intervention plans. Mealtimes and snacks were observed in Systems and the cottages. Improvements were noted related to texture and liquid consistency errors and general implementation of the plans. It was observed, however, that during snack times for individuals, that dining plans or PNMPs were not consistently out. When asked, some staff referred to the supervision cards, but those did not provide all the needed information. Staff stood to present fluids and when asked about what position they should be in, some knew they should be seated, but could not because there were no chairs or stools (they had been removed in an effort to discourage staff from sitting around). Rolling adjustable height stools should be considered for the dining rooms and day rooms for individuals who need assistance. One of the homes observed for lunch and dinner was 513 where significant issues in that home had been noted during each of the previous visits. This time, there was only one issue observed during the evening meal. Staff required prompts from the techs and PNMPCs to reposition individuals before, during, and outside meals, and this was not always done appropriately or effectively. On the positive side, the PNMPCs appeared to be more active and confident in their roles. A significant amount of training had occurred for

	them over the last six months. Monitoring had been done extensively during the last six months. It was of concern, though, that the home supervisors, backups, PNMPCs and Hab techs may not have had sufficient training and practice to become competent to conduct check-offs with direct support staff. A discussion with the facility director addressed that there should be some type of interdisciplinary project group that reviewed the issues around mealtimes and monitoring to develop systems and processes to address them. It is critical that there be strong training, effective check-offs to establish competency, oversight, and supervision to ensure compliance. Analysis of the findings from the monitoring should drive more concentrated attention to supervision, corrective action, training and drills. There had been a tremendous amount of concentrated and organized effort to address the elements of this provision. This was accomplished in part through the Immediate Action Plan developed soon after the previous review by the monitoring team. Each of the action steps had been completed. This resulted in an infrastructure for the department that included organizing staff into teams and the provision of extensive staff training of therapy clinicians, therapy technicians, PNMPCs, direct support staff, and QDDPs. A system of monitoring based on risk level had been developed and implemented. Further, a facility-wide mealtime monitoring project had been initiated as a function of the Immediate Action plan and included ALL staff including clinical staff from all departments, administrative support staff, and the facility director. There was ongoing review of the findings in an attempt to ensure accuracy and consistency. The entire facility clearly worked together to accomplish so much in a short time and are commended. A strong foundation was laid over the last six months and should enable the facility to make great strides in the direction of substantial compliance over the next review period.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to	<u>Core PNMT Membership</u>: The current core team members of the PNMT included Eric Herrera, PT; Jennifer Ochoa-Evers, MOT; Karin De La Fuente, MS, CCC/SLP; Donna Rice, RD/LD; and Michael Terry, RN With the exception of the nurse, each of these team members were part-time contract employees and served part-time only on the PNMT. Ms. Rice had participated on a PNMT at the facility since 10/28/10, Mr. Herrera and Ms. De La Fuente since 8/1/11, and Ms. Ochoa-Evers since 11/5/11. Mr. Terry was a full time dedicated team member. Back-up team members were assigned for each of the other members. <u>Qualifications of Core Team Members</u> Resumes/CVs were submitted for each of the team members listed:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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, 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.	• Michael Terry, RN, was hired specifically to serve as the only fully dedicated PNMT member. He had practiced initially as a LVN in 1995, with a subsequent BS degree in 2001. More recently he had completed a Master of Science in Nursing and Business Administration in 2011. He had worked as a night charge nurse or supervisor since 1996 with some limited experience in leadership roles as an assistant director, administrator on duty or director of nursing. Patient populations included general health care and psychiatry. There was no evidence of any experience with individuals with developmental disabilities. • Karin De La Fuente, MS, CCC/SLP, completed a Master of Science in 1988 and had practiced as a licensed speech-language pathologist since that time in school hospital, rehabilitation, home health, and outpatient settings serving adults and children. She had previously provided contract speech services at EPSSLC in 2005 to 2008 and most recently since 2010. • Eric Herrera, PT, completed a Master of Science degree in 2002 and has a provided part time PT services at EPSSLC since 2008 in addition to other medical center, rehabilitation and senior health centers for over eight years. He earned a specialty certification in McKenzie Mechanical Diagnosis and Therapy also since 2002. • Jennifer Ochoa-Evers, MOT, completed a Master of Occupational Therapy in 2010 with fieldwork experiences in rehabilitation center and public school settings. To date, her only work experience as an OT was just over one year at a rehabilitation facility serving the geriatric population. She had assumed a coordinator role for six months. There was no evidence that she had any previous experience with individuals with developmental disabilities. • Donna Rice, RD/LD competed a BS degree in Nutrition in 1979. It was known to the monitoring team that she had provided nutrition services at EPSSLC for at least several years, but this was not outlined in the resume submitted. Her current employment was listed as a clinical dietitian at the Del Sol Medical Center in El Paso where she had worked since 1991. • The back-up team members had varying degrees of experience in their respective fields and developmental disabilities. <u>Ancillary PNMT Members</u> Ancillary members noted to attend some of the meetings included back-up team members, RN case managers, IDT PT, OT or SLP members, dental hygienist, psychology, PNMP technicians, and QDDPs. These members often varied dependent on the individuals reviewed by the PNMT. See the breakdown of their attendance below. <u>Continuing Education</u> Continuing education was documented for the RD, PT, and SLP core members of the team	

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		including the state-sponsored webinars pertaining to PNMT and the Annual Habilitation Therapy Conference. The OT and nurse were relatively new to the facility and related continuing education appeared limited to on-the-job inservice training. Back-up members, including the PT, OT, and SLP had also participated in state-sponsored education offerings, though none was documented for the back-up dietitians. The self-assessment reported that six of 10 members had attended training on the PNMT process and three of 10 were trained related to nutritional management. Other training attended by only some, but not all, of the team members included clinical technology assessment, the role of dietary and the ABI/Doppler assessment for PAD (peripheral artery disease). <u>PNMT Meeting Frequency and Membership Attendance</u> A total of 30 PNMT meetings were documented from 8/4/11 to 12/1/11, during the period since the previous onsite review. Meetings were conducted one time a week during August 2011 and occasionally during additional weeks during that period, however, meetings were generally conducted two times per week as of 9/6/11. This was a significant increase over the previous review period. Documentation of these meetings and attendees were greatly more consistent than during previous onsite reviews by the monitoring team. Attendance by core team members (or back-ups) from 8/4/11 to 12/1/11 was as follows based on review of the attendance sheets submitted: • PNMT RN: 47% • RD: 90% • PT: 87% • OT: 90% • SLP: 73% Attendance by the core team members was adequate, particularly with the assignment and availability of back-up or IDT team members. The exception was representation by an SLP. There was no evidence of attendance by the core team SLP, back-up, or other SLP for 23% of the meetings for which minutes were submitted. This is an important team member and regular attendance is critical to the provision of appropriate and adequate services. Generally, there was a nurse case manager in lieu of, or in addition to, the PNMT nurse member (prior to the addition of this position to the team as of 8/18/11). The back-up PT attended 57% of the meetings in addition to the core team PT. Others included the following: • RN Case Manager (in addition to PNMT RN): 37% • QDDP: 50% • Dental Hygienist: 20% • PNMP technician: 17%	

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		• Psychology: 17% • Ombudsman: 7% • Other: 23%	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>PNMT Referral Process</u> Per the self-assessment dated 12/23/11, there were 22 individuals referred to the PNMT since July 2011, with 21 of those being self-referrals by the PNMT members. Based on the minutes submitted from 8/4/11 to 12/1/11, 18 individuals were identified who had been reviewed by the PNMT. Per a PNMT Process document (revised 10/31/11), the IDT or primary care physician could make a referral to the PNMT for individuals at high risk and not stable, or others for whom the IDT needed assistance in the development of an action plan. A completed referral form and specific documentation was to be submitted with the referral. The PNMT was to meet within five days of receipt of the referral in order to complete a Level of Involvement assessment. Self-referrals were indicated in cases of aspiration pneumonia, transition from non-oral to oral intake, gastrostomy tube placement, hospitalization, change in health status, or other physical nutritional management needs. There were three level ratings to which an individual's referral was assigned. Per the meeting minutes on 8/1/11, the PNMT established what information was needed prior to conducting a PNMT Screen/Referral. This information was to be provided at least two weeks prior to the scheduled meeting and included: • Integrated risk ratings • Status post-hospitalization, if applicable • Action plans and rationale by IDT • Current assessments • ISP agendas and all related documents to include addendums • BSPs, if any • Oral care program and positioning • Surgical recommendations • Medications During the meeting on 8/1/11, three individuals were discussed (Individual #191, Individual #52, and Individual #21). It was reported that a PNMT Screen for Individual #21 had been completed on 1/20/11, nearly seven months earlier due to hospitalization. A screen had also been completed for Individual #52 on 6/21/11, also due to hospitalization. A plan was developed to request and review documents for each at the next meeting (8/18/11). It was not clear why the PNMT had not reviewed Individual #21 prior to this, despite two hospitalizations for choking episodes with acute aspiration pneumonia and a hypoxemia episode. There was no evidence in the minutes that she had	Noncompliance

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		been reviewed previously by the PNMT. Interestingly, the meeting minutes for 9/1/11 indicated that Individual #21 had been referred to the PNMT and would be discussed at the next meeting. Though meeting minutes indicated that Individual #52 was also to have been reviewed at the meeting on 8/18/11, but there was no indication in the minutes that this occurred. There was no evidence of discussion related to Individual #52 until 9/6/11, when the meeting minutes stated that she had been referred to the PNMT. There, again, was no mention of her in the minutes until 9/22/11. It was reported that this was the second attempt for assigning a Level of Involvement because information from the IDT had not been received on time. Subsequent review was scheduled for 9/29/11. A Level 3 was assigned to ensure that her IDT addressed her risks of aspiration, choking, and respiratory compromise. Recommendations were to update her risk assessment and action plan, add oral care and medication administration to her PNMP, review her dining plan, and to consider a SAP to address dining plan recommendations. Specifics were not outlined, but a completion date of 10/31/11 was set. She was again reviewed as scheduled on 11/3/11. At that time, only one of the five actions was listed as completed. It was of concern that this had not been finalized until this time because issues related to liquid consistency and access had been identified in at least two previous reports by the monitoring team. The provision of a month to accomplish very simple updates to key support plans and her risk assessment appeared to be too generous a timeline and yet these tasks were remain uncompleted as of this PNMT meeting. This example demonstrated that the PNMT functioned as an oversight body to the IDT rather than as a support and resource to the IDT. The current format appeared to be that the PNMT made recommendations to the IDT for implementation or completion, and then the IDT was to "report back" in a prescribed timeframe. While the IDTs continued to require ongoing input, supports, and training in the development of health risk assessments and action plans, it was of significant note that most, if not all, PNMT members (or the back-ups) also served as IDT members. Thus, risk assessments that were inaccurate, actions that were not yet completed, and so forth were as much their responsibility as any other IDT member. There was extensive discussion with the Habilitation Clinical Coordinator regarding developing the PNMT to be more collaborative and providing of technical assistance and support to the IDTs rather than as primarily an oversight and authority role. The PNMT had elected to review each of the individuals with a history of aspiration pneumonia and/or who received enteral nutrition. These individuals were to have received an Aspiration Pneumonia/Enteral Nutrition Assessment completed by their IDTs and were also scheduled for review by the PNMT. The team had reviewed 18 individuals since 8/4/11. Most of these were self-referred rather than referrals generated by the	

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		IDTs. It was of concern, however, that several individuals had experienced significant health issues during that time, yet had not been referred to the PNMT for review. • One example was Individual #39 who had experienced numerous choking events requiring the Heimlich and partial airway obstruction in the last couple of years (8/17/10, 5/31/11 at lunch and dinner, and 8/1/11) and it was reported that he had another event on 1/2/12. Clearly, the IDT had not been successful in managing this concern to ensure his safety. • In addition, Individual #120 had a choking event requiring the Heimlich on 8/10/11 that was not reviewed by the PNMT. <u>PNMT Assessment and Review</u> Again, the self-assessment reported that 22 individuals had been reviewed by the PNMT, 18 of whom were listed in the meeting minutes dated 8/4/11 to 12/1/11. Comprehensive assessments were completed for those determined to be Level 1 only. The monitoring team requested PNMT assessments for the last two months for all individuals at Level 1, but comprehensive assessments for only two individuals were submitted (Individual #191 and Individual #115). Assessment planning documents and Action Plans were also submitted for these two individuals. Documentation for the others (each identified as Level 2 or 3) was limited to action plans and discussion logs. Review of this documentation revealed the following: • Individual #154: She was referred to the PNMT by the IDT because there were "facing positioning problems" and she had issues with circulation (medium risk) and skin integrity (high risk). She was seen four times by the PNMT and recommendations included the development of a positioning schedule, alternative positions with pressure mapping of heels and coccyx, and discontinuing use of the recliner for positioning. The same clinicians serving her in her home were also on the PNMT and these recommendations were standard practices that should not have required specialized review to accomplish. • Individual #2: She was a referral initiated by the PNMT on 7/25/11 for transition from non-oral intake to oral intake. She was identified as Level 3 because the IDT had an adequate plan developed and required only minimal supports from the PNMT. Documentation from 8/4/11 identified that there were six recommendations (though not listed in the discussion log on this date) and that the IDT had addressed recommendations four, five, and six, but did not have sufficient documentation from team members in order to address the other three. Subsequent discussion log dated 8/25/11 listed six items in the IDT Action Plan with dates listed. There was no update as to completion of these actions on 9/1/11, but two additional actions were added, including oral care and medication administration additions to the PNMP, and to ensure that nursing was	

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		providing chlorhexidine and using a suction toothbrush (9/29/11). On 9/29/11, it was reported that all were completed with the exception of updating the PNMP. Completion dates listed were each at least three weeks to one month after the dates listed in the plan. She was discharged from the PNMT as of 10/27/11. <u>Risk Assessment</u> Risk assessment ratings for the 13 individuals selected in the sample by the monitoring team were submitted. There were a number of inconsistencies in the risk ratings for a number of individuals. • Individual #93 was considered to be at high risk for osteoporosis, yet was at only medium risk for fracture. • Individual #2, Individual #71, Individual #32, and Individual #93 were considered to be at high risk for dental concerns, but were not considered to be at high risk for aspiration or infections. • Individual #71, he was identified at high risk for falls and osteoporosis, yet was considered to be at low risk for fractures. • Individual #67 was considered at high risk for osteoporosis and medium risk for falls, yet only medium risk for fractures. She was also listed with poor oral hygiene yet was considered to be only at medium risk for dental concerns. • Individual #120 was also listed with poor oral hygiene yet was considered to be at medium risk for dental concerns Though improved since the previous review, the rationales continued to be weak. As stated above, Individual #71 was considered to be at high risk for osteoporosis with that diagnosis and a medium risk for transfers. The rationale for falls stated that he was at low risk for falls because he was assisted for transfers. He was considered at low risk for fractures because he had no history. In fact, he would likely be at risk for fractures due to his significant osteoporosis. In the case of Individual #161, she was considered to be at high risk of aspiration and choking. It was stated that her oral hygiene program was to be discontinued as a result. It was of concern that the IDT would not provide oral hygiene because poor oral hygiene would actually increase her risk of infection from any aspiration. At the time of this risk assessment, she was considered to be at low risk for dental issues. There was nothing in her action plan to address this. In the case of Individual #120, he was considered to be at low risk for diabetes. The rationale was that he did not have a diagnosis of diabetes and was not on an ADA diet. There was no discussion of any conditions or family history that may have predisposed him to diabetes.	

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		Individual #2 was considered to be at medium risk for choking and aspiration. However, the rationale indicated that she was being transitioned from non-oral intake to oral intake, which would increase her risk of both. She had a diagnosis of dysphagia and a history of aspiration pneumonia. <u>PNMT Follow-up and Problem Resolution</u> Though difficult to follow due to the format, redundancy, and complexity of the documentation used by the PNMT, there generally appeared to be consistent follow-up on identified issues. However, there were numerous references to the lack of information provided by the IDT in order to progress with a specific plan. Improved collaboration between the PNMT and the IDTs was indicated to ensure that all team members provide key information for assessment, treatment planning, implementation, and review. As stated above, the current role of the PNMT appeared to be oversight, but should be technical assistance and support.	
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.	<u>PNMP Format and Content</u> PNMPs were reviewed for the 13 individual included in the sample of records selected by the monitoring team, as well as nine others for individuals who received enteral nutrition for a total of 22. These varied in format and content. A new format had been developed to address risks, triggers, and outcomes related to the prescribed interventions and supports. Not all the PNMPs had been converted. Numerous revisions were completed for individuals, but the meeting minutes for the PNMT indicated that there were a number of cases in which necessary changes had not been made in a timely manner (e.g., Individual #161, Individual #21, and Individual #154). There were 128 individuals identified with PNM needs and provided with PNMPs. There were 22 PNMPs reviewed. Comments are provided in detail below in hopes that the information will be useful to the facility. Overall, this was a very good set of PNMPs. As noted in this section of the report, improvements in implementation will be needed: • PNMPs were submitted for 22 of 22 (100%) individuals included in the sample. • PNMPs for 22 of 22 individuals in the sample (100%) were current within the last 12 months. • PNMPs for only 2 of 22 individuals in the sample (9%) were in the revised format. • In 22 of 22 PNMPs reviewed (100%), positioning was addressed. • In 19 of 19 PNMPs reviewed (100%) for individuals who used a wheelchair as their primary mobility or for transport, some positioning instructions for the wheelchair were included, though generally minimal. Pictures were included for most, though these were very small, making it difficult to see detail. The photos were from one angle only.	Noncompliance

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		• In 22 of 22 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 18 of 22 PNMPs reviewed (82%), the PNMP listed bathing instructions and listed equipment when needed. These varied in detail. The PNMPs consistently listed the equipment needed. Only one of the PNMPs reviewed provided toileting instructions. • In 22 of 22 (100%) of the PNMPs reviewed for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. • In 22 of 22 PNMPs reviewed (100%), instructions related to mealtime were included. Dining plans were also submitted for individuals included in the sample who received oral intake. • 15 of 22 individuals (54%) had feeding tubes and this was identified in their PNMPs (93%). Individual #71 was listed with a tube, but this was not clearly stated. Five other individuals received both oral and non-oral intake and this was identified in the plans. Instructions for no oral intake were clearly stated. • In 3 of 22 PNMPs reviewed (14%), dining position for meals or enteral nutrition was provided. In two others, this information was not in the dining section of the plan. There were 16 individuals who were to remain upright before, during, and after meals, snacks, and medication administration for reflux management, but where those were to occur was not specified. One individual was described as independent and did not appear to require reflux precautions. • In 12 of 12 PNMPs reviewed (100%), diet orders for food texture were included for those who ate orally. Assistance techniques for oral intake were not consistently provided in the plans. • In 5 of 12 PNMPs for individuals who received liquids orally (42%), the liquid consistency was clearly identified. • In 12 of the 12 PNMPs for individuals who ate orally (100%), dining equipment was specified in the dining equipment section. For those who did not have adaptive equipment, "none" was clearly stated. • In 19 of 22 PNMPs reviewed (86%), a heading for medication administration was included in the plan. The content provided varied from plan to plan. • In 20 of 22 PNMPs reviewed (91%), a heading for oral hygiene was included in the plan. The content provided varied from plan to plan. • 22 of 22 PNMPs (100%) reviewed included a heading related to communication. Specifics regarding expressive communication or strategies that staff could use to be an effective communication partner varied considerably. In some cases, a minimal description was included that described the individual's expressive communication. In others there was an extensive list of strategies staff should	

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		use, but nothing that described how the individuals expressed themselves. In the case that the individual had an AAC device, there were instructions for staff to use them, rather than the individual (also see section R of this report). Three of the ISPs submitted for the individuals included in the sample were not current within the last 12 months. The ISPs for Individual #25 and Individual #120 expired the week of this onsite visit and the ISP for Individual #40 was dated 9/20/10, that is, over 12 months old. ISP meeting attendance by PNM professionals was as follows for the 13 ISPs included in the sample (also see section F above): • Medical: 3 of 12 (25%) in attendance per the signature sheet • Dental Hygienist: 4 of 12 (33%) in attendance • Nursing: 12 of 12 (100%) in attendance • Physical Therapy: 3 of 12 (25%) in attendance • RD: 0 of 12 (0%) in attendance • Communication: 5 of 12 (42%) in attendance • Occupational Therapy: 7 of 12 (58%) in attendance It will not be possible to achieve adequate integration given these levels of PNM-related professional participation in the IDT meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective action plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. PNMPs could not be reviewed and revised in a comprehensive manner. Recent efforts to track attendance and to improve attendance were in place at the facility. Staffing vacancies were a significant barrier to improvements in this area impacting communication, collaboration, and integration of supports and services. The Physical Nutritional Management Plan was referenced in 8 of 12 (67%) of the ISPs reviewed, with review evident to some degree in seven of those. This generally pertained only to changes with no clear statements of effectiveness of the strategies. In the case of Individual #115, his plan was reproduced within his ISP, but IDT review for efficacy was not evident. In some ISPs, only the diet or weight aspects were mentioned. The PNMP was not referenced at all in ISPs for Individual #32, Individual #161, Individual #39, and Individual #120. In the other ISPs there was no consistency as to the manner or content of how the PNMP was addressed. It would be extremely difficult for staff to locate information needed to further understand the PNMP. The PNMP was not well integrated into the individual's ISP as a result. There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed by therapy clinicians, but the clinician's determination of the effectiveness of the	

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		strategies was not consistently described. This should improve as the new assessment format is refined through the audit process. There was no evidence of consistent review by the IDT in relation to identified risk and the efficacy of the interventions implemented. In some cases, statements from the assessments were included in the ISP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full IST. The QDDPs may require greater guidance as to consistent strategies to incorporate PNMP information into the ISPs and action steps. The PNMPs were updated by the therapy clinicians based on change in status or need identification. However, the PNMT identified some cases in which that did not occur in a timely manner.	
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.	<u>Supervision of PNMP Implementation</u> PNMPs and Dining Plans were developed by the therapy clinicians with limited input by other IDT members. Efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should ensure that there is improved IDT involvement in the development of the plans. Dining Plans were available in the dining areas. 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 strategies outlined in the plan. These were very small and added little useful prompts for staff. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright. 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 and in individual-specific training provided by the therapists and PNMPCs. An audit system had been developed and implemented for quarterly review of the PNMPs by the PNMPCs to assess whether they met format and content criteria. This should lead to improved consistency with content. A database had been designed to track compliance scores in order to ensure corrective action as identified. This was a higher level clinical task and it was of concern that the PNMPCs and techs were expected to accurately note errors or needs for revision and reconsideration should be given to this. Therapy assistants and therapists may be better able to accomplish this at least until all of the plans are converted to the new format. <u>Observations</u> Though improved since the previous reviews, errors were noted in (a) staff implementation, (b) recommendations outlined in the PNMP and/or Dining Plans and (c) the preparation of food texture modifications provided from the kitchen. Some	Noncompliance

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		examples are presented below in hopes that this detail will be useful to the facility: • Individual #83: She began to display agitation and disruptive behaviors during the meal. Staff followed her around and repeatedly told her to "relax, relax." She began to hit herself and staff attempted to intervene. They removed her from the area. Staff were not able to describe strategies in her BSP. • Home 513: The monitoring team asked staff who the mealtime coordinator was. The staff member was not able to identify who that was. Another staff member entered the dining area and she was asked about the mealtime coordinator. She indicated that she was the supervisor and introduced me to her back-up – the same staff member who denied knowing who the mealtime coordinator was. • Home 513: Kitchen staff cut up meat for chopped texture because there was not enough sent from the kitchen. She was observed to use ungloved fingers to place the pieces on the plate. Some of the pieces were larger than one half inch. When this was pointed out by the monitoring team, staff used hand over hand assistance to help individuals cut the meat into smaller pieces. • Individual #70 was seated in a posterior tilt. His legs were extended and the seat belt was loose. • Systems: PNMPCs did not consistently use good body mechanics for repositioning individuals. Fireman's carry approach was not an effective way for moving the pelvis back in the seat and achieving optimal alignment. • Individual #93 was not repositioned prior to beginning her meal. • Individual #70: The picture on his Dining Plan showed his head/neck in hyperextension. • Individual #71: Staff denied being trained on his Dining Plan. • Individual #189 was observed taking very large bites. His Dining Plan instructed that he should be redirected from overfilling his mouth. There was no intervention from staff to prevent this. • Individual #105's legs were extended in his wheelchair. He was pushed to the table for his meal. The PNMPC prompted staff to reposition him. • Individual #21 was seated at the table for over 15 minutes without any food. Staff made three requests for her food before it was served. • Individual #40: PNMPC intervened with DSP to follow the Dining Plan regarding her assistance techniques. • Individual #154 was noted to be coughing and clearing without staff intervention. She was forward in her wheelchair and her head was low on the head rest. • C Dorm: Staff stood to provide fluids for snack to individuals. • Individual #114 drank his beverage with multiple sips without a pause with staff assistance. • Individual #113 was seated in his recliner sitting on a cushion. He was rotated to the right. His left hip was not on the cushion. His trunk was leaning to the right.	

