United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: July 16 – July 20, 2012

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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.

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

(c) **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. 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.

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

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 from 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, the monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at EPSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. There was a newly appointed Settlement Agreement Coordinator, Priscilla Munoz. She did an outstanding job in her first review, ensuring that the monitoring team was able to conduct its activities as needed. She was readily available and very responsive.

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. 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 services and supports at the facility.

- Weight loss: During the onsite week, the monitoring team found many issues regarding the way individuals' weights, diet, and nutrition were managed. Many individuals appeared underweight and many had not had nutritional orders implemented correctly or timely. Comments are given in many sections of this report, especially in sections M and O. The monitoring team raised this topic to state and facility administration while onsite and in the weeks following the review, a number of actions were initiated. The new facility director will need to ensure that these actions are implemented, monitored and assessed, and modified as needed. Relevant outcome data should be collected.

- Mortality review: The way deaths were reviewed at EPSSLC, clinical and administrative, itself needs review. As detailed in section L, recommendations were not generated and limited information was available to the monitoring team.

- Risks and incidents: As the facility moves forward in responding to medical crises, incidents, allegations, and risks on an individual basis and by following proper documentation processes, the monitoring team wants to ensure that facility management understands that properly addressing these areas requires a facility-wide approach, especially when developing new activities and systems so that crises and incidents are less likely to happen in the first place.

- Community day programming: One of the highlights for the monitoring team was visiting and learning about the new community-based day programming that was occurring for about 40 individuals. These individuals were integrated into locations and activities with people from the community. This occurred in three different locations in El Paso. Although there were still a number of issues to address, the program was off to an excellent start. It was due to the efforts of Guadalupe Azzam, who was appointed to a new position as Active Treatment Specialist since the last onsite review. She had risen to the occasion, was energetic, and already had produced some good outcomes.

- Administrative and management: During the weeks prior to, during, and following the onsite review, there were a number of media reports about conditions at the facility, the annual ICFID survey was conducted, and a new interim facility director was appointed. All of this can contribute to making it more difficult for facility managers, clinicians, and staff to meet the many requirements of the Settlement Agreement. The monitoring team suggests that all managers and department heads make an extra effort to work together, take responsibility for improvements, and understand that achieving substantial compliance is very possible.

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

- There were 14 restraints used for crisis intervention between 1/21/12 and 5/8/12. Five individuals were the subject of restraints. This was a considerable decrease compared to the previous five month reporting period. The facility Trend Analysis showed an overall decline from May 2011 to April 2012.
- Some protective mechanical restraints were not routinely reviewed by IDTs or reported in terms of restraints at the facility. This needs to be corrected and there was a new statewide plan to do so, as part of the newly revised policies.
- There was minimal progress in meeting compliance with requirements for documenting and reviewing restraint incidents.
- Action taken by the facility to address substantial compliance since the last monitoring visit included:
    - A restraint discussion form was created to be used in the daily unit meeting to review documentation and justification for the use of restraint.
    - Psychology trained staff on use of the discussion form.
    - Director of Behavioral Services attended training on the new state restraint policy in Austin.
    - The Director of Behavioral Services trained the nursing department on restraint policy.
    - The new statewide restraint policy was adopted by the facility.

Abuse, Neglect, and Incident Management

- DFPS confirmed five cases of physical abuse and 21 cases of neglect between 12/1/11 and 5/31/12. There were a total of 43 investigations, involving 20 allegations of physical abuse, nine allegations of verbal/emotional abuse, one allegation of exploitation, and 42 allegations of neglect. An additional 16 other serious incidents were investigated by the facility, including three deaths.
- There were a total of 534 injuries reported between 1/1/12 and 5/30/12. These included 10 serious injuries resulting in fractures or sutures. Documentation indicated that a large number of injuries were resulting from behavioral issues, including peer-to-peer aggression.
- A considerable focus had been placed on documentation and investigation of unusual incidents.
- The thorough investigation and documentation of incidents should ultimately result in identification of those factors that continue to contribute to incidents at the facility. Recommendations resulting from investigations should include a focus on systemic issues that are identified and action steps should be developed to address those issues.
- To that end, EPSSLC had formed an ANE committee to review incident trends, and revised the training curriculum to emphasize the mandate to report suspected abuse and neglect.
- The facility needs to focus next on:
    - 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.
- Taking an integrated, aggressive approach to restructuring environments, supports, and programming to adequately meet the needs of individuals at EPSSLC and protect them from harm.

Quality Assurance

- EPSSLC continued to make good progress towards substantial compliance with many of the items of provision E. A facility-specific policy regarding how QA operates at EPSSLC was still needed. The new SAC and the QA director appeared to be developing a good working relationship. They should work on formalizing some of the aspects of their work that would support each other.
- The QA department had made progress towards creating a listing/inventory of data collected at the facility. The next step is to ensure that the list is comprehensive and as complete as possible. The QA narrative was an excellent first version. It was lengthy, but acceptable. Editing is now required. The QA matrix was also much improved.
- QA staff program auditors were busy conducting and documenting observations and monitoring. EPSSLC had not yet begun to revise any of the current self-monitoring tools or to create new tools. The exception was in pharmacy.
- Family members expressed dissatisfaction, especially with communication with the facility. A staff satisfaction survey also showed dissatisfaction. Some activities were implemented, however, there still seemed to be much dissatisfaction with communication, support, and relationship with facility senior administration. There were no measures of individual satisfaction or of others in the community with whom the facility interacted.
- EPSSLC held two meetings that directly related to the QA program, the monitoring committee and the integration committee. The monitoring team recommends that there also be a monthly meeting between the QA director, SAC, and discipline department head responsible for each provision item of the Settlement Agreement.
- There continued to be improvements in the QA report. Relevant data, in addition to self-monitoring tool data, must be added to the presentations of each provision of the Settlement Agreement.
- During the QAQI Council meeting observed by the monitoring team, the provision leaders presented data and some commentary, but there was little to no discussion, participation, or decision making from attendees.
- Corrective action plans (CAP) were readily and often created. The QA director was working on a more organized way to manage CAPs. He had initiated some data reporting on CAPs.

Integrated Protections, Services, Treatment, and Support

- EPSSLC had recently received training on the newest ISP process by DADS consultants, but was still awaiting training on the risk identification process. Observation of two ISP meetings and review of ISPs developed after 1/1/12 confirmed that teams were still at varying stages in developing integrated plans that included all needed supports and services based on preferences and needs of each individual.
- Overall, however, there had been a noticeable improvement in developing more meaningful plans based on individual's preferences and needed supports. It was apparent that teams were attempting to follow the format of the new ISP process and include all required information in the plan.
- Adequate assessments were not developed or revised when needed for most individuals. All team members were not participating in the planning process. For needs that had been identified, a service delivery system was not in place to ensure that supports were competently provided and progress or regression documented.
- There was better integrated discussion among team members in an attempt to identify risks. There had been a significant improvement in efforts by the QDDPs to involve all team members in the planning process.
- There had been little progress made on developing plans to provide functional training in the community. Although all plans provided opportunities for individuals to go out into the community, training was not being consistently implemented and documented while in the community. The facility had begun offering a community based day program. This was great to see. It was integrated and individuals were engaged.

Integrated Clinical Services

- The facility continued to make progress in this area. Several steps occurred at the local level in an effort to integrate clinical services.
- An Integration Committee was formed that came together each week to address specific problems with the objective of establishing policies and procedures that would facilitate integration of services. There was, however, a need for better agenda planning and data presentation.
- Throughout the week of the review, the monitoring team encountered a few good examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted. Continued work in this area is needed.

Minimum Common Elements of Clinical Care

- The facility had done a considerable amount of work in looking at assessments, primarily the timelines for completion. An assessment tracking database was implemented and two file clerks were re-allocated to ensure that assessments were placed in the records in a timely manner.
- Generally, the medical diagnoses were consistent with ICD nomenclature, however, indications for medications were frequently not consistent with ICD nomenclature.

- The medical director focused on the review of hospitalizations and management of individuals with diabetes and pneumonia. State office provided a rather robust set of clinical protocols, but these were not yet fully implemented. The facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines.

At-Risk Individuals

- While progress had been made, teams were still not accurately identifying risk factors. Risk plans were not being reviewed and updated as changes in health or behavioral status warranted. Risk plans did not include clinical indicators to be monitored or specify the frequency of monitoring and review.
- 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.
- The facility was still waiting on consultation and training on the risk identification process from the state office. This training should move teams further towards integrating the risk process into the ISP development process.

Psychiatric Care and Services

- Psychiatry services at EPSSLC made progress towards substantial compliance. More than half of the individuals received psychopharmacologic intervention (74 of the 125, 59%).
- There was a laudable effort placed into the completion of the comprehensive psychiatric evaluations in Appendix B format. Of the 74 individuals enrolled in psychiatry clinic, 56 or 75% had completed assessments. As a result, substantial compliance was found for J6. There were improvements with regard to collaborative case formulations that included specific diagnostic criteria utilized to determine the presence of a specific diagnosis.
- Only three records in the sample of 15 contained quarterly psychotropic reviews because, in order to complete this number of comprehensive assessments, the psychiatric clinic had fallen behind.
- In an effort to improve communication between psychology and psychiatry, an integration tool had been developed that outlined items, such as diagnosis changes and responsibilities of specific team members, such that communication and expectations remained clear.
- The monitoring team observed two separate psychiatric clinics, and one Neuro-Psychiatry clinic. 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).
- Substantial compliance in J12 was not maintained due to problems in tracking completion of the instruments, review of the instruments, comparison of the documents from one assessment to the next, delays in clinical

consultation/quarterly medication reviews, and issues with both the identification and ongoing monitoring of Tardive Dyskinesia (TD).

- Also concerning was the issue of medication regimen adjustments where changes in medication dosages or the addition/discontinuation of a specific medication were performed concurrently with no time for review of behavioral data to determine the appropriateness of the dosage change.

Psychological Care and Services

- Although only one of the items in this provision was found to be in substantial compliance, the monitoring team acknowledges the hard work of the psychology department, and noted several improvements since the last onsite review. These included initiation of external peer review monthly, an improved data collection system, and initiation of the graphing of replacement behaviors and of the collection of data reliability. In addition, there was evidence of data graphed in intervals necessary to make data-based decisions, and evidence that data were used to make treatment decisions. The department also showed improvements in the comprehensiveness of annual psychological assessments, the quality of PBSPs, and the collection of treatment integrity data.
- The areas in need of work on for the next onsite review include ensuring that all psychologists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts.
    - In terms of assessments, there needs to be an increase in the number of functional assessments for individuals with PBSPs, all functional assessments should include direct observations of target behaviors and a clear summary statement, and all annual psychological assessments contain the necessary components.
    - Graphing of replacement behaviors to all individuals with a PBSP needs to occur, as does ensuring that PBSPs are based on the hypothesized function of the target behavior (K9)
    - The department needs to establish data collection reliability goals, and ensure that those levels are achieved and initiate the collection of IOA.
    - Treatment integrity scores need to be tracked, and treatment integrity goals established., and ensure that those levels are achieved.

Medical Care

- The medical department made some progress, particularly in the provision of services. A mobile x-ray company completed basic roentgenograms onsite and provided digital results within one hour. Clinical staff now had electronic access to the individuals' laboratory results, which was of great benefit in making treatment decisions. An onsite gynecology clinic was added, and medical staffing improved with the addition of a second part-time clinic physician.
- Individuals received basic medical services, such as immunizations, vision, and hearing screenings. They also completed several cancer screenings, such as colonoscopies and mammograms with very high rates of compliance, but problems were noted particularly in the management of chronic issues, such as bowel and seizure management. Several individuals experienced bowel obstructions and required colostomies and the facility reported that an alarming 65% of individuals had refractory seizure disorder.
- The Annual Medical Summaries were not completed in a timely manner and Quarterly Medical Summaries were not done at all. IPN entries were generally written in SOAP format and most were legible.
- Mortality reviews were completed in accordance with state policy for deaths that occurred at the facility. There were no recommendations resulting from the death reviews completed by the facility.
- The facility made some, but not much, progress with regards to the development of a medical quality program and the development of medical policies and procedures.

Nursing Care

- Under the leadership of the CNE, who was appointed six months ago during the prior review, the Nursing Department made significant progress in many areas across the provisions of section M. The positive changes were initially noted during the review of the facility's document submission, self-assessment, action plan, and provision action information, which was completed at a level of competence beyond what was submitted for all prior reviews. The review of the document submission also revealed that the CNE had responded to, and acted upon, all recommendations put forward in the monitoring report.
- Several key positions within the Nursing Department were filled. The Nurse Hospital Liaison, Nurse Educator, and Infection Control Nurse positions were filled with nurses who immediately began to develop their roles and responsibilities.
- The Nursing Department continued to maintain good working relationships with other departments, most notably the quality assurance and pharmacy departments.
- Notwithstanding these positive findings, the results of the facility's self-assessments, audits, monitoring tools, etc. continued to reveal low scores across most provisions of section M. These findings were consistent with the findings of the monitoring team.

Pharmacy Services and Safe Medication Practices

- Progress continued to be seen in most areas of this provision. Communication improved between the clinical pharmacists and the medical staff as did documentation of the communication, but the facility had yet to demonstrate a reliable methodology for reviewing the need for additional laboratory testing and ensuring that it was completed prior to issuing medications.
- Quarterly Drug Regimen Reviews were competed in a timely manner, although the monitoring team identified some problems with the system and the recommendations being generated. The facility continued to have problems in the area of polypharmacy, most notable was the fact that the incorrect definition of polypharmacy was being used.
- Drug Utilization Evaluations were completed in a timely manner, but the P&T minutes did not always document discussion. More important, the minutes did not provide definitive closure for the corrective actions that were identified with the DUES. The facility continued to struggle with the adverse drug reaction reporting system. Very few were reported and most were initiated by the clinical pharmacist. The intense case analysis was completed by the clinical pharmacist and presented to the P&T instead of being referred to committee for review.
- The facility continued to make progress with regards to the medication variance system. Over a period of two years, a series of changes were implemented that resulted in decreased omissions and increased accountability with medications.

Physical and Nutritional Management

- There was a clear and definitive progress from the previous two onsite reviews.
- There was a fully-constituted PNMT, including a full time nurse. A meeting observed during this review showed significant improvement since the last review. Ms. Diaz was seen as a competent leader, appeared to understand PNM and the team process, and was a good facilitator of the meeting.
- There were concerns with issues related to weight loss/low weight for approximately 25 individuals that had not necessarily been identified by the IDTs. It was not acceptable to overlook significant weight loss because an individual continued to fall within his or her calculated ideal body weight range.
- There continued to be concerns related to mealtimes and position and alignment, though both areas were improved. There should be a focus on the less complicated seating systems because many were in poor condition and did not provide proper support and alignment. The therapists would benefit from continuing education in the area of wheelchair seating assessment and selection.
- QAQI Council should carefully examine issues around staff competency-based training and compliance monitoring. There was a tremendous amount of training and monitoring being done, yet staff could not and/or did not fully comply with their responsibilities related to implementation of PNM plans.

Physical and Occupational Therapy

- Significant progress continued to be made. The OT and PT clinicians conducted their annual assessments together and consistently worked in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services.
- Assessment consistency was found to be improved since the last review. The Clinical Coordinator completed audits of assessments that were completed by clinicians. The audit system was thorough, but was not conducted in a manner to establish and maintain competence, but rather was primarily an editing process.
- A number of individuals were listed with direct OT and/or PT as well as programs designed for implementation by DSPs or integrated into other SAPs. Documentation, however, was inconsistent and there was insufficient rationale provided to continue or discharge from services. These interventions were not well integrated into the ISP process.
- The department continued to need to move forward to the implementation of interventions beyond the PNMP with involvement in the home and day program areas to enhance the meaningfulness and functional activities that meet PNM needs.

Dental Services

- The dental clinic made progress in that additional individuals completed assessments and planned treatments and received dental services. Individuals received appropriate care to the extent that it could be delivered given a limited number of dental hours. The use of general anesthesia continued at EPSSLC, as did referral 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 and the number of visits for extractions far exceeded the visits for restorations. The percentage of individuals with poor oral hygiene increased, however, the rating period was changed, making the comparison difficult.
- As a dental system, however, there was not a great deal of progress. Many of the issues that surfaced in the January 2012 review were not addressed. The facility did not develop strategic plans to address oral hygiene or missed appointments.
- The facility utilized a contract dentist who was capable of providing the clinical services needed. His role was that of a clinician and not an administrator and his hours at the facility had been decreased. The clinic had no onsite dental director or administrative leadership.
- Data continued to be problematic and, at times, it appeared as though there was no oversight of the data. Oral hygiene ratings were dated December 2011 and the very first data element in the self-assessment was reported as 125%. Many of the document requests were simply not fulfilled or fulfilled incorrectly.

Communication

- The existing clinicians appeared to be strong in their knowledge and skills, though the variety of AAC and communication programs were limited. The current ratio for caseloads in the cottages and the systems areas continued to be moderately high. The staff were working through the completion of new comprehensive assessments for all individuals and were on track to accomplish this by the end of this calendar year.
- While it appeared that the clinicians were doing a good job of outlining specific communication strategies for use throughout the day, in PBSPs, and in SAPs, few other communication systems had been developed. It was anticipated that over the next six months with strong, consistent professional staff, this would be a focus and greater progress would be made.
- Overall, the monitoring team was very encouraged by the current strategies and infrastructure for staff training and monitoring in place to address communication supports and looks forward to continued progress.

Habilitation, Training, Education, and Skill Acquisition Programs

- Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, there were improvements since the last review. These included the development of a SAP checklist to monitor SAP content, initiation of an interdisciplinary team to develop plans to decrease dental/medical sedation, and expansion the new SAP format. There was also the re-initiation of graphed quarterly SAP data and evidence of data-based decisions for the continuation, discontinuation, or revision of SAPs. There was the initiation of new and creative day programming in the community and continued positive working relationship with the local public school district, with good outcomes for individuals.
- The facility should focus on the following over the next six months. The facility should ensure that the rationale for each SAP clearly states how acquiring this skill is related to the individual's needs/preference, and document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans. Each SAP should have a plan for maintenance. The department should conduct additional training on the implementation and data collection of SAPs, collect and track SAP integrity measures, develop a system to separately track recreational activities and training in the community, and establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved.

Most Integrated Setting Practices

- EPSSLC continued to make progress. The specific numbers of individuals who were placed remained stable, but at a low annual rate of approximately 5%. On the other hand, since the last review, 9 individuals were referred and 12 individuals were now on the referral list, the most at any one time since monitoring began.
- Opinions and determinations of professionals regarding community placement were being addressed more so than at the time of the previous review, however, more work was needed so that this is done in an adequate, thorough, and consistent manner. In reading the professionals' opinions, the monitoring team noted different "approaches" to these comments. There should be a consistent approach to this requirement that includes all three of these approaches.
- Obstacles to referral and placement at the individual level were not identified or addressed in a consistent manner. There was no indication if the identification of these obstacles led to a plan to address them.
- EPSSLC was engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. Most progress was seen in the organization and conduct of tours of community providers.
- The CLDPs included some descriptions of the content of what was to be trained to provider staff, but more detail was needed regarding this training. The CLDP assessments need to focus more upon the individual moving to a new residential and day setting.
- The lists of ENE supports was much improved. Some additional work was needed to ensure implementation of supports were adequately included in the list of ENE supports and that evidence of implementation was adequately defined.
- Since the last review, 12 post move monitorings for five individuals were completed. This was 100% of the post move monitoring that was required to be completed. All (100%) occurred within the required timelines. All (100%) were documented in the proper format, in line with Appendix C of the Settlement Agreement.
- Of the five individuals who received post move monitoring, four (80%) transitioned very well, appeared to be happy, and were having a great life. One individual, however, had difficulty in his placement, likely due, at least in part, to inadequate support provided by the provider.

Guardianship and Consent

- Very good progress was made towards substantial compliance with this provision. For example:
    - The continued efforts of sharing the guardianship process information during annual ISP meetings resulted in 17 additional referrals for guardianship.
    - Five family members filed for guardianship within the past six months with assistance from the Human Rights Officer.
    - Three applications for guardianship were filed with Lulac Project Amistad.
    - The guardianship process was completed for four individuals.

    - The Human Rights Officer provided training on Guardianship and Advocacy Policy to IDT and families.
    - The Priority for Guardianship list was updated.
- Activities for the next six months include:
    - IDTs need additional training and support to adequately determine the need for guardianship based on each individual's ability to capacity to make decisions.
    - The facility should continue to seek guardians and/or advocates for individuals with a prioritized need for assistance in making decisions.

Recordkeeping Practices

- There was continued progress with some of the items of provision V. A new department director was appointed and two new unit clerk positions were created and filled since the last review. This was a major plus for the department.
- Active records were overall satisfactory, however, there still remained numerous errors in recording, legibility, document placement, and document presence. Contents of the IPNs still needed to be resolved. Data and documents were not transferred from the individual notebooks into the active records in a timely manner. Often three or four months had gone by. Further, the individual notebooks were very, if not too, large.
- The new pink binders need to be incorporated into the recordkeeping policy and procedures, and into the monthly unified record audit processes. The master records continued to be satisfactory, however, there was still a need for a process to address missing items that should be present. The shared drive needed to be examined to determine if any unified records documents were only in the shared drive (i.e., electronic).
- An appropriate spreadsheet regarding state and facility policies for each provision of the Settlement Agreement was not maintained. Managing, documenting, and reporting staff training for these policies was needed.
- Monthly quality assurance review audits continued to be done thoroughly and consistently. Unfortunately, the department did not meet the five per month requirement over the past six months. Approximately 20-30 errors were reported for each unified record review. Most errors were related to legible signatures, credential entries, and signatures on verbal and telephone orders. Only about 25% were missing or outdated documents.
- Graphs of department activities and results of monthly audits had not improved. No action was taken to address the six aspects of V4 that were reviewed during the last monitoring review (and reviewed again during this onsite review).

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 looks 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

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>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.</td><td>
Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o DADS Policy: Use of Restraints 001.1 dated 4/10/12
o EPSSLC Policy: Use of Restraints dated 6/11/12
o EPSSLC Self-Assessment
o EPSSLC Provision Action Information Log
o EPSSLC Section C Presentation Book
o FY12 Restraint Trend Analysis Report
o Sample of IMRT Minutes
o EPSSLC QA/QI Council Quality Assurance Report
o List of all restraint by Individual 1/21/12 through 5/8/12
o List of all chemical restraint used for the past six months
o List of all medical restraints used for the past six months
o List of all restraints used for crisis intervention for the past six months
o List of all mechanical restraints for the past six months
o EPSSLC “Do Not Restrain” list
o List of individuals with desensitization plans
o Dental Support/Desensitization plans for Individual #20, Individual #70, Individual #33, Individual #83, Individual #126, Individual #84, Individual #169, Individual #82, Individual #57, and Individual #51.
o Restraint Reduction Committee meeting minutes for past six months
o Training transcripts for 24 EPSSLC employees
o Documentation for medical restraints and ISP for:
• Individual #161, Individual #66, Individual #123 (x2), Individual #111, Individual #116, Individual #118, Individual #89, Individual #50, and Individual #102
o ISPs, PBSPs, and ISPAs for:
• Individual #39, Individual #161, Individual #346, and Individual #13
o A sample of restraint documentation for crisis intervention including:
<table>
<tr><th>Individual</th><th>Date</th><th>Type</th></tr>
<tr><td>#161</td><td>2/16/12</td><td>Chemical</td></tr>
<tr><td>#161</td><td>3/2/12</td><td>Mechanical</td></tr>
<tr><td>#61</td><td>3/21/12</td><td>Physical</td></tr>
<tr><td>#39</td><td>3/22/12</td><td>Physical</td></tr>
<tr><td>#13</td><td>3/25/12</td><td>Physical</td></tr>
<tr><td>#39</td><td>3/30/12</td><td>Physical</td></tr>
<tr><td>#81</td><td>4/16/12</td><td>Physical</td></tr>
</table>
</td></tr>
</table>

	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 Michael Reed, Lead Investigator o Gloria Loya, Human Rights Officer o Valerie Grigg, Director of Behavioral Services Observations Conducted: o Observations at residences and day programs o Unit Morning Meeting 7/17/12 and 7/18/12 o Incident Management Review Team Meeting 7/16/12 o Annual PSP meetings for Individual #274 and Individual #322 o Human Rights Committee Meeting
	Facility Self-Assessment: EPSSLC submitted its self-assessment. It was updated on 6/20/12. 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. The facility reported it was using the audit tools to measure compliance with the Settlement Agreement. Results from this audit were not included in the self-assessment. The self-assessment indicated that all restraint incidents during the review period were reviewed for compliance with the requirements from section C. The facility had developed a restraint discussion form for review of restraints in the daily unit meetings. According to the self-assessment, information from this form was also used to evaluate compliance The facility self-assessment commented on the overall compliance rating for each provision item, based on restraint documentation audited, as well as, commenting on processes in place to address compliance with each item. The facility assigned a rating of substantial compliance to C2, C3, C6, and C8. The facility had met substantial compliance with C2. The other seven provisions in section C were rated as noncompliant. The facility rated C3 in compliance based on training percentages provided by the training department for overall compliance with restraint training requirements. The random sample of 24 training records reviewed by the monitoring team did not support compliance with training requirements. Although comments in the facility self-assessment of C6 acknowledged that medical restraints were not consistently documented as required by the state policy, the facility assigned a substantial compliance rating for this item. The monitoring team did not find compliance with documentation requirements.

The facility assigned a substantial compliance rating to C8 based on a three month sample of restraint reviews. The requirement for review of restraints within three business days was not supported by the sample reviewed by the monitoring team.

There was continued progress in developing an adequate self-assessment process. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the psychology department to identify areas of needed improvement in regards to restraint implementation and documentation. Particularly in areas where compliance ratings were not similar, the facility should review section C for methods used by the monitoring team to assess compliance.

Summary of Monitor's Assessment:

DADS updated its restraint policy as of 4/10/12. The policy included new definitions for each type of restraint and set new guidelines for restraint debriefing and monitoring. The facility had reviewed the new policies and had begun planning for implementation.

Based on information provided by the facility, there were 14 restraints used for crisis intervention between 1/21/12 and 5/8/12. Five individuals were the subject of restraints. This was a significant decrease in the number of restraints reported compared to the previous five month reporting period. The EPSSLC FY 2012 Trend Analysis indicated restraint totals fluctuated from May 2011 to April 2012, but showed an overall decline.

Month	Total Restraints	Month	Total Restraints
May 2011	11	November 2011	5
June 2011	13	December 2011	4
July 2011	10	January 2012	1
August 2011	6	February 2012	2
September 2011	11	March 2012	7
October 2011	8	April 2012	2

From 1/1/12 through 6/29/12, the facility reported 32 incidents of restraint used for medical treatment. This list included pretreatment sedation prior to medical appointments. Only one instance of dental pretreatment sedation was reported.

During observation at the facility, it was found that some protective mechanical restraints were not routinely reviewed by IDTs or reported in terms of restraints at the facility. This needs to be corrected and there was a new statewide plan to do so, as part of the newly revised policies.

Action taken by the facility to address compliance with section C since the last monitoring visit included:

- A restraint discussion form was created to be used in the daily unit meeting to review

	documentation and justification for the use of restraint. • Psychology trained staff on use of the discussion form. • Director of Behavioral Services attended training on the new state restraint policy in Austin. • The Director of Behavioral Services trained the nursing department on restraint policy. • An action plan was developed to address deficiencies noted in the last monitoring team report. • The new statewide restraint policy was adopted by the facility. The facility had made minimal progress in meeting compliance with requirements for documenting and reviewing restraint incidents. The facility was in substantial compliance with one of the eight provision items, and two of the sub-items of provision C7.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The facility provided a list of all restraints used for crisis intervention between 1/21/12 and 5/8/12: • 14 restraints occurred. • 14 were for crisis intervention. • Five individuals were the subject of restraints. • Two (40%) of five individuals only had one restraint during the reporting period. • Three individuals accounted for 12 restraints (86%). • None of the restraint incidents resulted in injuries to individuals. • 10 were personal hold restraints, • Three were chemical restraints, and • One was a protective mechanical restraint (arm splints). This was a considerable reduction from the 39 restraints involving nine individuals reported at the last monitoring visit. Overall, the month to month numbers showed a downward trend except for a spike (of seven) in the month of March 2012 due to an increase in restraints for Individual #39 (four of the seven restraints). There were 33 instances of dental/medical pretreatment sedation reported by the facility since 1/1/12. The new statewide restraint policy required that: • Restraints were not used unless necessary to prevent imminent physical harm in a behavioral crisis, to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior that has not yet been reduced by intensive supervision or treatment. • The least restrictive effective restraint necessary to prevent imminent physical harm in a behavioral crisis, or to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-	Noncompliance

#	Provision	Assessment of Status	Compliance
		injurious behavior was used. • Restraints were not used as punishment, as part of a positive behavior support plan, for staff convenience, or in the absence of or as an alternative to treatment. • Prone and supine restraints were prohibited. A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises. Sample #C.1 was a sample of seven restraints for five individuals. The sample included five physical restraints, one chemical restraint and one mechanical restraint. Three of the individuals in the sample had the greatest number of restraints. Two others had only one restraint. The individuals in this sample were Individual #161, Individual #39, Individual #13, Individual #61, and Individual #81. • Individual #161, Individual #39, and Individual #13 each had four restraints, accounting for 12 (86%) of the 14 restraints for between 1/21/12 and 5/8/12. • Individual #61 and Individual #81 each had one restraint. <u>Prone Restraint</u> Based on the state and facility policy review, prone restraint was prohibited. Employees were trained during New Employee Orientation and annual PMAB training, that prone restraint was prohibited. Based on a review of five physical 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 seven restraints. The following are the results of this review: • In seven of the seven records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • In three of seven (43%) restraints, staff documented events leading to the behavior that resulted in restraints. Exceptions included restraint checklists for: o Individual #161 dated 3/2/12 and 2/16/12, Individual #39 dated 3/30/12, and Individual #13 dated 3/25/12. The behavior leading to the restraint was documented, but not what occurred prior to the behavior.	

#	Provision	Assessment of Status	Compliance
		• Examples where staff adequately described events leading to the behavior: o The restraint checklist for Individual #39 dated 3/22/12 noted the he was refusing to stay in groups and complained of a headache. Staff prompted him to go see the nurse. o The restraint checklist for Individual #61 dated 3/21/12 indicated that he took a peer's soda and became aggressive when prompted to give it back. • Some examples where events leading to restraint were not adequately documented included: o The restraint checklist for Individual #161 dated 3/2/12 documented that she was restrained due to "handmouthing." Staff did not identify events that may have led to her agitation. o Restraint checklists for Individual #39 dated 3/30/12 noted that he attempted to hit staff following "refusal" behavior. There was no indication what he had refused to do or what activity he was engaged in prior to the incident. • In seven of seven records (100%), staff documented that restraint was used only after a graduated range of less restrictive measures had at least been attempted or considered, in a clinically justifiable manner. • On one (14%) of seven restraint checklists, staff documented that individuals were engaged in adequate programming or engaged in any activity prior to the behavior, thus, it was not possible to determine if restraint was used in the absence of or as an alternative to treatment or programming. The restraint checklist for Individual #39 dated 3/22/12 indicated that he was in a group session when the incident occurred. A number of individuals at the facility were wearing protective equipment (i.e., helmets, e.g., Individual #84, Individual #61). The facility was not consistently documenting and monitoring these restraints. IDTs were not addressing alternate strategies to reduce the use of protective equipment. There was no indication that plans to reduce the amount of time spent in restraint were addressed by the IDT. State policies identified a list of approved restraints techniques. Based on the review of documentation for seven restraints, seven (100%) were documented as approved restraints techniques.	

#	Provision	Assessment of Status	Compliance
		Dental/Medical Restraint The facility provided a list of pretreatment sedation and medical restraints to promote healing between 1/1/12 and 6/29/12: this included • 32 instances of pretreatment sedation for medical appointments and one instance of dental pretreatment sedation. Additionally, a list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there were 19 desensitization plans in place. Some progress had been made on developing desensitization plans and/or strategies to minimize the use of medical and dental restraints. The facility was not yet in compliance with provision C1. To do so: • Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, including whether or not the individual was engaged in activities, and all interventions attempted prior to restraint. • The long term use of protective mechanical restraints should be reviewed by the IDT as per the new state regulations and strategies should be developed to reduce the amount of time in restraint. • A schedule for monitoring the restraint and directions for the frequency of release from restraint should be included in ISPs. • Desensitization strategies should be considered by the IDT for all individuals requiring the use of pretreatment sedation for routine medical appointments. • IDTs for should focus on developing ISPs that support meaningful engagement throughout each individual's day.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The new statewide restraint policy required that any individual who is restrained as a result of a behavioral crisis must be released from restraint as soon as he or she no longer poses an imminent risk of physical harm to self or others. It further required that if a Crisis Intervention Plan is in place, the plan must describe the behaviors that signal there is no longer an imminent risk of physical harm to self or others. Safety Plans for Crisis Intervention (SPCIs) were in place for four individuals. Three of those individuals were in the sample reviewed. Psychologists had not yet developed Crisis Intervention Plans that complied with the new statewide guidelines. The Sample #C.1 restraint documentation for five physical restraints and one mechanical restraint 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 seven (86%) restraints reviewed indicated that the individual was released immediately when no longer a danger. The second page of the restraint	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		checklist was not included for Individual #81. • The longest physical restraint in the sample was 15 minutes for Individual #161 on 3/2/12. Four (67%) of the restraints in the sample lasted three minutes or less. The facility was in substantial compliance with C2	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	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 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 • 21 of 24 (86%) had current training in RES0105 Restraint Prevention and Rules. • 12 of the 17 (71%) employees with current training who had been employed over one year completed the RES0105 refresher training within 12 months of the previous training. • 22 of 24 (92%) had completed PMAB training within the past 12 months. o It was particularly concerning that the Incident Management Coordinator and Assistant Unit Coordinator did not have current PMAB training considering both were at some point responsible for determining when restraints were administered correctly. • 16 of the 18 (89%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. The facility had begun training all staff on the new statewide restraint policy. Although the facility was found to be in substantial compliance during the previous monitoring review, based on the sample reviewed at this time, substantial compliance was not maintained. Training for all staff was not completed within the required timeframes. The sample of training records used to assess compliance during this review did not support continued compliance. The facility was still not ensuring that training was completed annually as required by state policy.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 seven restraint records (Sample #C.1), documentation in seven (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 reported 32 incidents of pretreatment sedation used for medical and/or dental treatment in the past six months. The facility was still not capturing data in regards to dental pretreatment sedation or restraint during dental procedures. According to a list provided to the monitoring team, a desensitization program had been developed for 19 individuals since 5/20/12 who needed pretreatment sedation or restraint to have routine medical or dental care completed. The facility had not developed treatment strategies for all individuals who required the use of restraint for routine medical or dental treatment. Ten desensitization/dental support plans were reviewed for individuals requiring the use of pretreatment sedation for dental appointments. All plans in the sample included individualized strategies (also see S1 below). The facility had not developed desensitization strategies for medical appointments. The facility had created a "Do Not Restrain" list. The list was last updated on 12/7/11. There were 16 individuals at the facility who had been identified for placement on this list for which restraints would be contraindicated due to medical or physical conditions. The list did not specify what types of restraints should not be used. The facility physician developed the current list based on individuals identified as having a diagnosis of osteoporosis or identified as high risk for fractures. Not all individuals identified with osteoporosis, however, were on the "Do Not Restrain" list. Individual #81 was not on the "Do Not Restrain" list, though he did have a diagnosis of osteoporosis and was at an increased risk for fractures. He was restrained on 4/16/12. Other risk factors, such as aspiration, had not been considered in the development of the "Do Not Restrain" list. The facility "Do Not Restrain" list should be reviewed and updated frequently based on IDT assessment of risks involved in restraint for each individual. As noted in C1, the facility did not adhere to restraint monitoring and review requirements for all protective mechanical restraints. The facility should ensure that these protective restraints are documented, monitored, and reviewed. Teams should review all uses of protective mechanical restraints and document attempts at reducing the use of these restraints. If medical restraints are required for routine medical or dental care for an individual, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		ISP for that individual should include treatments or strategies to minimize or eliminate the need for restraint. The facility needs to ensure that all individuals are evaluated to determine whether or not restraint would be contraindicated due to risk factors. The facility was not yet in compliance with this provision item.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject 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.	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 seven restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In seven out of seven incidents of restraint (100%), there was assessment by a restraint monitor. • In the seven instances of restraint in the sample, 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 in seven (100%) out of seven instances. An assessment was documented for each restraint incident in the sample, however, restraint monitors were not adequately reviewing the restraint incident and noting errors in documentation or process. For example, • The restraint monitor completed a Face-to Face, Debriefing and Review for Crisis Intervention form for Individual #61 dated 3/21/12. She indicated that the individual was checked by a nurse following the restraint. The nurse's check was four hours late. • The restraint monitor for a restraint incident involving Individual #39 on 3/22/12 did not note that the nursing assessment was completed late. • The restraint monitor for a restraint incident involving Individual #161 on 2/16/12 indicated that the restraint checklist was completed correctly. Staff did not complete the reason for restraint check box or document the individual's actions or staff's actions during restraint. Based on a review of seven physical and chemical restraints for crisis intervention 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 three (43%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #39 dated 3/22/12 and 3/30/12; o Individual #61 dated 3/21/12; and o Individual #81 dated 4/16/12.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A sample of restraints used for medical pretreatment sedation was reviewed for compliance with monitoring requirements. Three of 10 (30%) documented monitoring by a licensed health care professional at least every 30 minutes from the initiation of the restraint. The exceptions were: • Individual #161 dated 6/29/12; • Individual #111 dated 5/17/12; • Individual #116 dated 5/22/12; • Individual #123 dated 5/2/12 and 6/6/12; • Individual #118 dated 5/3/12; • Individual #89 dated 5/23/12; The facility remained out of compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy. Restraint monitors should document any errors in documentation or procedure for restraint incidents.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with	A sample of seven 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 four (57%), continuous one-to-one supervision was indicated as having been provided on the restraint checklist. While it is assumed that one-to-one supervision was provided during physical restraints, staff should be trained to accurately reflect the level of supervision provided on the restraint checklist. • In seven (100%), the date and time restraint was begun were indicated. • In seven (100%), the location of the restraint was indicated. • Three (43%) indicated what events were occurring that might have led to the behavior resulting in restraint (see C1). • In seven (100%), the specific reasons for the use of the restraint were indicated. • In seven (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In six (100%), the names of staff who applied/administered the restraint was recorded. • In five (71%) of seven observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. The exceptions were the chemical restraint for Individual #161 and the physical restraint for Individual #81 (page 2 of the restraint checklist was missing). • In six (100%) of six physical restraint incidents, the date and time the individual was released from restraint were indicated. • In six (86%) of seven restraints, the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other	Noncompliance

#	Provision	Assessment of Status	Compliance
	Appendix A.	negative health effects were recorded. The exception was for Individual #81 (missing second page of restraint checklist). • 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 seven records (Sample #C.1), restraint debriefing forms had been completed for seven (100%). A sample of 10 restraint checklists for individuals receiving medical restraint was requested to ensure enhanced supervision was provided. Documentation of adequate supervision was only documented in four incidents (40%). Exceptions included: • Individual #89 dated 5/23/12 • Individual #118 dated 5/3/12 • Individual #123 dated 5/2/12 • Individual #116 dated 5/22/12 • Individual #111 dated 5/17/12 • Individual #161 dated 6/29/12 The facility had made some progress in adequately documenting restraint incidents, however, remained out of compliance with the documentation requirements of C6.	
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, one individual was placed in restraint more than three times in a rolling 30-day period. This represents a decrease from the two Individuals placed in restraint more than three times in a rolling 30-day period reported during the last review. This individual (i.e., Individual #39) was reviewed (100%) to determine if the requirements of the Settlement Agreement were met. His PBSP, safety plan (CIPs were not yet developed), and individual support plan addendum (ISPA) that occurred as a result of more than three restraints in a rolling 30-day period were requested. The facility indicated that no ISPA meeting occurred following more than three restraints in a 30-day period. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement.	Noncompliance

#	Provision	Assessment of Status	Compliance
		This item was rated as being in noncompliance because no ISPA meeting following more than three restraints in a rolling 30-day period occurred. In order to achieve compliance with this provision item, the ISPA should reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors. Additionally, if any of these factors are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	
	(b) review possibly contributing environmental conditions;	This item was rated as being in noncompliance because no ISPA meeting following more than three restraints in a rolling 30-day period occurred. In order to achieve compliance with this provision item the ISPA should reflect a discussion of possible contributing environmental factors (e.g., noisy environments), and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item was rated as being in noncompliance because no ISPA meeting following more than three restraints in a rolling 30-day period occurred. This item is concerned with a review of potential antecedents to the behavior that provokes restraint. Examples of issues that could be discussed here would be the role of antecedent conditions such as the presence of demands or novel staff on the behavior that provoke restraint. This discussion should also include how relevant antecedent conditions would be removed or reduced (e.g., the elimination or reduction of demands placed) to decrease the future probability of the dangerous behavior.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item was rated as being in noncompliance because no ISPA meeting following more than three restraints in a rolling 30-day period occurred. This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. In order to achieve compliance with this provision item, the ISPA should reflect a discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that provokes restraint. The ISPA minutes should also 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	Individual #39 had a PBSP to address the behaviors provoking his restraint. The following was found: • It was based on the individual's strengths, • It specified the objectively defined behavior to be treated that led to the use of the restraint, • It specified the alternative, positive adaptive behaviors to be taught to the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	individual to replace the behavior that initiates the use of the restraint, and • It specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The PBSP to weaken or reduce the behaviors that provoked restraint, were determined to contain clear, precise interventions based on a functional assessment (see K9). Individual #39's Safety Plan was also reviewed. The following represents the results: ▪ The type of restraint authorized was delineated; • The maximum duration of restraint authorized was specified; • The designated approved restraint situation was specified; and • The criteria for terminating the use of the restraint was 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	Although the facility recently began collecting integrity data, at the time of the onsite review, integrity data were not available demonstrating that Individual #39's 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 at EPSSLC that for some individuals engaging in dangerous behavior, the PBSP was modified when necessary (See K4 for examples). For Individual #39, the psychology department reviewed his PBSP and made an active decision that revision was not necessary. So, based upon the review of the individual's plan, this provision item was found to remain in substantial compliance.	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	A sample of restraint documentation 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. Four restraints in the sample (57%) were signed by the Unit Director within three days. Exceptions were restraints for Individual #161 (3/2/12), Individual #161 (2/16/12), and Individual #39 (3/30/12). Restraints for crisis intervention were to be reviewed in the daily unit meeting. Observation of this meetings confirmed that restraint incidents were reviewed and recommendations were made regarding follow-up (i.e., IDT should meet to discuss the	Noncompliance

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	appropriate.	restraint incident). Psychology staff also reviewed restraint incidents. The facility had a system in place to comment on errors. For example, it was noted that some of the restraint checklists in the sample did not document adequate monitoring by nursing staff. Although this was noted on the tracking form, there was no evidence that it had been adequately addressed. Nurses continued to complete late assessments. Restraints were also referred to the IDT for review and follow-up. The Restraint Reduction Committee reviewed restraint trends for the facility. To gain compliance with C8, the facility will need review all restraints within three business days.	

Recommendations:

1. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, including whether or not the individual was engaged in activities, and all interventions attempted prior to restraint (C1).

2. Desensitization strategies should be considered by the IDT for all individuals requiring the use of pretreatment sedation for routine medical appointments (C1, C4).

3. IDTs for should focus on developing ISPs that support meaningful engagement throughout each individual's day (C1).

4. The long term use of protective mechanical restraints should be reviewed periodically by the IST and strategies should be developed to reduce the amount of time in restraint. A schedule for monitoring the restraint and directions for the frequency of release from restraint should be included in ISPs (C1, C2, C4).

5. 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).

6. Ensure all staff have completed training on restraint implementation and documentation (C3).

7. The facility needs to ensure that IDTs are identifying individuals who should be on the "Do Not Restrain" list. (C4)

8. Monitoring by a nurse should be conducted and documented as required by state policy (C5).

9. Restraint monitors should document any errors in documentation or procedure for restraint incidents (C5).

10. All restraints should be documented consistent with Appendix A (C6).

11. Each individual's ISPA meeting minutes following more than three restraints in 30 days should reflect a discussion of each of the issues presented in C7a-d, and a plan to address factors that are hypothesized to affect the use of restraints. Additionally, there should be evidence that each individual's PBSP has been implemented with integrity, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent) (C7).

12. All restraints should be reviewed within three working days (C8).

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 Section D Self-Assessment 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 EPSSLC UII Action Plan Tracking o Comprehensive Investigator Training Curriculum o Unusual Incidents Training Curriculum o Preventing Abuse, Neglect, and Exploitation Training Curriculum o Information used to educate individuals/LARs 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 Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o List of staff who failed to report abuse, neglect, or exploitation (10) 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 (7) o Abuse/Neglect/Exploitation Trend Reports FY12 o Injury Trend Reports FY12 o QAQI Quarterly Report o List of incidence for which the reporter was known to be the individual or their LAR o List of employees that say they have been retaliated against for reporting allegations 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 Discovered injury investigations for Individual #112 dated 5/24/12 and Individual #32 dated 4/16/12. o ISPs for: • Individual #157, Individual #90, Individual #178, Individual #71, Individual #161, Individual #66, Individual #13, Individual #36, Individual #61, and Individual #84 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

- List of all serious injuries for the past six months
- List of all injuries for the past six months
- List of all ANE allegations since 1/1/12 including case disposition
- List of all investigations completed by the facility since 1/1/12
- List of employees reassigned due to ANE allegations
- Documentation of employee disciplinary action take with regards to the last three incidents of confirmed abuse or neglect.

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

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#41582932	Physical Abuse	Confirmed	3/21/12 6:18 pm	3/22/12 11:40 am	3/29/12
#41627312	Neglect	Confirmed	3/27/12 12:26 pm	3/28/12 1:49 pm	4/4/12
#41631612	Emotional/Verbal Abuse (3) Physical Abuse (1)	Unconfirmed (3) Unconfirmed (1)	3/27/12 3:05 pm	3/28/12 10:24 am	4/6/12
#41708995	Physical Abuse	Unconfirmed	4/4/12 5:42 pm	4/5/12 10:06 am	4/5/12
#41733453	Emotional/Verbal Abuse Physical Abuse	Confirmed Confirmed	4/7/12 9:45 pm	4/8/12 7:56 pm	4/16/12
#41781754	Physical Abuse	Unconfirmed	4/12/12 9:18 pm	4/15/12 3:00 pm	4/21/12
#41962592	Neglect	Confirmed	5/2/12 11:45 am	5/2/12 3:32 pm	5/7/12
#41999853	Neglect	Confirmed	5/7/12 5:00 am	5/7/12 4:15 pm	5/9/12
#42141713	Emotional/Verbal Abuse (1) Physical Abuse (4)	Unconfirmed (1) Unconfirmed (4)	5/21/12 5:15 pm	5/22/12 1:23 pm	6/1/12
#42218633	Physical Abuse	Unconfirmed	5/30/12 4:00 pm	6/7/12 9:57 am	6/8/12
#42259033	Neglect (3)	Confirmed (3)	6/3/12 5:25 pm	6/4/12 4:15 pm	6/13/12
#42290333	Physical Abuse	Unconfirmed	6/6/12 6:11 pm	6/7/12 10:01 am	6/15/12

Sample D.2	Type of Incident	DFPS Disposition	Date of DFPS Referral	DFPS Completed Investigation	Facility Completed Investigation
#41418943	Neglect	Unconfirmed Clinical Referral	3/1/12	3/7/12	3/7/12
#41844793	Neglect	Clinical Referral	4/19/12	4/18/12	4/20/12
#42258795	Neglect	Administrative Referral	6/3/12	6/13/12	6/15/12
Sample D.3	**Type of Incident**	**Date/Time of Incident Reported**	**Director Notification**		
#12-052	Serious Injury	2/9/12 4:30 pm	2/9/12 5:00 pm		
#12-072	Serious Injury	3/29/12 10:15 am	3/19/12 10:20 am		
#12-087	Serious Injury	6/2/12 6:45 am	6/2/12 5:45 pm		
#12-094	Serious Injury	6/12/12 10:45 pm	5/12/12 11:00 pm		
#12-095	Serious Injury	6/15/12 3:00 pm	6/18/12 unknown		

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs
- Jaime Monardes, Facility Director
- Mario Gutierrez, Incident Management Coordinator
- Michael Reed, Lead Investigator
- Gloria Loya, Human Rights Officer
- Andy Abrams, Director, Office of Inspector General

Observations Conducted:

- Observations at residences and day programs
- Unit Morning Meeting 7/17/12 and 7/18/12
- Incident Management Review Team Meeting 7/16/12
- Annual PSP meetings for Individual #274 and Individual #322
- Human Rights Committee Meeting

	Facility Self-Assessment: EPSSLC submitted its self-assessment. It was updated on 6/29/12. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one listed the actions that the facility completed towards substantial compliance with 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. The facility had implemented an audit process using similar activities implemented by the monitoring team to assess compliance. Rather than choosing a sample to audit, for most provisions, it appeared that the facility commented on procedures in place rather than looking at a specific sample to determine if those procedures were being followed or effective. For example, for item D3g, the facility self-assessment indicated that the IMC reviewed all investigations completed by DFPS. There were no comments regarding the adequacy of reviews. For item D2f, the self- assessment noted that an informal monitoring system is in place to identify any missing rights posters. The self-assessment did not note if posters had been found missing and replaced. The facility self-assessment indicated substantial compliance with 21 out of 22 items in section D. The monitoring team found the facility to be in substantial compliance with 18 of the 22 provision items. The facility rated D2e as noncompliant. The monitoring team found compliance with D2e based on the sample reviewed. The monitoring team only looked at the most recent sample of ISPs which could account for the different compliance percentages. It appeared that a system was now in place to ensure compliance with D2e. The monitoring team did not find compliance for D2d, D3g, D3i, and D4. The facility should consider an audit system that looks at a sample corresponding with each provision item to ensure that systems in place are achieving compliance with each item and any problems are identified and corrected. Trend reports should be used to analyze whether or not compliance with section D requirements has an impact on the number of incidents and injuries at the facility. Ultimately, a reduction in these numbers should be a result of improvements in the incident management system .

	Summary of Monitor's Assessment: According to EPSSLC's FY12 Quarterly Report, DFPS conducted 43 investigations at the facility between 12/1/11 and 5/31/12, involving 20 allegations of physical abuse, nine allegations of verbal/emotional abuse, one allegation of exploitation, and 42 allegations of neglect. Of the 72 allegations, there were five confirmed cases of physical abuse, and 21 confirmed cases of neglect. An additional 16 other serious incidents were investigated by the facility, including three deaths. There were a total of 534 injuries reported between 1/1/12 and 5/30/12. These 534 injuries included 10 serious injuries resulting in fractures or sutures. It was not evident that the facility was adequately addressing the high number of injuries documented at the facility with preventative actions. Documentation indicated that a large number of injuries were resulting from behavioral issues, including peer-to-peer aggression. The facility needs to aggressively address trends in injuries and implement protections to reduce the number of incidents and injuries. Some positive steps taken to address the provision items of section D included: • Formation of an ANE committee to review incident trends. • Revised the training curriculum to emphasize the mandate to report suspected abuse and neglect. A considerable focus had been placed on documentation and investigation of unusual incidents at the facility, but there had still been little focus on the prevention and reduction of unusual incidents. The thorough investigation and documentation of incidents should ultimately result in identification of those factors that continue to contribute to incidents at the facility. Recommendations resulting from investigations should include a focus on systemic issues that are identified and action steps should be developed to address those issues. Some systemic issues that appear to contribute to the alarming number of incidents and injuries at EPSSLC included: • Poorly trained staff, • Inadequate programming options, • Inadequate staffing patterns, • Lack of attention to risk factors, and • Failure to provide interdisciplinary supports. The facility needs to focus next on: • 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. • Taking an integrated, aggressive approach to restructuring environments, supports, and programming to adequately meet the needs of individuals at EPSSLC and protect them from harm.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The 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 appeared committed to ensure that abuse and neglect of individuals was not tolerated, and encouraged staff to report abuse and/or neglect, as illustrated by examples provided throughout this section D of the report. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, 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	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	Substantial Compliance

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	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.	• 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 43 investigations involving 72 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility between 12/1/11 and 5/31/12. From these 72 allegations, there were: • 20 allegations of physical abuse: o 5 were confirmed, o 14 were unconfirmed, and o 1 was inconclusive. • 42 allegations of neglect: o 21 were confirmed, o 12 were unconfirmed, o 1 were inconclusive, and o 8 were referred back to the facility for further investigation. • 9 allegations of emotional/verbal abuse: o 4 were confirmed, o 4 were unconfirmed, and o 1 was inconclusive. The facility reported that there were 16 other investigations of serious incidents not involving abuse, neglect, or exploitation between 12/1/11 and 5/31/12. This included: • 3 deaths, • 10 serious injuries, • 2 choking incidents, and • 1 unauthorized departures. This was a decrease from the 27 serious incidents reported during the five months prior to the last onsite visit. From all investigations since 1/1/12 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	

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		this sample (12 cases). • Sample #D.2 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation (3 cases). • Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS (5 cases). Based on a review of the 12 investigative reports included in Sample #D.1: • 10 of 12 reports in the sample (83%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. o In DFPS #41781754, an allegation of physical abuse was reported late by a DSP who allegedly witnessed the incident over two hours prior to reporting. The staff member was retrained on reporting procedures o In DFPS #41631612, allegations of abuse were reported to the Campus Administrator (CA) by a DSP. The CA then reported the allegations to the Incident Management Coordinator (IMC). According to the UIR, the DSP told the CA that she would not report to DFPS because she feared retaliation from administrative staff. The CA and Residential Supervisor contacted the DSP several times over the next two days requesting that she report the incident to DFPS. The CA and IMC did not report the incident to DFPS after attempts to reach the DSP were not successful. The DSP finally reported the incident two days later to DFPS. The DSP received disciplinary action for late reporting. No action was taken regarding the CA or IMC's failure to report the incident, but should have been. Immediate protections were not put into place and evidence was not secured until the incident was reported to DFPS. • 12 of 12 (100%) indicated the facility director or designee was notified within one hour by DFPS. • Seven of seven (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • 12 of 12 (100%) indicated that the state office was notified as required. • None of the cases in the sample were reportable to DADS Regulatory. In reviewing Sample D.3 (serious incidents), documentation indicated: • Four of five (80%) were reported immediately (within one hour) to the facility director/designee. UIR #12-095 documented notification of the director, but did not include the time of notification. • Documentation of state office notification, as required by state policy, was found in five of five (100%) UIRs.	

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		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 that contained information about notifications was included in: • 12 out of 12 (100%) investigation files in Sample #D.1. • 8 of 8 (100%) investigation files in Sample #D.2 and Sample #D.3. 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 a random sample of 24 employees at the facility. All employees (100%) in the sample had signed this form. The facility was in substantial compliance with this item, however, administrative staff should be made aware that they also have an obligation to report allegations of abuse, neglect, or exploitation and ensure immediate protections are put into place.	
	(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 policy 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 12 investigation reports included in Sample D.1, in 12 out of 12 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. The monitoring team was provided with a log of employees who had been reassigned since 1/1/12. The log included the applicable investigation case number and the date the employee was returned to work or, in some cases, was discharged. All allegations were discussed in the daily IMRT meeting and protections were monitored through meeting minutes for each open investigation. In 12 out of 12 cases (100%), there was no evidence that the employee was returned to his or her previous position 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 12 investigation files in Sample D.1, 14 (100%) UIRs documented at least some additional protections implemented following the incident. This typically consisted of three actions, including placing the AP in a position of no client	Substantial Compliance

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		contact, a head-to-toe assessment by a nurse, and an emotional assessment. There were no other immediate actions taken. The facility needs to more thoroughly document all immediate corrective action taken, including but not limited to discussion by the IDT, and environmental modifications. Careful consideration should be given to the immediate protections needed for each incident. The facility was in substantial compliance with this provision. All immediate corrective action should be documented in the investigation file.	
	(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. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included four employees hired within the past year. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 20 (100%) of 20 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. • 15 (75%) of the 20 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: • Six (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The facility was in substantial compliance based on current training percentages. There had been an improvement in ensuring that training was completed on time since the last monitoring visit, however, there were still a number of employees that failed to complete training in a timely manner. In order to maintain substantial compliance with this provision item, the facility needs to ensure that all employees complete training annually as required by state policy.	Substantial Compliance

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	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter. A sample of this form was reviewed for a random sample of 24 employees at the facility. All employees (100%) in 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. The facility reported that 10 employees failed to report abuse, neglect, or exploitation or did not cooperate with investigators during an investigation in the past six months (in eight different investigations). The facility was now tracking action taken in cases where an employee failed to report abuse, neglect or exploitation. As noted in D2a, in DFPS case #41631612, the Campus Administrator, Residential Supervisor, and Incident Management Coordinator were aware of an allegation that was not reported to DFPS immediately. The DSP was disciplined for not reporting the allegation, but the facility failed to acknowledge administrative staff's obligation to report the incident. When an allegation is reported to administrative staff, that staff then has an obligation to ensure that a report is immediately filed with DFPS. As a result, the facility did not maintain substantial compliance with this provision item.	Noncompliance
	(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. It was a clear and easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. A sample of 10 ISPs developed after 1/1/12 was reviewed for compliance with this provision. The sample ISPs were for Individual #172, Individual #90, Individual #178, Individual #71, Individual #161, Individual #66, Individual #13, Individual #36, Individual #61, and Individual #84. • Nine (90%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The exception was the ISP for Individual #84. In informal interviews with individuals during the review week, all individuals	Substantial Compliance

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		questioned were able to describe what they would do if someone abused them or they had a problem with staff. Most individuals named a staff member that they were comfortable telling they had a problem. The facility provided a list of four investigations since 1/1/12 where the individual self-reported abuse or neglect indicating that at least some individuals at the facility knew how to report abuse or neglect to DFPS. The facility self- assessment indicated that, based on a review of ISPs for inclusion of documentation that reporting information was shared with the individuals and/or the LAR (38%), this provision item was not in compliance. For the sample reviewed by the monitoring team, however, this information was included in 90% of the ISPs. The facility was in substantial compliance with this item.	
	(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 human rights officer with her name, picture, and contact information. The facility remained in substantial compliance with this provision item.	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 12 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and OIG of the allegation in seven (100%), as appropriate. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good	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 by stating that any employee or	Substantial Compliance

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	faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of EPSSLC. • 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 occurred. The facility was asked for a list of staff who alleged that they had been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. The facility reported one case where fear of retaliation was reported. It was investigated. Based on a review of investigation records (Sample #D.1), there were no other concerns noted related to potential retaliation for reporting. The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Staff were required to notify the facility director and DFPS of injuries of unknown origin where probable cause cannot be determined and to DADS Regulatory if the injury was deemed serious. The facility continued to: • Audit records to ensure that all serious injuries and unusual incidents were reported and investigated. • Review serious, repeated, or suspicious injuries in the daily unit meetings. • Conduct abbreviated investigations for discovered injuries that were suspicious in nature, involved individuals who had repeated injuries, discovered injuries for individuals who were on 1:1 level of supervision, or injuries to vulnerable areas. The monitoring team observed daily unit meetings held the week of the onsite review. All injuries were reviewed and discussed by the team. Serious injuries and trends of injuries were reviewed and recommendations were made by the team for follow-up. Additional information was requested when appropriate. Discovered injury investigations were reviewed for Individual #112 and Individual #32. Investigations were conducted by the facility investigator on non-serious injuries where the cause was unknown. Investigations included witness statements and a review of observation notes and injury reports. An additional sample of serious client injuries was reviewed for serious injuries occurring in the past six months to determine if injuries were reported for investigation. All serious injuries were routinely investigated by facility investigators.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	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. Seven DFPS investigators were assigned to complete investigations at EPSSLC. The training records for DFPS investigators were reviewed with the following results: • Seven investigators (100%) had completed the requirements for investigations training. • Seven DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. EPSSLC had four employees designated to complete investigations. This included the IMC, Facility Investigator, and Campus Administrators. 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. One of the Campus Administrators was late completing his refresher training. • Four (100%) had completed Root Cause Analysis according to training transcripts reviewed. The Campus Coordinators had not completed this course. There was no evidence that they had completed any of the investigations in the sample. • Four (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Trained investigators were completing all investigations at the facility. Additionally, facility investigators did not have supervisory duties, therefore, they would not be within	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		the direct line of supervision of the alleged perpetrator. The facility needs to ensure that all required trainings are completed within the mandated timelines.	
	(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 staff in any of the investigations failed to cooperate with the investigators.	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: • Of the 12 investigations completed by DFPS (Sample #D.1), seven 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. During the week of the monitoring review, the monitoring team had the opportunity to meet with Andy Abrams, OIG Director from state office. Discussion topics were OIG's role and practices, their positive relationship with EPSSLC, and their involvement in recent cases. This information was very helpful to the monitoring team in understanding OIG's role and the monitoring team appreciated the opportunity to meet with Mr. Abrams. The facility was found to be in substantial compliance with this provision.	Substantial Compliance
	(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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. • As noted in D2a, the facility failed to immediately safeguard evidence when an allegation was reported to the Incident Management Coordinator and staff delayed reporting the allegation to DFPS in case #41631612. Video surveillance was in place throughout EPSSLC, and investigators were regularly using video footage as part of their investigation. The facility remained in substantial compliance with this item.	
	(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 Contact occurred within 24 hours in 10 of 12 (83%) investigations. Exceptions included DFPS #41631612 and DPFS #41781754. • Twelve (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. This included gathering documentary evidence and making initial contact with the facility. • 11 of 12 (92%) were completed within 10 calendar days of the incident. • An extension was filed in the case that was not completed within 10 calendar days. Investigation #42141713 was the lengthiest investigation in the sample. It was completed on the 11th day. OIG was also investigating the incident, which may have resulted in a delay in the DFPS investigation. • All 12 (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 10 of the 15 DFPS investigations reviewed in Sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Three of those cases resulted in referrals back to the facility for further investigation. Concerns were appropriate based on evidence gathered during the investigation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Facility Investigations The following summarizes the results of the review of investigations completed by the facility from sample #D.3 : • Five (100%) of the UIRs reviewed indicated that the investigation began within 24 hours. • Five of five (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Three of five investigations included recommendations for corrective action. The facility was in substantial compliance with this item.	
	(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	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. DFPS Investigations 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 12 (100%), each serious incident or allegations of wrongdoing; o In 12 (100%), the name(s) of all witnesses; o In 12 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 12 (100%), the names of all persons interviewed during the investigation; o In 12 (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 12 (100%), all documents reviewed during the investigation; o In 12 (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. The facility had begun attaching an allegation and injury history to each investigation. This was a useful tool for the facility to identify investigation and injury trends.	Substantial Compliance

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	investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	o In 12 (100%), the investigator's findings; and o In 12 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of five facility investigations included in sample #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In five (100%), each serious incident or allegations of wrongdoing; o In five (100%), the name(s) of all witnesses; o In five (100%), the name(s) of all alleged victims and perpetrators when known; o In five (100%), the names of all persons interviewed during the investigation; o In five (100 %), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. o In five (100%), all documents reviewed during the investigation; o In five (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim known to the investigating agency. o In five (100%), the investigator's findings; and o In five (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this item.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 15 DFPS investigations included in Sample #D.1 and #D.2: • In 15 (100%) investigative files reviewed from Sample #D.1 and #D.2, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Sample #D.1,	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 12 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. o Eight of 12 (67%) were reviewed by the facility director and Incident Management Coordinator within five working days of receipt of the completed investigation. Exceptions included: ▪ DFPS #41582932 – reviewed 7 working days after completion, ▪ DFPS #42259033 – The investigation was completed on 6/4/12 and had not yet been signed by the facility director. The IMC had signed, but not dated the UIR. A methodological review by DFPS was requested. ▪ DFPS #41733453 – reviewed 10 working days after completion, ▪ DFPS #42290333 – reviewed six working days after completion. DFPS noted concerns or made recommendations in seven (58%) of the cases in sample #D.1. The facility maintained a log of follow-up action taken to address concerns and recommendations. • The facility tracking log included follow-up to DFPS concerns in four of the seven cases. • Documentation of follow-up to all DFPS concerns was found in six (86%) of the seven investigation files in the sample. o In DFPS #41999853, DFPS expressed concern regarding the failure of a witness in the case to document events. The facility UIR included a recommendation to address the concern. Follow-up was not documented in the investigation file. Sample #D.2 included three investigations that were referred back to the facility for further review. • Two were clinical issues referred back for further review by the facility. One case included a referral for an administrative issue. Reviews were completed by the facility in all cases. It appeared reasonable for all of these investigations to have been referred back to the facility for clinical reasons. • Documentation included a statement that a clinical review was completed in both cases where a clinical referral was made. • Details on these two cases are presented below and indicate the need for the facility to seriously attend to cases that are referred back to the facility for clinical reasons.	