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		His head was forward. There were extra pillows on the recliner not used for support. • Individual #21 was drinking with her head back in hyperextension. There were no instructions related to this on her plan. She was seated in a different chair in the day room for snack than her adapted dining chair used for meals. • Individual #189: He was observed during a medication pass. The nurse used a cup up to his mouth to get him to open and then put medications in his mouth on a spoon. He was immediately offered something to drink. There was significant residue from his mouth (pudding and medications) on the inside of the cup. • Individual #4 was presented with eight medications in one bite (observed by the monitoring team). <u>Staff Interviews</u>: Staff were asked the following questions. Accuracy with their answers are in parentheses: • Where is the PNMP/Dining Plan located? (100%) • What kind of transfer do they require? (100%) • What do you look for to ensure the individual is in the correct position? (0%) • Why does the individual need thickened liquids? (50%) • Why does individual eat modified texture foods? (50%) • Why does the individual require a specific utensil? (80%) • Why does the individual require a specific assistance technique? (0%) • What are the individual's risk indicators? What do you look for before, during and after the meal? (50%) • Does the individual have an Aspiration Trigger Data Sheet? Where is it kept? When do you document? (100%) • Have you been trained to implement this plan? (80%) • Who do you contact if you have difficulty with the plan or the equipment? (100%) There was a greater number of staff who appeared to understand the rationale for the strategies included in the plan and many were more confident when asked about elements of the plan. This was good to see and was likely due to the skills drills and questions routinely asked during PNMP monitoring. <u>Choking/Aspiration Events</u> Individual #39 had experienced numerous choking events requiring the Heimlich and partial airway obstruction in the last couple of years (8/17/10, 5/31/11 at lunch and dinner per SLP assessment on 6/2/11, and 7/30/11 per documentation of incident) and it was reported that he had another event on 1/2/12. Clearly, the IDT had not been successful in managing this concern to ensure his safety. Additionally, Individual #120 had a choking event requiring the Heimlich on 8/10/11 that was not reviewed by the	

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		PNMT. There was no evidence of assessment of these events by Habilitation Therapy for Individual #120 and none for Individual #39 since 6/2/11. No review by the PNMT was noted for either individual.	
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.	<u>New Employee Orientation</u> The training materials and check-off process had been revised and updated since the previous review with new content to address risk assessment and supports, as well as refinement of the competency checks for participants. This new content appeared to be comprehensive and well-organized. Basic skills checked off were extensive. Once the foundational, basic skill check-offs were completed, each new employee shadowed an experienced direct care staff on the home to which they were assigned. Validation of individual-specific skills were completed by the home supervisor or PNMPC. Steps for validation were prioritized in that certain steps must be performed accurately or the validation was repeated. Coaching and instruction occurred after a failed validation. After all of the home competencies were completed, staff signed a green sheet that was processed and maintained by CTD. In the case that a staff was not able to complete the home-based competencies, he or she was scheduled to re-attend the classroom aspect of the training. <u>Annual Refresher Training</u> Annual refresher courses were currently being provided in classroom settings and a new iLearn format related to aspiration and mealtime training for existing direct support staff had been developed. Lifting and transfers refresher training continued to be provided. <u>Individual-Specific PNMP Training</u> As described above, new employees shadowed experienced staff, then were trained and checked-off by the PNMPCs and home supervisors. This was to permit hands-on practice with individuals and to become competent in the implementation of individual PNMPs. When changes in the plans were made, the PNMPCs scheduled skill drills with staff two times a week for two weeks to ensure proper implementation. This was a relatively new process and should result in improved competency. It was of concern, however, that all check-offs were conducted by non-professional staff. If this was to continue it would be critical that routine observation, review, and validation be conducted to ensure that the level of instruction and adherence to guidelines was consistent with expectations. <u>Trainer Competencies</u> The PNMPCs participated in ongoing module training that included, among others: • Photo module • Communication and AAC • PNMP and DP audit process	Noncompliance

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		• Competency-based training process for communication and texture downgrades • Mealtime coordinator training • Review of DP • Hands on lifting and transfers • Communicating with difficult people • Wheelchair positioning • Competency-based training process Monitoring result meetings were held monthly to review findings and provide feedback for improvement. Mealtime Coordinator training was developed and implemented in December 2011. The Mealtime Coordinators were assigned the following responsibilities: • Check the environment before the meal • Ensure appropriate equipment was available • Ensure there were sufficient staff assigned • Coordinate who was in the dining area • Ensure that diet texture and liquid consistencies were correct • Assist with serving the meals • Provide oversight to staff • Assist with positioning, replacing utensils, getting seconds • Facilitate rotating individuals in and out of the dining area in a coordinated manner • Ensure that documentation was completed accurately Training was not consistently effective as evidenced by the implementation errors observed by the monitoring team and described above. The current system of monitoring was based on a targeted review of individuals at highest risk at an individually prescribed frequency to ensure appropriate implementation of supports designed to mitigate PNM risks (see below). This system should result in improved implementation via ongoing competence of staff.	
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.	<u>Monitoring Staff Competency and Compliance</u> Frequency of this monitoring conducted largely by the PNMPCs was based on risk levels established by the IDT and was identified in the action plans developed as an aspect of the risk assessment process. Data were entered into a database for analysis and review, recently changed to Access rather than Excel spreadsheets. This should permit greater flexibility in manipulating the information. Findings were sent to the QDDPs. Clinical professionals were to print out the summaries and forward them to QDDPs, ADOP, and QA for review and resolution. Requested and observed monitoring continued to ensure more extensive review of changes in interventions and the plans. Mealtime monitoring of the dining areas also continued. Compliance was reported to be very high, with percentages	Noncompliance

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		documented in the upper 90s. Validation of Monitoring by PNMPCs Validation monitoring was also scheduled routinely to ensure consistency of performance by the PNMPCs who conducted this monitoring. The monitoring team used the same mealtime monitoring form to review the Systems dining area for one meal. Findings were generally consistent with the PNMPC with three exceptions. • One staff denied being trained on individual's dining plan (Individual #71). This was not observed by the PNMPC. • A staff had to be prompted by the PNMPC to reposition an individual (Individual #44) during the meal as well as several others. This element was marked as a "yes" rather than a "no." • The PNMPC reported that staff were identifying opportunities to communicate with individuals, but this was observed to be absent by the monitoring team. Communication was limited to prompts and instructions related to the meal rather than interactive conversation or teachable moments.	
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.	Individual-Specific Monitoring As described above, the current monitoring system for implementation compliance and staff competency was based on individual risk levels, with the frequency of these built into IDT action plans. A specialized training for the QDDPs had been developed and provided in November 2011 to ensure improved understanding of the PNMP, training, monitoring, and the PNMT process. As described above, there was little evidence of this training in the ISPs reviewed, but should result in improvements with integration into the ISP over the next six months. PNMPs were revised as needed throughout the ISP year with modifications made based on monitoring and changes in status or needs. Review of the plans occurred during training, annual assessments, quarterly, and with IDTs via ISPAs. It was reported that reviews by the IDTs were occurring, but it was not reflected in the documentation. This was confirmed by the monitoring team. Guidelines for QDDPs to address this were included in the training. The monitoring team looks forward to seeing improvements with this over next six months. Effectiveness Monitoring As described above, effectiveness monitoring was limited to annual assessment, quarterly review, and with changes in status. There did not appear to be an elevated level of review of effectiveness of plans for individuals with increased risk. In fact, in some cases, the effectiveness of interventions and supports were not specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians.	Noncompliance

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		Validation of Monitoring by PNMPCs QA monitoring by the professional staff with the PNMPCs was scheduled routinely. There was also ongoing review of performance with feedback to ensure continued improvement. Training with the PNMPCs was observed as conducted by two therapy assistants. This was an excellent, challenging training. Expectations were very high and the department may want to review the roles and responsibilities of these non-licensed staff. This particular training was related to audits of the PNMPs. Some of the attention to detail and clinical skills required to identify issues with the plans would be more effectively demonstrated by licensed staff. This should not be a system that permitted clinicians to write plans that were less than accurate and expect that any problems would be caught by the PNMPCs. Perhaps a more effective system, at least initially, would be a peer review process conducted among the clinicians. This would remove the responsibility of clinical judgment from the PNMPCs.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	Individuals Who Received Enteral Nutrition There were 15 individuals listed who received enteral nutrition. Only Individual #115 and Individual #93 were listed as receiving oral pleasure feedings. Individual #115, however, was also listed with a diet downgrade having retuned to non-oral intake on 8/22/11. Individual #10 was provided some oral intake per his PNMP, though when this was provided was not described in the PNMP. There were three individuals who had tube placements since the previous review: Individual #161 (7/14/11), Individual #10 (8/19/11), and Individual #191 (9/16/11). Each of them had been reviewed by the PNMT. APEN Assessments A sample of APEN assessments was submitted for 10 individuals for whom these were completed since the previous review. Each was completed and had an attached Risk Action Plan. Measurable outcomes were provided in a few cases (typically that the individual would not experience aspiration or pneumonia), but without examination of the current plan and its effectiveness toward that end. In most cases, however, the plans merely stated to follow the PNMP. There were no specialized actions taken to address those with higher risk. In the case of Individual #46, the APEN indicated that the SLP would evaluate for potential for oral intake, though this was not addressed in her action plan in any way. Pathway to Return to Oral Intake The facility was to be commended because they had been appropriately aggressive in moving through a process for return to oral intake for a number of individuals. This was	Noncompliance

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		successful for Individual #71 and Individual #2, for example. In the case of Individual #71, he had recently returned to some level of oral intake, though continued to receive non-oral intake. Staff were observed to be assisting him during a meal. When interviewed the staff was able to state that he was at risk for aspiration and choking and that she was following his dining plan. The staff denied, however, being specifically being trained on his dining plan related to his oral intake. She stated that they were provided green sheets to read and that was the individual-specific training they received. Documentation was requested that related to this training for him. There was evidence that this staff person had been trained on his dining plan on 4/20/11 and 11/8/11. It was noted, however, that neither was competency-based training with return demonstration. This would be important in the case that an individual who was NPO and had returned to oral intake status in April 2011. By report, the SLP included direct support staff in the trial PO intake sessions conducted by the clinician, though there was no documentation of this. <u>PNMPs</u> All individuals who received non-oral intake in the selected sample had been provided a PNMP that included most of the same elements as described above. The formats for the PNMPs were somewhat varied, as described above. Sections were located in different places from plan to plan. This would make it difficult for staff to locate information in a consistently efficient manner. Only one of the plans for individuals who received enteral nutrition was of the new format. Individual #10's PNMP included oral care, but did not address medication administration. He appeared to also receive oral intake, but instructions regarding this were very limited. It was not clear whether he also received fluids orally because there were no instructions and no indication of liquid consistency. Individual #57's and Individual #161's PNMPs did not address oral care or medication administration.	

Recommendations:

1. Consider implementing an interdisciplinary project group to review the issues related to mealtimes and monitoring to develop comprehensive and collaborative systems and processes to address the identified concerns (O4 and O6).

2. Consider re-evaluation of the competency of PNMPCs and home supervisors in the performance of initial competency check-offs for new employees. Initial check-offs of new employees must be very consistent and stringent enough to get them started out on a sound foundation (O5).

3. Examine strategies available to staff in the event that food textures prepared and served from the kitchen are incorrect. It may not always be reasonable to send it back when the food only needs to cut appropriately into smaller pieces. If the texture is too small, this cannot be corrected and the food must be replaced (O4).

4. Ensure that PNMPs are available to staff for snacks (O4).

5. Ensure that staff are able to sit down while providing food and/or liquids at snack time. Consider providing rolling adjustable height stools in the day areas, and the dining areas, to ensure that staff are able to use optimal body mechanics while providing assistance within eye level range (O4).

6. Ensure that the PNMT functions as an assessment team that may include collaborative interaction and observation rather than merely a meeting forum to conduct record review and history or a team that polices the IDT. 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. Use caution in the assignment of Levels of Involvement to ensure that comprehensive assessments are provided to those who need them (O1).

7. Identify issues that require tracking relative to individuals evaluated by the PNMT, establish the baseline, gather new data over a prescribed period of time, then review the findings as a team in order to analyze the relevance to a problem or as evidence of a solution (O2).

8. Use a collaborative approach to assist the IDTs for improved activity analysis in the development of SAPs 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. Therapy staff should provide inservice training to staff regarding the appropriate use of physical prompts during meals to redirect (O4).

9. Consider a system of drills for modeling and coaching with staff, perhaps a "flavor of the week" approach. Selection of a particular theme with a focus of training, coaching and review would heighten staff awareness of these concerns and would likely yield overall improvements (O7-O8).

10. Ensure proper food preparation (O4).

11. The IDTs continue to require support regarding risk assessment and real time modeling to effectively complete risk assessments and action plans. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks (O2).

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:** <u>Documents Reviewed</u>: o Admissions list o Budgeted, Filled and Unfilled Positions (10/31//11) o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section P-Physical and Occupational Therapy o Settlement Agreement Section P: OT/PT Audit forms submitted o Individuals receiving direct OT/PT o OT/PT/SLP Assessment template o OT/PT Assessment Audit results o Tracking log of OT/PT assessments completed o Individuals with PNM Needs o List of hospitalizations/ER visits/Infirmary Admissions o PNM Monitoring tool templates o Completed PNMP Monitoring Forms submitted o Lists of individuals with PNMP monitoring tools in the last quarter o PNM Maintenance Log o NEO training curriculum for PNM and check-offs o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Poor Oral Hygiene o Chronic Respiratory Infections o Aspiration/Pneumonia o Individuals with Choking Incidents and related documentation (Individual #120, Individual #39) o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls without injuries o Falls with injuries o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals With Decubitus Ulcer During the Past Year o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation

	o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Orthopedic Devices and Braces o List of competency-based training in the last six months o OT/PT/S o LP Assessments for individuals recently admitted to EPSSLC: • Individual #134 and Individual #133 o OT/PT Assessments, ISPs, ISPAs, SAPs/SPOs and other related documentation for the following individuals: • Individual #78, Individual #161, Individual #6, Individual #10, Individual #34, Individual #1, Individual #178, Individual #59, Individual #70, Individual #72, Individual #16, Individual #105, Individual #12, Individual #57, Individual #102, Individual #5, Individual #60, Individual #116, Individual #43, Individual #45, and Individual #4 o OT/PT Assessments for the following: • Individual #127, Individual #42, Individual #79, Individual #65, Individual #100, Individual #8, Individual #89, Individual #112, and Individual #117 o PNMPs submitted o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 o PNMP section in Individual Notebooks for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 <u>Interviews and Meetings Held</u>: o Susan Acosta, DPT, Habilitation Therapies Clinical Coordinator o Jessica Cordova, MPT

	o Jennifer Ochoa-Evers, OTR o Heather Rodriguez, MPT, o Rocio Alvarenga, OTR Sandra Moreno, PTA o Frank Diaz DeLeon, COTA) o PNMT members o PNMP Coordinators o Various supervisors and direct support staff o PNMT meeting o Clinical meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs
	Facility Self-Assessment: EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as a document separate from the action plans for each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Some of these actions, however, continued to describe only what occurred during the last six months related to working towards substantial compliance rather than related to conducting a self-assessment. In some cases, the self-assessment provided an analysis of the effectiveness of the actions taken, however, in the case of staffing, the clinicians had been organized into two teams, which was thought to be a positive step by the facility, but it was not clear if the current staffing levels were appropriate and effective. Other sections more closely accomplished what would be expected in a self- assessment, such as audits conducted of PNMPs, assessments, SAPs, and other documentation with a report on compliance or performance. Audits of assessments had appropriately begun to review consistency of assessment formats but content areas continued to be weak, particularly related to the analysis of the clinical findings. The development of the overall strategic action plan should link to this self-assessment and activities completed should be included in the analysis as well. Even though continued work was needed, the monitoring team wants to acknowledge the tremendous efforts of Habilitation Therapies toward compliance with this section. This was an excellent effort. The facility self-rated itself as not in substantial compliance with section P elements. Actions taken were

	extensive and have created a sound foundation from which substantial compliance may be achieved with continued perseverance.
	Summary of Monitor's Assessment: There had been a tremendous amount of concentrated and organized effort to address the items of this provision. This was accomplished through the Immediate Action Plan developed soon after the previous review by the monitoring team. Each of the action steps had been completed. This resulted in an infrastructure for the department that included organizing staff into teams, and the provision of extensive staff training of therapy clinicians, therapy technicians, PNMPCs, direct support staff, and QDDPs. A system of monitoring based on risk level had been developed and implemented. There was ongoing review of the findings in an attempt to ensure accuracy and consistency. The entire facility clearly worked together to accomplish so much in a short time. Staffing levels were improved, though some existing staff had resigned and new staff were just recently hired. This created a need for additional staff training to ensure that supports and services were appropriate. Having to retrain new staff will always create a lag in progress with the elements of the Settlement Agreement, however, the systems that had been created over the last six months will provide better guidelines to new staff for consistency. The assessment process observed during this review had significantly improved. The report content had also improved, though the analysis of findings was issue-specific and in a list format. This did not promote an integrated comprehensive review of all the data presented. The analysis of findings was a key element for the development of an integrated therapy intervention plan, is required to provide a foundation for non-clinical supports and programs, and is an essential element of an appropriate clinical assessment. The new state format included health risk issues with a description of functional limitations, skill abilities, and potentials. The therapists viewed the discussion of potentials, however, as it related to teaching accomplished by others, rather than potentials for therapy-related outcomes. Information contained within the assessment report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective IDT should then drive the supports and interventions via the PNMP and other more direct services. There was emerging evidence that the therapists had begun to consider this and include statements in their assessments. The measurable outcomes were limited to staff actions rather to promote a change in functional status or skill acquisition. The OT and PT clinicians conducted their annual assessments together and the SLPs had begun to participate in the assessment process as well. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services. The assessment report was a combined OT/PT/SLP document. The monitoring team observed a clinical team meeting. This appeared to be a sound practice and the monitoring team looks forward to continued improvement in this area. The PNMPs continued to be reviewed with improvements in many areas. The positioning, transfer, and mobility sections should be more carefully examined. There was a lot of professional jargon, abbreviations,

	and complex instructions that made it difficult for staff to understand. It was not sufficient to say that the staff had been trained and should understand the plans, but also the plans must reflect instructions in a manner that is easy to understand and follow. The plans should serve as a reference when staff are unsure or want to check instructions. There was a continued need for improved staff attention to the details of proper positioning and alignment in wheelchairs and dining chairs, and compliance with the PNMPs. Attention to personal body mechanics used by staff also continued to need improvement. Review of gait belt use was also indicated. A number of individuals with gait belts did not appear to require them and/or they were not used correctly. Some staff were more confident in their responses to the monitoring team's questions and appeared have a better understanding of why they were doing what they were doing in relationship to the PNMP. This was likely associated with the skills drills and ongoing coaching and drills with staff related to risks and the rationale for interventions and supports. Continued implementation of this process 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 had been significant collaboration with program developers regarding the development of SAPs. More collaboration across disciplines will be necessary as the facility sees changes in behavioral supports. For example, with less sedation there will be a greater demand for meaningful and purposeful activities throughout the day. Therapies should play a key role in this process.

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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.	<u>Current Staffing</u> At the time of this onsite review, there was no one formally appointed to the position of Habilitation Therapies Director, however, Susan Acosta, previously a contract staff physical therapist, filled that role at EPSSLC with administrative assistance for state personnel-related issues. Her new title was Clinical Coordinator. This was a positive change and Ms. Acosta was bringing the facility forward towards achieving substantial compliance with this provision, as well as provisions O and R. The clinicians were organized into teams to serve each area of the facility. This was a good way to help focus the clinicians on specific caseloads. Each team consisted of a physical therapist, occupational therapist, and speech-language pathologist. The therapy team for the Systems area (A, B, and C Dorms, 38 individuals) included Jessica Cordova, MPT, Karin De La Fuente, MS, CCC-SLP, and Jennifer Ochoa-Evers, OTR. The team for the Cottages (506, 507, 508, 509, 510, 511, 512, and 513, 91 individuals) included Heather Rodriguez, MPT, Bahola Polo, MS, CCC-SLP, and Rocio Alvarenga, OTR. Only the two contract SLPs and one PT were the same as the staffing list from the previous review six months ago, though it was the same number of positions for SLPs and OT with an increase in PT staffing by one. The therapy assistants (Sandra Moreno, PTA and Frank Diaz DeLeon, COTA) were each assigned to both teams. The OTs, PTs, and one SLP were full	Noncompliance

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		time and the other SLP worked 30-40 hours a week. Ratios based on the above configuration were 1:38 for Team Systems and 1:91 for Team Cottages. Only one individual was listed with no PNM needs and three individuals were recently admitted to the Cottage areas and in the assessment process. Specific PNM needs were not yet identified for them at the time of this review. There were 5.0 full time equivalents (FTEs) for OT with a ratio of 1:33, comprised of two state positions, two contract clinicians, and two unfilled positions. Also, there were two PT FTEs, comprised of one state position filled with four contract staff with a calculated ratio of 1:26. These calculated ratios are good ratios. The COTA, however, should not be included in these ratios because he/she cannot fully carry an independent caseload. Per the state practice act, therapy assistants were not licensed to conduct assessments or develop intervention plans; they required supervision by the OT and PT respectively. They were, however, able to gather specific data for assessments, provide interventions, conduct staff training, conduct monitoring, and engage in other responsibilities. Their roles were adjunctive to service delivery by the PTs and OTRs and, as such, should not be fully counted when calculating staffing ratios. There was one PT technician, one OT technician, one speech technician, and one PNMT technician who supervised the five PNMPCs. The technicians were in addition to the therapy assistants. One technician was assigned to the therapy team in each area. An additional technician was assigned part-time to speech and part-time as a PNMP technician. There was one other PNMP technician assigned to both areas and one other technician designated as programs. One technician had resigned the week prior to this review. The fabricator resigned in August 2011 with a replacement hired as of 11/1/11. There were two wheelchair technicians, but the full time technician had also resigned as of 12/31/11, and the other worked only 10 hours a week. A replacement technician began employment half day in early December, and then went full time mid-December 2011. <u>Continuing Education</u> Four of the six OT/PT clinicians had attended state-sponsored webinars and the Annual Habilitation Conference in the last six months. Five of the six had attended additional continuing education, though the course hours were not reported. Heather Rodriguez had recently completed a PT program, graduating on 11/20/11, so additional continuing education would not be expected at this time. <u>New Admissions</u> There were two individuals newly admitted to the facility, Individual #133 and Individual	

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		#134. Each of these assessments were dated within one month of their admission dates, though they were not signed until much later and, as such, would not be considered complete until they were signed and in the record. <u>OT/PT Assessments</u> A new assessment format was used at the facility based on the one developed by the state. This new outline included medical history and current health issues that would impact the delivery of OT, PT, and speech services. A section of the report addressed the identified risk levels established by the IDTs. The outline also included sections to address the clinicians' analysis of findings, recommendations, measurable outcomes, monitoring schedule, interval for reassessment, and considerations for community placement. There were 10 current Habilitation Therapy Comprehensive Assessments OT/PT/SLP submitted reflecting this new format. Additional assessments current within the last year were included for 85% of the individuals, included in the sample of individual records requested by the monitoring team (11/13). Initial Assessments (1), Comprehensive OT/PT Assessments (8), and Habilitation Therapy Comprehensive Assessments OT/PT/SLP (2) were submitted. Other assessments included in the individual records were older than 12 months at the time of this review: OT/PT Comprehensive Assessments (6), OT/PT Assessment Updates (4) and an OT/PT Baseline Evaluation for Individual #191 completed on 8/13/08. Each of the individuals with assessment updates completed in 2010 had a more recent comprehensive assessment completed in 2011 with the exception of Individual #115. Assessments for individuals listed as participating in direct OT and/or PT services were requested for 13 individuals and were received for 12 of those. There was no evidence of an assessment for Individual #16. These assessments included OT/PT Comprehensive Assessments (9), and Habilitation Therapy Comprehensive Assessments OT/PT/SLP (3), each current within the last 12 months. The assessments for Individual #1, Individual #59, and Individual #161 were duplicated in multiple samples. The total number of assessments reviewed was 30. Analysis by the monitoring team of these was as follows: • 100% of the assessments were dated as completed prior to the annual ISP meeting. • One was an initial assessment for Individual #191 for admission to EPSSLC. • 50% of the assessments were completed using the new Habilitation Therapy Comprehensive Assessment OT/PT/SLP format. • 69% of the new format assessments were consistent with the outline submitted. Of these 69%: o 100% of these identified the date of the previous assessment. o 100% of these were signed and dated by each of the three clinicians. o 100% of these included an Analysis of Findings section.	

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		o 100% of these included a Recommendations section. o 100% of these included a Measureable Outcomes section. o 100% of these included a Monitoring Schedule section. o 100% of these included a Reassessment Schedule section. o 100% of these included a Factors for Community Placement section. There were sections of the assessments to identify personal outcomes and goals per the Personal Focus Assessment as well as strengths, challenges, and preferences related to functional skill acquisition. However, these sections rarely actually addressed potentials for skill development. For example, the fine motor sections addressed reach and grasp, but not manipulative skills or release. The justification for not needing additional supports was generally described as the individual functioning at a baseline, which in most cases, was not clearly established. Challenges were listed, but were not typically addressed via interventions, skill acquisition or supports. The analyses sections were separated for each of the risk indicators identified and also separated for functional skills in the areas of diet upgrades, activities of daily living, transfers, or mobility. Routine audits of the assessments were conducted by the Clinical Coordinator and a number of these were submitted in the Presentation Book for Provision P. The audit tool was not submitted, but the level of compliance data 11/1/11 to 12/31/11 was submitted with 100% compliance reported in 63 of 63 areas for December 2011, up from 100% compliance in 56 of 63 areas in November 2011. This audit appeared to reflect a review for format only rather than a qualitative review of content as well. Overall, the assessments were greatly improved and there was evidence of improved analysis of the clinical findings presented in a variety of sections in these new style assessments. Though in an effort to simplify these, there was no comprehensive, well-integrated analytic review of the objective data presented in the report to address the risk indicators and to clearly justify the supports and services recommended. Further, there were significant inconsistencies in the information reported in a number of the assessments and limited recommendations to address potential for skill acquisition. Some examples included the following: • Individual #127 (11/21/11): This assessment reported that her current risk assessment by the IDT for skin breakdown was low with a Braden score of 16/23. The functional evaluation section of the report, under skin integrity listed her Braden score as 14/23 indicating a high risk of skin breakdown, but that she had programs and equipment to reduce this risk. Pressure mapping strategies revealed that all pressures were adequate for therapeutic pressure relief in all positions. The analysis section related to skin breakdown referenced a Braden score of 18/23, which did not indicate high risk of skin breakdown, but also cited a Grade II pressure ulcer in 2009, dermatitis and a progressive decline in	

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		independence for repositioning and mobility. A gluteal abscess requiring wound care was listed under Medical History and a need for bigger shoes due to skin integrity issues listed under services provided in the last year. Recommendations indicated that a review of her risk indicators in several areas including skin integrity, though clearly the data presented was not consistent for an appropriate decision to be made by the IDT. • Individual #1 (10/14/11): She had been assessed by PT in March 2011 with a recommendation for evaluation in the orthotic clinic for shoes and inserts for ambulation using a gait trainer, however, this was not completed until October 2011. Though the inserts and shoes were on order, they were not available for assessment of her ambulation skills at that time, seven months later. In addition, her current risk assessment by the IDT (11/21/11) in the area of aspiration was reported to be medium due to respiratory compromise, history of pneumonia in the last year (9/27/10), and a diagnosis of GERD. She was also reported to have been sent to the ER for diarrhea and emesis with dehydration and low oxygen saturation levels as well as pneumonia and hypoxemia diagnoses on the same date. Risk of respiratory infection was listed as high, however, it was not clear how the risk level information was available to the therapists as the date of the OT/PT assessment was 10/14/11, prior to the date of the risk assessment. Individual #1 received all nutrition, hydration, and medications via gastrostomy tube and oral care via a suction toothbrush. There was no recommendation to re-evaluate her risk related to aspiration. • Individual #114 (19/19/11): It was reported that he had a PEG tube placement on 6/3/11, but no rationale for this was described in the assessment other than it served as an alternative to oral intake "if warranted." His choking and aspiration risk as identified by this IDT were reported to be medium, with low risk for gastrointestinal concerns. Gastroesophageal reflux was not listed as a diagnosis, though he was prescribed lansoprazole for GERD and had anti-reflux positioning strategies in place. There was a PNMP focus to reduce the risk of aspiration and reflux through positioning. The rationale for these was that he required special equipment for drinking and close staff supervision, and that he would eat his whole meal in three minutes. In the Oral Motor/Eating Ability/Nutritional Status section of the report, it was stated that he required full staff assistance for meals, but that he also held a wonder-flow cup for drinking. It was reported that he maneuvered around furniture and people in his home, propelling his wheelchair with his upper extremities. He participated in a FEET program to enhance his skill for self-propulsion for more functional distances, though it was reported that he had made little to no progress. It was stated that this program was recommended to be discontinued because he was not interested. It was also reported, however, that he self-propelled short distances to approach another person, though he became agitated and pulled on his peers. He was provided	

#	Provision	Assessment of Status	Compliance
		supervision by staff to ensure safety. There was no functional baseline reported, and no functional goals or statement of current status with regard to this important skill. There was no recommendation for further functional assessment of his interest in approaching others or his behavior of pulling on peers. It was further reported that he had the potential to eat independently, but did not like close proximity, so skill acquisition in this area was not recommended. Yet staff had to closely supervise him and provide total assistance for eating. • Individual #56 (10/14/11): He was described as independent in mobility and ambulation, had functional fine motor skills for reach, grasp, and manipulation, and printed his name legibly. He was independent for all dressing, bathing, toileting, and grooming tasks with minimal verbal prompts to initiate tasks or adjust clothing. He was reported to eat rapidly with reduced chewing and oral preparation of solid foods before swallowing, increasing his risk of choking. He used a plastic built-up youth spoon and fork, though based on this assessment, it was determined that regular utensils were more appropriate for him and were recommended. There was no evidence of assessment regarding his potential for cutting foods at the table, though based on his skill levels it should have been given consideration. It was stated that this diet modification was considered a support rather than a restriction because he demonstrated poor potential to upgrade to a regular diet due to the fact that he was not always "re-directable." Skill acquisition programs to address these issues were not recommended.	
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	<u>OT/PT Interventions</u> The primary intervention provided was the PNMP. These were addressed in detail in Provision O above. Other interventions via direct OT or PT were provided for a small number of individuals. There was one individual who participated in a skilled acquisition program (SAP) and four individuals with specific program objectives (SAPs) listed as individuals who received direct OT services. There were eight individuals who participated in a skill acquisition programs (SAP) and five individuals with specific program objectives (SAPs) listed as individuals who received direct PT services. Assessments, ISPs, programs, and documentation were requested for each of these individuals. Documentation was incomplete or absent related to these services. A few examples follow: • Individual #6: There was an OT/PT assessment dated 1/19/11 which included a recommendation for direct OT services to address improved righting equilibrium responses during supported sitting to provide additional seating options during meals. His ISP dated 2/8/11 indicated the IDT would discuss the need for direct OT "later once there was an OT on board." An identified need was not addressed because there was insufficient staffing. There was no evidence of an ISPA conducted in order to initiate an SAP. An additional re-assessment and revised plan was dated 5/2/11. Again, there was no evidence that there had been an	Noncompliance

#	Provision	Assessment of Status	Compliance
	outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	ISPA to discuss progress with the previous plan and there was no documentation by the OT. Quarterly ISP reviews documented a report by OT dated 6/14/11 that listed the goals, but not Individual #6's related progress. An OT tech, rather than the OTR or COTA, attended the quarterly meeting. Additional quarterly documentation (10/11/11) and a discharge summary, dated 10/5/11, reported that Individual #6 had met two goals, neither of which were included in the SAP documents submitted. There was no discharge summary to indicate that treatment had been discontinued. • Individual #16: There was no comprehensive assessment submitted though a referral-based PT assessment dated 7/18/11 recommended that an SAP be developed for locking the wheelchair brakes. There was an ISPA, dated 7/19/11, which stated only that the PT would begin to work with him regarding his new wheelchair. An SAP document was submitted, dated 7/21/11, related to a goal for locking his wheelchair brakes to be completed by 1/20/12. There were program change notes that documented criteria met 100% in August 2011, 90% in September 2011, and 100% in October 2011. This goal was considered to be met with 75% success rate for six consecutive months. • Individual #4: Per his evaluation dated 6/18/11, it was recommended that an SAP be developed to promote participation in dressing by raising his arms to put on and take off his shirt. There was no evidence of this in the documentation submitted, however, documentation was submitted related to holding his head away from his headrest for 60 seconds while visually tracking a moving object. This SAP was implemented by direct support staff and did not appear to include any involvement or review by OT or PT. Another recommendation, included in an interim PT assessment dated 8/31/11, recommended that an SAP to promote choices for bed positioning, but there was no evidence that this was implemented. There were no ISPAs submitted. OTs and PTs routinely completed a post-hospitalization assessment for individuals upon return to EPSSLC including Individual #4 (9/6/11), Javier Garza (6/2/11 and 6/1/11, 6/20/11 and 6/24/11, 1/2/12 and 1/5/12 by OT and PT respectively), Individual #161 (6/30/11, 7/18/11, 10/7/11, and 12/12/11), for example. In each of these cases the OT and PT assessments were not comprehensive and were not completed collaboratively, but rather separately. This did not represent an integrated approach to review of health and functional status after a significant event with potentials for changes in status and identified needs. As described above, findings were often not integrated into the ISP. Recommendations other than the PNMP were often not included and there was no evidence of therapist-designed skill acquisition plans or SAPs related to direct therapy services.	

#	Provision	Assessment of Status	Compliance
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.	Competency-based Training Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs was addressed in detail in Provision O above. No evidence of competency-based training for the implementation of OT or PT designed programs by therapy technicians or direct support staff was submitted with the documentation related to those for whom OT or PT services were provided (Individual #78, Individual #161, Individual #6, Individual #10, Individual #34, Individual #1, Individual #178, Individual #59, Individual #70, Individual #72, Individual #16, Individual #105, and Individual #4).	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	Monitoring A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was implemented at EPSSLC and addressed in Provision O above. Monitoring was conducted approximately 136 times for 99 individuals from September 2011 to November 2011. Approximately 15 individuals were monitored monthly across the quarter, six were monitored two times and the others were monitored once during the quarter. There was no consistent method used to document progress related to OT/PT interventions via SAPs. Progress summaries, discipline specific assessments, daily progress notes, program change notes, quarterly ISP documentation, and datasheets were noted in the records submitted. None of the individuals' documentation used the same system or frequency. In some cases the SAPs were well written, outlining a clear approach to intervention with measurable objectives, however, the documentation related to these interventions was often inadequate in providing sufficient data and comparative analysis of progress from month to month. There was also inconsistent justification to continue or discontinue the intervention. For example, Individual #105 participated in a PT program to self-propel his wheelchair the distance of the sidewalk around his home with minimal assistance and minimal prompts in less than 30 minutes. Documentation related to this intervention was submitted from 8/1/11 to 12/31/11. The data presented did not reflect a change in his functional status, though progress was implied in the monthly program change notes submitted with "he is progressing in many areas," though specifics related to this progress were not described. The timeframe for achievement was designated as six months, and each of the sessions was described as unsuccessful because all of the criteria had not been met. No changes were made to the criteria or program to address the issue of no progress in four months. For example, the criteria should have been adjusted or stated in smaller increments to reflect actual progress. Monitoring of wheelchairs, assistive devices for ambulation and other equipment	Noncompliance

#	Provision	Assessment of Status	Compliance
		provided by OT/PT were included in the routine monitoring of the PNMPs as described above in Provision O. Equipment provided was as follows: • Orthopedic shoes only (3) • Custom inserts only (9) • Orthopedic shoes and inserts (26) • AFOs (6) • Wheelchairs (34) • Transport wheelchairs (20) • Gait trainers (22) • Walkers (3) • Gait belts (44) There were maintenance checks to assess the working condition of these wheelchairs, gait trainers, and adapted chairs, as well as cleaning audits, conducted quarterly. Per the departmental audits, the maintenance checks were conducted consistently, but the cleanliness checks were less so. A log of work orders was generated and tracked for completion and timeliness with orders generated through routine PNMP monitoring, routine random checks, and reports by direct support and home management staff. There had been a gap in this service due to the changes in staffing in the wheelchair shop. This was sufficient, though the cleanliness checks should be done consistently. As found during the last monitoring review, the wheelchairs observed during this review appeared to be in good condition, though some were dirty and should be cleaned and kept clean.	

Recommendations:

1. There was a continued need to develop programs to address increasing or expanding functional skills. 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. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P2).

2. Integrate direct and indirect supports into the ISP through the development of SAPs 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).

3. Review the existing OT/PT assessment format to address summary/analysis. As currently written, these were not consistently sufficient to establish the rationale for the recommendations. It is recommended that a more concentrated analysis of objective data be implemented rather than having it risk issue specific but rather through the integrated and comprehensive analysis of all data presented in order to develop an

appropriate intervention plan. The development of a framework that included more specific guidelines for therapists in their treatment of the analysis of findings and justification for supports and interventions and the written reports would be useful, particularly with the addition of new therapy clinicians. 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 (P1).

4. The assessments should consistently include a review of the efficacy of existing supports and services with concrete justifications (P1).

5. Continued implementation of coaching and skills drills 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 (P3).

6. Clarify what constitutes a valid comprehensive assessment and subsequent updates. Ensure that updates reference a comprehensive assessment (P1).

7. Continue aggressive efforts to recruit OT/PT staff including OT, PT, COTA, PTA, and therapy technicians (P1).

8. Include oral hygiene status in OT/PT assessments not only positioning. Consider strategies to address sensory issues that may negatively impact the effectiveness of oral hygiene care (P1).

9. Measureable outcomes in the assessments should not be staff actions, but rather objectives to promote a functional status or skill acquisition for the individual, as well as health status (P1).

10. Shift focus of assessment audits to content and quality. This may be incorporated as a peer review function (P1).

11. The positioning, transfer and mobility sections of the PNMPs should be more carefully examined. There was a lot of professional jargon, abbreviations and complex instructions that made it difficult for staff to understand. It was not sufficient to say that the staff had been trained and should understand the plans but also the plans must reflect instructions in a manner that is easy to understand and follow (P2).

12. There was a continued need for improved staff attention to the details of proper positioning and alignment in wheelchairs and dining chairs and compliance with the PNMPs. Attention to personal body mechanics used by staff (including PNMPCs) also continued to need improvement (P3).

13. Review of gait belt use is also indicated A number of individuals with gait belts did not appear to required them or they were not used correctly (P2).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o EPSSLC Organizational Charts o EPSSLC Self-Assessment o EPSSLC Action Plan o Presentation Book, Section Q o Dental Data: o Listing, Individuals with Medical/Dental Desensitization Plans o Listing, Individuals Receiving Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Oral Hygiene Ratings o Dental records for the individuals listed in Section L o Desensitization plans for the following individuals: • Individual #85, Individual #47, Individual #20, Individual #88, Individual #63, Interviews and Meetings Held: o Howard Pray, DDS, Contract Dentist o Raquel Rodriquez, RDH o Jennifer Pacheco, RDH o Lilani Muthali, MD, State Office Medical Services Coordinator o Valerie Grigg, MA, BCBA, Director of Behavioral Services o Mary Ann Clark, RN, Chief Nursing Executive Observations Conducted: o Dental Clinic o Informal observation of oral hygiene regimens in residences o Pretreatment Sedation Meeting
	Facility Self-Assessment: The dental clinic submitted its self-assessment and action plan. For each provision item, the self-assessment listed (1) activities engaged in to conduct the self-assessment, (2) results of the self-assessment and (3) the self-rating. The self-assessment listed for item for Q1: Reviewed routine and emergency dental care provided by the dental clinic. The results of the assessment included were that routine care under anesthesia began in August 2011 and emergency care is available after hours.

	For Provision Q2, two activities were listed: (1) review of policies and procedures for dental clinic and (2) IDT meetings are attended by clinic staff and information made available to the teams. Future self-assessments should focus on activities similar to those completed by the monitoring team. That could include a review of data on the types of services provided and the implications of that data. Was very little restorative care provided? Was the number of extractions high? The monitoring team recommends that the dentist review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report and the recommendations provided throughout the report. This may result in a plan in which the assessment activities provide results that drive the next set of action steps. The facility rated itself in noncompliance with both provision items. The monitoring team agreed with those ratings.
	Summary of Monitor's Assessment: Progress was noted in the provision of dental services. Clinic was operated five days a week. The dentist provided services three days each week. There was no onsite dental director and the lack of a full time dental director may have contributed to a lack of forward movement in some areas. Overall, it appeared that individuals received appropriate care to the extent that it could be delivered. The use of general anesthesia started in August 2011 resulting in several individuals undergoing extensive treatment. Other individuals were referred to the community hospital for dental work to be performed under general anesthesia. The clinic itself appeared structured, but the dental program lacked structure. The state-issued dental policy was implemented and staff trained, but no other procedures were formally developed. There were no procedures related to the hygienists' roles in home care, special supports for those at high risk, or suction toothbrushing. Individuals received preventive care and emergency care. Very few individuals had restorative work completed. The majority of extractions occurred with the community dentist. The percentage of individuals with poor oral hygiene seemed slightly, but not significantly, improved. While the IDTs documented efforts undertaken to improve the oral hygiene of individuals, there was no facility-wide strategy targeted at improving oral health. When an individual missed appointments, the QDDP was not notified. The hygienist rescheduled the appointments. The monitoring team was informed that desensitization was under psychology and suction toothbrushing was under nursing. It was reported that almost everyone needed sedation to complete dental work. It was not clear how many individuals had been assessed for the appropriateness of formal desensitization. Five plans had been

	implemented and most of those were within the past three months. A few individuals appeared to have long standing needs based on the number of extractions performed.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	A part time dentist and two full time dental hygienists staffed the dental clinic. Dental clinic was operational five days a week. <u>Provision of Services</u> The dental clinic continued the use of the database for tracking appointments and services provided. Data generated by the database showed the following types of services were provided: Dental Clinic Appointments 2011 July / Aug / Sept / Oct / Nov / Dec Preventive: 34 / 31 / 39 / 21 / 37 / 13 Restorative: 1 / 1 / 4 / 0 / 0 / 0 Extractions: 0 / 4 / 2 / 1 / 0 / 0 Emergency: 1 / 2 / 4 / 3 / 4 / 1 The number of persons with extractions represents those individuals treated on campus. Six other individuals had extractions under general anesthesia at a local hospital. Those were either full mouth extractions or extractions involving multiple teeth. The number of persons receiving restorative care was low. The dentist explained that it was difficult to perform these procedures with uncooperative individuals. <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. <u>Oral Hygiene</u> The monitoring team requested the oral hygiene ratings for individuals who had annual exams during the last six months. A list of 129 individuals was submitted. This was more than twice the number of exams reported completed in the past six months. Oral Hygiene Ratings 2011 July 2011 / July 2011* / January 2012 Good: 20 / 9 / 14 Fair: 37 / 42 / 48 Poor: 38 / 43 / 33 Not Rated: 5 / 6 / 4 *Adjusted for edentulous population	Noncompliance

#	Provision	Assessment of Status	Compliance
		The data showed a decrease in individuals with good oral hygiene, an increase in fair, and a decrease in poor ratings. The dental hygienist reported that these ratings included edentulous individuals. Since those individuals usually have good oral hygiene ratings, adjustments of data might lead to an overall decrease in the percentage of individuals with good oral hygiene. The oral hygiene ratings for the 15 most recent annual dental summaries showed the majority of individuals (53%) in sample had poor oral hygiene. Moreover, the summaries consistently commented on the need for better brushing. The facility reported low rates of missed appointments. Behavioral issues and refusals presented barriers to the provision of adequate care. A review of risk rating tools and action plans demonstrated that teams were identifying individuals at high risk for poor oral health due to medical conditions and behavioral issues. There was some evidence that strategies to improve oral health were considered and implemented. It was difficult to determine if those interventions resulted in improved oral health. Approximately 13 individuals received suction toothbrushing. The focus was for those individuals who received total enteral nutrition or were recommended through the PNMT. The dentist wrote orders for the treatment. During interviews with the monitoring team, the dental clinic staff referred the monitoring team to nursing for additional information on suction toothbrushing. The monitoring team discussed this with the acting CNE who reported that the provision of suctioning toothbrushing was intended to be a joint effort of the nurse educator, the infection control nurse, and the RDH. That collaboration, however, did not occur. In fact, none of the discipline heads could really state how individuals were being assessed for response to treatment or how these efforts were coordinated. <u>Staff Training</u> The dental clinic staff indicated that the provision of oral care in the homes continued to be problematic. Efforts related to staff training continued. New employees received competency-based training in new employee orientation. Annual training for nurses and DCP was completed through iLearn.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q2</td><td>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.</td><td>
<u>Policies and Procedures</u>
The dental clinic provided the dental policy and procedure manual. This was the state policy without any changes or modifications made reflective of the facility.

<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 from June 2011 – December 2011 along with the dates of the previous assessment. Annual assessment compliance data are summarized below.

<table>
<tr><td colspan="8">Dental Annual Assessments
2011</td></tr>
<tr><td></td><td>June</td><td>July</td><td>Aug</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td></tr>
<tr><td>Number of Exams Completed</td><td>7</td><td>5</td><td>8</td><td>12</td><td>4</td><td>13</td><td>2</td></tr>
<tr><td>Number of Exams Completed Within Timelines</td><td>6</td><td>5</td><td>7</td><td>9</td><td>3</td><td>2</td><td>1</td></tr>
<tr><td>Completed Within Timelines (%)</td><td>86</td><td>100</td><td>88</td><td>75</td><td>75</td><td>15</td><td>50</td></tr>
</table>

A total of 53 annual dental exams were completed. All individuals were required to have annual dental assessment, so completion of 53 in seven months would not appear adequate. Additionally, the data showed that annual assessments in most months were not completed within one year of the previous annual assessment. The dental hygienist explained that the medical clinic had tracked appointment return dates. At the time of the onsite review, the dental clinic was tracking those dates.

<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. Entries were noted in the integrated progress notes but actual treatment was recorded in the dental progress notes. The Health Care Guidelines required documentation in the integrated progress notes.

<u>Failed Appointments</u>
The number of missed and refused appointments were tracked by the dental clinic. The data are summarized below.