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		Regarding Individual #63 DFPS 41844793 • Although it appeared as though this incident was referred back to the facility for peer review, there were no peer reviews for nursing conducted over the past six months. • Individual #63 suffered constipation, cough, elevated blood-ammonia levels (possibly medication induced), refused to eat and was seen by the MD on 4/6/12 because he "refused to eat x 5 days," and diarrhea on at least three occasions - 3/5/12, 4/1/12, and 4/8/12. • He was hospitalized on 4/9/12 for a very complicated pneumonia and required surgery. His record, however, did not indicate weight loss until he returned to the facility after he was hospitalized. There were, however, serious question regarding the validity of his weight data, which indicated he gained 31 pounds in one month. This was highly unlikely and never checked/verified. • There were many problems with this individual's nursing care after he returned to the facility, such as the physician's orders for three-day calorie count and dietary consultation were not implemented, the comprehensive nursing assessment completed after his return to the facility from the hospital was incomplete, and he failed to have adequate and appropriate planned interventions to address his health problems, needs, and risks. Regarding Individual #154 DFPS #41418943 • The facility QA Nurse conducted a QA Death Review for this individual. There were a number of findings and recommendations. There was evidence of actions taken to address only two of the 10 recommendations . • There was also no evidence that the Medical Director and the CNE collaborated on developing clinical indicators for the medical bowel management protocol, as recommended. • Individual #154's record indicated that in the year preceding her death she lost over nine pounds, but the exact amount is not known, because she was not weighed during the month preceding her death. This, and other problems, plagued the diet/nutrition/weight management processes at EPSSLC (see section M below). Two daily review meetings (IMRT) were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility.	

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		Facility Investigations • In four of five (80%) UIRs from sample #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon within five working days of completion. The exception was UIR #12-087. • Two of the UIRs included recommendation for follow-up. Documentation of follow-up was included in both of the investigative records, however, as noted in D3i, recommendations were not always adequate to protect individuals from further harm. The facility needs to ensure that all investigations are reviewed in a timely manner to ensure immediate completion of follow-up action when indicated. This item was not in substantial compliance.	
	(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 20 out of 20 (100%) 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 the sample. Six investigations in Sample D.1 included confirmed allegations of abuse or neglect. Documentation provided by the facility indicated that disciplinary action had been taken in five of six cases. Disciplinary action was still pending in DFPS case #42259033. The facility had developed a log to track follow-up action taken in regards to recommendations included in investigations. In seven of 12 DFPS cases reviewed from Sample #D.1, DFPS documented additional concerns or recommendations. In six of those seven cases (86%), the facility investigation file included documentation that concerns or recommendations were addressed. The exception was DFPS #41999853. DFPS expressed concern regarding the failure of a witness in the case to document events. The facility UIR included a recommendation to address the concern. Follow-up was not documented in the investigation file. Recommendations for programmatic actions were made in two of five cases reviewed for facility investigations in Sample #D.3. None of the cases documented that adequate protections were put into place to prevent similar incidents from occurring. It was not yet evident that the facility had a system in place to ensure swift programmatic action	Noncompliance

#	Provision	Assessment of Status	Compliance
		was taken to reduce the chance of similar incidents occurring. • UIR #12-052 involved a serious injury resulting from peer-to-peer aggression. This was the third incident in a three month period where the individual involved had turned over a peer's wheelchair. Two of the incidents resulted in serious injury to another individual. It was not evident that appropriate protections were put into place following the first two incidents. o The IDT met following the incident, but did not put immediate protections in place to ensure that other individuals in the home were safe. The team ruled out consultation with the BSC, on the basis that his risk of challenging behaviors had not changed from a medium risk. The individual was eventually moved to a different home 20 days after the incident occurred. • No recommendations were made for follow-up in UIR #12-072 on 6/2/12. The IDT met following the incident, but felt that this was an isolated incident not requiring additional protections to be put into place. • UIR #12-087 was investigation of a fracture attributed to SIB. There were no recommendations for additional protections to be put into place following the incident. The facility injury database indicated that she had 43 injuries documented over the previous year. Thirty-seven of those were attributed to SIB. It was noted on 4/12/12 that she was displaying an increase in agitation. Psychology attributed her behavior to attention seeking. On 6/26/12, she was seen in Neuro-Psychiatry Clinic and changes were made in her medication. The team also discussed revising her BSP at this time. It was not evident that immediate protections were put into place. • UIR #12-094 was a serious injury attributed to SIB. A reasonable recommendation was made for the IDT to meet and rule out pain as a possible contributing factor to the increase in SIB. The investigation file included emails within the nursing department discussing the individual's need for a therapy assessment. There was no documentation that the assessment was completed or any other action was taken to rule out pain as a cause of the SIB. • UIR #95 was the investigation of a serious injury which occurred when the individual turned over in his wheelchair. The UIR did not include any recommendations for follow-up. There was no indication that the IDT met following the incident. o Appropriate recommendations should have included IDT discussion of the incident, follow-up medical care needed, review of staffing levels in the community, and an assessment of his wheelchair to rule out damage. The facility did not have a system in place to assess whether outcomes of disciplinary or programmatic actions corrected a situation and/or prevented recurrence. For example,	

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		training or retraining of staff was the recommended action taken to address identified problems with staff performance related to incidents. There was no indication that any type of review or monitoring occurred to determine if the training resolved the issue. The facility needs to ensure that appropriate follow-up action is completed and documented. Follow-up needs to occur to ensure problems identified are corrected and remain corrected. The facility did not achieve 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.	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 allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had recently implemented the new statewide system to collect data on unusual incidents and investigations. Data were collected through the incident reporting system and trended by type of incident, staff alleged to have caused the incident, individuals directly involved, location of incident, date and time of incident, cause(s) of incident, and outcome of the investigation. Positive steps taken towards compliance included: • The facility had initiated a new process of compiling data on both a monthly and quarterly basis for allegations of abuse, neglect, mistreatment, and other unusual incidents and injuries. • An ANE committee had been formed to meet monthly in order to address trends, systemic problems, and barriers to protecting individuals. Trend reports were up-to-date and included an analysis of the data gathered by the facility. Recommendations for action to address trends were not included in the trend reports or in the facility's QA reports. Minutes from the ANE Committee indicated that trends were identified by the group (i.e., a number of incidents and injuries occurred because staff were not following PNMPs or BSPs). There was no evidence that the facility had developed a plan of correction to address systemic issues identified by the committee. 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	Noncompliance

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		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. The facility was not in substantial compliance with this provision item. The monitoring team expects to see the incident management department start to take a role in the facility's overall approach to addressing the frequency of occurrence of unusual incidents and injuries at EPSSLC. They should help to determine and address factors that contributed to incidents and injuries at the facility, such as lack of supervision, competently trained staff, ensuring preventative supports are in place, and availability of meaningful programming.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. 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. 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.	Substantial Compliance

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		According to information provided to the monitoring team, for FYI 12, criminal background checks were submitted for 582 applicants. There were a total of 9 applicants who failed the background check in the hiring process and therefore were not hired. 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 reported that an acknowledgement form was not available for nine of the employees in the sample. The facility remained in substantial compliance with this provision item.	

Recommendations:

1. Administrative staff should be made aware that they also have an obligation to report allegations of abuse, neglect, or exploitation and ensure immediate protections are put into place (D2b).

2. The facility needs to ensure that all employees complete training annually as required by state policy (D2c).

3. The facility needs to ensure that all required training is completed within the mandated timelines (D3a).

4. 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).

5. Cases referred back to the facility for clinical reviews reasons must be thoroughly investigated and handled (D3g).

6. The facility needs to ensure that appropriate follow-up action is completed and documented. Follow-up needs to occur to ensure problems identified are corrected and remain corrected (D3i).

7. Address factors that contributed to incidents and injuries at the facility such as lack of supervision, competently trained staff, environments, ensuring preventative supports are in place, and availability of meaningful programming (D4).

8. 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 are 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 #003.1: Quality Enhancement, new policy revision, dated 1/26/12 o EPSSLC facility-specific policy, "Quality Assurance Local Policy," dated 6/8/12, though it was merely a copy of the state policy • Signature sheets for two training sessions on this policy, April 2012 o Email from DADS assistant commissioner describing the formation of the statewide SSLC leadership council, 3/5/12 o Draft Section E self-assessment tool from state office, revised draft June 2012 (though still dated April 2012) o EPSSLC organizational chart, undated, but probably June 2012 o EPSSLC policy lists, undated, but probably June 2012 o List of typical meetings that occurred at EPSSLC, undated o EPSSLC Self-Assessment, 6/29/12 o EPSSLC Action Plans, 6/29/12 o EPSSLC Provision Actions Information, most recent entries 6/29/12 o EPSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/16/12 o EPSSLC DADS regulatory review reports, including 2567 for 6/25/12 onsite annual survey o List of all QA department staff and their assigned responsibilities, undated o EPSSLC QA department meeting notes, February 2012 through June 2012 (4 meetings) o EPSSLC QA plan narrative, undated but likely June 2012 o EPSSLC data listing/inventory, hard copy and electronic version, 6/12/12 o EPSSLC Quality Assurance matrix, included in hard copy and in electronic spreadsheet, 6/12/12 o List of databases and spreadsheets developed and maintained by the QA department, 6/30/12 o Set of blank tools used by QA department staff (6) o Trend analysis reports, all four data sets, one quarter, December 2011 through February 2012 o EPSSLC QA Reports, monthly, January 2012 through July 2012 (7) o Integration Committee minutes for 7/9/12 and agenda for meeting on 7/16/12 o Monitoring Committee minutes, 2/7/12 through 5/30/12 (5) and agenda and handouts for meeting on 7/19/12 o Data collection reduction committee summary report o Assessment database, two graphs, 1/1/12 through 7/31/12 o QAQI Council charter, undated o QAQI agenda and meeting minutes from 1/11/12 through 5/23/12 (8 meetings) o QAQI Council agenda and handouts, for 7/18/12 meeting o EPSSLC Corrective Action Plan, tracking, about 50 pages, undated but likely June 2012 o CAPs database screenshots

	o EPSSLC staff satisfaction survey information, including announcements, blank survey, results, summary of results, and action plan o Employee Advisory Committee Forum information o Brown Bag Lunch summaries o Town Hall Staff Forum summaries o DADS EPSSLC family satisfaction survey online summary, combined data since its inception o Bi-monthly facility newsletter, February 2012 through June 2012 o Self-advocacy monthly meeting minutes, monthly January 2012 through May 2012 o Notes about other self-advocacy group activities o Home meeting agenda and notes (none) <u>Interviews and Meetings Held</u>: o Victor Quiroz, Director of Quality Assurance o QA department staff: Elaine Lichter, Erna Matthews, Hector Sanchez, Elizabeth Rodriguez o Angela Brooks, Unit Director o Three meetings with family members of four individuals <u>Observations Conducted</u>: o Integration meeting, 7/16/12 o Monitoring meeting, 7/19/12 o QAQI Council meeting, 7/18/12 o Self-advocacy group, 7/19/12
	Facility Self-Assessment EPSSLC continued to use the self-assessment format it developed for the last review. The QA director had further developed what he presented last time by including additional activities and outcomes. In that regard, he made progress in that he was trying to look at actual activities and outcomes for each provision item. The most important next step is for the QA director to make sure that he includes everything in his self-assessment that the monitoring team looks at. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in his self-assessment (and perhaps in a new self-assessment tool, too). It is possible that new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. At this time, there was no self-monitoring tool for section E (though one was in development at state office). For example, for E1, the QA director self-assessed by looking at staff satisfaction survey, the QA plan, the self-monitoring tools for each provision item, external medical audits, the FSPI, and the QA matrix. These were all part, but not all, of what the monitoring team looks at.

	While onsite, the monitoring team was given a revised draft statewide self-monitoring tool for section E. This statewide tool was a vast improvement from the previous version and accomplished some of what is described in the paragraph immediately above. Although a good revision, the tool did not include all of the areas looked at by the monitoring team (see report below). Nevertheless, with further revision and additions, this tool may be useful to the QA department. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the QA director and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in noncompliance with all five provision items of section E. The monitoring team agreed with these self-ratings, however, as noted in the narrative report below, progress continued to be evident since the time of the last onsite review.
	Summary of Monitor's Assessment: EPSSLC continued to make good progress towards substantial compliance with many of the items of provision E. This was due to the extensive efforts of the QA director and the QA staff. A facility-specific policy regarding how QA operates at EPSSLC was still needed. Training and orientation of both the state and facility policies occurred for some, but not yet all, relevant management and clinical staff. The new SAC and the QA director appeared to be developing a good working relationship. They should work on formalizing some of the aspects of their work that would support each other. The QA department had made good progress towards creating a listing/inventory of data collected at the facility. It was managed as an electronic spreadsheet with 20 separate tabs. The next step is to ensure that the list is comprehensive and as complete as possible. It did not yet include all data. For instance, data from the QA matrix, key indicator list, and databases and spreadsheets need to be included. The QAD and SAC should always be adding and editing this spreadsheet as they learn about data being collected at the facility. The EPSSLC QA narrative was an excellent first version. It was 12 pages, lengthy, but acceptable. Editing is now required to reduce some areas, so that they take up less space. On the other hand, paragraphs should be added describing the QA data listing inventory and the QA matrix. The QA matrix was also much improved from the previous report. The QA staff program auditors were busy conducting and documenting observations and monitoring. EPSSLC had not yet begun to revise any of the current self-monitoring tools or to create new tools. The exception was the pharmacy director. She added two new sets of data to her quarterly presentations and had reduced self-monitoring to quarterly instead of monthly because her scores remained high. There are some important considerations as the facility revises/creates self-monitoring tools. Family members expressed dissatisfaction, especially with communication with the facility. A staff

	satisfaction survey also showed dissatisfaction. Some activities were implemented, however, there still seemed to be much staff dissatisfaction with communication, support, and relationship with facility senior administration. There were no measures of individual satisfaction or of others in the community with whom the facility interacted. EPSSLC held two meetings that directly related to the QA program, the monitoring committee and the integration committee. Both committees were relatively new and were still evolving. The monitoring team recommends that two additional meetings occur. The first is a monthly meeting between the QA director, SAC, and discipline department head responsible for each provision item of the Settlement Agreement. There continued to be improvements in the QA report. The QA report had apparently become a regular and typical part of the QA program and QAQI Council. This was all good to see. Relevant data, in addition to self-monitoring tool data, must be added to the presentations of each provision of the Settlement Agreement. During the QAQI Council meeting observed by the monitoring team, the provision leaders presented data and some commentary, but there was little to no discussion, participation, or decision making from attendees. Corrective action plans (CAP) were readily and often created. The QA director was working on a more organized way to manage CAPs. He had initiated some data reporting on CAPs.

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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 continued to make good progress towards substantial compliance with many of the items of provision E. This was due to the extensive efforts of the QA director and the QA staff. <u>Policies</u> The state's QA policy was finalized and disseminated since the last onsite review. The new policy was titled #003.1: Quality Assurance, dated 1/26/12. The new policy provided detail and direction to QA directors and facility staff, much more so than did the previous policy. EPSSLC had one facility-specific QA-related policy. It was called Quality Assurance Local Policy, dated 6/8/12. It really wasn't a facility-specific policy, but instead was the state policy with the El Paso SSLC letterhead on the first page. The QA director should also have a facility-specific policy regarding how QA operates at EPSSLC. One way to accomplish this without duplicative effort is to have a very short (e.g., one page) facility-specific policy that merely refers to the most current QA Plan narrative as being the most up to date description of how QA operates at the facility.	Noncompliance

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		Now that state policies had been developed (and the QA Plan narrative was in good shape, albeit still in draft), training and orientation of both the state and facility policies and their requirements needs to occur regularly and should:
		• Be provided to QA staff.
		  o QA staff were trained on the QA policy. They now need to be trained on the QA Plan narrative.
		• Be required for senior management, including but not limited to QAQI Council.
		  o Training had occurred for some, but not yet all, of the management staff on the QA policy, and no one was yet trained on the QA Plan narrative.
		  o Training for senior management might be done during an already-occurring meeting, such as taking 15 minutes during a QAQI Council meeting.
		• The QA director documented trainings on sign in sheets. This was good to see.
		
		The new state policy also called for a statewide QAQI Council, and for statewide discipline QAQI committees. The statewide QAQI Council requirement was being met by the recent (3/5/12) formation of the statewide leadership council. Statewide discipline QAQI committees were not yet in place.
		
		Also, given that the statewide policy was in development for more than a year, edits may already be needed. State office should consider this.
		
		The QA director gave the monitoring team an updated proposed statewide self-monitoring tool for section E. The monitoring team's comments on this draft are above, in the section "Facility Self-Assessment."
		
		<u>QA Department</u>
		Victor Quiroz remained as the QA director. It was good to see stability in this important position at EPSSLC. Mr. Quiroz was moving the facility forward in the development of its QA program.
		
		The Settlement Agreement Coordinator (SAC), Priscilla Munoz, was newly appointed since the last onsite review. She was very organized and thorough in the completion of her SAC responsibilities as they related to the monitoring team's work during, prior, and following the week of the onsite review. The SAC and the QA director appeared to be developing a good working relationship. They should, however, specifically work on formalizing some of the aspects of their work that would support each other. The SAC was onsite during the San Angelo review in June 2012. The working relationship between the SAC and QA director there can serve as a model.	

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		The QA director held a monthly staff meeting. Relevant topics appeared to be discussed. QA staff were supported to participate in additional trainings offered at the facility. The topic of professional development for QA staff should remain as a regular agenda topic. <u>Quality Assurance Data List/Inventory</u> The creation of a list of all of the data collected at the facility is an important first step in the development of a comprehensive quality assurance program. The QA department had made progress towards this by creating the beginning of a fairly comprehensive list. It was managed by the QA director as an electronic spreadsheet with 20 separate tabs. The tabs were for all aspects of service, support, and operation at the facility, including clinical services, administrative services, and all provisions of the Settlement Agreement. This was an excellent way to manage the data listing because it allowed for easy review and updating. To fully understand all of the data collected at EPSSLC, one would have to read all of the tabs. This, however, seemed reasonable to the monitoring team. Given that the listing/inventory was new, the next steps for the QA department are described below. • The listing inventory is to be the comprehensive list of all data at the facility. The current listing inventory did not include all data. For instance, there was also a QA matrix, key indicator list, and list of databases and spreadsheets. Many of these items did not appear in the data list inventory. All of the items in the QA matrix, key indicators list, and databases-spreadsheets list <u>also</u> need to be in the listing inventory. Remember, the listing inventory should contain every type of data collected at the facility. The QA matrix, key indicators, and databases-spreadsheets are subsets of (i.e., are selected from) the listing inventory. This was not yet set up properly in the EPSSLC data listing inventory. • Ensure that the list is comprehensive and as complete as possible. The QAD and SAC should always be adding and editing this spreadsheet as they learn about data being collected at the facility. The list will evolve over the first six months of its development and then will likely only need updating once per year or so. o During the week of the onsite review, the monitoring team learned of an important sets of data that were missing from the data listing/inventory: data related to weights, weight loss, and BMI. ▪ The nursing inventory listing contained an item called weights, however, those data were obviously not reviewed adequately, or perhaps the type of weight data being reviewed was inadequate. This was evident based on the problems in weight management as noted in sections J, L, and M of this report. ▪ The percentage of individuals with refractory seizures was very high. See section L.	

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		• The QAD and SAC should review the data listing inventory during the monthly meetings between them and the discipline department. This way additional items could be added and those items already on the list could be edited, as needed. • Consider adding two columns to the data listing inventory. These could indicate if the data were to be reviewed at QAQI Council, be included in the QA report, be reviewed during monthly meetings between QA and the discipline department, or not be reviewed at all. • Communicate with other SSLCs to share relevant data inventory related information. First, the actual data listing inventory electronic spreadsheets might be shared, so that QA directors can see how their colleagues are meeting this requirement. Second, whenever there is a serious problem identified related to an important set of data, each facility might be updated and asked to ensure the data are being managed and reviewed correctly. For instance, at El Paso SSLC, the weight issue described above might be shared with other SSLCs. Further, during recent reviews at other facilities, the monitoring team found other examples of important data not included in the QA program, such as number of hospitalizations, number of individuals diagnoses with diabetes, and the status of staff TB tests. • As noted above, the QA Plan narrative <u>might</u> also function as the facility-specific policy for quality assurance. <u>Quality Assurance Plan Narrative and Matrix</u> The QA Plan should consist of a QA narrative and a QA matrix. EPSSLC made good progress on both of these. The narrative was 12 pages, lengthy, but acceptable. Editing is now required to reduce some areas, so that they take up less space, such as starting the document at what is now item 1.4, reducing the job descriptions to a few sentences each instead of long bulleted lists, and reducing the length of item 5. On the other hand, the QA director should add a paragraph describing the QA data listing inventory and a paragraph about the QA matrix. The QA matrix was also much improved from the previous report. The purpose of the QA matrix is to show all of the data that the QA department will track, trend, and comment upon. Some, but not all, will go into the QA report; and some, but not all, will be reviewed by QAQI Council. The QA director and the monitoring team discussed this at length. Currently, 100% of the QA matrix was included in the QA report, and 100% of the QA report was presented at QAQI Council. This is acceptable, but ends up limiting the utility of the QA matrix and QA report. The EPSSLC QA matrix was included in the electronic spreadsheet along with the data	

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		listing/inventory. In fact, the QA matrix was the very first tab. One part of the QA matrix was a list called key indicators. These were data specifically chosen by QAQI Council to be presented either monthly or quarterly. This was a good way to get QAQI Council directly involved in identifying important indicators. As noted above, every item in the QA matrix should be, but was not, also in the data listing inventory. The monitoring team provides the following guidance to the QA director as he further develops the QA matrix. • All items in the QA matrix are data that are to be submitted to the QA department. • All items in the QA matrix receive review by the QA department. o Some of the summarizing and graphing of the data, however, can be done by the discipline/department prior to submission to the QA department (see E2 below). o All data should be trend-able data, or if not, should have some pre-determined red flag type of criterion to alert the QA department as to a possible problem. • The selection of what items are in the QA matrix should come from: o QAQI Council, o Clinical, service, and operational department heads, and o The QA director and SAC. • Typically, this will result in a number of "types" of items, such as: o A list of tools to monitor each of the provisions of the Settlement Agreement. Usually, these are the statewide self-monitoring tools, ▪ plus any other self-monitoring tools used by the department. o A list of data that the QAQI Council wants to see. At EPSSLC, these were called key indicators. o A list of data that the QA staff collect themselves. o Any other data that the QA department wishes to receive from the facility's many departments. o Any data that the discipline department heads determine are important to submit to the QA department. • All items on the QA matrix should also appear in the data list/inventory.	

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		QA Activities •QA staff activities: EPSSLC had a very good group of QA staff members and the monitoring team, as always, thoroughly enjoyed meeting with them. The were engaging, committed, knowledgeable about their tasks, and completely interested in doing their jobs at a quality level. QA staff spent their time collecting data implementing their department's own QA tools (there were six), completing statewide self-assessment tools primarily to assess interobserver agreement, and participating on various committees and in meetings. Data from their tools were part of the QA matrix, QA report, and QAQI Council agenda. In addition, QA staff (primarily the QA director) assisted the discipline departments in creating data collection tools, graphs, and databases. For example, this occurred with the nursing and pharmacy departments. •Self-monitoring activities: The DADS state office had recently given new direction to the facilities regarding these tools. The monitoring team's understanding was now that each facility could choose to use the current statewide tools, modify the current tools, or develop new tools. Thus, Settlement Agreement self-monitoring tools could become facility-specific. State office approval was not required, however, the facility department head was supposed to collaborate with his or her state office discipline coordinator. Further, state office did not require the facility to have any specific type of facility-level review and approval process, other than the involvement of QAQI Council. On the other hand, it seemed that the state office discipline coordinator could require the facilities to all use the same tool. EPSSLC had not yet begun to revise any of the current tools or to create new tools. The exception was the pharmacy director. She added two new sets of data to her quarterly presentations and had reduced self-monitoring to quarterly instead of monthly because her scores remained high. Self-monitoring tools can be very helpful if done correctly and if they direct managers to important areas and activities. That is, the content needs to be valid and needs to line up with what the monitoring team is assessing. Thus, the self-monitoring tools should become an important part of the self-assessment process for each provision. It may be that a well-designed and comprehensive self-monitoring tool <u>is</u> the self-assessment, or it may turn out that self-monitoring tool is but one of a number of sources of data and information that the department uses in self-assessing its substantial compliance with each provision item. The monitoring team has commented on the facility's self-assessment of each Settlement Agreement provision at the beginning of each section of this report.	