<table>
<tr><td colspan="7">Failed Appointments 2011</td></tr>
<tr><td></td><td>July</td><td>Aug</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td></tr>
<tr><td>Missed</td><td>2</td><td>1</td><td>2</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Refused</td><td>4</td><td>5</td><td>1</td><td>0</td><td>5</td><td>3</td></tr>
<tr><td></td><td>6</td><td>6</td><td>3</td><td>0</td><td>5</td><td>0</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Missed appointments were overall low. The hygienist continued to escort individuals to clinic when necessary. Missed appointments were rescheduled and the QDDPs were not sent email notification. The director of psychology was sent emails regarding individuals who refused treatment. Desensitization During a meeting with the monitoring team, the dentist explained that very little dental work could be performed without sedation. He provided the following data. In the population of 130 individuals, 20 were edentulous. One hundred of the 110 individuals required sedation for treatment in clinic. Eighty-five of the 110 individuals met the criteria for use of general anesthesia. Thirteen individuals received no pretreatment sedation. Ten of the 13 had not been seen and three were new admissions. The exact number of individuals who needed assessment for desensitization was not known. Three attempts were made to see individuals in dental clinic. If the third attempt was not successful, the individual was referred to the IDT to discuss pretreatment sedation and desensitization. The dentist presented this information at the pretreatment sedation meeting and a decision on the use of drugs was made. Consent was obtained from the LAR. The QDDP presented the information to the Human Rights Committee for approval. When the use of minimal sedation did not allow dental work or examination to be completed, the dental clinic made a referral back to the team for use of general anesthesia. The facility began providing routine care under general anesthesia in August 2011. This service was provided two days each month with approximately seven individuals treated during those days. The dentist believed strongly that this was the safest manner to provide care for most individuals. The number of individuals receiving pretreatment sedation and general anesthesia is below. Individuals Requiring Sedation and General Anesthesia 2011 | | July | Aug | Sep | Oct | Nov | Dec | | --- | --- | --- | --- | --- | --- | --- | | Oral Sedation | 8 | 10 | 8 | 10 | 8 | 11 | | General anesthesia | -- | 7 | 6 | 0 | 0 | 7 | | General anesthesia (community) | 1 | 2 | 1 | 1 | 1 | 7 | The majority of individuals receiving sedation did not have a desensitization plan. Five desensitization plans were implemented. Four were implemented between October 2011 and December 2011, and one in June 2011. The plans appeared individualized and based on the functional assessments, however, please see sections J and K for more detail	

#	Provision	Assessment of Status	Compliance
		regarding the quality of these plans. During various meetings throughout the week of the review, it became clear that pretreatment sedation and desensitization were viewed as the primary approaches to overcoming barriers to treatment. Individual #134 was discussed in the pretreatment sedation meeting. After one failed medical appointment, the decision was made to administer sedation. The individual was relatively new to the facility, had family contact, and was responsive to the family members. There had been no discussion of how to provide additional supports prior to the use of medication. When individuals could not be treated in dental clinic and the team requested desensitization, there was very little documentation of the use of other strategies. Very few individuals appeared to have been assessed. The monitoring team suggests that when barriers to the provision of dental treatment are identified that consideration is given to the many ways to overcome the barriers. A full spectrum of treatments and strategies, ranging from activities and interventions to full desensitization efforts should be considered.	

Recommendations:

1. The dental clinic will need a dental director to provide guidance, leadership and coordinate many of the actions that need to occur to move towards compliance with the Settlement Agreement (Q1).

2. Documentation of treatment must be entered into the integrated progress notes. In order to keep dental records current, an entry should be made in the dental progress notes that points to the IPN (Q1).

3. The facility must develop a formal plan to address the issue of oral hygiene. Consideration should be given to a home oral care program or some other type of program where training in the homes is increased. (Q1)

4. The dental clinic needs to develop a comprehensive set of policies and procedures (Q2).

5. The facility needs to organize a multidisciplinary workgroup to explore how to best serve the needs of the individuals who must overcome barriers to treatment. This should be approached with some sense of urgency (Q2).

6. A formal process is needed to address the issue of missed appointments. (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 Admissions list o Budgeted, Filled, and Unfilled Positions o Speech Staff list o SLP Continuing Education documentation o Section R Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section R-Communication Guidelines o Settlement Agreement Section R: Audit forms submitted o Process to Develop and Implement Assistive Communication Interventions o Screening and Assessment Process o Speech Language Communication Assessment template o Monitoring Tool templates for Communication and AAC o Individual Communication Monitor audit findings submitted o Completed Individual Communication Monitoring Forms submitted o SAP audit results o Communication Assessment audit results o AAC spreadsheet (undated) o Communication Matrix Assessment screening tool template o NEO training curriculum for PNM o Competency-based Training Steps and Guideline for Immediate Action and NEO o Non-foundational Training materials o Individuals with AAC devices o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o Minutes of SLP/Psychology meeting (8/11/11) o Individuals with PBSPs o Communication Master List o Tracking Log of Completed Assessments o Communication Assessment template o Communication Assessments for individuals recently admitted to EPSSLC: • Individual #134 and Individual #133 o Communication Assessments for the following: • Individual #127, Individual #42, Individual #79, Individual #65, Individual #100, Individual #8, Individual #89, Individual #112, and Individual #117 o PNMPs submitted o PNM assessment tool templates

	o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 o PNMP section in Individual Notebooks for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #32, Individual #161, Individual #191, Individual #120, Individual #40, Individual #71, Individual #154, Individual #115, Individual #93, Individual #2, Individual #25, Individual #39, and Individual #67 <u>Interviews and Meetings Held</u>: o Susan Acosta, PT, Habilitation Therapies Clinical Coordinator o Karin De La Fuente, MS, CCC/SLP o Amanda Torres, Speech technician o PNMP Coordinators o Various supervisors and direct support staff o PNMT meeting o Clinical meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs
	Facility Self-Assessment: EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as a document separate from the action plans for each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in

	to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Some of these actions, however, continued to described only what occurred during the last six months related to working towards substantial compliance rather than related to conducting a self-assessment. For example, R1 is about having sufficient staff with specialized training and competence relative to AAC. Activities identified appeared to be important and the self-assessment discussed the effectiveness of those actions, but did not address the full set of activities that would assist the facility to achieve compliance with this provision. For instance, there was no discussion of actions taken to increase the speech staffing levels and any success in this area. Even so, there were some activities that were more of what would be expected in a self- assessment, such as audits conducted of PNMPs, assessments, SAPs, and other documentation. Audits of assessments had appropriately begun to review consistency of format, but content areas continued to be weak, particularly related to the analysis of the clinical findings. These types of activities should be considered in each of the other provision items. For the next review, the monitoring team recommends that the Clinical Coordinator review each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should assist in the development of a self-assessment. In addition, the development of the overall strategic action plan should link to this self-assessment and activities completed should be included in the analysis as well. Even though continued work was needed, the monitoring team wants to acknowledge the efforts of Habilitation Therapies. This was an excellent effort. The facility self-rated itself as not in compliance with section R elements. Progress was limited in this area in large part due to the poverty of speech clinicians and, as such, the monitoring team concurred that that EPSSLC continued to be in noncompliance for provisions R1 through R4.
	Summary of Monitor's Assessment: Habilitation Therapies progress in the area of communication was less than that found for sections O and P. Staffing continued to be an issue relative to communication supports. Two staff were no longer providing services at EPSSLC, one of whom had been full time. Only two contract clinicians remained, both less than full time equivalents. Interviews were in process and during the week of this review, and it appeared that full time staff were to be hired, possibly to begin as early as 2/1/12. This should have a positive impact, however, there were concerns that the contract staff would be released. If this was the case, inadequate staffing would continue to be an issue in the provision of communication and mealtime supports. Progress with completion of communication assessments per the Master Plan was reasonable, but had become more limited since November 2011, due to lowered staffing levels. In addition, approximately only

	half of individuals considered to be highest priority had received a comprehensive assessment. Consistency of the implementation of AAC and communication plans continued to be problematic. A significant amount of new training had been initiated via the Immediate Action plan developed from the previous review. Home staff and PNMPCs had received training related to this area. While this was a great foundation, these staff would not be able to ensure that communication plans were effectively implemented alone. Clinical staff had limited time for inserting themselves in the environments and daily routines of individuals, however, this will be key to effective assessments, the selection of meaningful and useful communication supports, the development of communication programs, and to provide modeling of how to be an effective communication partner. 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.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	<u>Staffing</u> At the time of this review, there were two speech-language pathologists: Karin De La Fuente, MS, CCC-/SLP and Bahola Puentes Polo, MS, CCC/SLP. This was a decrease by two clinicians (one full time and one part time) since the previous review. At this time, Ms. De La Fuente contracted for 30-40 hours per week, providing services to individuals in the Systems area (38 individuals) as well as serving on the PNMT. Ms. Polo contracted for 40 hours per week and was assigned to the cottages therapy team (91 individuals). There was a speech technician and a half time speech aide. The reported ratio was 1:65 though this reported ratio was not entirely accurate. Moreover, the speech pathologists had responsibilities for all communication needs and all mealtime needs because all individuals at EPSSLC had potential needs in both of these areas. Fortunately, candidates had interviewed and accepted positions during the week of this review, thus, filling the two unfilled state positions for SLPs. It was reported, however, that the impact on existing, experienced contract staff was unknown. It was of concern if the contract positions would be dissolved in lieu of the state positions because the staffing ratio of 1:65 would continue to be significantly high in that case. Furthermore, the self-assessment (12/23/11) indicated that there was a lack of experience related to AAC and communication supports in the existing staff and that additional staff was needed due to the dual responsibilities in dysphagia and communication. <u>Continuing Education</u> Since the previous review, continuing education in the area of communication attended by Karin de la Puente included Drawing in the Remediation of Persons with Aphasia, Using Functional Communication to Decrease Challenging Behaviors, Optimize Learning	Noncompliance

#	Provision	Assessment of Status	Compliance
		in Children with Autism, and AAC communication in the Hospital for Adults with DD. Bahola Puentes Polo attended the ASHA Conference. The self-assessment reported that both contract speech clinicians had attended a Promoting Language Development Through the Use of Gestures and Symbols/Icons as well as the ASHA Conference related to communication. It was reported that the existing clinicians lacked expertise in the area of communication supports. There was a plan to hire speech clinicians with experience in AAC. Though two clinicians had reportedly been hired during the week of this review, their professional backgrounds were not known to the monitoring team.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	The Master Plan was again revised since the previous review. An Immediate Action (14 individuals) list and a Priority list (21 individuals) were developed. Deadlines for completion of the Matrix screening were listed for these. The intent was to identify those who would benefit from AAC. Per the self-assessment dated 12/23/11, all of the Immediate Action screenings were completed, though the Master Plan submitted indicated that these were all completed as of 10/30/11. Per the self-assessment, only half of these had received a Comprehensive Assessment. Also, 20 of 21 individuals had been reported to have a completed screen and less than half of those had a Comprehensive Assessment. All others were listed for completion of annual assessments at the time of the individual's ISP. There were 38 of 93 screenings and Comprehensive Assessments completed for this group as of 12/23/11. It was not clear, however, why 54% of those requiring immediate action or those who were considered to be a priority had not yet received a comprehensive assessment. Overall, per the documentation submitted, approximately 42% of individuals had yet to receive an appropriate comprehensive communication assessment at the time of this review. A new Comprehensive Assessment format had been developed by the state and was adopted at EPSSLC. Of the sample of 13 individuals selected for review by the monitoring team, 11 comprehensive assessments were submitted, two of which were updates. A brief assessment for Individual #161 was submitted post-hospitalization, but there was no evidence that a comprehensive assessment or update was completed. There was no communication assessment submitted for Individual #191, but instead, only a copy of the screening matrix, dated 9/29/11. Of the assessments submitted for the sample individuals, only 75% were current within the last 12 months. Only the assessment for Individual #25, dated 12/22/10 (assumed to be an error as the date of the ISP was identified on the assessment as 1/11/12) was in the new format. Two other assessments indicated that they were for 2010 ISPs, but were completed in 2011, again assumed to be lack of attention to detail. There were 10 additional assessments submitted in the new format.	Noncompliance

#	Provision	Assessment of Status	Compliance
		For 10 assessments, in general, the clinicians adhered to the basic format as outlined for this new assessment, however, the quality of the content varied and continued review and improvement were needed. Measurable objectives listed in nine of 11 assessments pertained to a staff action rather than a specific outcome for skill acquisition for the individual. Only in the case of Individual #127 was there a recommended skill acquisition program that had a measureable outcome. There was no analysis of the findings from the Communication Matrix Screening for those who had not yet received a comprehensive assessment. In most cases, the results were reported in the form of a canned statement in the assessment. Evidence was highly inconsistent as to how that information was used to identify a need for AAC or for other supports as intended. There were additional concerns about the assessments, related to content, rationale, and lack of recommendations for skill acquisition or improved communication abilities. Some examples included: • Individual #117: His Speech Language Communication Comprehensive Assessment was dated 11/15/11. It was reported that there had been an AAC Communication Consultation in the past year on 11/20/10, but the purpose or outcome of this consult was not described. He regularly refused and rejected AAC. By report, he was set in his ways and did not take direction from others well. He constantly carried a plastic tub full of cups around on his wheelchair tray and did not engage in other meaningful functional activities. There was a recommendation for a SAP to address guided communication for activities of daily living, but there was no rationale to justify this. • Individual #79: Her Speech Language Communication Comprehensive Assessment was dated 11/4/11. A previous assessment was cited that recommended participation in group speech therapy and a writing group. Functional goals, status, or progress related to this intervention, however, were not discussed in the current assessment submitted. She was described as a functional verbal communicator, but there were no recommendations for direct services, yet an annual comprehensive assessment was recommended. There was no rationale established for this. • Individual #8: His Speech Language Communication Comprehensive Assessment was dated 11/9/11. A previous assessment recommended the use of a communication picture book and wallboards to maintain or expand his current level of communication skills. He was described as a nonverbal communicator who used gestures, pointing, and leading behaviors. He also comprehended gestures and answered basic yes/no questions and he	

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		demonstrated functional use of objects. It was stated that he had fair to good potential for acquisition of new skills. There was an indication that he would benefit from a speech SAP related to yes/no questions and incorporated into his daily activities. Recommendations, however, included discontinuing the picture communication book, staff use of gestures, and speech SAP related to yes/no responses. There was no recommendation for the continued use of the wallboards previously recommended. There were no individual measurable objectives stated related to the speech SAP to reflect skill acquisition, but rather a statement that the IDT would discuss a toileting SAP. There was no evidence of collaboration with psychology to address his target behaviors through improved communication skills. • Individual #127: Her Speech Language Communication Comprehensive Assessment was dated 11/23/11. It was reported that she was able to produce and respond to simple "wh" questions and yes/no questions. She was also able to follow one to two basic verbal commands. A Talking Photo Album, wallboards, and a picture communication book were identified in the report as electronic augmentative devices, but there was no discussion about how they were used or their effectiveness. There was a recommendation that the SLP would develop a SAP to enhance her communication abilities and/or reduce her SIB behaviors due to anxiety. There had been no relationship established between her communication skills and anxiety or target behaviors. There was a measurable objective listed, but it was measuring participation in language activities. Performance criteria were vague and reflected a skill she was reported to already demonstrate. No one participated in direct speech intervention at the time of this review. There were 28 individuals who had AAC in addition to a Picture Communication Book and five who had some type of environmental control device (though not necessarily communication-related). There were 113 individuals who had been provided a Picture Communication Book. As was the case in the past, the most common other device was a Talking Photo album. In addition there was only one Step Sound, one Hip Talker, one Go Talk 20+, and one Put 'Em Around device. It was not clear if this continued lack of variety was related to the lack of experience of the clinicians or that that this represented an accurate appraisal of the needs of the individuals living at EPSSLC. Even so, none of these devices were observed to be in use by the individuals. The ISP meeting for one individual who had a device was observed. The individual had the device in his backpack, but it was not available for use during the meeting and did not	

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		have any related icons available for that purpose. There were a number of general communication devices in the homes including Put "Em Arounds (9 areas) and Wallboards (27 in 11 areas). Again, none were observed by the monitoring team to be in use. As stated above, many individuals living at EPSSLC had not yet received a comprehensive communication assessment and, therefore, it was not possible for the monitoring team to determine if all individuals who required AAC had been provided those supports. Further, routine participation by the clinicians in day programs and home activities was limited due to staffing. It was of concern that the SLPs were still not consistently involved in the development of SAPs for use in day programs and the homes (though this had increased somewhat since the previous review). Only one was noted in the sample of 10 assessments reviewed. Therapist-directed interventions in the form of individual programming or group activities were absent and no one participated in direct speech therapy. During the onsite review, the monitoring team observed a CLDP transition meeting for an individual who had very limited communication skills. His mother indicated that she intended to work intensively on this in the foster care arrangement to which he was moving. The EPSSLC psychologist agreed to develop a communication plan to assist in this. Although this was good to see, it begged the questions of why had this not been a focus during his years of living at EPSSLC, and why was the SLP not involved in the development of a plan for his transition. Further, communication needs were evident for each of the other individuals who had moved to the community during the last six months, yet there had been no recommendations for communication training during their time at EPSSLC and, furthermore, none for communication skill training in their community-based homes. An audit system similar to that conducted for OT/PT assessments was being implemented for communication assessments to ensure that the content and comprehensiveness of these was consistent across each of the clinicians, but appeared to address consistency of format only rather than content at this time. This should be addressed. There were at least 70 individuals who had not received a communication assessment prior to their most recent annual ISP meeting. Some individuals had received an assessment a number of months earlier (after the previous year's ISP), but there was no evidence that an update had been completed for the most recent ISP.	

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		There was no specific screening or assessment process for those with behavioral concerns and the potential need for AAC, even though the current comprehensive assessment had content areas related to behavior. There was no specific policy related to the identification of behavioral challenges and related communication deficits. One clinician participated on the Behavior Support Committee, but as observed by the monitoring team, she will need additional support and direction in order for her to play a more valuable role. Lists were requested of individuals with communication-related replacement behaviors in their PBSPs (44 individuals identified) and also for individuals who had behavioral concerns and severe communication/language deficits (71 individuals identified). On the Immediate Action list there were 11 individuals identified with behavioral issues and severe language deficits and four of these had not yet received an assessment, but instead merely a screening. On the Priority list submitted, there were 12 individuals with behavioral issues and severe language deficits and six of these had not yet received an assessment, but also merely a screening. As stated above, there was no evidence that this screening yielded any analysis of findings or rationale for interventions and supports unless the comprehensive assessment had been completed as well. Of the 71 individuals listed with PBSPs and replacement behaviors related to communication, there were a total of 17 on the Immediate Action or Priority list and nine of those had not received an adequate comprehensive communication assessment. The Master Plan had also listed individuals who were scheduled to receive a comprehensive communication assessment at the time of their annual ISP. There were 97 of those individuals who had a BSP, yet 26% of them had not received an assessment at the time of this review. Substantial compliance in this area will not be achieved by merely describing the PBSP 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 to improve and enhance communication skills is required. As stated above, an SLP currently participated on the BSC Committee, which was one step toward improved interdisciplinary communication in the development of communication programs, BSPs, and the coordination of their implementation via the ISP process.	
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	<u>Integration of Communication in the ISP</u> ISPs, ISPAs, assessments, and documentation were included in the 13 sample records. Two ISPs (Individual #25 and Individual #120) expired during the week of this review and one was not current within the last 12 months. This ISP for Individual #40 was dated 9/20/10.	Noncompliance

#	Provision	Assessment of Status	Compliance
	the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	There were: • No descriptions of expressive or receptive communication skills outlined in the ISPs for 42% of the current ISPs reviewed. • Very minimal descriptions of receptive and/or expressive communication included in the ISPs for 33% of the current ISPs reviewed. • Limited descriptions of receptive and/or expressive communication, with limited strategies for staff use outlined, in 8% of the current ISPs reviewed. In only one case, did the ISP include a more complete picture of the individual's communication skills and some strategies for staff to use (Individual #161, 5/12/11). Unfortunately, there was no current comprehensive communication assessment. An abbreviated communication assessment had been completed on 4/12/11, and a significant change in her status was reported at that time, stating that while she had previously been a verbal communicator, she no longer able to effectively do so at that time. The only recommendation was that the SLP was going to meet with the QDDP, nurse case manager, and clinic to determine how to address this significant change in status. There were no entries in the integrated progress notes or other consult documentation that this occurred. There was no evidence of interventions or supports related to communication despite this extreme change in her health and functional status. The SLP suggested that she had "severe immediate memory dysfunction." Recommendations were for speech to provide "stimulation techniques" five days a week. Again, there was absolutely no evidence that any intervention had been provided to Individual #161. There was no other evidence of assessment, interventions or supports provided in the last 12 months per the documentation submitted. The content of the ISPs and the recommendations in the communication assessments were not consistent. For example: • Individual #25: There was no recommendation for a low-tech device, such as a Talking Photo Album, in the communication assessment dated 12/20/10 (again, this date appeared to be an error). Her ISP dated 1/13/11 indicated that this was going to be provided. She was identified on the list of AAC as having been provided this device, but there was no evidence in her assessment that this was provided or whether it had been effective. No supports other than a communication dictionary for staff reference and picture wallboards in her home and activity room were identified for use in the assessment in addition to optimal communication strategies. These were referred to in the ISP, but not specifically outlined. • Individual #2: Her communication assessment indicated that a picture system, potential for use of a large switch for access, and a tangible object box to pair with daily activities were appropriate for her use in an AAC system. The SLP	

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		indicated that she had only been provided a picture book and wallboards, with no other recommendations. There was no description of how effectively these were used by Individual #2. Her ISP, dated 6/1/11, documented that she should use the communication dictionary and wallboards. Strategies for optimal communication were not clearly outlined in the assessment, but there was reference to these for addition to her PNMP. A communication book was listed as AAC provided to Individual #2. • Individual #39: There was no current communication assessment provided to him since 8/3/10, though he had participated in direct speech services. There was no reference to this in his ISP, dated 5/17/11, and the information recorded related to communication was based on the assessment from the previous year. There was an action step in his ISP that would re-instate his active treatment and communication plan for use of modified sign language and that he would learn to use 10 standard signs into his daily activities. There was no plan as to how this service would be provided and there was no evidence that it had been provided. Additional documentation in his individual record was limited to an SAP dated 5/25/11 for the provision of direct intervention in conjunction with trained direct support staff. Provisions for documentation were outlined in the plan, but none were evident in his record. It was not known whether this program was effective or whether Individual #39 had made any progress. Further, it was reported that when the communication assessment was completed outside of the annual ISP, the clinicians would participate in an ISPA in order to discuss the findings and recommendations with the IDT. This was not noted in any of the ISPAs that were submitted with the communication assessments. <u>AAC Systems</u> The majority of the individual systems provided were intended to be functional and many were portable for use across a variety of settings, however, they were very few in number and variety. Furthermore, they were not generally implemented throughout the day. Consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual was often not possible. <u>Staff Training</u> PNMPCs, Habilitation Therapy technicians, and home supervisors participated in training related to communication in order to conduct further staff training and competency check-offs as an aspect of the Immediate Action Plan instituted after the previous monitoring team review. Additional Immediate Action training was provided to direct support staff with competency check-offs conducted by PNMPCs, therapy technicians, and home	

#	Provision	Assessment of Status	Compliance
		supervisors. Individual-specific training related to optimal communication strategies was also provided, though exclusively by therapy technicians and PNMPCs rather than by the licensed speech language pathologists. The curriculum for NEO staff training in the area of communication had been completely revised to include functional opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. There was a basic competency check on all skills via a written test and check-offs for use of adaptive switches (but only five environmental control switches were provided to individuals at EPSSLC), Dynavox (but none were in use at EPSSLC), expressive communication, Go Talk (but only one provided), Hip Talker (only one provided), object board (none provided), picture board (none provided), picture book (113 provided), Put 'Em Around (one provided), receptive communication, sound generating devices (one provided), and Talking Photo Album (15 provided). Further competency checks were conducted by the PNMPCs or home supervisors in the home to which new staff were assigned. By report, the PNMPCs had been competency-trained to conduct monitoring and training in the area of communication. This training was extensive and should provide an ongoing foundation for staff implementation for communication programs and AAC systems as they are developed by the clinicians. However, there were very limited AAC supports provided at the time of this review and, as such, if not utilized routinely, initial staff competency will fade due to lack of opportunity for use throughout the day. While the general interactions of staff with the individuals 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.	
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	<u>Monitoring System</u> The Individual Communication Monitoring Form was used by the PNMPCs to monitor AAC. They monitored following the same schedule established for mealtimes. Monitoring findings were reported to the QDDPs and other specific departments for collaboration and identified problem resolution. Additional monitoring was scheduled per request or based on an observation noted by any therapy team member. Newly	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	issued devices were to be initially monitored two times a week for two weeks, then routine monitoring was scheduled according to that established by the IDT. An audit summary for the month of November 2011 submitted showed approximately 86% compliance, ranging from 0% to 100%, for 54 communication monitoring sheets for 44 individuals monitored during that month. Seventeen documented noncompliance with the PNMP for one to three essential elements. Eight forms documented compliance scores of less than 80%, the lowest acceptable score to be considered in compliance. Issues identified in these cases included that the equipment was not available, staff had not been trained, or that staff was not able to demonstrate the use of the AAC equipment. In one case, the equipment was not working and, in three cases, staff were not following the instructions for implementation of the communication/AAC system. There was no system in place at the time of this review for review of program effectiveness, beyond the annual assessment. As described above, this was not addressed in a number of the assessments submitted for review. In addition, monitoring sheets for individuals included in the record sample selected by the monitoring team were also requested. Actual monitoring sheets were not submitted, but findings from the monitoring database were provided for nine of the 13 individuals from October 2011 through December 2011. There was evidence of monitoring on 17 occasions for those nine individuals across a three-month period. This level of frequency was equivalent to less than two times each in a quarter. This did not match the intended frequency outlined in the procedures submitted and did not match the level of risk. Monitoring of communication programs and systems should be based on level of needs related to communication, though increased monitoring for an individual with changes in risk level would likely warrant monitoring across all areas to assess the impact of health status on functional performance. In the case of Individual #161, she had experienced significant changes in her health status, as well as a decline in her functional communication skills at several different times during the last year. She was monitored one time in November 2011 and once in December 2011. She was reported to only be provided a communication book.	

Recommendations:

1. PNMPs should include descriptions of expressive communication as well as strategies for use by staff (R3).

2. 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. (R1).

3. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the ISPs and in the PNMPs (R3-R4).

4. Measurable objectives in the assessments should be specific to changes for the individual related to communication skills not merely staff actions (R2).

5. The Communication Matrix did not provide useful information in the assessment process. This document was too cumbersome to be useful for staff and the clinicians did not use it for analysis of clinical findings. If this tool was to continue to be used a method to incorporate a functional interpretation of the results into the assessment and used in the identification of needs is critical (R2).

6. Develop strategies to address deficiencies in the analysis aspect of the communication assessments (R2).

7. Optimal communication strategies in the PNMPs focused predominately on what staff should do, not how the individual themselves communicated. While it was understood that this was included more extensively in the communication dictionary, a brief functional summary should be included in the PNMP as well (R3).

8. Optimal communication strategies appeared to be considered the extent of communication supports. While these were often excellent, they generally were a reflection of the individual's current abilities rather than methods to expand skills R2-R3).

9. Current communication abilities, staff strategies, objectives to expand existing skills and a discussion of the effectiveness of communication supports should be addressed consistently in the individual ISPs (R3).

10. Monitoring conducted by the PNMPCs will be functional only, presence of equipment, basic implementation but will not be a substitute for professional staff contact with direct support staff to model and provide feedback to enhance interactions and to ensure effective implementation of communication plans and strategies (R4).

11. Provide support and direction to the SLP who participates in the BSC (R2).

SECTION S: Habitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habitation, 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 Individual Support Plans (ISPs) for: • Individual #35, Individual #114, Individual #55, Individual #93, Individual #18, Individual #23, Individual #32, Individual #20, Individual #83, Individual #78, Individual #46, Individual #99, Individual #7, Individual #102, Individual #76, Individual #74, Individual #17, Individual #67 o Skill Acquisition Plans (SAPs) for: • Individual #78, Individual #46, Individual #83, Individual #32, Individual #20, Individual #23, Individual #18, Individual #93, Individual #55, Individual #114, Individual #35, Individual #133, Individual #178, Individual #59, Individual #10 o New Format SAPs for: • Individual #79, Individual #89, Individual #8, Individual #65, Individual #100 o Dental Desensitization Plans for: • Individual #85, Individual #47, Individual #20, Individual #88, Individual #63 o SAP data for: • Individual #78, Individual #46, Individual #83, Individual #32, Individual #20, Individual #23, Individual #18, Individual #93, Individual #55, Individual #114 o Quarterly reviews of SAP progress for: • Individual #95, Individual #152, Individual #44, Individual #162, Individual #154, Individual #107, Individual #189, Individual #71, Individual #191, Individual #191 o Active Treatment Committee Minutes, dated 1/6/12 o EPSSLC Self-Assessment, dated 12/23/11 o A list of training opportunities in the community, undated o A summary of community outings for the past six months, undated o A list of individuals employed on- and off-campus, undated o Section S Presentation Book, undated o SAP training presentation, undated o Active treatment data collected by the facility for July, August, September, October, and November of 2011 o List of individuals who attended public school (three individuals, should have been four) o ISPs, ARD/IEPs, and EPISD progress notes for: • Individual #69, Individual #35, Individual #81 Interviews and Meetings Held: o Janice Chowning, Active Treatment Coordinator

	o Mindy Partida, Program Developer o Nora Padilla and Aurora Ramos, QDDPs o Lorene Lopez, QDDP o Alex Euzaragga, Rosa Renteria, QDDPs o Mr. Lucero, Mr. Jones, EPISD special education classroom teachers <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 o EPISD public school: two classrooms at the local high school, high school choir practice
	Facility Self-Assessment: EPSSLC submitted its self-assessment, dated 12/23/11. EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. The self-assessment included a section for activities engaged in to conduct the self-assessment. For most provision items, however, this section appeared to include a description of activities the facility engaged in to achieve compliance with this provision item. For example, in S1 under the heading of <u>activities the facility engaged in to conduct the self-assessment,</u> the facility included "The need for integration and training among various disciplines has been identified and plan is in place to address this issue." The organization of the new self-assessment appeared to be an improvement over the previous POI, however, it appears the facility needs to do a better job of implementing this new tool. EPSSLC's self-assessment indicated noncompliance for the all 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 self-assessment 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 six 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 included: • Improvements to the skill acquisition training sheet/format • Integration of other departments in the development of skill acquisition plans (SAPs) • Improved quality of the SAPs The monitoring team suggests that the facility focus on the following over the next six months: • Expand the new SAP format to all SAPs at the facility • Consistently graph SAP data to increase the likelihood that the continuation, modification, or discontinuation of SAPs are the result of data-based decisions • Ensure that the SAPs are implemented with integrity • Initiate new procedures to improve individual engagement

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of 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> Individual Support Plans (ISPs) 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 skill acquisition plans (SAPs). SAPs were written and monitored by four program developers. Program developers were supervised by QDDPs, and SAPs were implemented by direct care professionals (DCPs). The facility recently introduced a new SAP format. Only five individual's SAPs in the new format were available for review. The monitoring team also reviewed the SAPs of 15 individuals in the previous format. The older SAPs were in the same format as those discussed in the last review (i.e., July 2011) and appeared to share similar strengths and weaknesses presented in that report. Therefore, this review will focus on the new format	Noncompliance

#	Provision	Assessment of Status	Compliance
		SAPs. An important component of effective skill acquisition plans is that they are based on each individual's needs and/or preferences identified in the Individual Support Plan (ISP), 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 represent a documented need and/or preference. The training sheet of the new format SAPs included a rationale for the selection of each SAP. The addition of a section to the SAP training sheet that required the rationale for choosing the target skill is a direct way to ensure and document that SAPs are based on individual needs and preference. In four of the five new format SAPs reviewed (80%), the rationale appeared to be based on a clear need and/or preference. For example: • The rationale for Individual #79's SAP of independently washing her stomach was that she was identified as a risk for fungal infection on her stomach, and she did not wash and dry that area adequately • The rationale for Individual #89's SAP of using the phone was that he enjoyed speaking to his mother (which was documented as a preference in his ISP), and being able to independently use the phone increased the likelihood of talking to his mother more frequently On the other hand, in one of the five SAPs reviewed, the rationale needed additional information to conclude that it was based on a need and/or preference: • The rationale for Individual #8's bed making SAP simply stated, "To improve Individual #8's independence with bed making." The facility should ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual. 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	

#	Provision	Assessment of Status	Compliance
		• 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 This represented another area where the facility had made improvements. The old format SAPs did not include plans for maintenance and generalization. All five of the new SAP training sheets, however, contained a space to discuss how to accomplish maintenance and generalization. The maintenance and generalization plans, however, did not consistently reflect the processes of maintenance and generalization. As defined in the training materials for the new SAP format, a maintenance plan ensures that the newly acquired behavior occurs following the end of formal training, while a generalization plan ensures that the behavior occurs in all the appropriate situations and circumstances outside of the specific training situation. An example of a good maintenance plan was: • Individual #8's SAP of making his bed in which the plan for maintenance was "Upon completion of this SAP Individual #8 will maintain his skill of bed making by performing the task daily upon waking." An example of an unacceptable plan for maintenance was: • Individual #100's SAP of wearing protective headgear in which the plan was "While in groups, encourage Mark to use his headgear and, while on outings, show him other people who are wearing caps." Overall, one of the five SAPs reviewed (20%) included a maintenance plan that was consistent with the above definition. The plans for generalization were generally more consistent with the above definition. An excellent example of a generalization plan was: • The generalization plan for Individual #79's self-help SAP read, "Provide her mother the training techniques and ask her to reinforce training when Individual #79 is visiting her mother." Overall, four of the five new format SAPs (80%) contained generalization plans that were consistent with the above definition. Three of five SAPs reviewed combined the maintenance and generalization (two of those	

#	Provision	Assessment of Status	Compliance
		represented examples of generalization and the other maintenance) plans into one plan. Since maintenance and generalization are different processes, they typically cannot be addressed in the same plan. It is recommended that all SAPs contain generalization and maintenance plans that are consistent with the above definitions. Another area of improvement since the last review was the expansion of the training methodology at EPSSLC. At the time of the onsite review, the facility was using total task training and forward and backward chaining. Review of implementation of these training methods, however, indicated that much more training and monitoring of SAPs at EPSSLC was necessary (see S3). The new SAP training sheets and training methodology represented improvements in the identification and training of SAPs at EPSSLC. The overall quality of the new SAPs reviewed was much improved. One reason for this improvement may be the integration of other departments' expertise into the SAP development process. • The program developers reported that the rehabilitation department had been very helpful in the writing of some the new SAPs. • Now the facility needs to expand the new SAPs and training methodology to all SAPs in the facility. To that end, it is also recommended that additional departments, such as psychology, be brought into the development of SAPs. <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 five plans were developed since the last onsite review. The psychology department had recently developed an assessment procedure to determine if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) was then developed. It is recommended that individualized compliance and dental desensitization plans be 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 treatment plans, will be reviewed in more detail in future site visits. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in the last report, EPSSLC included replacement/alternative behaviors in each PBSP. As discussed in K9, the training of replacement behaviors that require the acquisition of a new skill should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above.	

#	Provision	Assessment of Status	Compliance
		Communication and language skill acquisition The monitoring team was encouraged to learn that the speech pathologists at EPSSLC were assisting the program developers in the writing of selected SAPs. Service objective programming 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 QDDPs. 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 in the day programs and homes at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed in the table below. As reported in the past two reviews, the monitoring team was encouraged by the increase in group activities, and the addition of activity schedules and materials. Overall, the observation of engagement during this review, however, was mixed. In some homes visited (e.g., 513), individuals were clearly engaged in a variety of activities, and staff and individuals appeared to be enjoying the interaction. In other homes, however, individuals were sitting alone and sleeping or self-stimulating, and staff did not appear to be attempting to engage them. The table below documents engagement observed in various settings throughout the facility. The average engagement level across the facility was 51%, about the same as that observed during the last two reviews (i.e., 49% and 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.	

#	Provision	Assessment of Status	Compliance
		There was an improvement in engagement when meetings to improve engagement began, and schedules and materials initially were presented to DCPs. The level of engagement since, however, has stagnated at about 50%. The monitoring team suggests the facility now identify some new ways to motivate the staff to improve individual engagement. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
Cottage 509	2/6	2:6
Cottage 509	5/8	3:8
Cottage 508	1/3	0:3
Cottage 508	3/4	1:4
Cottage 508	4/5	1:5
Cottage 508	3/5	1:5
Cottage 510	1/9	3:9
Cottage 510	1/9	3:9
Cottage 510	1/9	3:9
Cottage 511	1/7	2:7
Cottage 511	3/9	3:9
Cottage 511	6/9	3:9
Cottage 512	1/2	2:2
Cottage 513	4/8	2:8
Cottage 513	6 /8	3:8
Cottage 513	7/8	3:8
Cottage 507	1/1	1:1
Cottage 506	2/2	2:2
C Dorm	2/5	1:5

#	Provision	Assessment of Status	Compliance

B Dorm	0/4	1:4
A Dorm	2/2	1:2
B Dorm	3/4	2:4
C Dorm	2/4	1:4
A Dorm	2 /5	1:5
Vocational Workshop	11/14	4:14
Vocational Workshop	5/8	1:8
Vocational classroom	1/2	0:2
Vocational classroom	0/3	0:3
Vocational classroom	3/4	1:4
Vocational classroom	2/6	1:6
Vocational classroom	2/3	1:3
Dorm A	3/7	4:7

Educational Services

Four individuals living at EPSSLC were under age 22 and continued to attend public school. One of these four was a new admission. All four attended the local high school. Their cases were managed by two QDDPs. The QDDPs reported that, overall, all four individuals were doing well in school and that a good working relationship continued to exist between the facility, EPISD, and the classroom teachers.

To that end, the QDDPs maintained regular contact with the teachers, visited the classrooms occasionally, and attended ARD/IEP meetings. Sometimes a program developer or psychologist attended these meetings.

The monitoring visited and observed at the EPISD high school. Both classroom teachers were pleasant and seemed knowledgeable about the EPSSLC students. QDDP Alex Euzaragga was also very comfortable in the school, an indication of a good working relationship. The EPSSLC students were in two different classrooms, in a segregated area of the high school with other special needs students. They were included with their typical peers for choir and orchestra. The monitoring team observed choir and the special needs students were in a large room with about 50 other typical students, though

#	Provision	Assessment of Status	Compliance
		seated on the side. The students attended extended school year programming during the summer, for eight weeks, four days a week, for half days. This appeared to be reasonable. The EPSSLC ISPs noted that the individuals were in school. The ISP for Individual #81 included information about his school goals. The new style ISPs will require the IDT to include more discussion and information. The IEPs of three students were reviewed. The objectives varied in number and depth across the three students. Individual #69's had the most objectives, Individual #35 had the least. Furthermore, many of the objectives were written in an unclear manner, such as "master daily living skills with 70% accuracy" (as also noted in the previous monitoring report). The QDDPs should feel comfortable asking for more detail at the ARD/IEP meeting, or during preparation for the ARD/IEP meeting if they are working with the classroom teacher in any way to prepare the ARD/IEP. If school objectives are written in a measurable way, they could be more easily incorporated into EPSSLC activities and the EPSSLC ISP. Similarly, school progress reports should be reviewed by the IDT during regularly scheduled quarterly review meetings (i.e., a special meeting does not need to be scheduled). This was also a recommendation in the last monitoring report. EPISD progress reports, however, gave a grade number, but didn't tell the reader anything about what it was that the student worked on, what he accomplished, or what he learned. Therefore, the QDDP should request additional information from the public school teachers as appropriate. Overall, the monitoring team acknowledges the positive efforts of the two QDDPs in their work with the public school program.	
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 beginning the use of the Functional Skills Assessment (FSA) to replace the Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. The monitoring team looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology) and individual preference, to identify meaningful individualized skill	Noncompliance

#	Provision	Assessment of Status	Compliance
		acquisition programs (also see comments regarding the FSA in sections F and T of this report). Finally, while the ISP attempted to identify individual preferences, no evidence of systematic (i.e., experimental) preference and reinforcement assessments (when potent reinforcers or preferences are not apparent) was 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	More work in the areas of the graphing of SAP outcome data, and integrity of the implementation of SAPs is needed before this item can be rated as being in substantial compliance. At the time of the onsite review, program developers at EPSSLC summarized SAP data monthly and QDDPs presented those data at quarterly meetings. The facility began the graphing of SAP data monthly prior to the last review (i.e., July 2011). None of the 10 quarterly data summaries reviewed by the monitoring team, however, included graphed data. Ten quarterly reviews representing the outcome data of 61 SAPs (based on the older format, see S1) were reviewed to determine compliance with this provision item. The monitoring team was pleased to find that the majority (79%) of the SAP quarterly reviews showed progress or the achievement of sustained high levels (i.e., above 90%) of SAP performance. There were, however, no examples of SAPs being modified or discontinued as a result of the absence of progress. It is recommended that the facility reinitiate the graphing of SAP outcome data to enhance the likelihood of data based decisions regarding the continuation, modification, or discontinuation of SAPs. The monitoring team observed the implementation of SAPs in the day programs and homes during the onsite review to evaluate if they were implemented as written. Additionally, SAP data sheets from several day programs and homes were reviewed to evaluate if data were completed as scheduled. The results from those observations were	Noncompliance

#	Provision	Assessment of Status	Compliance
		mixed. For example: • Individual #107 was working on his SAP of tolerating the application of hand lotion. The objective of the SAP was that Individual #107 would allow a DCP to apply the lotion on 90% of offered sessions. When the DCP attempted to apply the lotion to Individual #107's hands he pulled away, and the DCP discontinued the session (as indicated in the SAP training sheet). The DCP did not, however, record on the data sheet that Individual #107 refused to allow the application of the lotion. When asked why she did not record the refusal, the DCP replied that if she tries again latter Individual #107 often complies, and that she only records it when he is cooperative. Recording the data only when he is cooperative, does not allow the program developers to accurately determine the percentage of sessions that he is cooperative. Therefore, they cannot make data based decisions concerning the progress of Individual #107 on this SAP. • In one of the day programs four individuals were sitting at a table and when asked what they were doing, the DCP responded that they were working on money management SAPs. No SAP data sheets, however, were in sight during the five minutes the monitoring team observed. When questioned when the DCP would record the data from the four individual SAPs he was working on, he said after the individuals rotated to the next activity. It would be difficult to accurately implement and record data for four individuals at a time when the recording is delayed. • Current data for scheduled skill acquisition plan implementation were present in seven of 10 SAP data sheets reviewed (70%). These observations suggested that SAPs were generally being conducted as scheduled, however, it questioned if they were consistently being implemented as written. The only way 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.	
	(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 #78's identifying the women's room in the community). As discussed in the last review, there was, however, no way evaluate how often SAP training occurred, or how many individuals at EPSSLC had skill training, in the community. It is recommended that training activities in the community be separately recorded so that community training trends could be better tracked, and increased	Noncompliance

#	Provision	Assessment of Status	Compliance
		across the facility. Moreover, there were questions about the functionality of some, if not all, of the skills chosen for instruction in the community (see section F above). At the time of the review, no individuals at EPSSLC worked in the community.	

Recommendations:

1. Ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual (S1).
2. It is recommended that all SAPs contain generalization and maintenance plans that are consistent with their definitions (S1).
3. Expand the new SAP training sheet to all SAPs throughout the facility (S1).
4. Expand the number of departments involved in the development of SAPs (S1).
5. Individualized compliance and dental desensitization plans should be incorporated into the new SAP format (S1).
6. Replacement behaviors that require the acquisition of a new skill should be incorporated into the new SAP format (S1).
7. It is recommended that the facility reinitiate the graphing of SAP outcome data to enhance the likelihood of data based decisions regarding the continuation, modification, or discontinuation of SAPs (S3).
8. It is recommended that a plan be developed to collect and graph SAP integrity data to ensure that SAPs are conducted as written (S1).
9. Training activities in the community should be separately recorded so that community training trends could be better tracked, and increased across the facility (S3).
10. Demonstrate that the QDDPs commented on the EPISD goals/objectives, and/or that they understand what their students are working on at school (S1).
11. QDDPs should obtain and review EPISD progress reports for each individual. This review should be documented in the quarterly ISP review at EPSSLC (S1).

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 Organizational chart, undated o EPSSLC policy lists, dated 10/31/11 o List of typical meetings that occurred at EPSSLC o EPSSLC Self-Assessment, 12/23/11 o EPSSLC Action Plans, 12/28/11 o EPSSLC Admission and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/9/12 o Community Placement Report, last six months, through 12/31/11 o List of individuals who had been placed since last onsite review (4 individuals) o List of individuals who were referred for placement since the last review (6 individuals) o List of individuals who were referred and placed since the last review (0 individuals) o List of total active referrals (8 individuals, including 1 referred during the week of this review) o List of individuals who requested placement, but weren't referred (3 individuals) • Documentation of activities taken for those who did not have an LAR (2 of 3 individuals) • List of individuals who requested placement, but weren't referred solely due to LAR preference, (58 individuals, however, this list contained errors) o List of rescinded referrals (2 individuals) and • ISPA notes regarding each rescinding • EPSSLC special review team notes regarding each rescinding o EPSSLC description of the special review team process o List of individuals returned to facility after community placement (0 individuals) o List of individuals who experienced serious placement problems, such as being jailed, psychiatrically hospitalized, and/or moved to a different home or to a different provider at some point after placement (0 individuals) o List of individuals who died after moving from the facility to the community since 7/1/09 (0 individuals) o List of individuals discharged from SSLC following determination of ineligible for services (0 individuals) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (0 individuals) o APC weekly reports, four, 11/18/11 through 12/9/11

	• Statewide weekly enrollment report • EPSSLC detailed referral and placement report for senior management o List of obstacles to referral/placement for 31 individuals and summarized data o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred) o Variety of documents regarding • Provider fairs • Community tours • Trainings for facility staff • Family association presentation • Meetings with local MRA o CLOIPs completed by local MRA for the past six months (July 2011 through December 2011) o List of individuals who had a CLDP completed since the last review (4 individuals) o List used by APC regarding submission of assessments for CLDP (within the CLDP) o DADS central office written feedback on CLDPs (3 individuals) o Summary data table spreadsheet, graphs, and narrative from QA report (October 2011) for section T living options discussion o Three LOD observations completed by APC o State obstacles report and EPSSLC addendum, October 2011 o PIAC January 2012 reports, including description of the Community Transition Specialist positions o PMM tracking sheet listing post move monitoring dates due and completed o New-style ISPs and associated assessments for: • Individual #89, Individual #65 o CLDPs for: • Individual #130, Individual #132, Individual #68 o Draft CLDP for: • Individual #53 o In-process CLDPs for: • Individual #74, Individual #76, Individual #32 o Pre-move site review checklists (P) and Post move monitoring checklists (7-, 45-, and/or 90-day reviews) conducted since last onsite review for: • Individual #14: 90 • Individual #164: P, 7, 45, 90 • Individual #130: P, 7, 45, 90 • Individual #132: P, 7, 45 • Individual #68: P, 7 <u>Interviews and Meetings Held</u>: o Antonio Ochoa, Admissions and Placement Coordinator o Alice Villalobos, Post Move Monitor

	o Rosa Renteria, QDDP o Gisel Hita, program director, Gordon Israel, owner, Draco Services, Inc. o Haydee and Maria, direct care staff, Educare <u>Observations Conducted</u>: o CLDP Meeting for: • Individual #53 o ISP Meeting for: • Individual #84 o Quarterly ISP Review Meeting for • Individual #21 o Self-advocacy meeting, 1/12/12 o Post move monitoring at: • Community provider day program, Draco Services, Inc. • Community provider group home, Draco Services, Inc. • Community provider group home, Educare
	Facility Self-Assessment EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the APC included relevant activities in the "activities engage in" sections. He should, however, include activities that are in line with what the monitoring team assesses as indicated in this report. For example, for T1a, the APC reported that he "reviewed training and education opportunities…" and reviewed the CLDPs of four individuals. He did not write what he was reviewing these documents for. The APC's results were that the facility had done one provider fair, and that the CLDPs indicated that community placement was appropriate, not opposed by the individual or LAR, and consistent with the individual's ISP. The monitoring team, on the other hand, looked at many more items than just this for T1a, such as the rate of placement and referral, the inclusion of professional determination in the ISP process, and the way that the APC kept senior management informed of the referral and placement status of individuals at EPSSLC. For T1b1, the APC reported activities related to the identification of obstacles. The monitoring team,

	however, looked at the way ISPs addressed the protections, services, and supports for each individual, as well as the identification and addressing of obstacles. Similarly, for T1c1, the monitoring team looked at a variety of actions of the facility and provider, not only whether provider staff were named. In T1e, the monitoring team commented upon the quality of the list of essential and nonessential supports in addition to whether essential supports were in place on the day of the move and whether nonessential supports had an identified implementation date. To take this process forward, the monitoring team recommends that the APC review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the APC to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the APC and wants believes that the facility was proceeding in the right direction. This was a good first step. The facility self-rated itself as being in substantial compliance with seven provision items: T1c1, T1c2, T1c3, T1d, T1e, T1g, and T1h. The monitoring team agreed with four of these (T1c2, T1c3, T1d, and T1h). In addition, the monitoring team rated T2a and T2b as being in substantial compliance even though the APC self-rated the facility as being in noncompliance with T2a and he gave no rating for T2b.
	Summary of Monitor's Assessment EPSSLC made progress in many of the items of provision T since the time of the last onsite review. For example, more individuals who were on the referral list were placed in the community, more individuals were referred for placement, many of the individuals who had been on the referral list for a long time had been placed, and the APC engaged in many more activities related to the numerous requirements of this provision. The specific numbers of individuals who were placed, however, was at annual rate of only approximately 6 percent (4 placements in six months, census of 129). Further, only 8 (approximately 5%) of the individuals at the facility were on the active referral list. The list of individuals not being referred solely due to LAR preference contained 58 names (45% of the individuals). In two new style ISPs, there was no indication that the professionals' determinations were discussed during the meeting. In an ISP meeting observed, some but not all professionals gave their determinations. The individual, however, was ultimately referred because there were no obstacles identified and IDT members did not have a reason to not refer him.