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		There are some important considerations as the facility revises/creates self-monitoring tools (some of the following is repeated from the previous monitoring report): • Again, the content of the tools should be relevant and valid. • Some items in each tool may be more important than others. These should be highlighted in some way (e.g., weighted, asterisked, labeled as essential). • Consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. o It is possible to do too much monitoring, especially if it competes with the completion of other duties and responsibilities and/or if the additional monitoring does not provide any additional information. o At EPSSLC, there was some attention to this. The pharmacy department now implemented the current self-monitoring tool quarterly, and two new data sets were added. The nursing department now self-monitored four of the 12 statewide tools because they were unable to reliably implement all 12. Instead, they were focusing on the most important four and planned to add others over the next year. • Attend to duplication of efforts, such as two observers sitting in the same ISP meeting when it might have been done by one observer. •Satisfaction measures: As discussed in previous reviews, a variety of satisfaction measures are important indicators to include in a comprehensive QA program. Family and LAR satisfaction information was presented to the monitoring team cumulatively back to the start of the tool a couple of years ago. It needs to be presented for only the previous six months. Thus, the family satisfaction data presented were useless to this review. On the other hand, the monitoring team met with, or heard from, family members of four different individuals. The family members expressed dissatisfaction, especially with communication with the facility. Staff satisfaction was identified as a problem at the facility many months ago. The QA department put out a staff survey a few months ago. He planned to conduct this survey twice per year. This was a good idea. Approximately 25% of the employees responded. The responses, overall, were very negative. Facility management responded by initiating a brown bag lunch, town hall style forum, and employee advisory committee. Moreover, an 11-component suggestion list was created by the assistant unit director. Even though these activities were occurring, there still seemed to be much staff dissatisfaction with communication, support, and relationship with facility senior administration. After this onsite review, a new interim facility director was appointed and a search for a new permanent facility director was initiated. Family and employee relations should be	

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		priorities for the new facility director. There were no measures of individual satisfaction. One way to obtain some of this information might via self-advocacy committee. The human rights officer and might be able to assist with this. Satisfaction measures should also extend to others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth.	
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.	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. The activities that are relevant to this provision item are the facility's management and analysis of data, the QA report, the QAQI Council, the use of performance improvement activities, and the management of corrective actions and corrective action plans. Continued progress was demonstrated by EPSSLC. <u>QA Data Management and Analysis</u> The data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) <u>and</u> they need to be summarized. This was not yet occurring for all of the items in the QA matrix. The importance of QA department review of data plays a very important role in the QA process. Summarizing of data is typically done in the form of a graph or a table. Most typical, and most useful, will be a graph. The graphic presentations should show data across a long period of time. The amount of time will have to be determined by the QA director, perhaps in collaboration with the department or discipline lead. For most types of data, a single data point on the graph will represent the data for a month, two-month period, or quarter. The graph line should run for no less than a year. A proper graph takes time to initially create, but after that, only requires an additional data point to be added each month, quarter, etc. The facility should set an expectation for the service departments to submit data and graphic summaries each month. Some of this might be accomplished during QAD-SAC-Department meetings, which are discussed below. Many of these graphs can be inserted into the QA report and be presented to QAQI Council. But to reiterate, the QA department should be managing all of the data on the QA matrix of which some, but not necessarily all, will end up in the QA report.	Noncompliance

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		Two QA-Related Committees EPSSLC had two meetings that directly related to the QA program. Their activities were supposed to feed information to the QAQI Council and/or respond to discussion from the QAQI Council. Both committees were relatively new and were still evolving. • Monitoring committee o This group began meeting in February 2012. The purpose was to review the details of monitoring and data collection activities for all tools completed by the QA department and other facility staff (not including the statewide self-monitoring tools). In addition, the purpose was to integrate these activities with administrative actions and to address any duplicative efforts and/or efforts that gathered data that were not being used. o Topics included active treatment, stay backs from day programming, privacy, shower chairs, meal engagement. o Data were also reviewed and discussed (not just presented with no discussion). o The monitoring team observed one of these meetings and found it to be one of the liveliest meetings of the week. Participants were engaged and highly participatory. The attendees delved into the minutiae of the tools. This was the type of discussion that leads to tools that have more valid content, can be implemented easily and more reliably, and give the participants more ownership over the process. o This type of participatory forum would be one way to develop the next set of facility self-monitoring tools for each provision of the Settlement Agreement. • Integration committee (also see section G) o The primary purpose of this committee was to be a forum for multiple clinical and operational disciplines to work together to address specific problems at the facility. The expected outcome was the establishment of procedures. The committee met once each week. o Comments from the monitoring team: ▪ Ensure that graphic presentations are clear. During the meeting attended by the monitoring team, there was much confusion regarding some of the graphs presented by the QA director. ▪ The monitoring team recommends the committee consider using a portion of each meeting to focus on one discipline and how that discipline integrates with other disciplines, how it might do a better job integrating, and how other disciplines might integrate better with it. Perhaps 15-20 minutes of each meeting for the next few months for this activity would set the	

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		occasion for problem solving around the actual experience that each discipline had in integrating with other disciplines. <u>Two Possible Additional QA-Related Activities</u> • Monthly QAD-SAC meeting with discipline departments o The monitoring team recommends there be a monthly meeting of the QA director, SAC, and the staff person responsible for being the facility lead for each provision of the Settlement Agreement. During these one-hour meetings, review QA-related actions, review the data listing inventory, discuss data and outcomes, review conduct of the self-monitoring tools, create corrective action plans, and review previous corrective action plans. A set of graphs can portray the discipline's performance on the metrics that are part of the meeting agenda. The monitoring team believes these meetings, although time consuming for the QA director and SAC can be an excellent part of the QA program. o The monitoring team and the QA director discussed this at length during the onsite review. • QA director presentation to senior management o Although data are presented and there can be opportunity for discussion at the integration meeting, monitoring committee, and QAQI Council, the monitoring team recommends that the QA director have an opportunity to present to the senior management team (if such a team exists) or directly to the facility director. This would be for the QA director to bring to this executive team whatever he thinks is important for them to know about. The monitoring team understands that an interim facility director was appointed following the onsite review, a search was underway for a new facility director, and that the new director would be appointed in the next few months. The new facility director, working with the QA director, should determine how to proceed with the two currently operating meetings as well as the two additional recommendations provided above. <u>QA Report</u> The QA report was much improved from the version reviewed during the previous onsite review. It was shorter and more understandable. There was consistency in the way data were presented. Overall, the QAQI Council members appeared to be comfortable with the format because they were seeing it regularly (each month) and, as a result, the document was now a standard part of their professional activity at EPSSLC. The report continued to contain two major sections: one for each provision of the Settlement Agreement that was to be reviewed during that month's QAQI Council	

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		meeting, and one for data on key indicators. Each Settlement Agreement sections contained the tool data (question by question) and a page of graphs. Comments from the monitoring team are below. • The first two pages of text were no longer necessary. They described general mission statements about the facility. It was unlikely that anyone attended to these pages anymore. • Pages 4 and 5 provided an opportunity to describe the report. The current text should be edited to do so. • The term POI was no longer being used by DADS or the SSLCs, so it should be removed from wherever it appears in the QA report. • Continue to include a table of contents. It was helpful to the reader. • Move the key indicators to the beginning of the report (and to the beginning of the QAQI Council review of the QA report) because these are the most important pieces of data to the QAQI Council. That is, key indicators are the data the QAQI Council wants to see, review, and discuss every month. Add and subtract from the set of key indicators as necessary. For example, some data about weights-nutrition-diet should be added based on the monitoring team's findings during this monitoring review. • The current narrative reports were acceptable, however, although there was some analysis and interpretation of the data, the bulk of the narrative tended to be primarily about the mechanics of the statewide self-monitoring tools and the scores. Consider adding more interpretation and explanation of the data. Note also that some sections had little or no narrative (e.g., sections J and F). • Do not include practitioners' names associated with specific data, such as you did for the medical providers in the June 2012 report. • The presentation of the scores on every question of the self-monitoring tool allowed participants to zero in on those that scored low. It also allowed participants to see what was included in each tool. • Inclusion of <u>other</u> data: The department heads should present other relevant data in addition to 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. This was noted as a recommendation in the previous monitoring report. o For example, during the QAQI Council meeting observed by the monitoring team, the pharmacy director presented two new sets of data. This was probably the most interesting part of the meeting. The data were relevant to the provision of services by her department. The data were called quarterly key indicators. Instead, they should just be a part of her section N presentation. The same should be done for all of the	

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		provisions. o QAQI Council could help the department head determine what else to present. One way would be for the QAQI Council to refer to the data listing inventory to see what other types of data were being collected in the department. o Determining what other data to present could also be a topic during the monthly QAD-SAC-department meetings. o Consider data related to the major issue(s) raised in the previous monitoring review. • Because each provision only comes up at QAQI Council once per quarter, the QA director should an addendum to the QA report that describes the status of each of the other provisions. This could be a summary of the monthly QAD-SAC-Department meetings. It does not need to be reviewed or discussed at QAQI Council. • Another improvement in the QA report was the removal of the many pages of corrective action plan detail. Some CAP information, however, should be in each section of the report. The monitoring team recommends a simple piece of data, such as the number of CAPs that are active at this time. <u>QAQI Council</u> This meeting plays an important role in the QA program and is to be led by the facility director. Since the last onsite review, the QAQI Council met twice per month. One meeting was to review data, the other to discuss actions. Implementation of the monthly QAD-SAC meetings may obviate the need for one of these two meetings and QAQI Council could resume at once per month. The monitoring team reviewed the minutes of these meetings since the last onsite review. The minutes of the most recent two or three meetings were sparse and, as a result, the monitoring team could see the general topics, but could not really determine the type of discussion that occurred. The meeting observed by the monitoring team was, unfortunately, somewhat dull. Participants whose turn it was to present did so. They presented the results of the statewide self-monitoring data, but there was little discussion. Probably the most interesting part of the meeting was the presentation by the director of pharmacy of two new sets of data. This should be informative and instructive to the future development of the QAQI Council meeting. That is, although some rather dull data do need to be presented, the meeting, for the most part, should contain information of interest, and interesting, to the attendees. Consider what are the important indicators that line up with the facility's most important outcomes.	

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		The future of QAQI Council meetings will depend upon how the next facility director wants to proceed. He or she will need to follow state guidelines, as well as consider what had been done in the past at EPSSLC. <u>Performance Improvement Teams</u> EPSSLC did not have any Performance Improvement Teams (PIT). There were a handful of committees that were in operation (e.g., mealtime monitoring). The monitoring team recommends that the QA director maintain knowledge (written) of the status of each of these working committees. They do not need to be called PITs, however, there should be some way in which their activities are recorded so that facility management remains knowledgeable about their status. <u>Corrective Actions</u> The QA director and the facility management staff attended to corrective actions and CAPs. The QA director created a CAPs database in which he logged all of the corrective actions that were determined through the facility's committees, self-monitoring and self-audits, and data trends. There was also a separate database for corrective actions in response to the mock ICFID self-survey. There appeared to be more than 80 corrective actions that were being tracked. The overall system of managing CAPs, as required by provision items E2, E3, E4, and E5, however, was still in development, that is, it was not yet complete, standardized, and comprehensive. There was not yet adequate tracking of dissemination, implementation, dissemination, and modification. The QA director was aware of this and the CAPs system was one of the projects he was working on. The important point is that progress was occurring. One of his many goals was to separate CAPs into those that were to address more system issues versus those that were to solve a one-time or individual-specific issue. This made sense to the monitoring team. The monthly QAD-SAC-Department meetings can also present an opportunity for the review and documentation of the status of every CAP. On a positive note, the QA director created a set of data that he included in his section E QA report and presentation to the QAQI Council last quarter. It included data on the number of corrective actions that were active, the number completed, the number in process, and the number of committees/teams to which CAPs were assigned. This was good to see and the monitoring team recommends that it continue and even be expanded as deemed appropriate by the QA director.	

#	Provision	Assessment of Status	Compliance
E3	Disseminate corrective action plans to all entities responsible for their implementation.	EPSSLC was not in compliance with this provision item, however, progress was observed. 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, however, progress was observed. 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. Create a facility-specific policy regarding how QA operates at EPSSLC. The most current QA Plan narrative might meet this recommendation (E1).
2. Complete or initiate training to QA staff, and senior management and clinical staff on the new state policy and any QA-related facility-specific policies (E1).
3. Implement the statewide discipline QAQI committees, as per the new state policy (E1).
4. Consider whether the state policy might need any updates or revisions (E1).
5. The QA director and SAC should formalize the aspects of how they will work together (E1).
6. Ensure the comprehensive listing/inventory of all data collected at EPSSLC is complete. Ensure it includes all of the items from the QA matrix, key indicators, databases, etc. (E1).
7. Edit the QA plan narrative as suggested in E1 (E1).
8. Follow the suggestions regarding the QA matrix presented in E1 (E1).
9. Determine how to best use the statewide self-monitoring tools. Consider the suggestions made in E1 regarding development of facility-specific self-monitoring tools (E1).
10. Develop and then implement actions to address family and staff satisfaction issues (E1).

11. Ensure that the QA department reviews of all data on data matrix (E2).
12. In the integration committee, ensure graphic and data presentations are clear. One way to do so is to directly ask participants during the meeting if the data are clear and understandable to them (E2).
13. In integration committee, review each discipline and how they do, and how they can do better at integrating (E2, also section G).
14. Hold monthly QAD-SAC-Department meetings. Structure them and document the meeting (E2).
15. Consider a periodic presentation by the QA director to the facility's senior management (E2).
16. Consider the suggestions provided in E2 regarding the QA report (E2).
17. Add other additional relevant data to the QA report and QAQI Council presentations for each Settlement Agreement provision section (E2).
18. Keep a list of the many committees and work groups at EPSSLC (E2).
19. Create a system to meet the CAPs requirements (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:** <u>Documents Reviewed</u>: o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o DADS Procedure: Personal Focus Assessment dated 9/7/11 o EPSSLC Self-Assessment o List of all serious injuries for the past six months o List of all injuries for the past six months o EPSSLC Section F Presentation Book o EPSSLC QAQI Report o A sample of completed Section F audits done by EPSSLC o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, Quarterly Reviews (for some individuals in the sample) for the following Individuals: • Individual #15 (ISP only), Individual #88 (ISP only), Individual #28, Individual #178, Individual #157, Individual #61, Individual #161, Individual #71, Individual #13, Individual #66, Individual #154, Individual #90, Individual #39, and Individual #36 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Cynthia Martinez, QDDP Coordinator o Jaime Monardes, Facility Director o Guadalupe Azzam, ATS o Mario Gutierrez, Incident Management Coordinator o Michael Reed, Lead Investigator o Gloria Loya, Human Rights Officer o Valerie Grigg, Director of Behavioral Services <u>Observations Conducted</u>: o Observations at residences and day programs o Unit Morning Meeting 7/17/12 and 7/18/12 o Incident Management Review Team Meeting 7/16/12 o Annual ISP meetings for Individual #77 and Individual #102 o ISPA for Individual #99 o Human Rights Committee Meeting

	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 6/29/12 with recent activities and assessment outcomes. The QDDP Coordinator was responsible for the section F self-assessment. The most important next step is for the QDDP Coordinator to make sure that she includes everything in her self-assessment that the monitoring team looks at. There were a number of provision items where she noted that an adequate audit system was not in place to determine compliance. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in the self-assessment (and perhaps in a new self-assessment tool, too). It is possible that new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. The current assessment process relied heavily on the statewide section F audit tool. Many of the provision items in section F, however, required more than just a review of the ISP. For example, section F2e required confirmation that staff were competent at implementing training in the ISP. Interview and observation would be effective for measuring compliance. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the QDDP Coordinator and believes that the facility was continuing to proceed in the right direction. The QDDP Coordinator was recently trained on the new ISP process that was designed to meet the requirements of the Settlement Agreement. This should be very beneficial in developing an assessment process that measures compliance with the requirements in section F. The facility self-rated itself as being out of compliance with all provision items in section F. The monitoring team agreed.
	Summary of Monitor's Assessment As noted in the last report, DADS had revised the ISP process and hired a set of consultants to help SSLCs move forward in developing person centered ISPs developed by an integrated support team. Training had recently been provided on the ISP process by DADS consultants. The facility was still awaiting training on the risk identification process. Observation of two ISP meetings and review of ISPs developed after 1/1/12 confirmed that teams were still at varying stages in developing integrated plans that included all needed supports and services based on preferences and needs of each individual. Overall, there had been a noticeable improvement in developing more meaningful plans based on individual's preferences and needed supports. It was apparent that teams were attempting to follow the format of the new ISP process and include all required information in the plan. Adequate assessments were not developed or revised when needed for most individuals. All team members were not participating in the planning process. Without an adequate assessment process and participation by all team members in planning, IDTs could not develop plans to address individual's preferences and needs. For needs that had been identified, a service delivery system was not in place to

	ensure that supports were competently provided and progress or regression documented. As further discussed in section I, teams were still not accurately identifying risks and ensuring that plans were developed to address all risks. There was, however, better integrated discussion among team members in an attempt to identify risks. There had been a significant improvement in efforts by the QDDPs to involve all team members in the planning process. There had been little progress made on developing plans to provide functional training in the community. Although all plans provided opportunities for individuals to go out into the community, training was not being consistently implemented and documented while in the community. The facility had begun offering a community based day program. This was great to see. It was integrated and individuals were engaged. Attention had not yet been focused on ensuring that all necessary supports were provided while in the community.

#	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.	Progress had been made with regard to the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive steps taken by the facility included: • Six of eight QDDPs had completed Facilitation Skills training and been assessed by the QDDP Coordinator for competency on facilitation skills. The two QDDPs that had not yet completed training were recently hired on 6/1/12. • The QDDP Coordinator was now completing the statewide audit tool to assess compliance with this provision item. • QDDPs had completed training by the state office consultants on the new ISP process. The QDDP Coordinator was routinely attending ISP meetings to evaluate the facilitation skills of QDDPs. The facilitation tool used to assess compliance rated: • The QDDP's knowledge, preparedness, and whether he/she could demonstrate inclusiveness and assertiveness, • The QDDP's ability to solicit information using the ISP prompts, and • The QDDP's ability to guide team members through the ISP process.	Noncompliance

#	Provision	Assessment of Status	Compliance
		During the week of the review, the monitoring team observed two ISP meetings. Progress definitely continued to occur with regard to the facilitation of meetings. At both meetings, however, the QDDP failed to keep the meeting moving along resulting in very lengthy meetings where key information was not shared and very little long range planning occurred. Both QDDPs ensured that all team members were involved in discussion. Based on these observations and a review of ISPs, some of the areas in which progress had begun included: • Efforts were made to include the individual and focus the discussion on him/her. • A list of preferences based on assessment information was identified and used for planning. • More effort was being made to elicit information from all team members. • Although not consistent, there was an increase in the use of specific clinical data to support risk ratings. • Based on the meetings observed, QDDPs appeared to have come prepared with an agenda. Documents, such as a draft Integrated Risk Rating Form and a draft ISP format, appeared to provide team members with some relevant information and assist teams to remain focused. A sample of IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. QDDPs were in attendance at all annual meetings in the sample reviewed. Based on review of ISPs as well as during observations of meetings held the week of the onsite review, facilitation of team meetings was improving, but it was not yet resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. While progress had been made towards meeting substantial compliance, it will be important for the QDDPs to continue to develop 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. The facility remained out of compliance with this provision item.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs,	DADS Policy #004 described the Individual Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified in the Personal Focus Meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Personal Focus Assessment (PFA) was the document that should have identified the	Noncompliance

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	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.	team composition based on the individual's preferences, strengths, and needs. The facility had begun to track data on attendance at IDT meetings. QDDPs attended webinar training of the new PFA process. The facility audit indicated that attendance by the individual and LAR at annual ISP meetings was around 50% between March 2012 and May 2012. The facility self-assessment indicated that data regarding attendance by other team members at annual ISP meeting was between 25% and 67% for the three months audited. The audit found that the lowest participation in team meetings was for psychology staff and DSPs. ISP signature sheets were only included in two ISPs in the sample. These were for Individual #90 and Individual #28. • For Individual #90, the day habilitation staff, physical therapist, and SLP did not attend his meeting. His ISP indicated that he required direct skilled PT services and communication supports. • For Individual #28, there were no DSPs at her meeting. Her psychologist and SLP did not attend her annual meeting either. 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.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration. The facility had begun using a database to track submission of assessments prior to the annual ISP meeting. According to the facility self-assessment, the QDDP Coordinator had begun to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. The recordkeeping department was responsible for collecting data on the submission of assessments prior to the ISP meeting by various departments. Scores ranged from a low of 4% to a high of 100%. Submission of assessments by psychiatry, psychology, program developers, and the medical department ranked less than 50%. 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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regarding psychiatric and neurological assessments, section K regarding psychological and behavioral assessments, sections O and P regarding PNM assessments, section R regarding communication assessments, and section T regarding most integrated setting practices).

Examples of assessments that were completed less than 10 days prior to the annual ISP meeting date or after the meeting date included:
<table>
<tr><th>Individual</th><th>Annual ISP Meeting</th><th>Late or Not Updated Assessments</th></tr>
<tr><td>#161</td><td>5/9/12</td><td>Medical 7/26/11

Psychiatric 10/21/11

Nutritional 5/12/11</td></tr>
<tr><td>#71</td><td>3/7/12</td><td>Medical 3/13/12

Psychological 7/8/11</td></tr>
<tr><td>#178</td><td>3/5/12</td><td>Medical 3/14/12

Psychological 2/10/11</td></tr>
<tr><td>#154</td><td>5/8/12</td><td>Nutritional 5/7/12</td></tr>
<tr><td>#66</td><td>4/25/12</td><td>Vocational 4/23/12</td></tr>
</table>
The facility was using Personal Focus Assessment (PFA) as a screening tool to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. A sample of PFAs for ISPs developed after 3/1/12 was reviewed. Teams were still not consistently completing PFAs during the quarter prior to the annual team meeting as evidenced in the chart below. Five of nine (56%) reviewed were completed less than 30 days prior to the annual ISP meeting. Since the PFA is likely to result in the identification of other assessments needed, it should be completed early enough to allow for identified disciplines to complete assessments recommended prior to the annual IDT meeting.
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Individual	Annual ISP Meeting	PFA Completion Date
#178	3/5/12	2/20/12*
#66	4/25/12	4/23/12*
#36	4/9/12	2/13/12
#71	3/7/12	3/5/12*
#13	4/17/12	4/9/12*
#39	5/10/12	3/20/12
#161	5/9/12	2/28/12
#154	5/8/12	4/19/12*
#28	5/2/12	3/13/12
*denotes developed less than 30 days prior to the annual ISP meeting		

The PFAs reviewed appeared to be an adequate reflection of the individual's preferences and strengths. The PFA for Individual #28 was a good example of a PFA that was completed with thought and resulted in an assessment that was useful for planning. Recommendations were made for further assessment when needed. For example, the person completing the PFA noted the need for an updated vocational assessment. A vocational assessment was completed prior to the annual ISP meeting.

The state had recently developed a new tool to assess personal preference and support needs. The Preferences and Strength Inventory (PSI) was similar to the PFA, but was designed to be a rolling document that could be updated throughout the year as new preferences were identified or as preferences changed. The facility will need to be trained on how to complete the PSI and how to use it in planning services and supports.

ISPs developed after 3/1/12 were reviewed to determine if the list of preferences was adequate for planning. Significant progress had been made towards developing a list of individualized preferences and strengths for each individual in the sample.

Few ISPs described preferences for daily schedules. Given the high number of self-injurious behaviors, this type of information would be critical for support staff to know. Structuring an individual's day and environment to encourage participation and reduce self-injurious behaviors often relies on information such as:

- Does the individual like to wake up early or sleep in?
- Does he/she like quiet time in the morning? Or need quiet time after work to wind down?
- Does he/she need coffee in the morning before getting dressed?
- Does the individual prefer to shower/bathe in the morning or evening?
- Is he/she more productive at work in the morning or afternoon?
- Does the individual prefer to spend time alone in the evenings or socialize with

#	Provision	Assessment of Status	Compliance
		friends? • Does the individual prefer assistance from particular staff members? 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 were starting to use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. Outcomes based on preferences should be considered that might lead to greater exposure to the community. Discussion regarding the development of outcomes based on preferences was not as in-depth as it should have been in part due to time restrictions. Much of the discussion at meetings observed was dedicated to health and risks review. The facility was using the Functional Skills Assessment (FSA) to assess each individual's functional skills. 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. Staff were completing the checklists, but not using it to develop individualized recommendations from the results. The facility self-rated F1c as not in compliance based on the timely submission of assessments. The self-assessment did not look at the adequacy of assessments submitted. 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.	As described in F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for IDT members to review each other's assessments prior to the ISP meeting, nor were assessments completed with sufficient thoroughness. The facility had begun including assessment information in some skill acquisition plans (SAPs), but fell short of using assessment recommendations to develop individualized strategies for implementing training. For example, recommendations from Individual #66's communication assessment were included in each of his SAPs, but strategies were not individualized to ensure that implementation was consistent. Recommendations included the use of an AAC device or talking photo album. His SAP for identifying a traffic light indicated flash cards were to be used under materials needed. It was not clear what method of training should be implemented or what would constitute a correct response. Additionally, it was not clear that the choice of SAPs to be implemented were based on	Noncompliance

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		preferences and priorities. For example, his SAPs to improve his community integration skills included identifying a traffic light and a wheelchair accessible van. It was not clear why these were considered priority skills for him. Having opportunities to practice communication and socialization skills in the community would have been more inline with his preferences. The integration of assessment information varied widely among the sample reviewed. Some QDDPs were doing a better job integrating assessment recommendations into a working plan that included how supports should be provided throughout the individual's day. For example, the ISP for Individual #154 integrated assessment recommendations throughout the ISP. There were still, however, examples of where assessment information had been cut and pasted into the ISP without an effort to clarify the information so that all staff could understand how supports should be provided. For instance, one section of his ISP stated, "exhibits BLE AROM WFL as he was observed ambulating for campus distances and transitioning from sit to stand without limitation of ROM observed" and "exhibits BUE AROM WFL as he was observed with bilateral shoulders and elbows flexed hitting opposite side of head with right open hand." This information would be useless to most staff providing direct supports. Clear direction should be offered to staff providing supports without the use of professional jargon. 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 ADA and Olmstead Act require that individuals receive services in the most integrated setting to meet their specific needs. Training provided to the facility by DADS consultants included facilitating the living options discussion to include input from all team members. Only two ISPs had been completed after updated training was provided by the DADs consultants. The community living options discussion was well documented in both of the new ISPs. Action steps were developed by both teams to further educate the individual and/or family members on living options. The discussion for Individual #15 concluded with a determination that there were no barriers to community placement. The team agreed that necessary supports could be provided in the community. The IDT for Individual #88 determined that EPSSLC was the optimal living option based on her	Noncompliance

#	Provision	Assessment of Status	Compliance
		family's preference that she remains at EPSSLC. Both teams agreed that EPSSLC was the most appropriate living option at this time. The annual IDT meeting for Individual #77 was observed by members of the monitoring team. Her sister indicated that she did not wish to discuss community placement because when her sister lived in the community years ago, supports were not adequate. The LA did not attempt to provide additional information regarding supports that may now be available in the community. The QDDP, however, did encourage her sister to go visit some group homes with her to learn more about what is available in the community. Individual #88 expressed that work was important to her and she was interested in community employment. She was currently working at the facility's sheltered workshop. The team agreed to make a referral to DARS for an assessment of vocational skills. This was a positive step. An additional sample of ISPs was reviewed for training to be implemented in the community. Few of the outcomes for individuals in the sample addressed measurable training objectives to be implemented in the community based on preferences. Community based outcomes were often a general statement rather than a functional outcome to achieve a desired objective. For example, Individual #36 had an outcome that stated "engage in leisure activities of choice as time allows during the day." Individual #157 had an outcome that stated "will be taken to a different community outing at least once a month of her choice." This type of general statement outcomes was included in most of the ISPs in the sample. The facility had begun a community based day program at three local cultural centers. The new program offered excellent opportunities for community integration and functional training. About 40 individuals at the facility were involved in the community-based day program. Guadalupe Azzam, who was appointed to a new position as Active Treatment Specialist since the last onsite review, was working closely with community leaders and directors at the cultural centers to provide new opportunities for individuals in the community. Observation of programming at one of the day sites revealed meaningful programming occurring for many individuals. Individuals were involved in recreational sports, exercise classes, arts and crafts, gardening, and building relationships with other individuals from the community. It was evident that Ms. Azzam had a good working relationship with the center director and individuals from the facility were welcome at the center. She had broken down many barriers to community inclusion by ensuring that the relationship between the facility and the cultural centers was beneficial to both groups.	

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		Structured training, however, was not yet occurring in the community day program and staff were not yet documenting individual's responses to training opportunities. The facility was not ensuring that staffing patterns were sufficient and all supports needed were in place for individuals attending this off campus programming. Training should be formalized by developing individualized strategies and providing training to support staff on implementing training while in the community. Documentation should be maintained so that IDTs can build on training opportunities. The facility self-assessment determined that this item was not yet in substantial compliance. The monitoring team agrees with this self-rating. This provision is discussed in detail later in this report with respect to the facility's progress in addressing section T.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with 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;	DADS Policy #004 at II.D.4 indicated that the Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the "PST will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." The ISPs in the sample continued to include a list of the individual's preferences and interests. The facility had made progress in developing more comprehensive lists of preferences for each individual. While this list was a good starting point, limited exposure to new activities meant that this list was often limited. In order to meet substantial 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. Plans developed after 3/1/12 included a more comprehensive list of preferences, but plans did not consistently	Noncompliance

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		describe how those preferences would be supported. The two newest plans in the sample were much more comprehensive in describing what supports would be needed throughout the individual's day. Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences or that all supports were addressed in ISPs. There was minimal improvement in some of the homes in offering active treatment opportunities based on preferences. Observation of homes revealed that staffing patterns were often not sufficient to allow for individualized training. There was very little individualized training occurring in the systems building during the evening hours. During one observation, individuals from two of the dorms had been moved to the dining area because staff were pulled to go to other homes. Two staff were busy with mealtime duties while individuals were left sitting in wheelchairs with no interaction or attempts at engagement. In at least three of the homes visited, staffing patterns were not sufficient to carry out ISP training. These barriers to providing supports should be addressed by the facility. There was not a system to track training opportunities in the community or progress achieved through community training. As noted in F1e, there was minimal focus on training in the community and community employment. None of the ISPs in the sample included adequate discussion of supports and services that could be offered in the community. While most plans included opportunities to take trips to the community, plans did not include action steps to ensure 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.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in	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 objectives were not developed to ensure that participation was meaningful and behavioral indicators were not identified to determine successful implementation for all	Noncompliance

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	the most integrated setting appropriate to his/her needs;	outcomes. For example: • Individual #157's ISP included a community participation outcome that stated she would be taken to a different community outing at least once a month of her choice upon verbal prompting 80% of offered sessions for five reporting months. It was not clear what she would need to do to successfully complete this goal. Action steps included (1) DSP will get her ready to go out into the community and (2) DSP will ask her where she would like to go. This appeared to be a measurable goal for staff, not the individual. • Individual #36 had gained 23 pounds over the past year. The team had identified that he was at high risk for weight gain. His ISP did not include measurable, observable objectives to address his risk. His Risk Action Plan included an outcome stating "no rapid weight loss within the next six months." The plan did not note his current weight or desired weight range. There was no indication what rate of weight loss would be desirable. The team acknowledged that his lack of physical activity contributed to his weight game. Objectives were not implemented to encourage physical activity. • Individual #88 had a number of preferences and varied interests listed in her ISP. Few outcomes were developed to ensure that she would have the opportunity to have her preferences integrated into her day. Two outcomes were developed in an attempt to ensure that she had opportunities to engage in activities of choice. Neither was measurable. One stated that she would "get dressed up and with a friend and maybe eat out or go shopping every time she requested it" and the other stated she would "be offered a variety of leisure activities to participate in daily and assisted as needed." • Individual #15 had a number of action steps in place to address his risks. Many did not include measurable indicators to be monitored. For example, an action step to reduce his risk of constipations stated monitor bowel movements. There was no indication what frequency or consistency would be considered normal. He also had an action step to address his obesity that stated weigh weekly. Acceptable parameters for weight were not included. In reviewing the action plans that had been developed to address individuals' risk areas, adequate measurable clinical indicators generally were not included. This is discussed in detail in section I of this report. The lack of these clinical indicators resulted in teams not having a mechanism to measure whether the individual was progressing, declining, or remaining stable. The lack of meaningful, measurable goals contributed to low engagement levels throughout the facility. There was no system in place to ensure that individuals were engaged in meaningful activities for a majority of the day. This continued to be an area in	

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		which substantial effort was needed in order to comply with the requirements of the Settlement Agreement	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	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 ISP and considered an integral part of the plan. The newer plans in the sample were showing progress in attempts to integrate all supports into one plan. ISPs for Individual #15 and Individual #88 were more comprehensive in identifying supports needed but often referred to other plans (PNMP, HCP, BSP) for specific methods of support. Since these plans were not provided as part of the ISP, all information was not available to staff in one integrated plan. ISPs were still not adequate in describing how the individual preferred to spend his or her day and what supports were needed to ensure preferences were met. Assessment recommendations were cut and pasted into SAPs without consideration for which recommendations should be followed for each specific objective. SAPs should be individualized to describe methods that staff can consistently follow using relevant recommendations for support. In the sample reviewed, BSP recommendations were rarely included when developing strategies for implementation of outcomes. The facility self-assessment process found that assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members, so that information could be integrated among disciplines. 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.	Noncompliance
	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 F2a2 and further detailed in section S below. Methodology was not clear enough to ensure consistent implementation for many actions steps found in ISPs in the sample. For example: • Individual #39 had the following action steps that were not measurable and/or	Noncompliance

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		lacked strategies to ensure consistent implementation. o Will participate in blue group. o Will participate on more outings. o Continue monitoring his weight. The facility self-assessment indicated a 50% compliance rate with the requirements of this provision item. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The facility had not made progress towards compliance with this item. As noted throughout the report, plans did not adequately address supports needed by the individual to achieve the outcomes. Minimal functional learning opportunities were included in the ISPs in the sample. Outcomes tended to be general statements, particularly in regards to community outings. The facility needs to develop specific functional objectives to be implemented in the community. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. Most training was offered in a classroom setting. Few formal training opportunities were offered in the community. As noted in F1e, the facility needs to formalize training for the community day habilitation program. Individuals did not receive services in the least restrictive environment when possible. They did not get haircuts in the community, bank in the community or go to the pharmacy to get their medication. They were not able to choose, join, or regularly participate in group and social activities such as church, art, and gym classes. However, there was improvement noted via the new community day programming activities. 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.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. Generally, 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. Skill acquisition plans were developed for some action steps in the ISP with further detail for implementation, data collection, and review. As discussed above in section F2a2, many goals and objectives were not specified in	Noncompliance