	In the ISPs, it did not appear that all of the protections, services, and supports for safety and adequate habilitation were included and detailed. The Functional Skills Assessment (FSA) did not appear to be used at all in the preparation of the ISP. Some skill acquisition topics were individualized and appeared functional and meaningful. Other skill acquisition topics appeared to be nonfunctional, if not silly. A plan to address identified obstacles via an action plan as a service objective or training objective was not explicitly noted in the ISPs. The APC was beginning to gather data on the obstacles across the facility. He had written an assessment report regarding these obstacles. DADS created a report summarizing obstacles across the state and included the facility's report as an attachment to the report. The monitoring teams, DADS central office, and DOJ recently agreed on the specific criterion for this the education of individuals and LARs regarding community living options. The monitoring team expects that DADS will soon provide more specific direction to the APC and the facility regarding the expectations for achieving substantial compliance. EPSSLC was already engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. The three CLDPs reviewed by the monitoring team were not developed in a timely manner. In the future, this will likely not be the case because the CLDP was now initiated at a meeting following referral. IDT members were very involved in the placement activities of the individuals who were placed. Each of the three individuals visited a number of providers and IDTs were thoughtful about choosing a provider. This CLDP meeting observed during this review was much better than the CLDP meeting observed during the previous review. Clearly, the APC had responded to the monitoring team's recommendation regarding the content, length, and style of the meeting. This meeting lasted one hour and 40 minutes (last time it was two and a half hours). Participation was active and most everyone was engaged. The APC made good use of the time by focusing on comments from each of the clinical disciplines and the identification of essential and nonessential (ENE) supports. Progress was made on the most important part of the CLDP, that is, the identification and definition of essential and nonessential supports (ENE). More ENE supports were included that related to the overall preferences as well as the needs of the individuals. There were some examples of ENE supports that were individualized. Additional attention needed to be paid to the severe communication deficits and needs of the individuals and to what was evident as the most important aspects of the individuals' lives. There was improvement in having any ENE support that called for an inservice having a corresponding ENE support for implementation of what was inserviced. There should also be a requirement for staff to document this implementation every day. The APC had not yet, but should, graph data related to his department's activities. Overall, the PMM did a thorough and complete job of post move monitoring. She was thorough, looked at every item (rather than just asking staff to verbally report on them), and interacted extensively with the

	staff and individuals. Community providers continued to be prepared to provide residential and day supports to additional individuals. The monitoring team continued to be impressed by the services provided by Draco Services to all of the individuals who have transitioned from EPSSLC to their day programs and homes.

#	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.	EPSSLC made progress in many areas of provision T since the time of the last onsite review. For example, more individuals who were on the referral list were placed in the community, more individuals were referred for placement, many of the individuals who had been on the referral list for a long time had been placed, and the APC engaged in many more activities related to the numerous requirements of provision T. In the previous report, the monitoring team recommended that the facility's QAQI Council initiate a performance improvement team. That was not done, according to the facility director. Instead, additional resources and support were provided to the APC and that resulted in increased activities and progress. The monitoring team recommends that the facility again consider a performance improvement team, perhaps specifically focusing on referrals for placement. 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). Even though there was progress, the specific numbers of individuals who were placed was at annual rate of only approximately 6 percent (4 placements in six months, census of 129). Further, only approximately 5% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 4 individuals were placed in the community since the last onsite review. This compared with 1, 1, 3, and 1 individuals who had been placed during the periods preceding the previous four reviews. o This was the largest number of individuals placed during any six-month period since monitoring began. • 6 individuals were referred for placement since the last onsite review. o 0 of these 6 individuals were both referred and placed since the last onsite review. • 8 individuals were on the active referral list, including one who was referred at	Noncompliance

		his annual ISP meeting during the week of the onsite review (Individual #84). This compared with 9, 10, 4, and 7 individuals at the time of the previous four reviews. o Only one of these individual was on the list for more than 180 days, and the PMM noted that a home had now been identified for her (Individual #110). At the time of the previous review, 6 individuals had been on the referral list for more than 180 days. o Individuals came off of the referral list either via placement or via the rescinding of the referral. • 3 individuals were described as having requested placement, but were not referred. This compared with 2 individuals at the time of the previous review. o 1 was not referred due to LAR preference, 1 was not referred due to medical problems, and 1 was not referred due to legal citizenship reasons. o A review was held for the individual not referred for legal reasons. A review was not, but should be, held for the individual not referred due to medical problems. • The list of individuals not being referred solely due to LAR preference contained 58 names. o This was an excellent attempt by the facility to gather and report this information, and was an improvement from the previous report. o The data list, however, needed additional review because it contained, at least a few, errors. For example, one of these 58 individuals was already on the referral list, and one other individual was not referred due to medical reasons. • The referrals of 2 individuals were rescinded since the last review. This compared to 2 individuals at the time of the previous review. o Each individual's IDT met and an ISPA report was issued that provided information indicating that the decision to rescind was reasonable. One was rescinded due to serious medical needs, and one due to psychiatric and medical instability. o A special review team was held to review each of these two rescindings. The ISPA and the SRT report provided a lot of detail regarding the IDT's decision to rescind the referral of each particular individual. This was good to see, however, the APC should also do a detailed review (i.e., root cause analysis) of each of these rescinded cases to determine if anything different could have been done during the time the individual was an active referral, in other words, to assess the overall referral and placement processes. • 0 individuals were returned to the facility after community placement. This compared with 0 at the time of the previous review. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated,	

		or who had run away from their community placements were not available. A detailed review/root cause analysis should be conducted for any of these or similar types of significant post-move events. • 0 individuals had died since being placed. • 0 individual was discharged under alternate discharge procedures (see section T4 below). Each of the above bullets should be graphed separately, as recommended in the previous report. EPSSLC had not yet begun to do this. These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). Community providers continued to be prepared to provide residential and day supports to additional individuals. The state had taken other action towards this provision item: funding was obtained for new positions that were to be fully dedicated to assisting individuals to move to the community. These were to be called community transition specialists. The plan was for there to be at least one of these positions at each SSLC. <u>Determinations of professionals</u> 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 ISP assessment process, during the annual ISP meeting, and be documented in the written ISP. EPSSLC had made some progress via a revised and updated ISP/IDT statewide process. The new process was only very recently implemented at EPSSLC. It required that professionals state their determination in their annual assessments. These determinations of the professionals were to then be discussed at the annual ISP meeting and documented in the finalized ISP document. At the time of this review, all QDDPs had completed their training, but implementation of this aspect of the new process was not yet being done correctly or adequately. For instance, two new-style ISP documents were available for review by the monitoring team (for Individual #65 and Individual #89). Both were conducted in early December 2011 and both were done by the same QDDP (i.e., this was a small number of ISPs that didn't sample from all QDDPs). In the ISP assessments, statements regarding the professional's determination and opinion about the appropriateness of community referral and placement were in only the speech/language, habilitation, and day program assessments. There was no statement or	

		opinion in any of the other assessments (e.g., medical, nursing, dental, nutrition). Moreover, the statements in the three discipline department assessments varied in detail and were, generally, broad, such as the individual was a good candidate or that the IDT should consider community placement if all services can be provided. A more declarative statement needs to be provided in each assessment. Furthermore, in these two written ISPs, there was no indication that the professionals' determinations were discussed during the meeting. For Individual #65, the ISP stated that the IDT recommended that he continue to live at EPSSLC primarily because he had not had much exposure to the community. For Individual #89, the ISP stated that the LAR preferred him to remain at EPSSLC. The professionals' opinions were not noted at all. Further, at the end of the ISP document, it stated that, "The IDT has determined that Individual #89 should continue to reside at EPSSLC. This determination is based on his LAR's wishes for Individual #89 to keep residing at the center." Professional members of the IDT need to give their professional determinations, even if they are in disagreement with wishes of LAR. IDT members should understand that the preferences of the individual and the LAR will be honored by the facility, even if the determinations and opinions of professionals are for referral for community placement. In the annual ISP meeting for Individual #84 (observed by the monitoring team), the QDDP made some general comments about the professionals' determinations, but did not ask every professional to provide his or her opinion. At the end of the meeting, however, the QDDP asked, "so, does everyone think he can move into the community?" No one had any reason to not refer him and no obstacles were identified, and so, he was referred. It was as if the decision to refer was made because there was no reason to not refer. This is, in part, why the new ISP process and the Settlement Agreement require that IDT members give their individual opinions and that obstacles are discussed. Without these requirements, it is unlikely that Individual #84 would have been referred. <u>Preferences of individuals</u> EPSSLC appeared to work to honor the preferences of individuals. This was seen during ISP meetings, self-advocacy activities, and in the actions of the rights officer. <u>Preferences of LARs and family members</u> EPSSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. The first-time identification of so many individuals who's IDTs would them for placement if not for LAR preference indicated that EPSSLC greatly supported the preferences of LARs and family members. It also indicated an area for discussion with state office (also see T1g below) given this large percentage of individuals at EPSSLC (45%).	

		Senior management The APC continued to complete a statewide weekly enrollment report. This contained data for statewide office. In addition, as recommended in the previous report, he also completed a more detailed weekly placement and transfer report for senior management. It contained more detail than the state report, such as brief paragraph about each individual who was on the referral list, and upcoming group tours for other individuals. It was emailed to senior management. The monitoring team recommends that it be verbally presented to senior management each week as part of the APC's plan to make senior management more aware of referral and placement activities. This might occur at the beginning five or 10 minutes of a meeting where senior management is already gathered, such as the daily IMRT.	
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. A revision was being developed over the past months and was expected to be disseminated soon. Part of the reason for the delay may have been due to changes that were occurring to the ISP process. It is likely that once the state policy is officially disseminated, changes may be necessary to any facility-specific policy and/or additional facility-specific policies may need to be developed. Any facility-specific policies should be subjected to the state office process described in V2 below, including the training of all relevant staff on any policies.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies	As noted above, DADS and the SSLCs were embarking on another revision to the ISP process. This was the third (or so) revision to the process since the initiation of the Settlement Agreement, however, this was not unexpected because revisions to such a major part of service provision often require repeated revisions, modifications, or even overhauls. The monitoring team wishes to acknowledge DADS' efforts to continue to work to improve the ISP process so that it meets the needs of the individuals while continuing to progress towards meeting substantial compliance with the Settlement Agreement. To this end, DADS recently brought in three consultants who have developed a new ISP document format, revised the way the meeting was to be conducted, and provided training to EPSSLC staff. Moreover, the consultants were working with the DADS central office coordinator of most integrated setting practices to ensure that the many requirements of provision T would be addressed. To briefly summarize, there was a brand new ISP meeting format, and a brand new ISP written document format. Overall, the new ISP was designed to address the many items that are required by the Settlement Agreement, ICFMR regulations, and DADS central	Noncompliance

	intended to overcome such obstacles.	office. Further, the consultants included items that had been missing from previous ISP formats, such as professional's opinions, and the identification of obstacles (though correct implementation was not yet occurring). <u>Protections, Services, and Supports</u> Given that this major process change was just underway regarding both the ISP meeting and the ISP document, the monitoring team reviewed only two new-style ISP documents (the only two that were available from the facility) and attended the ISP meetings during the onsite review week. Some comments are provided below. Other comments regarding the facility's ISPs are provided in many other sections of this monitoring report, particularly in sections F and S. The following comments are based upon only two, the first two, of the facility's new-style ISPs. It is not clear if these are indicative of what will eventually be the ISP format and content for all of the individuals at the facility. • It did not appear that all of the protections, services, and supports for safety and adequate habilitation were included and detailed. o Problems in assessments, including the listing of recommendations, from various disciplines (as noted throughout this report) might be competing with the IDTs' ability to successfully include all protections, services, and supports in the ISP. • It did not seem that the ISPs included adequate information from each individual's various plans (e.g., PBSPs, PNMTs, Dining Plans, HMPs, psychiatric treatment plans). • The Functional Skills Assessment (FSA) did not appear to be used at all in the preparation of the ISP. The FSA was not fully completed and the ISPs made no reference to the FSA, such as whether and how the FSA might have been used to determine progress or identify skills for training. • Only "speech" and "mobility" were in the section called "Independence." There was nothing related to any other areas of independence, such as personal hygiene, domestic tasks, or leisure time. • Some skill acquisition topics were individualized and appeared functional and meaningful. Examples included preparing a toothbrush, shaving, adding soap to the laundry, correctly sorting recycling items, dialing telephone of parents, making coffee, and giving money to a cashier at the community store. • Other skill acquisition topics appeared to be nonfunctional, if not silly. Examples included selecting photographs of the dental staff, identifying pictures of items that could be bought for 50 cents, identifying a picture of a bus stop, and putting stolen items into a box (why not also provide positive reinforcement for appropriate behavior when around items belonging to other people?). In Individual #65's ISP, in one place it said to add a photo of his father to his communication book and in another place in the ISP it said to discontinue use of	

		the communication book. Obstacles to Movement This aspect of this provision item (the identification and addressing of obstacles for each individual) continued to be inadequately addressed at EPSSLC. The two new-style ISPs contained no mention of obstacles, even though the blank template contained sections for this. Perhaps these sections were deleted from these two ISPs. Similarly, a plan to address identified obstacles via an action plan as a service objective or training objective was not explicitly noted in the ISPs. In the ISP meeting observed by the monitoring team, there were only occasional references to whether there were any obstacles. Perhaps there would have been more discussion of obstacles if the IDT had not referred him for placement. The APC had begun a listing of the one obstacle identified as the most significant for each individual. He also summarized these data in a table. This was good to see. At this time, 31 names were on the list. The listing of only a single obstacle, however, was problematic because it made it impossible to understand if the listed obstacle was the sole reason for the individual not being referred. The APC should also see section F1e of this report for additional information relevant to this provision item.	
	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.	Progress was evident because the APC had engaged in many more activities regarding this provision item since the time of the last onsite review. The monitoring teams, DADS central office, and DOJ recently agreed on the specific criterion for this provision item. The monitoring team expects that DADS will soon provide more specific direction to the APC and the facility regarding the expectations for achieving substantial compliance. EPSSLC was already engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. Below are the agreed-upon activities (i.e., the bullets) and EPSSLC's status for each. Individualized plan • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Measurable, and provides for the team's follow-up to determine the individual's reaction to the activities offered o Includes the individual's LAR and family, as appropriate o Indicates if the previous year's individualized plan was completed. EPSSLC status: Progress had been made, but this activity was not yet occurring at the required criterion. Some ISPs described what the individual had done, whereas	Noncompliance

		others described what the individual might do during the upcoming year. The new ISP format provided more guidance to the IDT and QDDP in addressing the education of each individual and LAR, however, the QDDPs will need to ensure that they address each of the three bullets listed immediately above. Moreover, the quality of the discussion regarding referral needs to improve. Detailed examples are provided in section F1e of this report. <u>Provider fair</u> • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers) o Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs <u>EPSSLC status</u>: The APC had made good progress regarding the provider fair. First, he was now conducting two provider fairs each year (i.e., every six months). Second, he continued to have one provider at a time, over the course of the entire month. Third, providers attended more than once each month, and each time set up their table in a different building on campus. This was a good way to do this because it allowed for providers to be on campus frequently and also gave individuals, staff, and families (though families rarely attended) multiple opportunities to interact with providers. Further, it gave individuals lots of chances to learn and practice their skills at talking with providers. Fourth, the APC summarized satisfaction evaluative comments from last year's participants. He shared these comments with the providers for them to consider as they prepared for the next upcoming fair. The process of implementation, evaluation, and refinement should continue. <u>Local MRA/LA</u> • Regular SSLC meeting with local MRA/LA <u>EPSSLC status</u>: The APC appeared to have a good working relationship with the local authority. He met bi-monthly and reviewed relevant topics. EPSSLC was engaged in this activity at the required criterion. <u>Education about community options</u> • Outcomes/measures are determined and data collected on: o Number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options. o Number of individuals and families/LARs who refuse to participate in the CLOIP process. • Effects are evaluated and changes made for future educational activities <u>EPSSLC status</u>: The APC had not yet started to address this activity. The APC reported that he read every CLOIP worksheet. The APC should also summarize the data from all of the CLOIP reviews, including the recommendation made by the MRA/LA CLOIP worker.	

		Tours of community providers • All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Places chosen to visit are based on individual's specific preferences, needs, etc. • Individual's response to the tour is assessed. EPSSLC status: The APC made a lot of progress in this area. He implemented a system for there to be two community tours each month, held a training session with QDDPs regarding the tour process, and collected reports of the experiences of the individuals. The information given to the monitoring team showed that two group tours occurred almost every month since September 2011. Further, there was a packet of information for each group tour that contained a list of each individual who participated followed by one page for each individual that described the individual's experience and reaction (nine questions and comments). This was very good information. There were also packets for single-person tours of providers for individuals who were on the referral list. As the APC moves forward, he should report on what happened with the information collected about each individual's experience (i.e., how was it used by the IDT), and how he ensured that all individuals at the facility had the opportunity to participate, if appropriate. Further, the APC and facility should understand that the purpose of the community tours is to expose individuals to these community homes and day programs. Therefore, the ongoing participation of each individual should be evaluated on an individual basis. Visit friends who live in the community EPSSLC status: The APC was not yet implementing this activity. Education may be provided at • Self-advocacy meetings • House meetings for the individuals • Family association meetings or • Other locations as determined appropriate EPSSLC status: The APC made progress on this set of activities. He and/or the PMM presented to the family association regularly, most recently on 8/13/11. In addition, the APC presented at the self-advocacy group meeting during the week of the onsite review and planned to do so quarterly. His presentation was observed by the monitoring team. The content was relevant and appropriate. The human rights officer followed up by discussing obstacles with the group. This presentation, however, was at a level far above the understanding of every individual in attendance.	

		A plan for staff to learn more about community options • management staff • clinical staff • direct support professionals EPSSLC status: The APC conducted a number of trainings across the facility. First, he presented at new employee orientation regarding most integrated setting policies and practices. He said that he tried to impart a perspective of EPSSLC as a transition facility for individuals who were working towards community placement. Second, he had begun to have meetings/trainings with each of the facility's discipline departments. He planned to do this quarterly. In addition to informing them of the referral and placement process, these quarterly sessions can provide the APC and the QDDP coordinator the opportunity to work directly with discipline departments on the many areas of section T that are relevant to them, including assessment contents, updating assessments for CLDPs, determination of relevant training objectives, and so forth. Third, he sent our policies via email. Fourth, he held inservices. Individuals and families who are reluctant have opportunities to learn about success stories • As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant; • Newsletter articles or presentations by individuals or families happy with transition EPSSLC status: The APC was not yet implementing this activity. The monitoring team noted that family members of three of the individuals on the referral list (the three for whom the facility submitted their in-process CLDPs) were involved in the referral and placement activities. All three were described as being somewhat reluctant, but willing and interested in learning more and pursuing placement.	
	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	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed during the living options discussion at the annual ISP meeting, or at any other time if requested by the individual, LAR, or IDT member. In addition, a listing was given to the monitoring team showing every individual and whether the IDT referred the individual for placement. The monitoring teams have been discussing this provision item at length with DADS and DOJ. To meet substantial compliance with this provision item, the facility will need to show that: • Professionals provided their determination regarding the appropriateness of	Noncompliance

	placement pursuant to such policies, procedures, and practices.	referral for community placement in their annual assessments (this was not yet occurring for all professionals) • The determinations of professionals were discussed at the annual ISP meeting, including a verbal statement by each professional member of the IDT during the meeting (this was not evident in the ISP meetings observed) • Living options for the individual were thoroughly discussed during the annual ISP meeting (this was somewhat evident) • Documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the individual, as well as the decision regarding referral of the entire team, including the individual and LAR (this was not yet occurring). As the facility and state move forward on this provision item, they may want to consider ways of prioritizing referrals and/or an interim process to referral for some individuals.	
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. Three CLDPs were reviewed by the monitoring team (the facility submitted four CLDPs, but one [Individual #164] was reviewed in the previous report and, therefore, was not included in this report). <u>Timeliness</u>: These three CLDPs were not developed in a timely manner. Moreover, these three individuals were referred in April 2010, August 2010, and December 2010. Even so, a number of activities had occurred over the previous six months related to their transitions, especially regarding the visitation and consideration of multiple possible providers. As a result, all three had been placed. <u>Initiation of the CLDP</u>: Rather than waiting until right before the individual moved, the CLDP document was to be created at the time of referral with an expectation that its contents would be developed and completed over the months during which referral and placement activities occurred. The APC and the QDDP were the primary writers of the CLDP, though the APC was responsible for the overall content of the document. The APC also gathered information from other disciplines to include in the CLDP. This process had only just begun. Three of these in-process CLDPs were reviewed and, as somewhat expected, the amount of information corresponded with the length of time since the individual had been referred. At EPSSLC, the CLDP started at the meeting following referral, which was called the APC-PMM-IDT post-referral meeting. <u>IDT member participation</u>: IDT members were very involved in the placement activities of the individuals who were referred. They helped choose possible providers, set up and	Noncompliance

		attend visits to residences and day programs, and actively participated in supporting the individual to make the best possible choice of providers. As a result, the process of choosing and determining a provider was individualized. Some examples and comments are below: • Each of the three individuals visited a number of providers. They visited their day programs and residences. One individual also visited foster care locations. Sometimes, overnight visits occurred, too. There were only a handful of residential providers in El Paso. As a result, facility staff had developed positive working relationships with the providers. • IDTs were thoughtful about choosing a provider. All three of these individuals could not express themselves, so IDT members discussed a variety of factors, such as the individual's response to visits, and what the IDT member thought would be the best placement for the individual based on his or her preferences and needs, and the provider's likely ability to meet these preferences and needs. • After the individual visited providers, the IDT reviewed the visit. In two instances, actions were taken: o The provider reported night sweats during the overnight visit. The medical director ran additional lab tests and examined the individual (there were no findings of note). o The QDDP for one individual saw steps in various places in and around the home. Although it was only a few steps, he felt that the steps could be a problem for the individual. As a result, the chosen provider proposed a different home for the individual that had no steps at all. <u>CLDP meeting prior to move</u>: The APC held a CLDP meting prior to each individual's move. For two of the three individuals, a second CLDP meeting was held because their moves were delayed. CLDP meetings should be as efficient and useful as possible. The monitoring team observed the CLDP meeting for Individual #53. This CLDP meeting was much better than the CLDP meeting observed during the previous onsite review. The APC had responded to the monitoring team's recommendation regarding the content, length, and style of the meeting. This meeting lasted one hour and 40 minutes (last time it was two and a half hours). Participation was active and most everyone was engaged. The APC made good use of the time by focusing on comments from each of the clinical disciplines and the identification of essential and nonessential (ENE) supports. The APC repeatedly referred to ENE supports throughout the meeting. There was also a lot of participation from the individual's mother (the individual was going to move into a foster care arrangement with her) and from direct care staff. There was discussion of how the facility should monitor in a foster home. Other positive aspects included the APC noting that he needed to get more information from the overnight shift at EPSSLC regarding some of the individual's overnight toileting needs, and the community provider stating that she	