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	person(s) responsible for the data collection, and the person(s) responsible for the data review.	individuals' ISPs, but were in other plans that should have been integrated into the ISP (e.g., health management plans, PNMPs, psychiatric treatment plans). Even when plans included objectives, such as those related to PBSPs, individuals' ISPs did not consistently identify the specific data to be collected, the frequency, and/or the persons responsible for reviewing data collected. Little progress had been made in developing measurable outcomes. Most ISPs still lacked guidance that would instruct staff in collecting consistent data to evaluate the effectiveness of training in the day program and community, and/or to monitor health and therapy related supports. Overall, the plans defined very little objective data that would be collected, reviewed, and used to make decisions regarding the efficacy of plans. Findings for the two newest plans in the sample were: • Individual #15 had an outcome to participate in community events at least monthly. Staff were to document where he went and the length of the activity in the shift notes. The QDDP was assigned to review data monthly. As noted previously, this type of outcome did not permit analysis of progress towards meeting any particular goal. • As noted in F2a2, Individual #88 had two community based outcomes that were not measurable. It was unclear what data should be collected and what would be considered a successful trial. 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 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 G1 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 often not completed prior to the annual meetings. IDTs will need to work together to develop ISPs that coordinate all services and supports. Recommendations from various assessments should be integrated throughout the ISP. Recommendations for some assessments were cut and pasted into the SAPs, but were not specific to the objective. Not all relevant recommendations were used to develop teaching strategies for the SAPs. For example,	Noncompliance

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		SAPs for Individual #39 included a list of communication recommendations. They did not include recommendations from his BSP even though he was at high risk for challenging behaviors. As noted in F2a3, PNM, healthcare management plans, and dining plans were not submitted as part of any of the ISPs. These plans should be attached to the ISP and considered an integral part of the plan. The facility did not have a process to ensure coordination of all components of the ISP.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in 10 out of 16 (63%) records reviewed. This continued to be a problem at the facility. The facility's self-assessment indicated that monitoring for current plans in homes revealed a 90% compliance rating. A system needs to be put into place to ensure records contain current ISPs. As noted in F1d, ISPs did not always include staff instructions for support that were clear enough for DSPs to follow. Staff interviewed by the monitoring team were not consistently familiar with healthcare plans, and risk action plans. Some staff interviewed could not describe risks and interventions needed by individuals whom they were assigned to support. The facility self-assessment indicated that there was no process in place to monitor DSPs comprehension of plans for individuals whom they support. As noted in F1c, it was not clear in most ISPs as to 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 ISP 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.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the	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. There was no indication that all supports were reviewed at least monthly. It was not evident that team members were using data collected to drive revisions in teaching strategies or supports. Monthly reviews should address the lack of	Noncompliance

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	progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	implementation, lack of progress, or need for revised supports. Follow-up on issues occurring during the month should be consistently documented. When support and services are not in place or not implemented, the team should take immediate action to either ensure supports and services are implemented or revise the ISP. It was not always evident that monthly reviews were used to determine progress or lack of progress. For example, data were filled in once daily for all SAPs for Individual #71 regardless of the frequency to be implemented. Some outcomes were to be implemented weekly and others twice daily. The data code was identical for each day. It seems unlikely that all SAPs were implemented every day with no change in response. The monthly data sheet was signed off on by the program developer. No recommendations were made. Quarterly reviews by the QDDP were completed for each individual using the monthly reviews from each discipline. These reviews were comprehensive, covering all areas of services and supports. Some QDDPs, however, were copying the complete monthly review by each discipline into the quarterly report. This made it lengthy and difficult to determine overall progress or regression. A summary of any progress along with recommendations would be a better format for a quarterly review. For example, the quarterly review dated 3/8/12 for Individual ##161 included five pages of nursing notes regarding healthcare issues from the three month period, but no summary or recommendations. It was difficult to determine her health status and any changes in supports that may be needed. An ISPA was observed for Individual #99. The team did not have data needed to adequately discuss his progress. His sister expressed concerns over his current weight. Team members could not answer questions about his diet and what he was eating on a routine basis. He had an ultrasound two weeks prior to the meeting. The team did not have the results from that assessment and no one on the team had followed up on the assessment. He was assigned 1:1 staff. There was discussion regarding the continued need for a higher level of supervision. His psychologist did not have data necessary for the team to make a determination. When supports are put into place, the team needs to decide what information should be gathered and who will review the information. Other examples where data were not collected and reviewed in a timely manner to ensure that supports in place were appropriate were found in documentation reviewed. • The April 2012 quarterly nursing assessment for Individual #61 noted that neurology had ordered an echo and thyroid exam to rule out metabolic causes for her increase in seizure activity. Results of those exams could not be found for review. A Holter monitor had also been ordered for palpitations. The nurse noted that results of that test could not be found for review either.	

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		• The January 2012 quarterly review for Individual #178 indicated that no data were available for the three months reviewed for his bathing objective. 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 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. The facility was still waiting for additional training to be provided by the state office on integrating risk information into the new ISP format. QDDPs were utilizing the new format, but had not yet been trained on the risk identification processes. 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 monitoring and training to direct support staff. This had improved implementation in some homes, but had little impact on training that was occurring in day programs. The facility's self-assessment indicated that data were not available regarding training on specific plan implementation. The facility self-rated the provision as being out of compliance 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	Of the ISPs in the sample reviewed, all (100%) had been developed within the past 365 days. The facility self-assessment indicated a 98% compliance rate with the development of ISPs within required timelines, and a 90% compliance rate with filing completed ISPs within timelines.	Noncompliance

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	ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current plans were available in 10 of 16 individual notebooks in the sample. As noted in F2d and other areas of this report, plans were not always revised when supports were no longer effective or applicable. Informal interviews with staff indicated that not all staff were not adequately trained on the requirements of individual ISPs. 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 was using the statewide section F audit tool to monitor requirements of section F. Other tools had been developed to measure timeliness of assessments, participation in meetings, facilitation skills and engagement. 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 some progress in this area. They had just begun to analyze findings and develop corrective action plans.	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. Efforts need to be made to ensure all team members are in attendance at IDT members in order to ensure adequate integration occurs during planning (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 will need to identify each person's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

9. 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).

10. 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)

11. 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).

12. 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).

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

14. 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).

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

16. 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).

17. 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).

18. 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 EPSSSLC Section G Self-Assessment o EPSSLC Section G Action Plan o EPSSLC Provision Action Information o EPSSLC Sections G Presentation Book o Presentation materials from opening remarks made to the monitoring team o Organizational Charts 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 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 Integration Committee Meeting o Dental Clinic o Psychiatry Clinics o Daily Unit Meetings o Medical Clinic o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described for each of the two provision items, a series of activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. The self-assessment was an expansion of the self-assessment completed for the last review. It listed numerous activities that were completed to conduct the assessment, then provided the results of each assessment. In most instances, a score was provided. This information was used by the facility director to determine a compliance rating. In the case of provision G1, the activities reviewed were those that the director focused on as important for integration. It may be important to consider other activities as well. The state draft policy, Minimum and Integrated Clinical Services offered examples of how the various

	disciplines could potentially collaborate to provide integrated services. These examples should be considered for inclusion in future self-assessments. In moving forward, the monitoring team recommends that the facility director and medical director both review this report. Most items will likely be executed by the medical director with the support of the facility director. For each provision item in this report, the medical director should note 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. Again, the state draft policy should also be reviewed for additional guidance. The facility found itself in noncompliance with both provision items. The monitoring team agrees with the facility's self rating.
	Summary of Monitor's Assessment: The facility continued to make progress in this area. Several steps occurred at the local level in an effort to integrate clinical services. The facility director served as the lead for this very important provision. There was no local policy to guide the work done in this area, however, an Integration Committee was formed. Participants of this committee included the discipline heads who came together each week to address specific problems at the facility with the objective of establishing policies and procedures that would facilitate integration of services. The committee did not engage in detailed data analysis. One major flaw was the lack of an agenda. The meeting built on the minutes of the previous meeting which allowed for topics to essentially "fall off." The monitoring team attended this meeting and thought that it provided a good forum for the various disciplines to discuss problems and barriers to integration. The format, possibly the lack of an agenda, and problems with data presentation resulted in a meeting that was not efficient and wasted a significant amount of time as the facility staff attempted to decipher their own data and graphs. Nonetheless, the monitoring team learned a great deal about the facility's integration activities though this meeting and thought that activities and efforts in this area were strong. As with every onsite review, the monitoring team had the opportunity to meet with the facility and medical directors to discuss integration activities at the facility. The facility director largely reviewed the self – assessment. There were many activities involving integration that perhaps the facility and medical directors had not given ample consideration. In that regard, this meeting served as a complement and extension of previous integration meeting, allowing for further and more detailed discussion. Throughout the week of the review, the monitoring team encountered a few good examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted. Continued work in this area is needed.

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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 need.	To determine compliance with this provision, the monitoring team reviewed state procedures, conducted interviews, completed observations of activities, and reviewed records and data. During the conduct of this review, examples of integration of clinical services were observed. There were also several instances in which integration needed to occur, but did not. The following are examples of integration that were noted: • Daily Unit Meeting - The facility conducted a daily unit meeting that was chaired by the unit director 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. o The format of the meeting did not allow for the appropriate discussions of clinical issues. There did not appear to be any detailed minutes of the medical discussions that occurred in these meetings. Moreover, documentation did not show a strong presence of the clinical leaders of the facility. • Pretreatment Sedation - The medical director chaired a multidisciplinary committee that developed an assessment process for desensitization. The Pretreatment Sedation Committee met to identify, strategize, and implement various levels of desensitization to maximize outcomes of preventive health goals. • Medication Error Committee – The collaborative efforts of nursing, pharmacy, and medical were an excellent example of integration of clinical services. Over a period of two years, continuous and ongoing efforts had resulted in a series of changes that produced positive results such as decreasing bin returns and errors of omissions. • Psychiatry and IDT - When quarterly psychiatry clinics or other psychiatric clinical consultation occurred, there were generally members of the IDT present for integration including psychology, nursing, pharmacy, and therapy services. • Neurology and Psychiatry – Integration between neurology and psychiatry improved with the addition of the weekly neurology clinic in October 2011. The monitoring team observed this clinic during the past two reviews and found it to be a reasonable approach to integration. • Psychology and Psychiatry - Integration of psychology and psychiatry was improved. Psychiatry and psychology had regular meetings to foster integration between the departments. Integration of psychology and medical (around medical and dental desensitization) improved with the initiation of interdisciplinary meetings. • Pharmacy and Medical– The clinical pharmacists and medical staff worked closely to improve the safety of medication practices. Overall, the pharmacy and medical staffs demonstrated consistent efforts to deliver services, at many levels,	Noncompliance

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		in an integrated manner. • The PNMT met routinely for individuals identified with needs for review. IDT members generally attended these meetings to ensure integration of clinical findings and recommendations into the ISP and specific health plans for implementation. During the meeting observed during this review, it was noted that there was excellent participation and collaboration among the PNMT and IDT members yielding a more cohesive and coordinated plan. Several areas offered great opportunities for improvement: • ISP Process - During the onsite review, the monitoring team attended one of the facility's ISPA meetings, which was held to review and possibly revise Individual #99's level of supervision. Although the meeting was fairly well attended, not all relevant, clinical services were represented at the meeting. In addition, some clinical services representatives failed to properly prepare for the meeting. Thus, aspects of Individual #99's health and behavior problems were inaccurately and/or incompletely portrayed during the evaluation of Individual #99's need for enhanced or 1:1 supervision. • Psychiatry - With the resource issues present in psychiatry, there was a paucity of regularly scheduled quarterly psychotropic medication clinics completed. The psychiatrist was utilizing ISP meetings in order to evaluate individuals and documenting psychiatry clinic occurring simultaneously with the ISP meeting. Unfortunately in doing so, pharmacy was not in attendance. • Pretreatment sedation – Although SAPs and plans were developed, the effectiveness of the plans was largely unknown. • MOSES and DISCUS Evaluations – The assessments were completed by nursing and finalized by the psychiatrist. The data did not appear to be reviewed at any level by the primary providers. Relevant information found in these assessments was never acknowledged in the annual assessments or IPNs by the primary medical providers. To that end, the integration of psychiatry, neurology, and medical was lessened by a failure to adequately share information or document that the information was shared. • Dental- There appeared to be a disconnect between dental and other clinical services with regards to suction toothbrushing. This was seen in the last review and, to some extent, was again observed. The various clinical disciplines were not aware of the requirements that were outlined in the draft policy for suction toothbrushing with regards to the use of chlorhexidine. True integration of this service would require that all disciplines be aware of the requirements.	

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G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	In order to review compliance with requirements of the Health Care Guidelines, the consults and IPNs for eight individuals were requested. A total of 50 consults completed after January 2012 (including those from the record sample) were reviewed: • 47 of 50 (94%) consultations were summarized by the medical providers in the IPN o 32 of 47 (68%) consultations were documented in the IPN <u>within five working days</u> The clinic physicians, who were not members of the IDT, usually reviewed the consults in a timely manner, but not consistently within the required five working days. For the most part, they wrote very brief summaries of the consults <u>without</u> indicating agreement or disagreement. Moreover, the summaries <u>did not</u> indicate when consults required referral to the IDT. Failure to refer to the IDT resulted in delays in integration of plans and recommendations with existing supports. The summaries also did not also appear to be helpful to the team in understanding the medical problems of the individual. The following example illustrates this finding: On 2/29/12, after Individual #63's annual physical examination, blood tests, and chest x-ray, his EPSSLC physician noted that his chest x-ray revealed an "abnormal possible nodule on the left" and stated that he/she "will order CT of chest," as was suggested by the non-facility clinical professional. There was no evidence, however, that Individual #63 received a CT scan. Thus, during Individual #63's 4/9/12-5/7/12 hospitalization for treatment of a complicated pneumonia, his non-facility clinicians again noted a "mass in the left lung," and recommended a "chest CT scan." According to Individual #63's record, he failed to receive the CT scan until 6/8/12. According to the CT scan report, there were two pulmonary nodules identified. Although an ISPA occurred one week after Individual #63's CT scan, the only references to his IDT's review of his status, the non-facility clinicians recommendations, and/or integration with existing supports and services were two sentences – one sentence that referenced that that he had "a lesion in the lungs," and one sentence that referenced his pulmonary consultation appointment at Texas Tech was scheduled to occur on 6/18/12." The compliance rate for Question #27 in the external medical audits was 87%. This question addressed documentation by the medical provider. The facility's self-assessment noted that the external audit cited question #28 as NA. The self-assessment noted the facility's internal audit scored 100% with question #28. The facility should take note that state office has deemed question #28 not applicable and, therefore, should follow suit and similarly remove that question from the facility audit.	Noncompliance

Recommendations:

1. The facility should draft a local policy or guidelines to provide some direction of this provision. (G1).

2. EPSSLC, like most SSLCs, should consider implementing a daily morning clinical services meeting. This meeting would allow for clinical staff to focus on the events of the past 24 hours that occurred on campus with the clinical leaders of the facility (G1).

3. The daily unit meeting should record minutes for the medical which should be reviewed for accuracy and signed by the medical director. When follow-up is required, the minutes should document action steps, responsible persons, and timelines for follow-up. (G1).

4. The facility needs to develop a system to assess if integration of clinical services is actually occurring. This will require creating measurable actions and outcomes (G1).

5. DADS should develop and implement policy for Provisions G1 and G2 (G1, G2).

6. The monitoring team recommends that for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g., Surgery Consult, 1/1/12) (G2).

7. The medical director should review and address the various clinical issues discussed in the body of the report (G1, G2).

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:** Interviews and Meetings Held: o Jaime Monardes, Facility Director o Ascension Mena, M.D., Medical Director o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Dental Clinic o Psychiatry clinics o Daily medical meeting/Medical rounds
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions (provision action information). For the self-assessment, the facility described for each of the seven provision items, a series of activities engaged in to conduct the self-assessment, the results of the self-assessment and a self-rating. The self-assessment was an expansion of the self-assessment completed for the last review. This version listed many activities and reviews that were completed to assess compliance with the Settlement Agreement. Each activity was associated with a score or a result that was used to help determine a self-rating. The self-assessment for this provision addressed only those issues that related to the medical department. In the case of item H1, there was no report of compliance rates for nursing assessments, psychological assessments, or psychiatric assessments. Substantial compliance can only be achieved when all clinical areas have met the requirements. Moreover, the medical director rated this provision item in substantial compliance in spite of the fact that the facility reported 15% compliance for timely submission of Annual Medical Assessments. In moving forward, the monitoring team recommends that the medical director follow guidance from state office provided in the form of policy issuance or otherwise. Moreover, the medical director should review, for each provision item in this report, 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. The facility found itself in substantial compliance with H1 and noncompliance with H2 – H7. The monitoring team found noncompliance with all with all seven-provision items.

	Summary of Monitor's Assessment: The facility's medical director was assigned as the lead for provision H. The facility had done a considerable amount of work in looking at assessments, primarily the timelines for completion. An assessment tracking database was implemented and two file clerks were re-allocated to ensure that assessments were placed in the records in a timely manner. Generally, the medical diagnoses were consistent with ICD nomenclature, however, indications for medications were frequently not consistent with ICD nomenclature. The medical director focused on the review of hospitalizations and management of individuals with diabetes and pneumonia. State office, through the development of a rather robust set of clinical protocols, had provided the foundation for assessing compliance for some elements of care. The facility had not fully implemented the protocols. The facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The state office policy, which remained in draft, required each department have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice. The facility had done a considerable amount of work in looking at assessments, primarily the timelines for completion. An assessment tracking database was implemented and two file clerks were re-allocated to ensure that assessments were placed in the records in a timely manner. Assessments were submitted 10 days prior to the ISP. Tools were being developed to evaluate the quality of the assessments as well, however, not all departments had developed quality tools at the time of the onsite review. With regards to a change in status, the medical 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 monitoring team, however, noted that the unit team minutes contained relatively little detail about the medical issues that occurred in the facility over the past 24 hours. Closure and follow-up were not always evident. This meeting was cited as an important component for many aspects of services for the facility, yet participation of key staff such	Noncompliance

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		as the medical and pharmacy directors, based on documentation in the minutes, was quite low. This report contains, in the various sections, information on the required assessments. This provision item essentially addresses the facility's overall management of all assessments. In order to determine compliance with this provision item, the monitoring team participated in interviews, completed record audits, reviewed assessments and facility data. The results of those activities is summarized here: • Annual Medical Assessments were found in all of the records in the record sample. The overall compliance with timely completion (365 days since previous assessment for the sample reported in section L) was 100%. The validity of this finding is discussed in section L. The facility's initial assessment of the timeliness of medical assessments showed only 15% compliance with timely submission further calling into question the manner in which the AMAs were dated and signed. The medical department's data as reported in the self-assessment showed 100% compliance with annual assessment requirements. The quality of the assessments was problematic and is discussed further in section L1. • The medical staff did not complete Quarterly Medical Summaries as required by the Health Care Guidelines, thus, compliance with this requirement was 0%. • Quarterly Drug Regimen Reviews were completed in a timely manner, although the monitoring team had some concerns about the content of the reviews as discussed in section N. • Annual Dental Assessments – Compliance with timely completion for the six month review period was 92%. • Regularly scheduled quarterly and annual nursing assessments were present in all of the 20 sample individuals' records. This was an improvement from the findings of prior reviews. Nonetheless, a review of the individuals' nursing assessments revealed that although there were some improvement in some areas of the nursing assessments, all assessments failed to provide one or more components of 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. • Psychiatry clinic was delinquent with regard to completion of quarterly medication reviews. They had completed a large percentage of Comprehensive Psychiatric Evaluations (75%). As discussed in section J, while there were improvements in this documentation, there was the need for quality assurance monitoring and peer review. Assessments were completed on an annual basis for all individuals by OTs, PTs,	

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		and SLPs in a single document that addressed all PNM needs in one assessment. The communication assessment was a stand-alone document, though a brief description of communication was included in the combined assessment. There were consistent post-hospitalization assessments completed for individuals upon discharge and return to EPSSLC. Documentation was routinely noted and in most cases, this was thorough. These were not typically collaborative across all disciplines, however. Additional assessments were conducted for delivery of assistive equipment such as AFOs, specialized shoes, wheelchairs, mealtime positioning, referrals from the IDT and/or physician, and post-hospitalization, for example. Most were completed in a very timely manner from the referral date. • Not everyone had an initial psychological assessment. Functional assessments were not completed for all individuals with PBSPs, and annual psychological assessments were not completed for all individuals. Several problems noted throughout the monitoring review were related to required assessments. It was clear that the facility was not meeting several basic requirements and will need to take immediate action to correct this. The monitoring team emphasizes that the facility must monitor all three elements that this provision item addresses: (1) the timelines for completion of scheduled assessments, (2) the appropriateness of interval assessments in response to changes in status, and (3) the quality of all assessments (compliance with generally accepted professional standards of care). This provision item remains in noncompliance due to the lack of timeliness with assessments as well as the overall inability to demonstrate how the facility ensured the adequacy of response to a change in status.	
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.	In January 2012, the medical director provided training to the medical staff related to ICD nomenclature. The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the medical diagnoses were consistent with ICD nomenclature. • The monitoring team noted that indications for medications were frequently inappropriate and not consistent with ICD nomenclature. For example, medications were prescribed for sleep instead of insomnia or rash as opposed to dermatitis. These diagnoses were repeated on the drug profiles for months without correction. • The monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Additionally, records reviewed revealed some examples of documentation of specific criteria exhibited by an individual indicating a particular diagnosis. As stated in section	Noncompliance

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		J, although improved, this was an area in need of further attention. • Across all sample individuals' reviewed, the nursing diagnoses drawn from the assessments failed to capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks.	
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 medical director focused on the review of hospitalizations and management of individuals with diabetes and pneumonia to assess this provision. State office, through the development of a rather robust set of clinical protocols, had in fact provided the foundation for assessing compliance for some elements of care. The multidisciplinary protocols described a series of actions or interventions that the medical and nursing staff needed to take in managing certain conditions. The facility had not fully implemented the protocols and EPSSLC had not had an external audit that included the medical management component. The clinical guidelines could be used to develop clinical indicators that would allow measurement of response to treatment. Development of additional guidelines would help to further establish a medical quality program for the facility. In order for the monitoring team to assess compliance with this provision item, the usual activities of interview and document reviews were completed. • The absence of complete nursing diagnoses was a serious problem because the HMPs, and the selection of interventions to achieve outcomes, were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. Thus, the overwhelming majority of the individuals reviewed failed to have HMPs that referenced specific, individualized nursing interventions developed to address all of their care needs, including their needs associated with their health risks. • A limited number of direct interventions were implemented by OT and/or PT, while there were a number of interventions integrated into SAPs for implementation by technicians or DSPs that did not require skilled therapy. • Diabetes flowsheets were added to the active records for those individuals with the diagnosis of diabetes mellitus. This was a best practice standard and should benefit the individuals as long as there is a process that ensures the document is implemented for those with diabetes and reviewed on a regular basis. Data that are recorded and not reviewed serve no purpose. The monitoring team observed numerous discrepancies in the facilities diabetes data, which must be corrected. The facility had no systems in place to measure the timeliness and appropriateness of interventions largely due to the lack of clinical indicators.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 facility had completed some, but not sufficient, work in this area. The unit meeting was revamped in late June 2012 to have a more focused medical section and include a medical report with "clinical indicators," such as hospitalizations, ER visits, etc. The state issued clinical guidelines did not appear to be fully implemented at EPPSLC. The medical director referred to the clinical pathways as new, but they had been issued for over six months. They were not localized, not included in the department manual, and not provided to the monitoring team. The facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization of health care delivery. The facility will need to give considerable thought to this process to ensure that a solid combination of clinical indicators is selected. This must be established for individuals and for facility aggregate data. Specific examples related to clinical indicators include: • There was no evidence of consistent review of interventions provided. For example, in the case of Individual #70, he was provided PT services implemented by therapy technicians with supervision by the PT to address wheelchair mobility. This was initiated on 11/23/11 and discontinued on 5/22/12 due to little progress toward goals. There were some PT Progress Summaries included in some cases in the Habilitation Therapy tab of the individual record. These indicated that he demonstrated excellent skills related to self-propelling his wheelchair, but that he became agitated when required to follow a specific route during these sessions. He was discontinued from this intervention though there was no clear evidence that the IDT had collaborated to address potential strategies to address this concern. • Across all records reviewed, the clinical justification for the goals/indicators of the efficacy of treatments were unclear. For example, most individuals had goals that indicated that they would suffer no untoward outcomes, and all individuals' HMPs' goals were associated with outcomes that would/would not occur over the next 12 months. During the onsite review, the monitoring team attended one individual's ISPA meeting where components of the individual's risk assessments/risk action plans were reviewed. It was clear that the individuals' team would continue to benefit from additional training and support regarding outcome identification, measurement, and evaluation. • Process and outcome indicators related to the management of diabetes mellitus were assessed with an audit completed by the medical director. This is	Noncompliance

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		discussed in section L. The monitoring team again emphasizes that clinical indicators must be developed for all clinical areas.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The facility did not have an overarching plan to address this provision item and there was no systematic monitoring of health status of all individuals. Databases were established to track some elements of preventive care, diabetes, and seizure management, but there was no evidence that these data were used in any meaningful way. For example, the seizure data showed that 65 % of individuals had intractable/refractory seizure disorder. A 65% refractory rate was cause for immediate review by the facility because this is an unusually high percentage and it should have been questioned. Additionally, the monitoring team found problems with the accuracy of data in several of the reports submitted. Data management appeared problematic at EPPSLC. The proper IT infrastructure and data is critical for much of the work that needs to be done. Development of a system to monitor health status will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The first step in the process is to define what is important to the individuals and what is important that the facility monitor. The facility needs to proceed with developing a comprehensive list of indicators based on these findings. It is likely that a two-tiered system is needed. One that looks at the individual and one that looks at aggregate data. In both cases, the starting point is deciding what to measure. As of the review, there were no systems for effectively monitoring the health status of individuals that were being consistently implemented at EPSSLC. Although the nursing assessment process vis a vis acute, quarterly, and annual assessments, would/could serve as such a system, there was no evidence that it was implemented, partially or otherwise. Thus, health plans (acute and chronic), which were in place for days, weeks, months, and even years, were not adequately reviewed/revised and modified to meet the individuals' needs and the changes in their health status and risks.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to	As mentioned in H5, the facility needs to establish a comprehensive set of clinical indicators. Many of those will be based on clinical guidelines developed. Many other indictors could and should be included. Examples would include the rate of hospitalizations, readmission rates, the incidence of pressure ulcers, the days of healing for pressure ulcers, the number of acute interventions required for bowel management,	Noncompliance

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	clinical indicators.	the prevalence of dehydration, and the prevalence of undesired weight loss. Once the indicators are established and treatment expectations outlined, audits of records and other documents will indicate if treatments and interventions were appropriate. The monitoring team found that there was little evidence that changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes resulted in revisions to their HMPs. For example, individuals with plans to address constipation were not modified in response to their failure to have regular bowel movements; individuals with plans to address their risk of dehydration were not modified in response to actual episodes of dehydration, hyponatremia, etc.; and individuals with plans to address the risk of side effects of their medications, especially psychotropic medications, were not modified in response to episodes of adverse reaction(s) to medication(s).	
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.	State office had developed a draft policy for Provisions G and H. The facility had developed a local policy for H, but none for G.	Noncompliance

Recommendations:

1. The facility must ensure the following with regards to assessments:
    a. All assessments must occur within the required timelines. This will require tracking of scheduled assessments in all clinical disciplines.
    b. Interval assessments must occur in a timely manner and in response to a change in status.
    c. All assessments must meet an acceptable standard of practice
    d. Tools must capture the quality of the assessments (H1).

2. The medical director will need to ensure that the medical diagnoses are consistent with the signs and symptoms of the condition (H2).

3. EPSSLC, like most SSLCs, should consider implementing a daily morning clinical services meeting. This meeting would allow for clinical staff to focus on the events of the past 24 hours that occurred on campus with the clinical leaders of the facility.

4. The facility must develop a comprehensive list of clinical indicators across all clinical disciplines. The timeliness and clinical appropriateness of treatment interventions will be difficult to measure without establishing clinical indicators that assess (1) processes or what the provider did for the individual and how well it was done and (2) outcomes or the state of health that follow care (and may be affected by health care) (H3, H4).

5. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).

6. Provide all staff with the copies of the applicable clinical guidelines, protocols, policies, and procedures, ensure that training has been completed, and hold staff accountable for use (H).

7. In addition to tracking assessments, the QA nurse will need to generate a report on a regular basis, perhaps quarterly, that shows compliance with timelines, appropriateness of assessments, the quality of assessments and other chosen indicators. If deficiencies are noted, a corrective action plan should be developed to address the problems. This should apply to all clinical disciplines (H1).

8. The medical director will need to ensure that the medical diagnoses are consistent with the signs and symptoms of the condition (H2).

9. The facility must develop a comprehensive list of clinical indicators across all clinical disciplines. The timeliness and clinical appropriateness of treatment interventions will be difficult to measure without establishing clinical indicators that assess (1) processes or what the provider did for the individual and how well it was done and (2) outcomes or the state of health that follow care (and may be affected by health care) (H3, H4).

10. The facility must have a system that regularly reviews clinical guidelines, protocols and selected indicators to ensure that current practices are implemented and the most relevant indicators are being measured (H3, H4).

11. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (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 EPSSLC Policy: At Risk Individuals 8/30/11 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Integrated Risk Rating Form dated 12/20/10 o DADS Quick Start for Risk Process dated 12/30/10 o DADS Risk Action Plan Form o DADS Risk Process Flow Chart o DADS Risk Guidelines date 12/20/10 o List of individuals seen in the ER since 6/2/11 o List of individuals hospitalized since 6/7/11 o List of all choking incidents o List of individual at risk for aspiration o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individual with contractures o List of individual with GERD o List of individuals at risk for choking o Individuals with a diagnosis of dysphagia o List of individuals at risk for falls o List of individuals at risk for weight issues o List of individuals at risk for skin breakdown o List of individuals at risk for harm to self or others o List of individuals at risk for constipation o List of individuals with a pica diagnosis o List of individual at risk for metabolic syndrome o List of individuals at risk for seizures o List of individuals at risk for osteoporosis o List of individuals at risk for dehydration o List of individuals who are non-ambulatory o List of individual who need mealtime assistance o List of individuals at risk for dental issues o List of individual receiving enteral feedings. o List of individuals with chronic pain. o List of individuals considered missing or absent without leave o List of individuals required to have one-to-one staffing levels 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 ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #15, Individual #88, Individual #28, Individual #178, Individual #157, Individual #61, Individual #161, Individual #71, Individual #13, Individual #66, Individual #154, Individual #90, Individual #39, and Individual #36. <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Cynthia Martinez, QDDP Coordinator o Jaime Monardes, Facility Director o Mario Gutierrez, Incident Management Coordinator o Michael Reed, Lead Investigator o Gloria Loya, Human Rights Officer o Valerie Grigg, Director of Behavioral Services <u>Observations Conducted</u>: o Observations at residences and day programs o Unit Morning Meeting 7/17/12 and 7/18/12 o Incident Management Review Team Meeting 7/16/12 o Annual PSP meetings for Individual #274 and Individual #322 o ISPA for Individual #99 o Human Rights Committee Meeting
	Facility Self-Assessment: EPSSLC submitted its self-assessment. It was updated on 6/29/12. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one listed the actions that the facility completed towards substantial compliance with 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. The facility had implemented an audit process using similar activities implemented by the monitoring team to assess compliance. A sample of risk assessments was reviewed using the statewide section I audit tool. In conjunction with the section I audit tool, the facility utilized other audit tools in place at the facility. For I1, the record audit was used to determine if assessments were available prior to completion of the risk assessment. Findings from the facility self-assessment were similar to findings by the monitoring team. The facility rated each of the three provision items in section I as out of compliance. The monitoring team agreed. The

	current audit system was focused on documentation and timeliness of assessments. As the facility gains a better understanding of the risk process, it will be important for the audit process to evaluate quality and efficacy of risk assessments and plans.
	Summary of Monitor's Assessment: While progress had been made on meeting compliance through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, the facility was not yet in compliance with the three provisions in section I. Teams were still not accurately identifying risk factors. Risk plans were not being reviewed and updated as changes in health or behavioral status warranted. Risk plans did not include clinical indicators to be monitored or specify the frequency of monitoring and review. As noted in section F, assessments were not being consistently completed prior to ISP meetings. 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. Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. For example, a number of individuals had been identified as high risk for weight gain or loss. Teams were waiting until a significant weight change occurred before aggressively addressing the risk. Plans should be implemented immediately when individuals are at risk for harm. The facility was still waiting on consultation and training on the risk identification process from the state office. This training should move teams further towards integrating the risk process into the ISP development process.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The 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.	Noncompliance

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		The state office hired a team of consultants to work with facilities on developing person centered support plans. This was to include a risk identification process that would result in one comprehensive plan to address all support needs identified by the IDT. The risk identification process had undergone several revisions in the past year. As noted in section F, the consultants had not yet provided training and technical assistance to EPSSLC on the risk process. The facility was moving forward slowly with the risk process in anticipation of further changes in the state policy and procedures. The facility had taken some steps to address the development of an adequate at risk process including: • A database was being used to track the submission of assessments by each discipline prior to the annual ISP meeting. The recordkeeping department was assigned to enter assessment submission information in the statewide database. • Risk rating forms and action plans had been developed for all individuals. • Attendance of key team members at ISP meetings was being tracked in a database. • Changes in risk status were being identified at morning unit meetings. As noted in section F, all disciplines were not routinely completing assessments prior to annual ISP meetings or attending ISP meetings. The lack of input by team members, either through the completion of adequate assessments or attendance at meetings, contributed to IDTs not having the necessary information to accurately identify risk factors. The state policy required that all relevant assessments were submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. The facility had begun using a database to track submission of assessments by discipline and attendance at IDT meetings. There were some discrepancies with data reports submitted by the facility. These databases will be a useful tool when the facility begins consistently collecting and analyzing data. As noted in section F, the submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals. A sample of ISPs, assessments, and the facility risk rating list were reviewed to determine if risks were being consistently identified and addressed by IDTs. Overall, there had been improvement in the action plans written to address identified risks, though the quality of plans was not consistent. The concern still remained that not all risks were identified by IDTs through the assessment process. Teams were also not consistently identifying clinical indicators to be monitored in regards to risks.	

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		The risk discussion was now held during the annual ISP meeting. At the two ISP meetings observed, all disciplines contributed to the risk discussion. Risk determinations were based on integrated discussion. The risk discussion, however, still remained a separate part of the ISP meeting. Supports to address risks were not discussed in relation to the individual's preferences. The following are some examples where risks were not appropriately identified in documents reviewed, or where ratings conflicted with assessment information. ▪ Individual #36 had a diagnosis of osteoporosis. He was rated as high risk for osteoporosis. He had a number of supports in place to address his unsteadiness and risk for falls. He was also at high risk for seizures which could contribute to the risk for falls. The team rated him as medium risk for falls and fractures without considering that these four areas were interrelated, thus, he was at high risk for injury (including fractures) due to falls. All team members should be aware that he was at high risk for falls and fractures, therefore, it is critical that adequate supports be provided to minimize his chance of serious injury. ▪ Individual #161 was rated as medium risk for choking and aspiration. An MBSS from March 2012 documented a flash penetration of thin liquids. She was on a chopped diet with nectar thickened liquids supplemented with meals via G-tube. Though she had no history of aspiration or choking, she was obese, had a significant history of emesis, and had been hospitalized a number of times in the past year, thus, increasing her risk for aspiration. She was rated as low risk for respiratory compromise. She had a bilateral pulmonary embolism in June 2011, pleural effusion in July 2012, and was taken to the ER for respiratory distress during the past year. She was rated as medium risk for cardiac concerns. She was obese and took medication for tachycardia indicating that her risk was high. The team rated her at medium risk for challenging behaviors. She had a BSP in place and had four chemical restraints due to behavior in the past year. The use of chemical restraints added additional health risks, including the risk of aspiration. Her challenging behaviors were a high risk to her health and safety. She was rated as medium risk for weight concerns, though she was obese. The team rated her as medium risk for GI concerns though she had an extensive history of emesis. She was rated as medium risk for infections even though she had frequent bouts of cellulitis, numerous UTIs, and a leg abscess in the past year. The IDT needs to have an integrated discussion regarding her numerous risks and how they are interrelated. Risk ratings should be assigned conservatively. Additional examples are listed at the end of section M5 and in section O2.	

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		For both short and long range planning, the teams will need to: • Frequently gather and analyze data regarding health indicators (e.g., changes in medication, results from lab work, engagement levels, mobility). • Ensure that assessments are updated and submitted prior to annual ISP meetings and all relevant disciplines attend meetings and participate in discussions regarding risks. • 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. • Ensure that data collected regarding incidents and injuries is frequently analyzed for indication that supports may not be adequate for safeguarding individuals. The facility's self-assessment indicated that the facility was not yet in substantial compliance for this provision based on quality of the risk rating system. The monitoring team agrees with this assessment.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The 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. The facility self-assessment of I2 indicated that between October 2011 and March 2012, there had been 34 individuals identified with a change of status. Twenty-two (65%) of those were addressed within five days. As noted throughout this report, it was still not evident 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. Additionally, there continued to be problems with health risk ratings that were not consistently revised when significant changes in individuals' health status and needs occurred. A sample of records was reviewed to determine if changes in circumstance should have	Noncompliance

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		resulted in an assessment of current services and support, risk ratings, and/or plan revisions. Although it appeared that teams were usually meeting immediately following a critical incident, it was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time. ISPAs were used to document initial discussion when a change in status was identified. There was not always documentation of follow-up when recommendations were made by the IDT. The following are examples of where IDTs did not address risks in a timely manner. • Individual #36 was discharged from the hospital with dehydration on 5/3/12. He was again treated for dehydration on 5/8/12. His IDT did not meet until 5/10/12 to review his risks and develop action plans. It did not appear that adequate plans and monitoring of his risks were immediately put into place. He was taken to the emergency room for dehydration again on 5/15/12. There was no evidence that the team reconvened to review his risk action plan. • Individual #28 experienced a significant weight loss (10%) between 2/5/12 and 3/3/12 when she dropped from 58 pound to 52 pounds. Even though she was already below her IWR and this was a significant drop, the IDT did not meet to discuss her weight loss until 4/10/12 after she was hospitalized. • Individual #114 seriously injured a peer when he pulled his wheelchair over. The team met immediately following the incident, but ruled out consultation with the BSC on the basis that his risk of challenging behaviors had not changed from a medium risk. This incident was the third incident where he had turned over a peer's wheelchair. It was the second serious injury to another individual. As a result, adequate protections were not put into place to prevent injury to other individuals until almost a month after the third incident. 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 based on adequate assessment. 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	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 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.	Noncompliance

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	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.	According to lists provided to the monitoring team, plans were in place to address all risks for those individuals designated as high risk or medium risk in specific areas. Most plans in the sample did not include the clinical indicators to be monitored. For example, • The Risk Action Plan for Individual #90 included action steps to reach the low end of his IBW within the next quarter. His IBW was not included. He was to be weighed weekly and staff were to complete a three day calorie count. His plan did not indicate what his weight range should be or when DSPs should alert medical staff if he continued to lose weight. There were no parameters for what his calorie intake should be. His action steps for GI problems stated continue with head of bed elevation, but did not state the degree that his bed should be elevated. His action plan for osteoporosis stated, "improve BMD," but again, no range was noted. • Individual #154 had an action plan to address his risk for constipation. One of the action steps stated to encourage intake of fluids. There was no further information on how much fluid he should have or where his fluid intake would be documented. His BMD was to be monitored, but no range was given. 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. 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 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. Ensure attendance or at least input by all relevant team members in the risk process (U1)
4. 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).

5. Ensure IDTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).

6. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).

7. 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 (I1 and I2).

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 One example of a dental desensitization plan and four examples of skills acquisition 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; Personal 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 Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy o Facility-wide data regarding polypharmacy, including intra-class polypharmacy o For the last 10 <u>newly prescribed</u> psychotropic medications: Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent

	form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses 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 #61, Individual #27, Individual #37, Individual #9, Individual #52, Individual 188, Individual #89, Individual #76, Individual #79, and Individual #40 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 7/17/12 regarding Individual #9, Individual #104, Individual #89, Individual #157 and Individual #112. o All data presented, doctor's orders, and physician's documentation for psychiatry clinic 7/16/12 regarding Individual #61 and Individual #79. o Documentation regarding the ISP meeting for Individual #77. o Documentation regarding the number of ISP meetings dental attended in the previous six months. o Five examples of polypharmacy justification documentation. o Schedule of psychiatry clinic for the previous six months designating if clinic was performed during an ISP meeting. o Information presented at the integration meeting observed 7/16/12. o For individuals no longer participating in psychiatry clinic, the reason for discontinuing services. o Any available data regarding Reiss Screens. o Template for psychiatry/psychology integration tool and five examples of each (annual, quarterly, psychiatry clinic). o Listing of every individual receiving TIVA in the last six months. o All data presented, doctor's orders, and Dr. Chavez-Rice's documentation for psychiatry clinic 7/18/12 regarding Individual #8 and Individual #51 o Information presented at pretreatment sedation meeting 7/16/12 o Draft revised monitoring tool for section J 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 #13, Individual #23, Individual #59, Individual #8, Individual #104, Individual #66, Individual #112, Individual #69, Individual #73, Individual #114, Individual #39, Individual #79, Individual #83, Individual #90, Individual #32 <u>Interviews and Meetings Held</u>: o Eugenio Chavez-Rice M.D. facility lead psychiatrist with Nohemi Ostos, C.P.T., psychiatry clinic staff o Mary Ann Clark, R.N., Chief Nursing Executive o Ascension Mena, M.D., Medical Director o Amista Salcido, Pharm.D., Pharmacy Director with Giovanna Villegran, Pharm.D. o Valerie Grigg, M.A., BCBA o Howard Pray, D.D.S., facility dentist with Raquel Rodriguez, RDH o Nohemi Ostos, C.P.T. <u>Observations Conducted</u>: o Observation of two psychiatry clinics including the following individuals: • Individual #61, Individual #79, Individual #8, and Individual #71 o Observation of ISPA meeting for Individual #77. o Observation of Neuro-Psych clinic regarding: • Individual #9, Individual #104, Individual #89, Individual #157 and Individual #112. o Observation of pharmacy meeting including pre-sedation meeting o Observation of individuals in two facility homes. o Meeting with family member of Individual #112 o Psychiatry/Psychology weekly meeting o Observation of Integration meeting o Observation of Pharmacy & Therapeutics meeting
	Facility Self-Assessment EPSSLC continued to use the self-assessment format it developed for the last review. There were some additions made to the self-assessment, and the psychiatric clinic had developed a monitoring tool, which they planned to implement during the upcoming monitoring period. Review of this monitoring tool

	indicated that facility staff had reviewed the monitoring report and were planning to perform a review similar to that performed by the monitoring team. It will be important for psychiatry clinic to ensure that they have included all items reviewed by the monitoring team in their tool. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in the self-assessment. Currently, much of the facility self-assessment was based on the completion of Appendix B evaluations. For example, the self-assessment for J3 was noted in noncompliance due to the need to complete the remainder of the comprehensive psychiatric assessments in Appendix B format. The monitoring team, however, reviews this and other items in order to make the compliance determination; these include diagnostic concordance between disciplines, psychiatry input into the PBSP, and non-pharmacological interventions available for an individual inclusive of engagement in activities. These and other items are reviewed in order to ensure that psychotropic medications are not used as a substitute for a treatment program. These items had been identified in the updated monitoring tool and, as such, it was apparent that the psychiatry clinic team was proceeding in the right direction. The facility self-rated itself as being in substantial compliance with four provision items: J1, J11, J12, and J15. The monitoring team agreed with two of these J1 and J15. Additionally, J6 was found in substantial compliance based on the laudable efforts surrounding completion of Appendix B evaluations.
	Summary of Monitor's Assessment: Psychiatry services at EPSSLC made progress towards substantial compliance. Nevertheless, the facility was found to be in noncompliance with 12 of the 15 items in this provision of the Settlement Agreement. More than half of the individuals received psychopharmacologic intervention (74 of the 125, 59%). There was a laudable effort placed into the completion of the comprehensive psychiatric evaluations in Appendix B format. Of the 74 individuals enrolled in psychiatry clinic, 56 or 75% had completed assessments. There were improvements with regard to collaborative case formulations that included specific diagnostic criteria utilized to determine the presence of a specific diagnosis. While there were some improvements in the consistency of psychiatric diagnoses across the evaluations of different disciplines, there remained some challenges. This was likely attributable to the number of diagnosis changes that had occurred in the intervening period since the last monitoring review, which totaled 52. In an effort to improve communication between psychology and psychiatry, an integration tool had been developed that outlined items, such as diagnosis changes and responsibilities of specific team members, such that communication and expectations remained clear. The monitoring team observed two 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 15 individuals revealed that only three records contained quarterly psychotropic reviews performed in the previous six months. This was reportedly because, in order to complete this number of comprehensive assessments, the psychiatric clinic had fallen behind with regard to completion of quarterly psychotropic medication reviews. One area previously in substantial compliance, J12, was not sustained. There were noted deficiencies in tracking completion of the instruments, deficits in the review of the instruments, deficits in comparison of the documents from one assessment to the next, delays in clinical consultation (e.g., quarterly medication reviews), and issues with both the identification and ongoing monitoring of Tardive Dyskinesia (TD). Specifically, in the prior review, there were 14 individuals identified with TD, during this review there were reportedly no individuals residing at the facility with a diagnosis of TD. TD is a chronic condition that does not remit over time. Most concerning was the issue of medication regimen adjustments where changes in medication dosages or the addition/discontinuation of a specific medication were performed concurrently 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., J1, J6, J15), however, in other areas, while isolated improvements were seen, the facility staff must create a system for the provision of psychiatric services. Approaching this section as an isolated task list will not achieve the desired results, instead, a comprehensive, collaborative, integrated psychiatric service is required.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<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 20 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.	Number of Individuals Evaluated At EPSSLC, 74 of the 125 individuals (59%) received psychopharmacologic intervention at the time of this onsite review. There had been a focus on the completion of evaluations in the Appendix B format, such that 56 had been performed (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 delays in the completion of quarterly psychotropic medication reviews due to the focus on completion of the comprehensive evaluations. Evaluation and Diagnosis Procedures Via the monitoring team's observation of two 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. Issues noted in the previous monitoring report with regard to the need to utilize specific diagnostic criteria when determining diagnoses had resolved. As discussed in J6 and J8 below, where examples were provided, both the use of diagnostic criteria and the collaborative process with other disciplines was improved. There remained, however, cause for concern with regard to psychotropic medication regimens. Clinical Justification In order to improve documentation regarding evaluating and diagnosing individuals in a clinically justifiable manner, the psychiatric staff designed a form called the "quarterly psychiatric medication review." There was evidence of the use of these forms in some records, however, as discussed in detail in this report, the quarterly psychiatric clinical encounters had been occurring on an inconsistent basis during this monitoring period. During the previous monitoring visit, 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. This had not occurred. Tracking Diagnoses and Updates The psychiatry clinic had developed a tracking system to monitor diagnosis changes. Between the dates of 1/5/12 and 5/18/12 they had documented diagnosis changes for 52 individuals. The volume of diagnosis changes had reportedly led to some documentation and treatment issues between providers (e.g., psychiatry and psychology) ultimately leading to the development of the integration tool implemented in March 2012. As noted in J3 below, there remained a percentage of documents where diagnoses were not consistent between disciplines. A facility-specific policy and procedure might help with development of a system to ensure appropriate	Noncompliance

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		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), the concerns with multiple medication regimen alterations even in the context of documented diagnoses, the unacceptable gaps of time between quarterly medication reviews, and the recent combining of psychiatric clinic with ISP meetings, this item was rated as being in noncompliance. The facility self-assessment had also rated this item in noncompliance.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	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. An issue noted in the previous monitoring report that, 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), had improved during the interim period. In an effort to improve communication between psychology and psychiatry, the facility had instituted an integration tool as of March 2012. This document, completed by psychology during psychiatry clinic, allowed for clear communication and delineation of expectations for each department. The monitoring team reviewed the active positive behavior support plan (PBSP), sometimes referred to as a behavior support plan (BSP), in the sample of 15 records reviewed. While the majority of individuals prescribed medication had a PBSP on file, this information was missing in the records of Individual #112 and Individual #90. In addition, as discussed in J9, Individual #77 (not included in the sample of 15 records described above) had a PBSP that required revision as it was dated 7/28/10. Of the reminding 13 records, seven reflected consistent diagnoses (e.g., the psychiatric and psychology diagnoses were the same). Five had different diagnoses, and one record, that of Individual #66, was missing the diagnosis page on the PBSP. The content of the PBSPs is reviewed in section K of this report. It was notable the BSP documents 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. Review of quarterly psychiatric medication reviews revealed improvements in the risk benefit analysis for treatment with specific medications authored by psychiatry as discussed further in J10. There was also evidence	Noncompliance

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		of improvements in the collaborative case formulations as noted in the examples reviewed in J6 and J8 below. What was concerning was the high percentage of individuals participating in psychiatry clinic who met criteria for polypharmacy (67%). Additionally, there were noted issues with rapid changes in the medication regimen, including either the addition of, or dosage increases of, more than one medication at a time (discussed further in J6, J9, and J13 below). 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. For instance, individuals require active engagement during the day. 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. For example, Individual #13 was noted to be outside, alone for hours each day. He sat alone on a bench or walked the sidewalks. There was, however, no indication that psychotropic medications were being used as punishment or for the convenience of staff. It will be important for collaboration to continue 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 reduced, as there were three instances of emergency psychotropic medication utilization between 1/1/12 and 7/16/12 compared to eight incidents in the previous six months. For the current review period, the three instances involved one individual. Individual #161 received emergency psychotropic medication on three different occasions, with the last time on 2/16/12. As was discussed with psychiatric and primary care staff during this and the previous monitoring visit, there was concern on the part of the monitoring team regarding the	

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		multiple medications utilized for both chemical restraint episodes and pretreatment sedation. For example, this individual received a total of Phenobarbital 130 mg on 1/21/12. On 2/2/12 she received Haldol 10 mg and Ativan 2 mg. On 2/16/12 she received Haldol 10 mg, Ativan 2 mg, and Benadryl 10 mg. As indicated in the previous monitoring report, 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 that this individual experienced little benefit as a result of the chemical restraint, as per the psychiatric documentation entitled "Face to Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint" dated 1/23/12, "…Phenobarbital 130 mg IM stats…not only didn't help but made patient behavior worse." A review of this individual's record revealed that multiple medication regimen adjustments had occurred since 1/1/12: • 1/2/12 Clonazepam 1 mg three times per day was tapered over 21 days to discontinuation. • 1/25/12 Tegretol total dosage 600 mg daily was cross-tapered over 19 days with concurrent increasing dosage of Lamictal. Lamictal was started at 50 mg daily, increasing over the next 14 days to a total of 150 mg daily. This increasing dosage titration of Lamictal was more rapid than recommended. Increasing dosages of Lamictal have an inherent risk of the development of Stevens Johnson syndrome, a potentially lethal skin rash. The dosage titration recommended by the FDA is Lamictal 25 mg daily for two weeks, then 50 mg daily for two weeks, then 100 mg daily. • 2/29/12 Haldol 5 mg twice daily was tapered to discontinuation over 21 days concurrently with an increasing dosage of Latuda, titrated to 40 mg over 10 days. • Cogentin 2 mg in the morning was added at this time. • 4/3/12 Latuda dosage increased to 60 mg daily to address agitation, screaming, kicking, and SIB. • 4/20/12 Lithium started 300 mg daily to address, per the clinic documentation, PTSD flashbacks characterized by agitation, aggression and SIB. It should be noted that Lithium is not indicated for the treatment of PTSD or flashbacks associated with PTSD. Per the order of this date, the indication for the medication was mood instability. • 5/3/12 Lithium increased to 300 mg twice daily for mood instability. The above medication regimen changes were concerning with regard to rapidity of tapers and dosage titrations. There was also cause for concern that these changes did not represent an organized response to this individual's behavioral and psychiatric	

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		challenges. Monitoring Team's Compliance Rating Due to the paucity of non-pharmacological interventions, and the apparent over reliance on psychotropic medication, this provision remains 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.	Extent of Pretreatment Sedation There was a listing of individuals who received pretreatment sedation for either medical or dental clinic. This listing indicated a total of 69 incidences of pretreatment sedation for medical clinic attributed to 20 individuals. There was one individual noted who received pretreatment sedation for dental clinic. Of these 20 individuals, 15 (75%) were enrolled in psychiatry clinic. It was noted that the manner in which the data were presented indicated up to a total of three sedations to complete one procedure. This was due to combinations of medications administered in order to achieve sedation. For example, Individual #111 received pretreatment sedation on 2/14/12 in order to undergo an ultrasound. She received three medications including Haldol 5 mg, Phenobarbital 130 mg, and Lorazepam 2 mg. The use of multiple medications is concerning because combinations can result in increased side effects, including but not limited to respiratory suppression. Combinations, such as these, could be considered conscious sedation. Review of the provided document revealed 22 instances of the use of two or more medications. There were 13 instances of the use of three medications, with the last example dated 5/13/12 where Individual #67 received the medications Lorazepam 1 mg, Haldol 5 mg, and Phenobarbital 64.8 mg prior to a mammogram. The document provided to the monitoring team did not provide the information required for tabulating the extent of TIVA. This information was requested again during the monitoring visit. Data provided revealed that since 1/19/12 there were 35 instances of TIVA at EPSSLC. Of these, 22 (62%) individuals were currently receiving treatment via psychiatry clinic. An additional five individuals received TIVA during dental treatment performed off campus. 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 or 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, and route of the medication, and date of ISP that documents review to minimize the need for the use of pretreatment sedation medication. This collated information will allow the facility to better review the use of sedation.	Noncompliance

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		Interdisciplinary Coordination 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 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 monitoring visits. During the meeting held for this monitoring period, it was reported that there were no individuals pending pretreatment sedation scheduled for review. Desensitization Protocols and Other Strategies A list of all individuals with medical/dental desensitization plans and date of implementation were requested. The monitoring team was provided with a list of 19 individuals who had a current dental desensitization plan. There were reportedly no current medical desensitization plans. The lack of medical desensitization plans (or other considerations), as discussed above, because there were individuals receiving multiple medications in pretreatment sedation for medical procedures. 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. The facility had attempted to develop a triage or assessment process to identify individualized strategies and interventions inclusive of IDT involvement in the protocol. A committee, chaired by the medical director, had been designated and a flow sheet for the assessment process had been devised. From this, there had been two formal dental desensitization plans developed. The remainder of the 19 plans discussed above were skills acquisition plans. A sample of five dental skills acquisition plans was received. These were apparently individualized, however, were blank and did not indicate if there had been any attempts to educate the individual or if there had been any progress toward skill development.	

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		Monitoring After Pretreatment Sedation A review of provided documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented 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. In addition, the facility must reduce reliance upon the use of multiple medications for pretreatment sedation. This is dangerous and could result in serious side effects to the individual. As these multi-medication sedations were being utilized as pretreatment sedation for medical procedures, the committee addressing the triage and assessment for desensitization should focus on medical sedation as well as dental.	
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 74 individuals) received psychopharmacologic intervention requiring psychiatric services at EPSSLC as of 7/16/12. 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 staff members were working hard, but due to the level of need, were struggling to provide services. This was further complicated by the prolonged absence of one of the clinic staff members. In order to maintain the clinic structure, temporary staff assistance should be considered. Determination of Required FTEs During the previous monitoring visit, 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	Noncompliance

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		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 the search for additional psychiatry contract providers was ongoing. 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 a focus on completion of comprehensive psychiatric assessments in the intervening period since the last monitoring report. For further information regarding this issue, please see the discussion under J13, J12, and J9. <u>Monitoring Team's Compliance Rating</u> 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.	<u>Appendix B Evaluations Completed</u> EPSSLC psychiatry staff focused on the completion of comprehensive psychiatric evaluations per Appendix B during this monitoring period. Documentation revealed that out of a total of 74 individuals receiving treatment via psychiatry clinic, 56 individuals (75%) had psychiatric evaluations performed according to Appendix B. At the time of the last monitoring visit, only 16 initial psychiatric evaluations had been completed for the individuals enrolled in psychiatric clinic. Given the paucity of psychiatric resources available at the facility, this was impressive. It was, however, not without sacrifice. As indicated in other areas of this report, the focus on assessments had resulted in delays in completion of quarterly psychiatric clinical assessments. In addition, in an effort to conserve time and resources, annual and quarterly ISP meetings were utilized as psychiatry clinic encounters. For further information regarding this topic, please see J9. A sample of Appendix B style evaluations were reviewed for the following 10 individuals: Individual #61, Individual #27, Individual #37, Individual #9, Individual #52, Individual 188, Individual #89, Individual #76, Individual #79, and Individual #40. 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, with three documenting multiple changes over the past year. For further information regarding this topic, please see J8, J9, and 13.	Substantial Compliance

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		In the sample documents reviewed, there were noted improvements in the collaborative case formulation inclusive of the use of DSM-IV and DM-ID criteria in making diagnoses. There was also copious information included from other disciplines (obtained via the ISP). While challenges remain (see the example below and the example outlined in J8), overall, there were improvements. For example: • Individual #89: In the initial psychiatric evaluation dated 5/9/12 there was documentation of anoxia and spinal cord injury at birth. This individual had a previous history of diagnoses that included psychotic and mood disorders. His case was reviewed by the IDT, and the diagnosis was revised to paranoid disorder due to acquired and/or congenital brain damage. The DSM-IV and DM-ID criterion utilized by the IDT to arrive at this diagnosis were documented. There was a review of the symptoms or behaviors that this individual was experiencing that led to the specific diagnosis. There was a case formulation tying together the information provided from the various disciplines, utilizing information that was taken directly from the ISP document. o While this was an improvement, there were issues noted with the psychotropic medication regimen. For example, a taper of Clonazepam was initiated 3/27/12. It was a reduction of a total of 6 mg over a period of 43 days (i.e., 8 mg to 2 mg per day). A rapid reduction can precipitate seizure activity and this individual had a pre-existing history of seizure disorder. Also, after long term treatment, there was the possibility of detoxification reactions. Additional medical records were not available for review, so it was not possible to determine if there was monitoring for detoxification symptoms during the rapid taper. o There was also an increase of Trazodone from 150 mg to 200 mg on the date that the Clonazepam taper was started. On 3/10/12, Fluvoxamine titration was started with a dosage of 150 mg achieved on 5/10/12, Melatonin 9 mg started 5/15/12, and the antipsychotic medication Latuda started 5/16/12. All Appendix B evaluations included information regarding the integrated treatment plan that was taken directly from the ISP document. While this was 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. In addition, instruction in the treatment recommendations must include non-pharmacologic intervention and pharmacologic intervention as summarized in Appendix	

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		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. Monitoring Team's Compliance Rating There were improvements in the collaborative case formulations noted including the utilization of DSM-IV and DM-ID criteria. There had also been a focus on completion of Appendix B evaluations and comprehensive case formulations. There was room for improvement, and the documents themselves would benefit from peer review. The facility psychiatric staff had reportedly sent work samples to other facility psychiatrists for review and feedback. As the bulk of the evaluations had been completed, this provision will be placed in substantial compliance. There are other areas, specifically medication regimen alterations, which must be addressed, and are the subject of other provisions.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Reiss screen, 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. Some of the data presented to the monitoring team for this provision were unreliable. Reiss Screen Upon Admission The facility had three new admissions for the previous six months with all of these individuals being administered a Reiss screen (based on information provided to the monitoring team). One of the three was referred and received a comprehensive psychiatric evaluation and was being followed in psychiatry clinic. Reiss Screen for Each Individual (excluding those with current psychiatric assessment) Per documentation reviewed of a listing of individuals residing at the facility who were not currently receiving treatment via psychiatry clinic, there were 51 individuals who would be appropriate for Reiss screening. Of these, 29 individuals had documented completed screens. There were five individuals who were referred to psychiatry clinic following screens performed during the previous monitoring period. Of these, none were still followed. There were four individuals currently participating in psychiatry clinic who received Reiss screens during this monitoring period. Given the data provided, it was not possible to determine the reason for the screening because 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. 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	Noncompliance

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		Reiss Screen, and which were screened due to a change in behavior or circumstance and then entered the clinic. Interviews with psychology staff revealed that all individuals not currently enrolled in psychiatry clinic had been screened, however, provided data did not support this report. What was noted during the previous monitoring review was that psychiatry reviewed all completed screens and this practice had continued. <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> Individuals who 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 were referred to psychiatry clinic via a form entitled "Psych Clinic Referral." This process must be formalized in policy and procedure <u>Monitoring Team's Compliance Rating</u> Given that there was not documentation indicating that all individuals not participating in psychiatry clinic had undergone baseline screening, and that it was not determinable if individuals were screened due to a change of status (e.g., change of staff, death of a family member, behavioral changes) 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 had a facility specific policy and procedure regarding psychiatry in effect dated 4/28/11, and this document required the implementation of a system to integrate pharmacological treatments with behavioral and other interventions, however, it did not delineate a procedure. <u>Interdisciplinary Collaboration Efforts</u> The monitoring team observed two separate psychiatric clinics, and one Neuro-Psychiatry clinic. Per interviews with psychiatry 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). There were improvements 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. It was notable	Noncompliance

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		that graphed, up-to-date data were provided, but psychology must improve the analysis of the data and their assessment of what the presented data means. 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. Some staff verbalized concern that the IDT still relied on anecdotal evidence when making decisions. In an effort to improve this, psychology had begun a pilot program where daily data cards were provided to direct care staff. Interviews with psychology staff revealed that in the three homes where the data card system had been implemented, integrity checks were occurring more frequently and by their calculations, the integrity of data had improved (reliability had reportedly increased from 18% to 93% in these homes). 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 two psychiatry 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 in the use of data with regard to making adjustments to the individual's psychotropic medication regimen such that this process would comport with generally accepted professional standards of care. A review of the psychological and psychiatric documentation for 15 individual records did reveal case formulations that tied the information regarding a particular individual's case together. In the interim period since the previous monitoring visit, the psychiatrist had focused on the completion of comprehensive psychiatric assessments. In order to complete these assessments, the psychiatrist had been sharing the draft document with psychology staff who then added information from the PBSP and psychology assessments to the document. In addition, information from other disciplines (OTPT, speech, medical) was added to the comprehensive assessment. The case formulation information improved over previous reviews, and there was apparent increased use of	

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		DSM-IV and DM-ID criteria in the assessment and diagnostic process. A good example: • In the comprehensive psychiatric assessment for Individual #32 dated 3/30/12, diagnoses, including "Impulse Control Disorder due to febrile convulsions and mesial temporal sclerosis" and "profound mental retardation" were documented. Per the case formulation, "suffered anoxia…during birth…later febrile convulsions…suspect…mesial temporal sclerosis and orbitofrontal and frontotemporal disconnection syndromes that have driven his behavior…damage to these areas is characterized by sudden aggressive behaviors, impulsiveness, loss of frontal control, self injurious behavior…at the behavioral support group meeting, the IDT discarded the diagnosis of ADHD because it didn't fulfill the criteria…new diagnosis as Impulse Control Disorder…and Mesial Temporal Sclerosis…based on unprovoked episodes of aggression…episodic SIB…impulsiveness…episodic unprovoked agitation and…anoxia…and febrile convulsions as a child…has also been determined from the Functional Assessment Report that…behaviors…originated by seeking attention and thus…the pharmacological interventions would be minimally successful which has been the case up to the present time." While this case formulation was improved from prior monitoring reviews, there remained issues. The above example gave a specific diagnosis of mesial temporal sclerosis. This diagnosis, per Columbia University Neurosurgery, is "closely related to temporal lobe epilepsy…" Mesial temporal sclerosis is the loss of neurons and scarring of the deepest portion of the temporal lobe and is associated with certain brain injuries. The brain changes associated with this disorder are usually identified via MRI. There was no report of MRI results in this individual. There was no report of a seizure diagnosis in this individuals record. In addition, given this diagnosis, it would be prudent to refer him to neurology clinic, but there was no documentation of neurology consultation following this diagnosis. Review of the plan for continued treatment did not reveal plans for neuroimaging or for neurology referral. 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 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.	