		would begin to send staff from the day program to EPSSLC to get to know the individual. Two items during the meeting require additional comment. First, the IDT noted that a door alarm might be necessary on the front door as an added protection from wandering out of the front door. The provider said that this was a restriction and, therefore, a full BSP would be necessary. The APC should find out if this was a regulatory requirement that applied to foster care arrangement. Second, during the meeting, it became evident that the individual had very limited communication skills. The individual's mother commented that she would be working intensively with him on communication (that was good to hear). The EPSSLC psychologist said that she would develop a communication plan and include positive reinforcement in the plan. That was also good to hear, but it begged the question of why his communication skills were not more of a focus during his many years living at EPSSLC (also see section R above). <u>Post post-move monitoring IDT meetings</u>: IDT meetings were only beginning to occur after every post move monitoring visit. Please see T2b below.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	Three completed CLDPs were reviewed by the monitoring team. The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the MRA and community provider. Implementation of the new CLDP policy and facility QA processes will likely bring the facility closer to substantial compliance with this provision item. Some comments regarding the actions in the CLDP are presented below. • The CLDPs identified the need for training for community provider staff. Sometimes topics for content were also listed. • The CLDPs did not, but should, indicate which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff). • The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, showing competency in actually implementing a plan, such as a PBSP or nursing care plans. • Progress had occurred regarding provider training. o There was a lot of documentation showing that staff had been trained. For instance, there were sign in sheets for numerous inservices conducted by different EPSSLC clinical departments. o More trainings contained a competency requirement than ever before. For example, trainings for mechanical lifts and for two person manual transfers required a competency demonstration (Individual #183). o Some competency training only required answers to a written question	Noncompliance

		test. This was good to see and showed progress, however, the facility should determine if demonstration of the skill would be more appropriate (e.g., food consistency and texture). o More, if not most, areas should have a competency demonstration component. If a competency component is not required, a rationale should be provided. • The CLDP contained a somewhat standardized list of items and actions to occur on the day of the move. The content of this list was appropriate, however, it did not identify who was responsible for these actions, and how their completion was to be monitored and ensured. • Actual implementation of ENE supports by staff should be required in the essential and nonessential support sections, not only inservicing. This, however, had shown improvement at EPSSLC. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. • Also see comments in T1e below. DADS central office conducted reviews of each of EPSSLC's three CDLPs. The monitoring team reviewed these comments. These comments, however, were not as thorough as the monitoring team had seen in the past. It is possible that the full set of comments for these individuals was not presented to the monitoring team. • As noted in previous reports, state office should consider developing a metric to determine if facilities are making progress, that is, whether the feedback from state office is helping to reduce errors and improve content of the CLDPs.	
	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 and the timelines for these actions. This included the day of move activities, ENE supports, and other pre- and post-move 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 review (none of the three individuals placed had an LAR). For the three in-process CLDPs and for the draft CLDP, LAR involvement was evident, as it was during the CLDP meeting. Further, although none of these seven individuals could clearly express their opinion, the IDTs adequately strove to assess their preferences.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive	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.	Substantial Compliance

	assessment of needs and supports within 45 days prior to the individual's leaving.	Tony also wrote that he uses the summary template located within the body of the CLDP to keep track of the summaries submitted and the 45-day time limit. The monitoring team's review of the three CLDPs indicated that the sets of assessments of all were updated within 45 days prior to the individual leaving the facility. The APC listed the assessments and their submission dates in the CLDP. The dates of the assessment were also at the beginning of each assessment update section of the CLDP as well as on the assessment itself, which was attached to the CLDP. In addition, most of the assessments commented on the individual soon moving to the community and appeared to tailor their comments to the upcoming move. The quality and content of the assessments, however, needed improvement as detailed in section F1c. In order for EPSSLC to maintain substantial compliance with this provision item, the quality of IDT assessments will need to improve.	
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.	Three CLDPs were reviewed along with their attachments, typically assessments, ISPA meetings, and ISPs. Comments are below: • Extra efforts were given to those referrals that were more than 180 days old (see T1a and T1c). • IDT participation was strong (see T1c). • Progress was made on this, the most important part of the CLDP, that is, the identification and definition of essential and nonessential supports (ENE). o More ENE supports were included that related to the overall preferences as well as the needs of the individuals. • There were some examples of ENE supports that were individualized: o Some favorite daily activities and preferences were in an ENE support (though they needed more specificity) (Individual #68). o Given the opportunity to watch his favorite movies at home at least three times a week (Individual #132). o Implementation of chopped, high fiber, diet; prune juice given; positioned at 15 degrees during meals and 30 degrees after meals (Individual #183). • Even so, more work needs to be done regarding the identification of the full set of ENE supports for each individual. Evidence of this is provided below. o Each of the individuals had severe communication deficits and needs. The ENEs did not adequately address this need, as also noted in T1c1 above. o The ENE supports failed to include what was evident as the most important aspects of two of the individuals' lives: attention from and interaction with others (Individual #183), and helping others (Individual #132). Wording in assessments, such as reference to something the individual "loves" (as was the case for these two individuals), should serve as an indicator to the APC an IDT for consideration for additional and	Noncompliance

		specific attention in the list of ENE supports. o Two of the individuals appeared to be on quite a lot of psychotropic medication. Even though that is the responsibility of the psychiatrist, it seemed to the monitoring team that more discussion should have occurred regarding the type, dosage, and number of psychotropic medications (Individual #68, Individual #132). o Individual #132's information indicated two potentially opposing ENE supports. One was regarding his favorite foods (e.g., hamburgers, French fries) and another was his restricted diet, calorie management, and chopped food diet. The CLDP didn't address this likely soon-to-be challenging issue for the provider. o The IDT seemed to miss an important recommendation from psychology for Individual #132, that is, that he have a structured schedule of activities during the evening and weekend. Perhaps the provider interpreted this as activities for him engage in in the community (e.g., community outings), whereas the monitoring team believes the intent of the recommendation was that he be kept busy and active while <u>at home</u>, too. o The CLDPs did not call for SAPs to be carried forward and implemented. They should have. • Many inservice ENEs included details of what topics were to be covered. • Any ENE support that calls for an inservice should have a corresponding ENE support for <u>implementation</u> of what was inserviced. EPSSLC had made progress on this, however, it was not being done for all inservice ENE supports. A rationale should be provided for any ENE inservice support that does not have a corresponding ENE support for implementation. • For ENEs regarding implementation, although improved, still didn't fully provide detail about what it was that was supposed to implemented, such as the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. • There should also be a requirement for staff to document this implementation every day. This is reasonable for the IDT to request of a provider, and providers have been receptive, if not desirous, of having this guidance and expectation. Further, it not only makes the expectations clear to provider staff, it allows the PMM to more efficiently monitor this aspect of implementation. • There were no specific references to the use of positive reinforcement, incentives, and/or other motivating components to an individual's success, even though these were indicated as being important to these individuals. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. For each of the individuals, the pre-move site review was conducted by the PMM and	

		indicated that each essential support was in place. • Each of the nonessential supports have an implementation date. All of them did.	
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 ISP meeting, the CLDP document, and the post move monitoring documents. The monitoring team recommends that the APC take a close look at all three self-monitoring tools to ensure they contain the proper content, that the instructions for completion of self-monitoring are adequate, and that the criterion for scoring is valid. Only one of these three was being implemented at EPSSLC. Data were summarized in the QA report for October 2011. The QA department summarized the data since February 2011 every month on a spreadsheet table. Data were also graphed by the QA department (see section E above). The other two tools need to be implemented, too. Inter-rater agreement was done by the QA department. Disagreements were found between the QA department and the APC. This was addressed, reported in the QA report, and a plan to work together for six months was implemented. In addition, the APC was implementing an observation tool for the living options discussion section of the annual ISP meeting. The APC said he did this for three to five ISP meetings each month. He said he provided verbal feedback to the QDDP immediately following the meeting. The information from this tool was not otherwise summarized, charted, or graphed. The APC should update this tool as per the new-style ISP (the tool was last updated in 2007). Further, he should coordinate his efforts with the QDDP Coordinator because it is the QDDPs who will continue to implement this important aspect of most integrated setting practice procedures at EPSSLC. The APC had not yet, but should, graph data related to his department's activities as per this provision item as well as what is noted in T1a above.	Noncompliance
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	Activities at the facility and state levels demonstrated progress towards substantial compliance with this provision item. The APC was beginning to gather data on the obstacles. • Data for five fiscal years, 2007 through 2011, were reported in the new annual report. Data included number of placements, types of obstacles identified (even though the data collection system was noted to be flawed), and the concerns of	Noncompliance

	such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	LARs and individuals that led to their preference to not be referred. • The APC had newly collected data on 31 individuals. Data on the other individuals need to be collected, too. • The data system needs to be able to separate out the difference between an obstacle to referral and an obstacle to placement. • The data system only allowed one obstacle to be recorded per individual. This confounded the data. • The data on the 31 individuals indicated that 14 (45%) were not referred due to LAR preference. The data system, however, did not indicate if this was the sole reason for non-referral or if it was one of a number of obstacles. • The APC had another list of 58 individuals who were described as not being referred due to LAR preference. As noted above in T1a, this was an excellent attempt to gather and report this information across the facility, however, it contained a number of errors and, therefore, needed to be reviewed and updated. Interestingly, or perhaps coincidentally, 58 individuals were 45% of the total census, the same percentage as found in the smaller sample of 31 individuals. The APC was not yet analyzing the data. • As noted, data accuracy and validity need to be improved. • Assistance from QA and state office might be helpful in analyzing data once it is collected. • For example, graphs of the data presented in the APC's report could be trended over successive months (also see T1a and T1f). The APC had written an assessment report regarding these obstacles, with data through 8/31/11 (i.e., for fiscal year 2011). It was a good first report and outlined the major concerns of the APC and the facility's initial plans to address each. • Lack of emergency psychiatric services and behavioral crisis intervention • Lack of physical and nutritional management supports in the community • Lack of real work opportunities o For the above three bulleted concerns, the APC wrote that he and the facility were to work with local stakeholders. • Problems in the way the facility collected data on obstacles. o The APC described a plan that included trending and analyzing data and presenting it to QAQI Council. • A high level of individual and LAR reluctance o The majority of LAR concerns were about feeling uncomfortable with the individual living in the community and providers not being able to meet needs. The APC proposed educational opportunities to help ease fears.	

		DADS took steps to overcome or reduce these obstacles. • DADS created a report summarizing obstacles across the state and included the facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. • The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the facilities collect) data regarding obstacles. • DADS indicated actions that it would take to overcome or reduce these obstacles o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
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	The monitoring team was given a document titled "Community Placement Report." It was for the previous six months, through 12/31/11. 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 IDT except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above, the APC had begun to assemble this list (of 58 individuals), separate from the Community Placement Report.	Substantial Compliance

	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.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if	EPSSLC maintained substantial compliance with this provision item. The previous monitoring report indicated that the facility needed to indicate yes/no for each ENE support, and it needed to begin to IDT meetings following every post move monitoring visit. At this time, a yes/no indication was in each post move monitoring report for each ENE support, and the IDT meetings following each post move monitoring were beginning to occur. <u>Timeliness of Visits</u>: Since the last onsite review, 10 post move monitorings were called for and all 10 (100%) occurred. Of these 10, 10 (100%) occurred within the required timelines of 7-, 45-, and 90-day intervals. The PMM visited both the day and residential sites, and conducted the post monitoring visits at whatever time made the most sense based on the individual and his or her schedule. Two additional post move monitorings were conducted during the week of the onsite review (see T2b), but were not included in this review of documentation because the reports were not yet completed. <u>Content of Review Tool</u>: Of the 10 post move monitorings, the completed review tools for all 10 (100%) were reviewed by the monitoring team. Nine of the 10 tools were completed on what was now the new format. The new format had many improvements over the previous version. These are worth pointing out here:	Substantial Compliance

	indicated, notifying the appropriate MRA or regulatory agency.	• Explicit yes/no indication regarding the presence of each ENE support • Indication of what evidence the CLDP required be reviewed and what evidence the PMM actually did review • Eight sets of additional standardized relevant questions • Report of the LAR/family member's satisfaction • Report of the individual's satisfaction On the other hand, the monitoring team was disturbed by the loss of narrative information that was evident in every one of the old style forms. That is, in the old format, the PMM wrote a brief objective description of her findings for each of the ENE supports (a couple of sentences) as well as an overall summary of the post move monitoring, including important subjective impressions, at the end of the form (a couple of paragraphs). These sentences and paragraphs made for easy reading and were very useful in understanding the post move monitoring visit and the overall experience of the individual in his or her new day and home environments (as also noted in the previous monitoring report). This appears to have been lost in the new form and should be re-visited by state office. It is likely that the PMMs at all of the facilities would agree with this observation and could contribute to addressing it. Even so, the EPSSLC PMM wrote a sentence or two about almost every ENE at the end of each section of the post move monitoring form. Furthermore, she added the most current post move monitoring comments to the previous notes in a cumulative fashion. This was helpful to the reader. There should be a subjective paragraph at the end of the report that gives the PMM's overall impression of the placement (day and residential). For each ENE support, the PMM should explicitly indicate if each bulleted item (in each ENE that had bulleted items) was addressed, such as in the inservice, at appointments with physicians and other healthcare providers, and during in-home and/or community activities. In other words, it was good to see the bullets being used in the ENE, but the post move monitoring report needs to very that each and every bullet was implemented. <u>Use of Best Efforts to Ensure Supports Are Implemented:</u> IDTs, the APC, and the PMM put a lot of effort into these placements. As a result, all five of the placements appeared to be very successful. The PMM did follow-up as needed to ensure that supports were implemented, such as when a personal chair needed repair (Individual #164), and when there was confusion about suppository and constipation treatment (Individual #183).	

		IDT meetings were beginning to be held following every post move monitoring visit. Documentation was provided for two of the 10 meetings, however, reference to information to the IDT was noted in many of the other reports. In the future, the facility should submit documentation of these meetings to the monitoring team. The importance of these meetings was evident. For example, the IDT suggested a number of ways of making Individual #183's adaptive equipment even more effective. That discussion might not have occurred without this meeting. The monitoring team recommends that the PMM ensure that she gets input and commentary from IDT members at these meetings regarding the provider's implementation of skill acquisition plans, promotion of language and communication, and activities in the home (i.e., Community Home section, question #1). It appeared to the monitoring team that these aspects of some of the individual's new lifestyle and supports might not have been addressed adequately by the provider. The IDT can provide more information to the PMM so that she can do a more thorough assessment of these components of service provision and support at the provider agency.	
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 observed two post move monitorings, one at the Draco Services day program for Individual #68 and one at an Educare residence for Individual #132. In addition, the monitoring team visited the Draco Services home of Individual #68 and Individual #183 even though it was not for an official post move monitoring activity. Overall, the PMM did a thorough and complete job of post move monitoring. She was thorough, looked at every item (rather than just asking staff to verbally report on them), and interacted extensively with the staff and individuals. At the Draco day service program, the PMM observed the individual, the overall environment, asked questions of the direct care staff, and then met with the program manger, nurse, and other senior staff. She went through the ENE supports and the post move monitoring form's question items. As a result, a number of important topics came up that will require the PMM to do follow-up with the IDT: the individual was having bowel movements on the floor at home (psychology), he was still taking six cans of Ensure each day but was now eating more than he had while at EPSSLC (nursing, nutrition), and provider staff being surprised by the amount of toileting issues (APC). Even given these issues, the individual was doing quite well at Draco. Reports from Draco later in the week indicated that they had quickly followed-up on all actions for which they were responsible. In addition, while at the day program, the monitoring team saw two individuals who were observed during post move monitoring activities during previous onsite reviews. Both appeared to be doing very well, too. Individual #124 was well-dressed, appeared	Substantial Compliance

		happy, and was interacting with staff. Individual #14 told the monitoring team that things were going great for her and that she loved her new home and the day program. At the Draco home, the monitoring team observed Individual #68 and Individual #130. They lived in a beautiful home operated by Draco Services. Individual #130's bedroom and bathroom had been extensively modified for her adaptive equipment and individual needs. The program's director, Gisel Hita, was present at the home. She continued to demonstrate a high level of energy, competency, and commitment to the individuals. The monitoring team also met the owner of Draco Services while at this home. The monitoring team continued to be impressed by the services provided by Draco Services to all of the individuals who have transitioned from EPSSLC to their day programs and homes. Post move monitoring was observed at the Educare home of Individual #132. The PMM again diligently went through every relevant ENE support. She interviewed the staff, asked to see items, and walked throughout the home. The PMM asked for documentation of all inservices, documentation about all health care plans, and she cross-checked the outing log with the vehicle's mileage log. The individual appeared to be happy and his ENE supports were in place. This home was spartanly furnished and appliances, furniture, and cabinets were worn. The home seemed more like a "program" than a home. For example, a fire evacuation diagram page was taped to the wall, papers were stuck on the refrigerator, and there was an odd smell in the home. The PMM inquired about it and the staff said it had to do with some sort of leak that had been recently fixed. The PMM should always also feel empowered to bring home environment concerns forward to the IDT and the APC.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	

T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the 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. Reconsider the formation of a performance improvement team, focused on referrals (T1a).
2. Hold a review for the individual who requested placement, but was not referred due to legal reasons (T1a).
3. Correct the list of 58 individuals identified as not being referred solely due to LAR preference (T1a).
4. Do a root cause analysis type of review for the two rescinded referrals that looks at the referral and placement processes (T1a).
5. Collect data on any serious post move events, such as hospitalization, psychiatric inpatient admissions, incarceration, move to a new home with the same provider, move to a new provider, etc. (T1a).
6. Graph all relevant admissions, referral, and placement department data (not only the statewide self-monitoring tool data) and include in the QA program (T1a, T1f).
7. Include professionals' determinations in the written assessments, verbally during the ISP meeting, and in the written ISP document (T1a).
8. The APC should verbally present referral and placement information and updates to senior management (T1a).
9. Implement new state policy once it is disseminated (T1b).
10. Develop new facility-specific policies once the state policy is disseminated (T1b).
11. Address the comments in the six bullets in T1b1 regarding the new ISP (T1b1).
12. Identify and address obstacles to referral and to placement at the individual level (T1b1, T1g).
13. Have an individualized annual plan in the ISP regarding the education of the individual and LAR on community living options (T1b2).
14. Collect relevant data on education and CLOIP activities (T1b2, T1g).
15. For community tours, describe what is done with the information collected about individuals' participation, and also ensure that every individual has the opportunity to participate, unless there are reasons not to do so (T1b2).
16. Address LARs and individuals who are reluctant to consider community referral (T1b2).
17. Find out if the door alarm in a foster care placement requires a full BSP (T1c).
18. Address communication needs of individuals earlier in the CLDP process (as well as overall in the facility) (T1c).

19. Indicate what provider staff will need to be trained and inserviced, and the training methodology to be used (T1c1).
20. Include a requirement for competency-based training in more ENE supports that call for inservicing (T1c1).
21. Indicate how facility and community clinicians (e.g., psychiatrist, psychologist) will collaborate (T1c1).
22. Ensure ENE supports cover the wide variety of areas relevant to the individual's life (T1e).
23. Include a more extensive discussion of psychotropic medications (T1e).
24. Ensure that any topic that is inserviced has a corresponding ENE support for implementation, or if not, that a rationale is provided (T1e).
25. Consider creating a checklist for providers to use to help them implement, monitor, and document implementation of ENE supports (T1e).
26. Use all three statewide self-monitoring tools (T1f).
27. Assess the content of the statewide self-monitoring tools (T1f).
28. Update the facility's LOD observation tool (T1f).
29. The APC and QDDP coordinator should collaborate on observation tools related to the conduct of ISP meetings and QDDP activities (T1f).
30. Review the new post move monitoring form; consider the inclusion of more commentary from the PMM (T2a).
31. Indicate the PMM's findings for every bulleted item for ENE supports that contain bulleted items within a single ENE support (T2a).
32. During the post post move monitoring IDT meetings, the PMM should solicit commentary from the IDT regarding the provider's implementation of SAPs, the provider's implementation of language and communication strategies, and the provider's support of the individual to be engaged in activities in the community and while at home (T2a).
33. The PMM should not hesitate to bring forward any general concerns she may have regarding the overall quality of the residential or day program (T2b).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Tracking sheet of activities taken to obtain LARs o Determination of Need of Guardian/Priority Tool o EPSSLC Priority List for Adults without Guardians o Individual Support Plans: • Individual #59, Individual #72, Individual #93, Individual #114, Individual #23, Individual #18, Individual #78, Individual #46, Individual #188, Individual #34, Individual #81, Individual #27, Individual #89, Individual #20, Individual #55, Individual #83, Individual #178, Individual #65, and Individual #35 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Gloria Loya, Human Rights Officer o Valerie Grigg, Director of Behavioral Services o Aurora Ramos, QDDP o Nora Padilla, QDDP Observations Conducted: o Observations at residences and day programs o Daily Unit Meeting 1/9/11 o Incident Management Review Team Meeting 1/9/11 and 1/11/11 o Human Rights Committee Meeting 1/11/11 o Annual ISP meetings for Individual #70 and Individual #84
	Facility Self-Assessment: EPSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. For the self-assessment of Section I, the facility's description of "activities taken" did not offer enough information to determine what steps the facility was taking to assess compliance. For example, for UI, the facility had reviewed the guardianship priority tool, reviewed the guardianship priority list, and reviewed updates to the list. It was not clear how these steps resulted in a substantial compliance self-rating. Action plans were developed to address findings of the facility self-assessment, however, these action plans

	did not necessarily address findings of the self-assessment. For example, the self-assessment found that the facility was not evaluating individual's ability to give informed consent. Action plans did not address developing a tool or method to assess the ability to give informed consent. To take this process forward, the monitoring team recommends that the Human Rights Officer (HRO) review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the HRO to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other.
	Summary of Monitor's Assessment: Some positive steps that the facility had taken in regards to consent and guardianship issues included: • The facility had partnered with the ARC of Texas to obtain advocates for some individuals at the facility. • The Human Rights Committee continued to meet and review all restrictions of rights. • The facility had a self-advocacy group comprised of individuals residing at the facility. • The Human Rights Officer continued to work with families applying for guardianship. 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 individuals needing an LAR, IDTs were not adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. While the facility was pursuing guardianship for a number of individuals at the facility, the efforts did not appear to be related to those individuals determined by the facility to have the greatest prioritized 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 a Human Rights Committee (HRC) in place to review restrictions requested by the IDT. At the HRC meeting observed, committee members engaged in good discussion regarding the need for the proposed restrictions prior to giving approval. The HRC did not address individual's ability to give informed consent in regards for the need for guardianship when reviewing rights assessments.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The facility self-assessment indicated that EPSSLC continued to move forward to meet the mandates of this provision, but were still waiting on a process from the state office to determine individual's ability to give informed consent. The facility self-assessment indicated that EPSSLC was not yet in compliance with the requirements of UI. The facility had a list of 65 individuals at the facility that did not have an LAR. Thirty-three of those individuals had been determined to be Priority I (high need) for guardianship. Guardianship was being sought for those individuals who had family that may be interested in guardianship first. A sample of 19 ISPs was reviewed for evidence that the team had discussed the need for guardianship. Nine (47%) individuals in the sample did not have guardians. There was evidence in only one (11%) of the nine ISPs reviewed that teams were discussing the need for guardianship in relation to the individual's ability to make decisions or give informed consent. For others: • The ISP for Individual #59 did not include adequate discussion regarding his ability to give informed consent. He was an adult without legal guardian. Although, the team noted that his mother was an active advocate on his behalf, there was no indication that guardianship had been discussed with his mother. The team noted that he did not need an advocate. • The ISP for Individual #72 did not include any discussion regarding his ability to give informed consent or his need for a guardian or advocate. • The ISP for Individual #65 indicated that his father acted as an advocate on his behalf, but was in poor health. According to his rights assessment, the IDT had determined that he was unable to give informed consent for medical, financial, restrictive practices, media releases, or release of records. There was no record of discussion regarding the need for guardianship. • The ISP for Individual #93 indicated that she was unable to give informed consent. The team had referred her to the Human Rights Officer in order to be assigned an outside advocate. While advocacy would be beneficial for her, there was still nobody to make legal decisions for her. The team should have referred her for guardianship. • Individual #114's ISP stated that he did not have the capacity to express or/and indicate preferences regarding living options or other areas of interest. He did not have active family involvement or a guardian. The team did designate him a Priority 1 for guardianship. IDTs need to hold more thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship should be	Noncompliance