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		Integration of treatment efforts between psychology and psychiatry 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 compared to prior monitoring visits. Other integration efforts between psychiatry and psychology included the attempts by psychiatry to attend some ISP meetings and opportunities for interaction during psychiatry clinic with the psychologist and other disciplines. In addition, psychology staff had developed an integration tool that was utilized during psychiatry clinic. This tool, instituted in March 2012 was developed to prompt conversation between psychology and psychiatry during clinic. In addition, the tool allowed for "clear communication and determination of the expectations of psychiatry and psychology after the clinical encounter…it should help us to avoid miscommunication..." Coordination of behavioral and pharmacological treatments As noted in J9 and 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, one medication at a time 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, or in the clinical documentation reviewed. In an effort to provide information regarding generally accepted clinical practices of medication management in this population, a specific textbook was recommended to the facility psychiatrist by the monitoring team. Monitoring Team's Compliance Rating While notable improvements had been made, there were ongoing challenges with the integration of pharmacological treatments with behavioral and other interventions, specifically multiple medication regimen changes occurring on the same day in the apparent absence of data requiring these changes. As such, this provision remained in noncompliance. For additional information regarding this issue, please see J9 below.	

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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 (though some improvements were observed, as noted above). During psychiatry clinic, the psychiatrist asked pertinent questions regarding behavioral challenges, how these were being addressed via the BSP, questioned the function of specific behaviors, and asked about any non-pharmacological interventions. 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 were reported improvements in the psychiatrist's attendance at ISP meetings as in psychiatric clinic was being merged with the ISP. This, however, was not acceptable. Review of data regarding quarterly psychiatric clinic revealed overdue quarterly reviews. Specifically, review of the document entitled "Individuals Prescribed Psychotropic Medication" that included information regarding the individuals clinical contact with the psychiatrist, there were a total of 17 individuals who did not have documentation of psychiatric clinic/quarterly reviews since 3/1/12. Documentation received regarding the psychiatrist's attendance at ISP meetings did support the reported attendance. There were a total of 36 ISP attendance sheets dated between 1/2/12 and 6/13/12. Of these, the psychiatrist signed 29 (this was a reduction from 34 reported during the prior monitoring period). Psychiatry clinic support staff signed the remaining seven. Data presented indicated that there were a total of 35 ISP meetings regarding individuals participating in psychiatry clinic during this period. As such, the psychiatrist attended 82% of the scheduled ISP meetings. This was positive, however, as stated above, the attendance at ISP meetings was in lieu of formal psychiatry clinic, which was not acceptable. What was positively noted was the constellation of staff continuing to participate in psychiatry clinic, such that this clinic encounter would also qualify as an IDT gathering.	Noncompliance

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		Treatment via Behavioral, Pharmacology, or other Interventions The following example highlighted the continued problems of multiple medication regimen adjustments, lack of physician documentation, and an inadequate development of the treatment plan by the IDT. • Individual #148 was recently admitted to the facility with psychotropic medications, including Valproic Acid, Zoloft, and Topamax. • Upon admission, Valproic Acid was discontinued and Clonazepam was added for the indication of "stereotypic movement disorder" per the verbal order of the primary care physician. A review of the IPNs did not reveal documentation by the physician, or any other provider, regarding these medication changes. • A month or so later, Topamax was discontinued, the dosage of Zoloft was increased by 50 mg to 150 mg, and Tegretol 100 mg twice daily was added for "agitation" per the order of the psychiatric physician. Documentation indicated that this psychiatric consultation was performed during the annual ISP review. • Also at this time, "the IDT reassessed his diagnoses and deleted depression and stereotypical movement disorder with SIB and instead agreed upon the diagnosis of Pervasive Developmental Disorder, Autistic type…his medications were reassessed and his Zoloft was increased to 150 mg for SIB and he was started on Tegretol for agitation…at this time we don't have enough time elapsed to see if the changes have improved his SIB and aggression." • A week or so later, Zoloft was discontinued, the dosage of Clonazepam was doubled to a total of 1 mg twice daily, the dosage of Tegretol was increased to a total of 200 mg three times daily, and Paxil 30 mg was started per order of the psychiatric physician. ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports 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, these interventions were either not occurring or were occurring on a sporadic basis. For example, • An ISP meeting was observed for Individual #77. During the meeting, it was reported that data were collected regarding refusals, SIB, aggression, damaging clothes, and taking food. The PBSP was dated 7/28/10, that is, two years ago.	

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		• Discussion during the ISP revealed a lack of clarity regarding refusals. It was apparent that this individual was, at times, refusing transitions (e.g., from home to workshop). These data were being utilized in making pharmacological regimen adjustments, which was inappropriate. • The ISP planned to revise the PBSP and track SIB and aggression. There were also reported plans to monitor refusals, beginning with allowing this individual several choices in activities, other than when refusal could lead to a health or safety hazard. • It was concerning that the monitoring team had to illustrate the above issues with regard to data collection and refusal definitions to the IDT. <u>Monitoring Team's Compliance Rating</u> 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 continue to move toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological in an effort to reduce the reliance on psychotropic medication. 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.	<u>Policy and Procedure</u> A review of DADS policy and procedure "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." This was reiterated in the facility specific policy "Psychiatry Services," 4/28/11. There were no procedures for this process delineated. <u>Quality of Risk-Benefit Analysis</u> 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 15 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 quarterly psychiatric medication review for Individual	Noncompliance

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		#104 included a listing of all psychotropic medications, with a brief listing of the most serious risks and a brief listing of the potential benefits of each medication. A concluding statement was included, "the IDT agreed that at this point the benefits of…medications outweigh the risks that he might decompensate and cause serious harm to himself or others as has been seen in the past when he wasn't controlled." Similar documentation was located in the records of Individual #61 and Individual #79, all of whom had recent psychiatric quarterly medication reviews. This documentation was located on the revised quarterly psychiatric medication review, the regular completion of which may address some of these issues. As discussed with facility staff, the risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician, however, the success of this process will require a collaborative approach from the 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 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. This issue during this monitoring period was that psychiatry was behind in the completion of quarterly assessments. In an effort to complete the comprehensive psychiatric assessments, the psychiatrist had been attending ISP meetings and conducting psychiatry clinic during that time in an effort to conserve resources. As such, of the 15 records reviewed, this documentation was found in only two records. Other risk analysis documentation was located in the comprehensive psychiatric evaluations. It was apparent that this information had been cut and pasted from the behavioral support plans authored by psychology (e.g., Individual #69). Only selected	

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		side effects for Seroquel XR were listed, with serious side effects of Neuroleptic Malignant Syndrome and TD not mentioned. There were no side effects listed for the Adderall. As such, this was not a complete analysis of risk vs. benefit. <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. <u>Human Rights Committee Activities</u> 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 #161, presented to HRC Committee 4/20/12 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. • Lithium 300 mg in the morning was presented. The justification for the medication included episodes of agitation and aggression. • The listing of side effects presented did not include the potential for Lithium toxicity, thyroid effects, or kidney effects. • The individual had a history of hypothyroidism, which may be exacerbated by treatment with Lithium. This is not necessarily a contraindication to treatment with this medication, however, HRC should be aware of these risks prior to approving a new medication.	

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		• This medication was proposed in addition to this individual's current medication regimen that consisted of Latuda, Imipramine, Ativan, Lamictal, and Cogentin. • There was no mention of the HRC referral form that the addition of this medication would equal six medications for this individual. • There was no notation of the HRC questioning the multiple medications and the potential for side effects from the previous medication regimen. For additional discussion regarding multiple medication changes please see J13. <u>Monitoring Team's Compliance Rating</u> 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.	
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.	<u>Facility-Level Review System</u> 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. <u>Review of Polypharmacy Data</u> Documentation presented during the polypharmacy oversight committee meeting 7/19/12 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. This number was currently reported as 46 for June 2012 • The total number of individuals who met criteria for antipsychotic polypharmacy had decreased from six in December 2010 to three in December 2011. There was a slight trend upward early in 2012, with a total of six individuals prescribed antipsychotic polypharmacy in February 2012 and March 2012. This number had trended down, to four individuals in June 2012. • 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. This number had remained relatively consistent at 3.39 in April 2012. A review of the active psychoactive medication list by drug class listing for June 2012 revealed that there were four individuals meeting criteria for intraclass polypharmacy for antipsychotic medications, two individuals with intraclass polypharmacy for	Noncompliance

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		antidepressant medications, two individuals with intraclass polypharmacy for benzodiazepines, two individuals with intraclass polypharmacy for sedative medication (inclusive of Zolpidem and Trazodone), and 12 individuals with intraclass polypharmacy under miscellaneous (inclusive of medications such as Benztropine, Lithium, Guanfacine, Propranolol, Guanfacine). This was a total of 22 individuals. In the previous monitoring report, this number totaled 17 individuals. There were an additional 37 individuals with intraclass polypharmacy for seizure medications. 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. There was cause for concern because, more recently, psychiatry clinic had been occurring during both quarterly and annual ISP meetings (see the discussion under J12 for more information). Pharmacy did not attend these meetings and, therefore, pharmacy was not present for these psychiatric clinical encounters. Per a review of the active psychoactive medication list by drug class provided by the facility pharmacy, there were a total of 50 individuals who met criteria for psychotropic medication polypharmacy. It was concerning during the visit that both psychiatry staff and pharmacy staff were not using the correct definition of polypharmacy, rather believed that the polypharmacy definition was based on the number of medications prescribed for a specific indication. It is notable that as there were a total of 74 individuals in psychiatry clinic, 67% of all individuals participating in psychiatry clinic met criteria for polypharmacy. The vast majority of these individuals met criteria for polypharmacy based on the total number of medications prescribed. There were 46 individuals prescribed antipsychotic medications at the facility (a decrease from 49 individuals the previous monitoring review). Of these: • Four individuals were prescribed two antipsychotics (increased from three during the previous monitoring review). • None were prescribed three antipsychotics. Regarding other classes of medication: • A total of 42 individuals were prescribed antidepressant medications (an increase from 38 during the previous monitoring review): o Of these, two were prescribed two antidepressant medications (no change from the last monitoring period). • There were 56 individuals prescribed anxiolytic medications (no change from the previous monitoring period). o Of these, two were prescribed two anxiolytic medications (no change from the previous monitoring period).	

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		• Six individuals were prescribed stimulant medication (no change from the previous monitoring period). o There was no polypharmacy noted in this class. • 18 individuals were prescribed sedative medication (an increase from 14 during the previous monitoring period) o There were two individuals prescribed polypharmacy in this category, one was prescribed two medications and the other individual was prescribed three medications (an increase from one in the previous monitoring period). Of the total of 109 individuals prescribed psychotropic medication from any class in the month of June 2012: • A total of 60 individuals were prescribed two or more psychotropic medications from the same class. The majority of these individuals (37) 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. It was noted that this number had decreased from 39 noted in the previous monitoring period. 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 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. Review of Polypharmacy Justifications Documentation regarding polypharmacy (undated) for Individual #61 (treated with two antipsychotic medications) stated "we challenged her Zyprexa and were successful tapering it…remained asymptomatic for six moths…then had a breakthrough psychotic episode and when we restarted it she compensated quickly…since then…has been in partial remission albeit she still displays fixed delusional ideas that have never gone away. Presently her behavior is without major disturbances, agitation, or aggression and she has not shown any side effects or complications at this time." Records indicated that this individual was seen for an annual evaluation on 5/3/12 with the last quarterly	

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		3/15/12. This example notes that there were attempts to reduce the medication regimen, and is the case for many individuals with a thought disorder; she did well for a period of time. Given the emergence of symptoms, the medication was restarted and she returned to baseline. This was a good description and justification for polypharmacy. Documentation regarding polypharmacy (undated) for Individual #59 (treated with two antidepressant medications) stated "has been for the longest time on this combination of antidepressants…we suppose…the Remeron more as a hypnotic and Zoloft as the main SSRI…has serious suicidal attempts by stabbing himself in the abdomen twice, the IDT has felt that it's better to maintain him with this antidepressant polypharmacy than risk decompensation and the possibility of more suicidal [sic] attempts, thus IDT has not challenged the combination with which he's [sic] stable at the present time." A review of this Individual's medical record revealed a comprehensive psychiatric evaluation dated 4/4/12. This document did not mention polypharmacy. Further documentation revealed that this individual was seen on "rounds" 3/1/12 and in psychiatry clinic 1/20/12. It should be noted that the monitoring team observed this individual in his home. He was experiencing significant difficulty on that day, rolling about on the floor, refusing to interact with staff, and showing an angry irritable affect. This example raised questions, as the documentation located in other areas did not include a discussion or mention of polypharmacy. There were also behavioral and mental health challenges noted when observing this individual, which called into question the level of stability he had achieved with the current regimen. This individual may benefit by having a review of his psychopharmacological treatment plan. Documentation regarding polypharmacy for Individual #104 (treated with five psychotropic medication) provided evidence of the facility's erroneous interpretation of the polypharmacy definition. The rationale for polypharmacy dated 3/13/12 stated, "…has responded to this combination of psychotropics…he does not have true polypharmacy in that each medication is of a different class, but have similar indications." This example demonstrated issues that arise with the use of an incorrect definition for polypharmacy. <u>Monitoring Team's Compliance Rating</u> The facility had made strides with regard to this provision item, however, given the ongoing challenges noted above with regard to use of an erroneous definition of polypharmacy, issues with documentation regarding the rationale for polypharmacy in	

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		the individual records where polypharmacy was present, the lapse in timely review of individuals in psychiatry clinic (further discussed in J12), 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.	<u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> In response to the document request for a spreadsheet of individuals who have been evaluated with MOSES and DISCUS scores, the facility provided a spreadsheet containing information including the individual's name, home, nurse case manager, MOSES score, MOSES date, DISCUS score, DISCUS date, date signed, conclusion, and action taken. This document was difficult to follow, as it did not provide results for each individual over a period of time, but rather results for each month. This required the reader to check each month in succession searching for information for a particular individual. For example, • Individual #66's data from January 2012 through June 2012 were reviewed. Per the spreadsheet, a document was signed 1/20/12, but it was not possible to determine if this document was a MOSES or a DISCUS. There was documentation of a DISCUS performed 3/16/12. There was no other notation for this individual, quarterly DISCUS data were missing from June 2012, and completion of the semi-annual MOSES was not documented. • Individual #13 was documented to have both MOSES and DISCUS assessments performed in March 2012, April 2012, and May 2012. This was curious because these assessments are performed according to a three or six month schedule, unless an individual was experiencing significant side effects or the exacerbation of a movement disorder. This was not the case for this individual These examples indicated difficulties with the current tracking system. This must be addressed so staff can quickly glance at the list and determine if a particular individual requires an assessment. The current tracking document was insufficient for these purposes. A tracking system similar to that piloted at Lufkin SSLC may be beneficial. Nevertheless, the monitoring team's review of 15 records revealed that, for this sample, the assessment tools were being administered within the appropriate time frames. <u>Training</u> A review of documentation provided regarding inservice training for nursing case managers revealed that training regarding the MOSES was provided 10/31/11 to three staff members. Additional staff members requiring training regarding the MOSES were not indicated. For the DISCUS, a document was provided indicating that three nursing case managers were lacking training. Of the other nurses, 19 had received the training (three of these	Noncompliance

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		received training in 2008, 16 received training in 2011, 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 and included the signature of the psychiatrist. There was cause for concern as it was apparent that in some cases, previous scores were not compared to current scores. • Individual #90 had a MOSES score of 17 on 5/16/11. The more recent score 1/20/12 was 49. This second rating form was signed by the psychiatrist with documentation provided by the nurse examiner of the increased scores, but the psychiatrist indicated no side effects present and no action necessary, with no additional written explanation, especially given changes in medications that had occurred. A review of this individuals MOSES also revealed concerns regarding weight loss. A review of the record revealed in December 2010 a weight of 138.5 pounds, 133.2 pounds in June 2011, and 116.5 pounds in February 2012. This would be pertinent to note and indicate if the changes in psychotropic medication could have exacerbated mental health symptoms that resulted in weight loss, or if this were more likely related to another health condition. Several individuals who had experienced significant weight loss over the interim period since the previous monitoring period. For example, Individual #32 was prescribed the stimulant medication Ritalin for a period of time. This medication can cause a loss of appetite and subsequent weight loss. Review of MOSES scales performed 2/3/12 revealed a documented weight of 155 pounds, with no notation regarding weight issues by the examiner. A subsequent MOSES scale performed 4/14/12 revealed a documented weight of 147, again with no notation regarding weight issues by the examiner. A review of psychiatric documentation for 15 individuals revealed that in 100% of the documentation reviewed, MOSES and DISCUS results were included. Furthermore, during psychiatry clinics observed during this monitoring review, the psychiatrist was presented with MOSES and DISCUS examinations (among other data) for review. This indicated that when the individuals were seen in clinic, the documentation was reviewed and utilized. Out of 74 individuals participating in psychiatry clinic, there were few who were seen during a regularly scheduled psychiatry clinic during the previous quarter, and in fact, clinic staff were behind with regard to completion of quarterly reviews. More recently, psychiatry clinic was being conducted during the individuals' quarterly or annual ISP meetings in an effort to save time and allow the psychiatrist to attend the ISP. Other clinical contacts were occurring during Neuro-Psychiatry clinic, rounds, or via	

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		emergency psychiatry clinics. It was discussed with the psychiatrist and clinic staff that it was not appropriate for psychiatry clinic to occur during an ISP as other issues in addition to psychiatric care and treatment must be discussed at that time. Therefore, psychiatry clinics must be scheduled for routine follow-up in order to avoid reliance on other meetings or emergency psychiatry clinic. Data provided for the previous monitoring period indicated that 14 individuals had the diagnosis of tardive dyskinesia (TD). Data provided for this monitoring period revealed that there were no individuals with a diagnosis of TD. TD has a chronic course and is an irreversible movement disorder, therefore, these data were questionable. 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 the issues outlined above including difficulties with tracking completion of the instruments, deficits in the review of the instruments, delays in clinical consultation (e.g., quarterly medication reviews), and apparent issues with both the identification and ongoing monitoring of TD this provision will be rated in noncompliance. During the previous monitoring period, it was apparent that there was more attention paid to the clinical correlation of information obtained via the MOSES and DISCUS. During this current period, there were multiple examples located where side effects were noted on the instruments, but not addressed clinically (e.g., weight loss). There were additional issues with regard to timeliness of clinical correlation. In the prior review period, the facility was performing quarterly reviews in a more timely manner. In this review, there were marked deficiencies in this area. Finally, there were changes with regard to the designation of individuals with Tardive Dyskinesia who were previously identified, but no longer followed. These changes resulted in the current noncompliance rating.	
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	<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 a facility specific policy entitled "Psychiatry Services" dated	Noncompliance

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	an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	4/28/11 did not outline procedures for the completion of specific psychiatry related tasks, nor did it outline requirements for psychiatry clinic (e.g., what information was to be presented at clinic, specific forms to be utilized, use of the integration tool, etc.). A new quarterly medication review format had been devised during the previous monitoring visit. 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 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). <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 15 individuals, there were no specific treatment plans for psychotropic medication, however, the required elements were included in the quarterly medication review document. Of the 15 records reviewed, however, only three records had quarterly medication reviews between 1/1/12 and 7/16/12. Quarterly medication reviews were not consistently in records. As stated above, quarterly reviews had not been the focus in the intervening period since the last monitoring review. 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 except where included in quarterly documentation. For example, the quarterly psychiatric medication review for Individual #61 outlined the symptoms the individual was experiencing indicating diagnostic criteria for a specific diagnosis. There was documentation of specific medications utilized and the target symptoms, there was notation with regard to the rationale for polypharmacy, a specific risk/benefit analysis for the use of a particular regimen, and a timeline for expected response to the medication. <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	

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		allow for their consistent attendance or participation in the ISP process. There was indication via both staff report and document review that the ISP meetings had been utilized to perform psychiatry clinic. This was not appropriate. There are many issues that need to be discussed by the ISP during the meeting, and combining these two events would result in neither being conducted appropriately. In addition, pharmacy staff were not able to attend the ISP meetings which were being utilized as psychiatry clinics, so pharmacy input was not regularly received. Documentation received regarding the psychiatrist's attendance at ISP meetings is presented in J9 above. 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 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> During the monitoring review, two psychiatry clinics (for a total of four individuals) were observed. In all instances the individual was present for clinic. All treatment team disciplines were represented during each clinical encounter. The team did not rush clinic, often spending more than 40 minutes with the individual and discussing the individual's treatment. During these clinics, the psychiatrist made attempts to review behavioral data. In all instances, the data were up to date, however, the graphs were difficult to read. 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). It was also necessary that as data were up to data and graphed that psychology staff begin to analyze the data and present to the IDT including the psychiatrist their interpretation of what the data mean in the context of behavioral health care for a specific individual. The current information, although relevant, was insufficient if the goal was to implement an evidence-based approach in evaluating medication efficacy associated with a psychiatric disorder. There were noted improvements in collaborative case formulations documented via the	

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		comprehensive psychiatric evaluations. See J6 and J8 for specific examples. Documents reviewed did reveal a review of the symptoms or behaviors that an individual was experiencing that led to the specific diagnosis. There was a case formulation tying together the information provided from the various disciplines, utilizing information that was taken directly from the ISP document. All Appendix B evaluations reviewed included information regarding the integrated treatment plan that was taken directly from the ISP document (see J6 above). 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. Additional communication improvements resulted from the initiation of the integration tool utilized in psychiatry clinic. 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. Specific examples are outlined in the discussion regarding J3, J6, and J9. <u>Monitoring Team's Compliance Rating</u> A review of a sample of 15 records revealed varying quality in documentation for the	

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		psychiatric reviews and a paucity of quarterly psychotropic medication 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.	
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.	<u>Policy and Procedure</u> 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 during the previous monitoring review, 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 was 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. An interview with the facility psychiatrist and psychiatry clinic staff revealed that there had been no progress with regard to this provision. Staff readily admitted that they had focused their energies in other areas (e.g., completion of comprehensive psychiatric evaluations per Appendix B). <u>Current Practices</u> 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. Documentation of consents for psychotropic medication for nine individuals was reviewed (Individual #188 medications Vyvanse and Tegretol; Individual #148 medications Paxil and	Noncompliance

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		Tegretol; Individual #73 medication Latuda; Individual #161 medication Lithium; Individual #12 medication Latuda; Individual #89 medication Latuda; Individual #90 medication Latuda; Individual #9 medication Effexor; and Individual #27 medication Latuda and Clonazepam). 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 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. It was also worthy of comment that the individuals noted above were the nine individuals most recently prescribed psychotropic medication. Of these nine, five were prescribed Latuda, an atypical antipsychotic medication (Individual #73, Individual #90, Individual #89, Individual #12, Individual #27). The use of the same medication for multiple non-approved indications was questionable and should be reviewed. 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 48 individuals. At the time of the previous review, there were 44 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	Substantial Compliance

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		been efforts to coordinate care with neurology. The neurologist had a scheduled weekly clinic at the facility with the last Tuesday of every month designated as Neuro-Psychiatry clinic. The facility had contracted with a neurologist, who had been present in clinic for the past nine months. Records provided revealed that of the 48 individuals identified above, 24 were seen in the previous six months. There were 14 individuals seen between July 2011 and January 2012. There were 8 individuals who had not seen neurology in the previous year. There were two individuals with no documentation of neurology consultation (Individual #75 and Individual #27). Documentation from Neuro-Psychiatry clinic was reviewed. There was notation of collaboration between the neurologist and the psychiatrist in each of the five examples reviewed. Additionally, the monitoring team observed the clinic. During the observation, five clinical encounters occurred. There was discussion and collaboration between the physicians, however, much of the discussion was dominated by psychiatry. There was also cause for concern with regard to multiple medication regimen changes. The following case example will be utilized to illustrate this: • Individual #89 presented to clinic in the company of his family. There was evidence of improvement in target behavior and no noted changes in ambulation, with a taper of Sinemet initiated during the previous clinical encounter. It was determined that dosages of both Sinemet (a dopamine agonist) and Latuda (a dopamine antagonist) would be decreased. From the discussion during clinic and documentation reviewed, it was difficult to determine if this individual's neurological issue was due to Parkinson's disease or to the side effects of antipsychotic medications (e.g., Parkinsonian side effects due to antipsychotic medications). Given the concurrent medication dosage changes, it will not be possible to determine this via a medication taper. Also worthy of comment was that behavioral data were up to date and graphed appropriately. For example, data regarding Individual #112 were presented and there was a noted decrease in target symptoms. The individual had 268 instances of OCD symptoms in June 2012, and 91 instances in the first two weeks of July 2012. This indicated that thus far, the individual had a 33% reduction in symptoms. During this clinic, family members were present for three individuals. Medical issues and symptoms discussed during clinic were complicated, and it was apparent in several cases that the family members did not understand the rationale for the ultimate decision. It is imperative that family members are welcomed and included as part of the individual's team. It is also imperative that family members are educated regarding the individual's medical condition, medication regimen, and plans for future treatment.	

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		Adequacy of Current Neurology Resources Given the current monthly Neuro-Psychiatry clinic, with approximately four individuals seen in each clinic, and a total of 48 individuals currently requiring Neuro-Psychiatry consultation, each individual would be seen approximately once per year in the combined clinic. The allotment of hours provided for Neuro-Psychiatry clinic did not factor time for follow-up care secondary to medication changes. As indicated by the clinic schedule data, individuals were not seen in clinic annually. As the physicians continue this clinical consultation, they will need to determine if the current contract hours are sufficient. Monitoring Team's Compliance Rating While the increased neurology consultation hours and the designated "Neuro-Psychiatry" clinic were improvements, this clinic will need to demonstrate consistency in collaboration with improved coordination of medication regimen changes. Additionally, as stated in the previous report, 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. Neurology resources must be reviewed to ensure appropriate utilization and the need for additional resources. This provision will remain in substantial compliance for now, but additional efforts outlined above must be made in order to maintain this rating.	

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 discussions regarding treatment planning and behavioral support planning to reduce the need for restraint (J3)

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

4. Reduce the reliance on multiple medication combinations for pre treatment sedation and emergency situations (J4).

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. Continue attempts to recruit additional psychiatric staff. Resources including telemedicine and collaboration with local medical schools or residency programs could be considered (J5).

9. Determine the need for additional assistance for psychiatry clinic support staff including the possibility of temporary staff (J5).

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

11. Develop quality assurance or a peer review monitoring process for comprehensive psychiatric evaluations and other psychiatric documentation (J6).

12. 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).

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

14. Review the data collection and presentation regarding the completion of the Reiss Screen in order to ensure consistency and clarity (J7).

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

16. 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).

17. Continue the development of combined assessment and case formulations for individuals (J8).

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

19. 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).

20. Follow the generally accepted professional standard of care to change medication dosages slowly, one medication at a time while simultaneously reviewing the data regarding identified target symptoms (J8, J9, J13).

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

22. 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).

23. 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).

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

25. Improve documentation of psychiatric review, and clinical correlation of DISCUS and MOSES examination results (J12).

26. Ensure that individuals with a diagnosis of TD are appropriately identified and monitored (J12).

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

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

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

30. 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).

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

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

33. 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).