#	Provision	Assessment of Status	Compliance
		based on this discussion. The facility was 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 process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. The Human Rights Officer also provided information to community agencies on advocacy opportunities at the facility. The facility did have some rights protections in place, including an independent assistant 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.	Noncompliance

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 Organizational chart, undated o EPSSLC policy lists, dated 10/31/11 o List of typical meetings that occurred at EPSSLC o EPSSLC Self-Assessment, 12/23/11 o EPSSLC Action Plans, 12/28/11 o EPSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/9/12 o List of all staff responsible for management of unified records o Tables of contents for the active records, master records, and individual notebooks, updated February 2011 o Training rosters sign in sheets for new staff orientation (July 2011 through December 2011), and two special training sessions for QDDPs and Program Developers (September 2011) o A spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, dated 12/9/11 o Email regarding state office expectations for facility-specific policies, from central office SSLC director of operations, Donna Jesse, 3/15/11 o Description of the recordkeeping department's quality assurance audit procedures, undated o Description of the recordkeeping department's procedures for managing and monitoring the errors identified in the monthly unified record quality assurance audits, undated o Blank statewide self-assessment tool, and facility's table of contents tool o Graph presentations of the data from the self-assessment tools, presented in the QA report o List of individuals chosen for recordkeeping audits, last six months, 30 individuals o 15 completed audits of active records, individual notebooks, and master records, September 2011, October 2011, and November 2011 (five each month), included the state self-assessment form and the facility's table of contents/guidelines form. o Documents related to the quality assurance audits: emails, list of errors, list of items that were corrected, medical consultation list, and some graphs, for five months July 2011 through November 2011 o Blank form used for special auditing of active records and individual notebooks, and a list of those staff who conducted these special audits o Description of how the facility implements and assess the utilization of records o Results of V4 interviews following ISP meetings, August 2011 through October 2011, total of four individuals, six to eight interviews per individual. o Review of active records and/or individual notebooks of: • Individual #47, Individual #9, Individual #169, Individual #117, Individual #21,Individual

	#27, Individual #61, Individual #110 o Review of master records of: • Individual #79, Individual #134 Individual #178 Interviews and Meetings Held: o Priscilla Munoz, Medical Records Coordinator o Priscilla Guevara, Unified Records Coordinator o Jaime Monardes, Facility Director 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 had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document, separate from another document that listed all of the action plans for each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the Medical Records Coordinator (MRC) and the Unified Records Coordinator (URC) included relevant activities in the "activities engaged in" sections. They should, however, include activities that are in line with what the monitoring team assesses as indicated in this report. They also should ensure that these activities are indeed activities to assess whether they are meeting the provision item. It should not include activities they engaged in to meet the provision item. This is a fine and sometimes difficult distinction to make. For example, for V1, they described the quality assurance audit review process. This was a correct description of an activity engaged in to conduct the self-assessment. The monitoring team, as detailed in the report below, commented on other items as well. For V2, the MRC and URC noted that they self-assessed by looking at the spreadsheet of policies. This was also a good activity. The monitoring team also looked at whether the facility was following the DADS 3/15/11 memo regarding facility-specific policies and whether a training process was in place. For V4, the MRC and URC should work on how they will assess the components of this provision item that are described below in section V4. To take this process forward, the monitoring team recommends that the MRC and URC review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team

	commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead them to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the MRC and URC and believes that the facility was proceeding in the right direction. The facility self-rated itself as being in noncompliance with all four of the provision items of section V. The monitoring team agreed.
	Summary of Monitor's Assessment: The MRC and URC were responsive to comments in the previous report. The active records were consistent in format and content. The facility, however, still struggled with keeping them as organized as they could, and should be. This continued to be due, most likely, to there being many clinical and program staff who had responsibility for putting documents in, and taking documents out of, the active records. As a result, some documents were frequently in the wrong place in the record, such as the active problem list, and the contents of some sections were out of order. Legibility of entries and proper signatures had somewhat improved, but only recently. Efforts were being put into securing the records room, especially in one of the homes where an individual had a history of destroying record books if access was available. The active records were large, heavy, and multi-volume. Consideration should be given to documents that might not need to be in there. The integrated progress notes (IPN) contained many insertions and documents that are not typically expected to be in the IPNs. This included sick call reports, printed emails, printed paragraphs cut and glued in, copies of consultations, and body check inspection forms. The individual notebooks had many different staff responsible for adding documents, thinning, and/or moving documents. This likely contributed to the variation in their organization, neatness, and clarity. Consideration should be given to removing any items that do not need to be in the individual notebooks, such as communication books and a PNMP log. Master records were created for every individual. They were well organized, neat, and consistent. The facility should determine what to do about items that remain missing. Not all policies were yet in place, though continued progress was evident. All of the aspects of the DADS memo from 3/15/11 need to be addressed. The facility should develop a policy and system regarding implementation and training of relevant staff on both the state policies and the facility-specific policies,

	Unified record quality assurance review audits were done by the URC and were completed in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool, the other was the table of contents review tool. Errors were noted and tracked. Some errors cannot be corrected. Therefore, the URC should separate these from the errors that can be corrected in her tracking and follow-up systems. The URC reported that she could only follow-up on one of the five audits to see if corrections were done. This was due to her competing work responsibilities. The facility needs to address this. The URC conducted a set of brief, but informative, interviews with IDT members after one of the ISP meetings each month. The IDT members reported good use of the active record and individual notebook.

#	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 with this provision item and made additional improvements in recordkeeping activities and records management. Recordkeeping practices continued to be managed by the competent Medical Records Coordinator (MRC), Priscilla Munoz, and the equally competent Unified Records Coordinator (URC), Priscilla Guevera. They were serious about recordkeeping, were responsive to comments and recommendations in the previous monitoring report, and were bringing the facility closer to substantial compliance. The state policy remained as the facility policy, with a few additions. Given that EPSSLC did not have any home secretaries or records clerks, the MRC and URC should consider whether a facility-specific policy on recordkeeping would be of value. The table of contents and maintenance guidelines were updated in February 2011 and had not changed. The URC engaged in a lot of training activities at the facility. First, she taught a section of new employee orientation. Second, she taught update refresher courses for current staff. Third, she created and taught training sessions for QDDPs and for program developers. The MRC and URC were responsive to comments in the previous report. For example: • Again, given there were no additional recordkeeping staff, and given that the facility had identified missing documents as a problem, the facility director initiated a project for <u>all</u> active records and individual notebooks to be audited for the presence/absence of a short, specific list of current documents (e.g., BSP, ISP). This was done in October 2011 and again in December 2011. As a result, there was a decrease reported by the URC in these documents missing from the active records and individual notebooks.	Noncompliance

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		• The URC was now using the medical department's list of non-facility consultations when she did the active record audits so that she could determine what documentation should be in each of the tabbed sections under medical consultations (though see V3 below). <u>Active records</u> The active records were maintained. They were consistent in format and content. The facility, however, still struggled with keeping them as organized as they could, and should be. This continued to be due, most likely, to there being many clinical and program staff who had responsibility for putting documents in, and taking documents out of, the active records. As a result, some documents were frequently in the wrong place in the record, such as the active problem list, and the contents of some sections were out of order, such as the ISP section for Individual #117. Even with the thinning/purging schedule, there were old documents found, such as SAPs from March 2011 Individual #169 and ISP reviews from 2007 Individual #21. Three additional findings are of note: • The active records were large, heavy, and multi-volume. Consideration should be given to documents that might not need to be in there. One example was the Functional Skills Assessment. It was almost 50 pages long and, as far as the monitoring team could tell, was never used after its completion (or perhaps ever at all, see sections F, T, and S). Some individuals had both the FSA and the old-style PALS assessment in the record (e.g., Individual #117). In these cases, over 100 pages were in the active record, carried and moved day after day, unnecessarily adding to the bulk and weight of the record. • The integrated progress notes (IPN) contained many insertions and documents that are not typically expected to be in the IPNs. This included sick call reports, printed emails, printed paragraphs cut and glued in, copies of consultations, and body check inspection forms. Although the monitoring team understands that these types of entries may appear to save time for the enterer, it made it more difficult to read the IPNs in an integrated manner. That is, many of these inserted documents contained more information than was necessary to be in the IPN, thereby competing with the readability of the IPN. The MRC and URC will need to work with the facility director, medical director, CNE, habilitation director, and others to solve this problem so that it meets the enterer's needs as well as the goals of having an IPN system. • Important information sometimes did, and sometimes did not, make it into the IPN. For example, a consultation note said that an ECG was unable to be	

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		performed for Individual #117 on 12/20/11, but there was nothing in the IPN. A bone density test was unable to be performed on 10/14/11, but this was reported in the IPN. Progress in some areas, however, was noted: • Legibility of entries and proper signatures had somewhat improved, but only recently. o There continued to be problems with content and legibility of nurses' notes and signatures, incomplete signatures, such as nurses' signing only their first name and the first initial of their last name, failure to note the time of the entry in the IPNs, notes out of sequence, and erroneous entries written over and not properly designated as errors. • The program change tab provided an easy way to find information about updates to programs. • More efforts were being put into securing the records room, especially in one of the homes where an individual had a history of destroying record books if access was available. • Materials for the implementation of SAPs were included in the individual notebooks, making it easier for staff to implement the plans. <u>Individual notebooks</u> EPSSLC had chosen to keep individual notebooks for all individuals. Similar to the active records, many different staff had responsibilities for adding documents, thinning, and/or moving documents. This likely contributed to the variation in their organization, neatness, and clarity. Further, the MRC and URC were responsible for moving documents at the end of the month into the active record for every individual at the facility. Also similar to the active record, consideration should be given to removing any items that do not need to be in the individual notebooks. Some examples are below: • There was a PNMP log sheet that was in every individual's notebook, but it seemed these were not being used. • Communication books were in the individual notebook. For most individuals, this made it harder for them to use it and, therefore, they were used less often than they might otherwise have been. • Extra binders were seen in many of the offices. Some were for the overt aggression scale, but it didn't appear that they were being used. <u>Master records</u> Master records were created for every individual. They had made new ID sheets for every individual (another large task). The master records were well organized, neat, and	

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		consistent. The MRC and URC were working to obtain items that were missing. Fortunately, and due to their perseverance, they found many documents in the overflow folders. The facility should determine what to do about items that remain missing. As recommended in the last review, there should be some sort of procedure, rubric, flow chart, or guideline that the MRC and URC can follow that would indicate how to obtain those missing items and how to document their actions to show their efforts even if the document cannot be located. <u>Overflow files</u> 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.	EPSSLC had a single page spreadsheet that indicated the status of state policies and the status of facility-specific policies. This was maintained by the facility's QA department. Not all policies were yet in place, though continued progress was evident. The spreadsheet, however, should be expanded to include all of the aspects of the DADS memo from 3/15/11 (as detailed in the previous monitoring report), that is, a column for date submitted to state office for approval, and date the policy was approved by state office (state office might have comments or edits that require the facility to make revisions; if so, this should also be noted on the spreadsheet). To show implementation and training of relevant staff on both the state policies and the facility-specific policies, the facility should develop a policy and system with the following components: • It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided. • For each policy, consideration should be given to defining who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility. • Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions	Noncompliance

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		need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training). • A system to track which staff had completed which training.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Continued progress was made towards substantial compliance with this provision item. Overall, the MRC and URC had worked hard and put into place some new procedures. Five reviews were being conducted each month, as required. Overall, the reviews were done in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool for provision V. At EPSSLC, the results of this review were entered into a two-page computer document. This made it very easy to read and understand. It also had a total percentage of "yes" scores. The other was the table of contents review tool for the active record, individual notebook, and master record. The URC used the table of contents review tool to indicate whether items were or were not in the active record, individual notebook, and master record. She also assessed the presence/absence of the components of these items (e.g., signature, legibility, date) and quality (when appropriate to do so). Then, she used this information to complete the statewide form. The table of contents review at EPSSLC included a rating of both of the columns that were on the form: document was present, and document guidelines were followed. This was good to see, especially because the rating was not the same every time, such as for Individual #111 regarding her psychological evaluation, PBSP, and annual medical summary. The URC began using the medical appointments listing in mid-September 2011. Using this document, however, is likely to be very time consuming because the list included all of the appointments for the individual, not just non-facility consultations with medical specialists. Moreover, the URC must look at each month's list for the previous six or so months to determine what appointments were attended by the individual. For example Individual #133 saw the podiatrist on 9/22/11. His unified record audit was conducted a few days later and, as would be expected, the consultation note was not yet in his record. A better way to do this is to have a cumulative list of these consultations that is in alphabetical order by individual that lists the date, type of consultation (e.g., cardiac), and physician's name. Some errors cannot be corrected. Therefore, the monitoring team recommends that the facility separate out those errors that can be corrected. Thus, there would be two types of data that come out of the audits: total number of errors, and total number of errors that require correction. The total number of errors that require correction are a subset	Noncompliance

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		of the total number of errors. In addition to the statewide form, the table of contents forms, the URC kept a handwritten running list of all errors and needed corrections as she went through each volume of the active record and the individual notebook. The URC sent out emails following each of her audits. Many emails were sent. Some included more than one EPSSLC staff, clinician, and manager. Some included more than one error. The monitoring team did not determine if every error had a corresponding email, however, it appeared likely given the number of emails. The monitoring team recommends that the URC include positive comments in the emails and also provides positive feedback and praise when appropriate. In this way, her emails are more likely to be read and attended to. The URC, however, reported that she had received a good response so far from all whom she had been emailing and talking to. Each month, all errors were listed on a lengthy spreadsheet. Then, on a copy of this spreadsheet, the URC indicated, in the far right column, if the item had been corrected. This did not seem to be a good way to follow-up, manage, and keep track of errors needing correction. Again, separating out those errors that need correction from those errors that cannot be corrected would make this process more manageable for the URC. The URC reported that she could only follow-up on one of the five audits to see if corrections were done. This was due to her competing work responsibilities. The facility needs to address this. The MRC and URC had begun to table and graph some of their data. It was great to see that they had started on this activity. They summarized each month's data in two tables. One table listed the type of error. The other table listed each of the discipline departments. Then they made a line graph of the data about the different types of errors. They also totaled the number of errors: July 282, September 343, October 351, and November 303. The monitoring team recommends that the MRC and URC instead graph their data in the following way: There should be one line graph for each of the following, with one data point per month, with successive consecutive months one after the other: • Number of unified records audited • Average score on statewide self-assessment tool portion of the audit • Average number of errors found per individual • Average number of corrections needed per individual • Percentage of corrections needed that were corrected within a specified time	

#	Provision	Assessment of Status	Compliance
		period (e.g., one month).	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	Continued progress was demonstrated by the recordkeeping staff. Recently, the monitoring teams, DADS, and DOJ agreed that a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item that was submitted by the monitoring teams would be used by the facilities for the next onsite review. Even though EPSSLC did not yet have this list, the items are presented below. It is also likely that the DADS state office coordinator for recordkeeping will provide additional direction and guidance to the MRC and URC. <u>Records are accessible to staff, clinicians, and others</u> EPSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Although some records were not available for several hours during the day and afternoon shifts, compared to the prior monitoring review, there was significant improvement noted in the presence of records on the dorms and cottages. When or if records were missing, there was evidence that they had been signed out for legitimate reasons. For example, records were signed out to the medical clinic, psychiatry clinic, ISP meeting, etc. • The individual notebooks did not appear to be consistently accessible to staff. In many homes the individual books were piled up in backpacks several hours after the individuals returned to the home. In one home (i.e., 506), the individual notebooks were locked in an office, and DCPs told the monitoring team that they were not allowed to take the individual notebooks into the community with individuals. • The habilitation therapists provided glued-in notes (in the form of program change forms) due to difficulties accessing the records for documentation in a timely manner. This was effective in getting the information in the record, but seriously affected readability and the sequence of entries. <u>Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> EPSSLC was not yet self-assessing this. The monitoring team, however, observed that: • In the homes, during an evening observation by the monitoring team, only three of 13 PBSP datasheets were completed in a timely manner and seven of 10 SAPs were completed as prescribed. o In home 512, a staff member was with Individual #104 in his bedroom recording some SAP data. • The review of 20 individuals records revealed that data, such as daily vital signs, weekly weight, blood-sugar levels, etc. were not consistently recorded in over three-fourths of the records reviewed. This was especially significant since these data were important health status indicators used by clinical professionals	Noncompliance

#	Provision	Assessment of Status	Compliance
		to monitor effective of medications, treatments, supplements, etc. <u>IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> EPSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Across all 20 records reviewed, it was evident that the individuals' physicians and the FNP used the active record during their evaluations and when making care and treatment decisions. • It was not evident, however, that nurses thoroughly reviewed the record during their conduct of regularly scheduled (quarterly, annual) and ongoing assessments, during development of nursing care plans, and/or in preparation to ISP/ISPAs. Rather, it seemed that nurses relied upon information (accurate or not) that was documented in the prior quarterly/annual assessment versus information gleaned from a thorough review of the active record when conducting assessments and making nursing care decisions. • Habilitation Therapies entries were limited to program change forms rather than progress notes. This did not contribute to an integrated flow of information throughout the record. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> The URC conducted a set of brief, but informative, interviews with IDT members after one of the ISP meetings each month. The IDT members reported good use of the active record and individual notebook. IDT members' most frequent suggestion for improvement was more frequent thinning of the active records and individual notebooks so that they were not so large and heavy. The URC also wrote a paragraph or two summarizing the interviews. This was good to see. It was not clear, however, how this summary (or the information from the interviews) was used by the facility. Also, the URC wrote that there was no evidence that the records were used as required by this provision item, however, the monitoring team believes this was based only on her observation of ISP meetings. The active record appeared to regularly used for extensive review in the completion of OT/PT/SLP and PNMT assessments. <u>Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item</u> The URC observed an ISP meeting each month to see if the records were used during the meeting. As discussed during the last review, this was not a good use of the URC's limited time. Further, absence of the use of the records at the ISP meeting is not, in and of itself,	

#	Provision	Assessment of Status	Compliance
		an indication that the records were not being used as required by this provision item. For instance, it is possible that the record did not need to be consulted at that time. On the other hand, the active record should be available and should be consulted if questions come up during the ISP meeting. The facility will need to come up with a way of self-assessing this aspect of this provision item that does not require the MRC or the URC to observe full ISP meetings. In addition, regarding the use of the records during meetings and clinics, the monitoring team found the following: • The primary care providers used the active records while evaluating and treating individuals in the medical clinic. Entries were made in the IPN regarding treatment and orders for medications, treatments and diagnostics were written. • Records were available during psychiatry clinic and staff referred to them and reviewed documentation. • There was cause for concern, however, that the psychiatrist did not review relevant documentation prior to making clinical decisions between actual clinic visits (e.g., when responding to a crisis, or when asked to see an individual outside of the scheduled clinic). This was apparent, as lab evaluations requested at one visit were not documented as reviewed in later clinic encounters. • During neuro-psychiatry clinic, the psychiatrist and neurologist utilized the active record in clinic. They frequently referred to the record to check lab values and other diagnostics. • At Individual #84's ISP meeting, the nurse practitioner had two volumes of his active record out in front of her. They were opened and she referred to them often during the meeting. • The record was referenced during the PNMT meetings to confirm information, though in most cases, it was expected that team members would come prepared to present this information rather than needing to look it up during the meeting.	

Recommendations:

1. Consider whether a facility-specific policy on recordkeeping would be of value (V1).

2. Reduce the number of documents that are in the wrong place in the active records and individual notebooks (V1).

3. Consideration should be given to documents that might not need to be in the active record (e.g., FSA) and individual notebook (V1).
4. Address the insertion of various forms, cut and pastes, etc. into the IPNs (V1).
5. Examine whether communication books should be removed from the individual notebooks (V1).
6. Determine how to proceed regarding items missing from the master record (V1).
7. Complete the development of state and facility policies for each of the provisions of the Settlement Agreement; expand the spreadsheet to include columns for all of the information in the state office memo of 3/15/11 (V2).
8. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).
9. Fix the system used to inform the URC of medical consultations from non-facility clinicians (V3).
10. Separately track the total number of errors, and total number of errors that require correction (V3).
11. Include positive comments in the emails, and provide positive feedback and praise when appropriate (V3).
12. Develop a better system of tracking the correction of errors (V3).
13. Make data graphs as described at the end of V3 (V3).
14. Implement and monitor the five aspects of assessing the use of records to make care, treatment, and training decisions (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
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ADA	American Dental Association
ADA	American Diabetes 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
AMS	Annual Medical Summary
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
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
AV	Alleged Victim
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
BMP	Basic Metabolic Panel
BON	Board of Nursing
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
CAL	Calcium
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

CIN	Cervical Intraepithelial Neoplasia
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
CPT	Certified Psychiatric Technician
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
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DES	Diethylstilbestrol
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	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EC	Enteric Coated
ECG	Electrocardiogram
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
ENE	Essential Nonessential
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
FNP-BC	Family Nurse Practitioner-Board Certified
FOB	Fecal Occult Blood

FSA	Functional Skills Assessment
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
GFR	Glomerular filtration rate
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
HMO	Health Maintenance Organization
HMP	Health Maintenance Plan
HOB	Head of Bed
HPV	Human papillomavirus
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
ICA	Intense Care Analysis
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
IPE	Initial Psychiatric Evaluation
IPN	Integrated Progress Note
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LA	Local Authority
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOC	Level of Consciousness
LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse

MA	Masters of Arts
MAP	Multi-sensory Adaptive Program
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCG	Microgram
MCP	Medical Care Provider
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
MHA	Masters, Healthcare Administration
MI	Myocardial Infarction
MISD	Mexia Independent School District
MISYS	A System for Laboratory Inquiry
ML	Milliliter
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOT	Masters, Occupational Therapy
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
MPT	Masters, Physical Therapy
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
NIELM	Negative for Intraepithelial Lesion or Malignancy
NL	Nutritional
NMC	Nutritional Management Committee
NMES	Neuromuscular Electrical Stimulation
NMS	Neuroleptic Malignant Syndrome
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OC	Obsessive Compulsive
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill
ODD	Oppositional Defiant Disorder
OIG	Office of Inspector General
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
P&T	Pharmacy and Therapeutics
PAD	Peripheral Artery Disease
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCFS	Preventive Care Flow Sheet
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
PKU	Phenylketonuria
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
PTT	Partial Thromboplastin Time
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council

QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
ROM	Range of Motion
RPH	Registered Pharmacist
RPO	Review of Physician Orders
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
RX	Prescription
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
SDP	Systematic Desensitization Program
SETT	Student, Environments, Tasks, and Tools
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
S/P	Status Post
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
TAC	Texas Administrative Code
TAR	Treatment Administration Record
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
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
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
TX	Treatment
UA	Urinalysis
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
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
WS	Worksheet
WT	Weight

XR	Extended Release
YO	Year Old