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

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

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

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

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

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

40. 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 #23 (2/12), Individual #39 (5/30/12), Individual #161 (6/12), Individual #114 (12/15/12), Individual #100 (3/12/12), Individual #109 (1/18/12), Individual #61 (6/6/12), Individual #108 (2/12), Individual #35 (1/20/12), Individual #66 (5/12) o Functional Assessments for: • Individual #81 (5/12), Individual #40 (3/5/12), Individual #18 (3/30/12), Individual #23 (5/15/12), Individual #120 (5/2/12) o Annual Psychological updates for: • Individual #148 (4/27/12), Individual #66 (4/12), Individual #96 (2/7/12), Individual #161 (1/25/12), Individual #12 (1/19/12), Individual #100 (3/29/12), Individual #50 (3/23/12), Individual #172 (2/15/12), Individual #52 (3/21/12), Individual #9 (2/1/12), Individual #76 (6/18/12), Individual #119 (6/12), Individual #75 (6/21/12), Individual #152 (6/12), Individual #37 (4/13/12), Individual #15 (6/13/12) o Inventory of all data collected at the facility, dated 6/12/12 o Provision Action Information, dated 6/29/12 o Corrective Action plans in the last 6 months o Minutes of QAQIC, PET, and PIT meetings in the last 6 months o El Paso Self-Assessment, dated 6/29/12 o El Paso Action Plans, dated 6/29/12 o List and dates of annual psychological assessments, undated o List and dates of PBSPs, undated o Section K Presentation book, undated o List of all individuals receiving counseling/psychotherapy, undated o List of all individuals with a functional assessment completed in the last six months o Psychological update template, 4/20/12 o Monitoring for Behavior Support Plan, undated o Treatment Integrity System, undated o Data Integrity System, 2/16/12 o Data Cards, undated o Teaching Behavior Support Plans/Working Plans, undated o Procedures for the Peer Review Committee o Graphs with replacement behaviors for: • Individual #13, Individual #61, Individual #17, Individual #23, Individual #75 o Graphs with phase lines for: • Individual #119 and Individual #13

	o Counseling Treatment Plan for: • Individual #191 o Anger Management Treatment Plan for: • Individual #61 o Circles Treatment Plan for: • Individual #120, Individual #37, Individual #56, Individual #88, Individual #112, Individual #13 o Health Counseling Treatment Plan for: • Individual #161 <u>Interviews and Meetings Held</u>: o Valerie Grigg, Director of Behavioral Services o Angela Brooks, Unit Director o Carmen Molina, Associate Psychologist <u>Observations Conducted</u>: o Pre-Sedation/Desensitization Planning Committee Meeting o Behavior Support Meeting o Peer Review Meeting • Staff present: Valerie Grigg, Director of Behavioral Services; Carmen Molina, Associate Psychologist; Marisela Franco, Associate Psychologist; Martha Davis, Associate Psychologist; Mario Rodriquez, Associate Psychologist • Individuals presented: Individual #111 and Individual #133 o Psychiatry/Psychology Integration meeting o Psychiatric Clinic Meeting • Individuals presented: Individual #8, Individual #51 o Observations occurred in various day programs and residences at EPSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals
	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. The self-assessment included many relevant activities in the "activities engaged in" sections. As suggested in the last review, the monitoring team believes that the self-assessment should include activities that are identical to those the monitoring team assesses as indicated in this report. For example, for K4, EPSSLC's self-assessment included a review of cottages using the new data system and a review of the new data integrity data system. These are topics that are included in the monitoring team's review of K4. This self-assessment, however, did not include several additional items that are necessary to

	achieve substantial compliance with K4 and are, therefore, included in the report. As the report below indicates, the critical items for K4 (and, therefore, the items that are suggested to be reviewed in the self-assessment) are: • A data system that includes the collection of target and replacement behaviors. • A data system that is simple and flexible. • Evidence that data collection is reliable. • Evidence that interobserver agreement (IOA) is collected, reliability goals are established, and attempts are made to ensure that those goals are achieved. • Graphing of data and progress review occur at least monthly, with more frequent graphing as necessary. • Evidence of progress, or evidence of some activity (e.g., modification of PBSPs, retraining of staff, etc.) to address lack of progress. • Evidence that data are used to make treatment decisions in psychiatric clinics, peer review meetings, ISP meetings, etc. The monitoring team suggests that the psychology department review, 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 psychology department 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. EPSSLC's self-assessment indicated that one item (K2) was in substantial compliance. 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 suggest 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: Although only one of the items in this provision was found to be in substantial compliance, the monitoring team acknowledges the hard work of the psychology department, and noted several improvements since the last onsite review. These included: • Initiation of external peer review monthly (K3) • Initiation of an improved data collection system (K4)

	• Initiation of the graphing of replacement behaviors (K4) • Initiation of the collection of data reliability (K4) • Evidence of data graphed in intervals necessary to make data-based decisions (K4) • Evidence that data were used to make treatment decisions (K4) • Improvements in the comprehensiveness of annual psychological assessments (K7) • Improvements in the quality of PBSPs (K9) • Initiation of the collection of treatment integrity data (K11) The areas that the monitoring team suggests that EPSSLC work on for the next onsite review are: • Ensure that all psychologists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts (K1) • Establish data collection reliability goals, and ensure that those levels are achieved (K4) • Initiate the collection of IOA (K4, K10) • Increase the number of functional assessments for individuals with PBSPs (K5) • Ensure that all functional assessments include direct observations of target behaviors and a clear summary statement (K5) • Ensure that all annual psychological assessments contain the necessary components (K7) • Track treatment integrity scores, establish treatment integrity goals, and ensure that those levels are achieved (K11) • Expand graphing of replacement behaviors to all individuals with a PBSP (K4, K10) • Ensure that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior (K9)

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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	This provision item was rated as being in noncompliance because, at the time of the onsite review, none of psychologists at EPSSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as applied behavior analysts (BCBAs). At the time of the onsite review, 4 of 5 psychologists who wrote PBSPs (80%) were either enrolled, or completed coursework, toward attaining a BCBA. The one psychologist that was not enrolled or completed BCBA coursework was a new employee who had committed to begin coursework in the fall. Thus, this represented a decrease from the last review when 100% of the psychologists were either enrolled in or completed BCBA coursework. 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

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	freedom from undue use of restraint.		
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility continued to be in substantial compliance with this item. The director of psychology had a master's degree, was a BCBA, and had more than five years of experience working with individuals with intellectual disabilities. The supervisees that were interviewed had indicated that they had positive professional interactions with, and received professional support from, the director of psychology. Finally, under the director's leadership, the department had continued to improve their knowledge and application of applied behavior analysis, leading toward the attainment of compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	As discussed in the last report, EPSSLC utilized an internal peer review system, and recently added external peer review. At the time of the onsite review, however, the external peer review meetings had not consistently occurred. Therefore, this item was rated as being in noncompliance. In addition to the review of PBSPs requiring annual approval, the internal peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #11 and Individual #133's PBSPs. The peer review meeting included active participation from all of the department's psychologists, and appeared to result in the identification of several new treatment strategies to address Individuals #111 and Individual #133's target behaviors. Review of minutes from internal peer review meetings indicated that the majority of psychologists in the department regularly attended peer review meetings. Meeting minutes also indicated that internal peer review meetings consistently occurred weekly. Additionally, in two of the last four months prior to the onsite review, the facility conducted external peer review by including a participant from outside the facility. Operating procedures for both internal peer review committees were established. It is recommended that the operating procedures be expanded to include external peer review. In order to achieve substantial compliance with this provision item, the facility needs to ensure that internal peer review consistently occurs weekly, external peer review consistently occurs at least monthly, and there are operating procedures for both internal and external peer review.	Noncompliance

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K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team was encouraged by the improvements in this provision item. In order to achieve substantial compliance, however, the facility needs to initiate the collection of interobserver agreement (IOA) for all individuals with a PBSP, establish acceptable data collection reliability and IOA levels, and ensure that those levels are achieved. Additionally, the facility needs to expand the graphing of replacement/alternative behaviors to all individuals with a PBSP, and provide monthly progress notes for all individuals with a PBSP. The facility continued to conduct hourly data collection (i.e., target and replacement/alternative 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 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. In the last report (January 2012), the monitoring team did it's own data collection reliability and noted that the target behaviors for only three of 13 data sheets (23%) reviewed were completed up to the previous hour. This was noted to be a serious problem because if the DCPs are not accurately recording data, the psychologists cannot evaluate the effects of their interventions. In order to address this poor data collection reliability, the facility recently began to collect data collection reliability, and initiated a new data collection system. In this new system DCPs were given individual preprinted data cards (and a pouch to carry them in) that contained the target and replacement behaviors for each individual assigned to them. One advantage of the data card over the previous data collection system was that the card was easier for DCPs to access and, therefore, increased the likelihood that data were recorded every hour. At the time of the onsite review, the data cards were used in three cottages (i.e., 506, 513, and 512). As in past reviews, the monitoring team did its own data reliability. The results were as follows: • All DCPs in those cottages using the data cards were carrying the cards for the individuals to whom they were assigned. Additionally, all DCPs using the new data card system reported that it was easier, than was the previous individual book system, to keep up with hourly data recording. • Fifteen of 23 (65%) of data cards reviewed were recorded up to the previous hour, while five of 13 (38%) of the data sheets located in the individual books were recorded up to the previous hour.	Noncompliance

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		This outcome was consistent with the facility's data reliability results, which indicated that data reliability averaged 34% prior to the introduction of the data card system, and 71% following the initiation of the new data collection system. These observations indicated that the new data card system was an improvement over the previous system where data were recorded in separate books. The monitoring team is encouraged by these results, and that the facility began to collect its own data collection reliability. It is now recommended that the facility expand the use of the data card to more homes and day programming sites, establish specific reliability goals in each treatment site, and staff be retrained or data systems modified, if scores fall below those goals. During the last review, the facility began the collection of inter-observer agreement (IOA) measures. IOA collection, however, was recently discontinued. 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. Therefore, it is recommended that the collection of IOA be reinitiated. Once IOA is collected, 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 IOA 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 this systems in one or two homes. This will allow the facility to work out the logistical challenges (as they were doing with data collection reliability) to better assess the additional resources that will be necessary to implement it across the all homes and day/vocational sites. Another area of improvement at EPSSLC was the flexibility in the graphing of data in increments based on individual needs (rather than all individuals' data graphed in increments of one month). For example Individual #8's target behaviors were graphed in weekly increments to better understand recent changes in his behavior. Additionally, the monitoring team encountered some graphs (e.g., Individual #13) that were simplified by reducing the number of data paths and adding of phase lines to mark medication changes and/or other potentially important events (e.g., a new roommate). Another area of improvement was the beginning of graphing replacement behaviors (e.g., Individual #23). It is now recommended that the simplified graphs and graphing of replacement behaviors be expanding to all individuals with PBSPs graphs. Finally, the monitoring team was encouraged to find these more useful graphs present in the psychiatric meetings, resulting data-based treatment decisions. As reported in the last two reports, there continued to be evidence that Positive Behavior	

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		Support Plans (PBSPs) were modified based on the absence of progress. A list of all individuals with PBSPs indicated that 13 had PBSPs that were revised prior to the annual review. Nevertheless, available data of the most severe behavior problems (i.e., physical aggression and SIB) indicated that five of eight individual's severe target behaviors were either unchanged (Individual #61 and Individual #108) and occurring at high rates (relative to levels established as objectives), or getting worse (Individual #161 and Individual #114, and Individual #39), 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 an analysis of the potential reasons for the lack of progress be conducted, and based upon the results of this analysis, appropriate corrective actions be initiated. Additionally, these actions (e.g., retraining of staff, initiation of a functional assessment) should be documented in the progress note or PBSP. 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, as reported in the last review, there were no updated progress notes available for review. All individuals with PBSPs should have current monthly progress notes. The monitoring team recognizes the substantial efforts the facility made on this provision item. Clearly, there had been a meaningful improvement, and EPSSLC appeared to be on a very productive course toward future improvement in this area.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological assessments for all individuals, and the absence of functional assessments for each individual with a PBSP. <u>Psychological Assessments</u> The director of psychology reported that not all individuals at the facility had initial psychological assessments. No full psychological assessments were reviewed because none were completed since the last review. All individuals at EPSSLC should have an initial (full) psychological assessment. Additionally, these initial psychological assessments should include an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status.	Noncompliance

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		Functional Assessments The director of psychology had indicated that, at the time of the onsite review, 24% of 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 their target behaviors. A list of all functional assessments completed in the last six months indicated that five were completed since the last review. All five of those functional assessments (100%) were reviewed to assess compliance with this provision item. As found in the last report, the functional assessments included all of the components commonly identified as necessary for an effective functional assessment. 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 can contribute to understanding why a target behavior occurred by conducting/administering questionnaires, interviews, or rating scales. All five of the functional assessments reviewed included appropriate indirect assessment procedures. Four (i.e., Individual #81, Individual #40, Individual #18, and Individual #23) of the functional assessments reviewed (80%) utilized direct assessment procedures that were rated as complete. This represented an improvement in the percentage of direct observations rated as complete in the last review (i.e., 60%). An example of a complete direct assessment procedure is described below: • Individual #23's functional assessment described direct observations of him engaging in physical aggression and taking drinks from others that suggested antecedents (not having access to preferred drinks) to the target behavior, and consequences (getting access to preferred drinks) following the target behavior. This direct observation revealed that Individual #23's target behaviors were most likely maintained by positive reinforcement (i.e., access to preferred items). The remaining functional assessment (Individual #120's) included direct observations, but none of those observations included an example of the target behavior and, therefore, did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. Direct and repeated observations of target behaviors in the natural environment are an	

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		important component of an effective functional assessment. All functional assessments should attempt to include direct observations that include 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. As discussed in the last report, 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. It is recommended that all functional assessments include direct observation procedures that include observation of the target behavior (or an explanation why that was not possible), and provide information about relevant antecedent and/or consequent events affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This was consistent with the last report when all functional assessments included potential antecedents and consequences. As discussed in the last report, 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. Three (i.e., Individual #23, Individual #120, and Individual #81) of the five functional assessments reviewed (60%) included a clear summary statement. This represented a decrease from the last review when 100% of the functional assessments reviewed were judged to have a clear summary statement. As reported in the last review, there was no evidence 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). Overall, two (Individual #81 and Individual #23) of the five functional assessments reviewed (40%) were evaluated to be comprehensive and clear. This represented a decrease from the last report when 60% of the functional assessments reviewed were evaluated as acceptable.	

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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.	Because no initial (full) psychological assessments were available for review, it could not be determined if they were current and complete. Therefore, 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, or more than 12 months old, for 41 of the 125 individuals (33%) at EPSSLC. All individuals should have an annual assessment. The monitoring team reviewed 16 of the 27 annual psychological assessments (59%) that were completed since the last onsite review, to assess their comprehensiveness. Nine of the 16 annual assessments reviewed (56%) contained all of the components described in K5. The other seven annual assessments did not have a medical component. This represents a sharp improvement in the comprehensiveness of annual assessments from the last review when 20% were judged to be complete. All psychological updates will need to contain all of the components described in K5. The director of psychology recently completed a new template of annual assessments that included all five components discussed in K5. The monitoring team is optimistic that the annual assessments will continue to improve in the next review. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of a recent admission to the facility in the last six months indicated that this component of this provision item was in compliance.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than	Psychological services, other than PBSPs, were provided at EPSSLC. More work is needed before this provision item can be considered to be in substantial compliance. Psychological assessments, functional assessments ISPs, and PBSPs reviewed did not	Substantial Compliance

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	PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	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, 12 individuals participated in counseling/psychotherapy. Treatment plans and progress notes for nine of these individuals (75%) were reviewed to determine progress with this provision item. The facility continued to offer individual counseling and 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 consistently 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 As reported in the last review, the treatment plans reviewed, however, did not include a plan to generalize skills learned to living, work, leisure, and other 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.	
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	This item was rated as being in noncompliance because many PBSPs were not updated (at least annually), and several of those reviewed did not contain interventions that were 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. All PBSPs should have current approvals and consent. A list of individuals with PBSPs indicated that 88 individuals at EPSSLC had PBSPs. Sixteen of these (18%) were more than 12 months old. All PBSPs should be reviewed when necessary, and at least annually. Forty-one PBSPs were completed since the last review, and 10 (24%) of these were reviewed to evaluate compliance with this provision item. All PBSPs reviewed included descriptions of target behaviors, however, one (Individual #109) of these was not operational (10%). This represents an improvement from the last two reviews when 25% of PBSPs were rated as not operationally defined. The	Noncompliance

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	Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	reason Individual #109's target behaviors were not rated as operational is highlighted below: • Individual #109's PBSP defined aggression as "… attempting to use objects as weapons…attempts to cause bodily damage." This definition required the reader to infer if Individual #109 was indeed intending to use objects as weapons and intending to cause bodily damage. An operational definition should not require DCPs to infer an individual's intentions. An operational definition should only include observable behavior. An example of a well written operational definition was: • Individual #100's target behavior of aggression was defined as "…hitting, kicking, grabbing, pushing/shoving another person…." All PBSPs should include operational definitions of target behaviors. All 10 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but three (i.e., Individual #114, Individual #109, and Individual #108) of these (30%) identified consequences that appeared to be inconsistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening undesired behavior. This represented an improvement in the effectiveness of antecedent and consequent procedures reported in the last two reviews when 50% were judged to be inconsistent with the stated function. An example of a consequent intervention that appeared to be incompatible with the hypothesized function was: • Individual #114 PBSP hypothesized that his "pulling on staff/individuals" target behavior was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). Individual #114's PBSP included, that following the target behavior, DCPs should assist him with engaging in activities he enjoys and remove all other objects. If, however, avoiding undesired activities was reinforcing for Individual #114 (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of his target behavior. Encouraging (and allowing) him to indicate that he wanted to leave the area BEFORE he engaged in the undesired behavior would potentially be an effective antecedent intervention. After the targeted behavior occurred, however, Individual #114 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 (i.e., replacement behavior) before he engages in physical aggression. The PBSP needs to clearly state that removal of the undesired activity should be avoided, whenever	

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		possible and practical, 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 #161's PBSP hypothesized that one function of her aggressive behavior was to gain others' attention. Antecedent interventions included providing her with staff attention when she exhibited appropriate behaviors, and encouraging/reinforcing her for engaging in her replacement behavior (i.e., telling staff what she wants) before she was aggressive. Her intervention following aggression included ensuring others safety, but minimizing attention to Individual #161 by keeping eye contact to a minimal. Finally, Individual #161's PBSP specified that once she was calm, attention should be provided if she appropriately requested it. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior. Replacement behaviors were included in all of the 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 one (i.e., Individual #114) of the 10 (10%) PBSPs reviewed, replacement behaviors that could be functional were not functional. This represents an improvement from the last report, when 33% of replacement behaviors that could be functional were not functional. The replacement behavior that was not functional was: • Individual #114's PBSP hypothesized that his undesired behaviors were maintained by negative reinforcement. His replacement behavior was to follow staff prompts. This may be important for Individual #114 to acquire, however, it does not appear to be functional. An example of a functional replacement behavior for a target behavior maintained by negative reinforcement would include teaching/reinforcing another way to escape or avoid unpleasant activities, such as asking for a break. Eight of eight functional replacement behaviors discussed above appeared to represent behaviors that staff needed to encourage and reinforce (i.e., skills that the individual already had in his or her repertoire), rather than new skills the individual needed to acquire. For example:	

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		• Individual #39's replacement behavior was using his communication skills to convey his needs and wants. The PBSP included instructions for staff to encourage Individual #39 to use his gestures and body language to communicate his desires. Based only on the reading of the PBSP, the monitoring team can only speculate as to if these replacement behaviors were in the individual's repertoire, or if they required the acquisition of a new behavior. The purpose of introducing this distinction is that when the replacement behavior requires the acquisition of a new behavior, it should be written as a skill acquisition plan (SAP; see S1). Regardless of whether a replacement behavior is part of an individual's repertoire or requires the acquisition of a new behavior, it needs to reinforced when it occurs. The explicit reinforcement of functional replacement behaviors was included in all 10 of the PBSP reviewed. This represents another area of improvement for EPSSLC. In the last review, the majority of PBSPs reviewed did not specify the reinforcement of replacement behaviors. Overall, seven (Individual #161, Individual #100, Individual #61, Individual #35, Individual #66, Individual #39, and Individual #23) of the 10 PBSPs reviewed (70%) represented examples of complete plans that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented a dramatic improvement over the last two reviews when 50% (i.e., July 2011 review) and 33% (January 2012 review) of the PBSPs reviewed were judged to be acceptable. The monitoring team was encouraged by the overall progress in the quality of PBSPs at EPSSLC, and looks forward to continued improvements in this provision item.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions,	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite review (see K4). A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment and for achieving substantial compliance of this provision item. Target behaviors were consistently graphed, and replacement behaviors were beginning to be graphed at EPSSLC (see K4). None of the 10 PBSPs reviewed contained graphed replacement behaviors, however, in the course of conducting this review, the monitoring team encountered five graphs that included replacement/alternative behaviors. It is recommended that replacement/alternative behaviors be graphed for all individuals with PBSPs.	Noncompliance

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	psychiatric treatment, and use and impact of psychotropic medications.	As discussed in K4, the facility had begun to simplify the graphs by indicating event changes (e.g., medication changes) with phase lines rather than multiple data paths (see K4). Two (i.e., Individual #119 and Individual #13) of 12 graphs reviewed were simplified. It is recommended that the facility expand the use of the simplified graphs.	
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.	Another area of improvement since the last review was the establishment of the collection of treatment integrity. This provision item was rated as being in noncompliance, however, because at the time of the onsite review, treatment integrity was not consistently collected and tracked across all PBSPs. EPSSLC continued to monitor the reading level of each PBSP to ensure that they were written so that DCPs could understand and implement them. 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. Treatment integrity measures were occurring and being tracked at EPSSLC, but the self-assessment indicated that measures were not reliable. The monitoring team reviewed the treatment integrity tool the facility was using and observed a treatment integrity session and believes that the treatment integrity tool is an adequate method for assessing treatment integrity. It is recommended that the facility now expand treatment integrity to each PBSP, schedule treatment integrity assessments at regular intervals, establish minimal treatment integrity standards, and work with DCPs to ensure that those levels are achieved. The monitoring team looks forward to reviewing integrity data during the next onsite review.	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 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 did 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. The director of psychology indicated that a competency based	Noncompliance

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		component was not consistently occurring during training, however, the addition of integrity assessments (K11) during training, would appear to address this requirement in the future. There was no system in place to ensure that all staff (including relief staff) implementing PBSPs had been trained. The facility's self-assessment indicated that 67% of staff implementing PBSPs were trained. Additionally, there was no systematic way to identify all staff that 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 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 125 individuals and employed five psychologists responsible for writing PBSPs. Additionally, the facility employed two psychology assistants and three 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 peer review meetings occur weekly, external peer review occurs monthly, and procedures exist for both internal and external peer review (K3).
3. Expand the use of the data cards to more homes and day programming sites, establish specific reliability goals in each treatment site, and staff retrained or data systems modified, if scores fall below those goals (K4).
4. Begin collecting IOA data (K4, K10).
5. Establish specific IOA and data collection goals and arrange to provide staff with performance feedback to achieve and maintain those goals (K4, K10).

6. It is recommended that the simplified graphs and graphing of replacement behaviors be expanded to all individual's with PBSPs graphs (K4, K10).

7. If an individual is not making expecting progress, the progress note or PBSP should indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).

8. All individuals with PBSPs should have current monthly progress notes (K4).

9. All individuals should have an initial (full) psychological assessment. Additionally, these initial psychological assessments should include an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status (K5).

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

11. All functional assessments should include a direct observation of target behaviors that provide additional information about the antecedents and consequences affecting the target behavior, or a brief explanation of why a direct observation is not practical (K5).

12. 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).

13. All individuals should have an annual assessment (K7).

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

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

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

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

18. Each Individual's PBSP should be revised with necessary, but at least annually (K9).

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

20. 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).

21. Expand treatment integrity to each PBSP, schedule treatment integrity assessments at regular intervals, establish minimal treatment integrity standards, and work with DCPs to ensure that those levels are achieved (K11).

22. 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).

23. Revise the self-assessment so that it includes the topics that the monitoring team commented upon in the report (self-assessment).

24. Establish six-month goals to focus upon for the next onsite review (self-assessment).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.1: 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 EPSSLC Policy/Procedure: Medical Care, 6/22/11 o EPSSLC MOSES and DISCUS Examinations, 12/10/09 o DADS Clinical Guidelines: • Urinary Tract Infections 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 External Medical Review Data o Listing of Medical Staff o Medical Caseload Data o Mortality Review Documents o Clinic Tracking Log o Neurology Clinic Schedule o Physician Orders, January – June 2012 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, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, MARs, annual nutritional assessments, dental records, and annual ISPs, for the following individuals: • Individual #28, Individual #161, Individual #2, Individual #63, Individual #15, Individual #162, Individual #104, Individual #191, Individual #32, Individual #90 o Annual Medical Assessments the following individuals: • Individual #115, Individual #1, Individual #67, Individual #50, Individual #184, Individual #116, Individual #123, Individual #66, Individual #157, Individual #161 Individual #52,

	Individual #36, Individual #195, Individual #195, Individual #128, Individual #129 o Neurology Notes for the following individuals: • Individual #155, Individual #59, Individual #128, Individual #61, Individual #3, Individual #9, Individual #113, Individual #115, Individual #54 o Consultation Referrals and IPNs and for the following individuals: • Individual #12, Individual #13, Individual #19, Individual #25, Individual #83, Individual #1 Individual #6, Individual #134 <u>Interviews and Meetings Held</u>: o Ascension Mena, MD, Medical Director o Eugenio Chavez-Rice, MD, Psychiatrist o Jaime Monardes, Facility Director o Denise Jones, APRN, FNP o Veronica Bahner, RN, Medical Clinic Nurse o May Ann Clark, RN, Chief Nurse Executive o Elaine Lichter, RN, Quality Enhancement Nurse <u>Observations Conducted</u>: o Daily Unit Team Meeting o Medical staff meetings o Neurology-Psychiatry Clinic o Medical Clinic o Integration Committee Meeting
	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. The medical director expanded the self-assessment by including additional activities and outcomes. Some of the activities were based on recommendations taken from section M, but they were relevant to the provision of health care services. Each activity was aligned with a data point or outcome, however, the outcome was not necessarily the one most associated with the outcome discussed in the monitoring report. Nonetheless, these data were used to determine a self-rating of substantial compliance or noncompliance. It will be essential for the self-assessment to align with the topics in the monitoring team's report. For example, in the case of the Annual Medical Assessments, the self-assessment, like the monitoring report, should assess timeliness, adequacy of family history, inclusion of transition statement, etc. The facility rated itself in substantial compliance with provisions L1 and L2 and in noncompliance with L3 and L4. The monitoring team found noncompliance for all four provision items. The difference in the L1 and L2 ratings was due to the facility not including all relevant topics in the self-assessment.

	Summary of Monitor's Assessment: The medical department made some progress since the last compliance review, particularly in the provision of services. A mobile x-ray company completed basic roentgenograms onsite and provided digital results within one hour. Clinical staff now had electronic access to the individuals' laboratory results, which was of great benefit in making treatment decisions. An onsite gynecology clinic was added and medical staffing improved with the addition of a second part-time clinic physician. Individuals received basic medical services, such as immunizations, vision, and hearing screenings. They also completed several cancer screenings, such as colonoscopies and mammograms with very high rates of compliance, but problems were noted particularly in the management of chronic issues, such as bowel and seizure management. Several individuals experienced bowel obstructions and required colostomies and the facility reported that an alarming 65% of individuals had refractory seizure disorder. The Annual Medical Summaries were not completed in a timely manner and Quarterly Medical Summaries were not done at all. IPN entries were generally written in SOAP format and most were legible. External and internal medical audits were conducted and the facility's data documented improvement in most areas. EPSSLC had not had not completed a round of medical management audits. Mortality reviews were completed in accordance with state policy for deaths that occurred at the facility. There were no recommendations resulting from the death reviews completed by the facility. The facility made some, but not much, progress with regards to the development of a medical quality program and the development of medical policies and procedures. Although there was no structured medical quality program, a diabetes audit was completed and a local protocol for the management of urinary tract infections was developed. A review of upper respiratory tract infections was completed and guidelines for management were developed. Overall, there had been no local policies developed based on the numerous stated issued clinical guidelines.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical staff was comprised of a fulltime medical director and a full time advanced practice registered nurse. Three contract physicians provided part time services. The internal medicine physician continued to work on Thursdays and Fridays. A family	Noncompliance

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	with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	practitioner began working three weeks prior to the review. He saw individuals in the clinic on Monday, Tuesday, and Wednesdays. The third contract provider completed special reviews as needed. The facility maintained the contract for weekend on call coverage. A new clinic nurse started in March 2012. She was a long term employee of the facility having worked previously as a nurse manager. The caseload structure at EPSSLC was an unusual one. The medical director carried the full caseload even though there was a full time board certified family nurse practitioner working at the facility. Even though the medical director was the physician of record, much of the care provided to the individuals occurred in the medical clinic through the contract physicians. The nurse practitioner's clinical role appeared to be decreasing and shifting more to completion of Annual Medical Assessments. This was an underutilization of resources and was discussed with the medical director. Overall, EPSSLC had the equivalent of two full time primary care physicians and a full time APRN, which was quite generous staffing. The collaborative agreement between the advanced practice registered nurse and the medical director was not properly executed at the time of the January 2012 visit because the medical director's signature was not dated and the nurse practitioner's signature was dated prior to the employment date of the medical director. This agreement is an important one and is regulated by statute/Nurse Practice Act, yet it was not addressed until June 2012. The agreement included in the document request was not dated by either party and included a note at the bottom that stated, "updated June 2012." The facility director should ensure the APRN is working within the framework of state statutes by having a properly executed collaborative agreement. **Physician Participation In Team Process** The medical staff conducted sick call in the morning. The afternoons were usually reserved for annual exams, ISPs, and other meetings. The clinical staff continued to meet daily as part of the daily unit meeting. As noted in the previous monitoring report, this was not the optimum forum for engaging in robust clinical discussions regarding the events that occurred during the preceding 24 hours. **Overview of the Provision of Medical Services** Individuals were generally seen in the medical clinic. They were provided with preventive, routine, specialty, and acute care services. The facility conducted onsite neurology, neuropsychiatry, dental, gynecology, and psychiatry clinics. Neurology clinic was conducted every Tuesday with the last Tuesday of each month dedicated to a joint neurology-psychiatry clinic. Individuals who required acute care services were admitted to University Medical	

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		Center. Labs were also completed at University Medical Center. The facility recently acquired the ability to review labs online. Roentgenograms were also being done at the facility. A mobile unit was able to complete basic studies and provide digital images to the medical staff within one hour. There was evidence that some good care was provided and there were examples of care that needed improvement. Individuals who were hospitalized did not receive consistent follow-up care. The various sections of this report will provide examples of both the high and low points noted during this review. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content. For the Annual Medical Assessments included in the record sample: • 10 of 10 (100%) AMAs were current • 2 of 10 (20%) AMAs included comments on family history • 8 of 10 (80%) AMAs stated "family history not available" • 9 of 10 (90%) AMAs included information about smoking history • 0 of 10 (0%) AMAs included information regarding the potential to transition The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous year's assessment. For the sample of Annual Medical Assessments submitted by the facility: • 15 of 15 (100%) AMAs were completed in a timely manner. • 2 of 15 (13%) AMAs included comments on family history • 13 of 15 (87%) AMAs stated "family history not available" • 15 of 15 (100%) AMAs included information about smoking history • 0 of 15 (0%) AMAs included information regarding the potential to transition The AMA format was revised and the revision represented an improvement. Generally, these assessments continued to need improvement. Many of them failed to include very important issues and diagnoses resulting in plans of care that were simply inadequate.	

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		Examples are provided in the case examples below. For the purpose of this review, the AMA was considered timely if it was completed within 365 days of the previous summary. The sample of AMAs provided to the monitoring team all appeared to be completed in a timely manner based on the assessment dates. The documents were usually signed by the medical providers four to six weeks after the date that the assessment was stated to be completed. Usually, transcriptions are signed within 72 hours. The facility's self-assessment documented that 90% of AMAs were found to be completed and up to date. The facility's initial assessment audit data showed 15% compliance with the requirement for timely submission of Annual Medical Assessments. The facility director reported that corrective actions had been implemented to address this finding. <u>Quarterly Medical Summaries</u> Quarterly Medical Summaries were not being completed as required by the Health Care Guidelines and in accordance with state issued medical policy. The medical director reported the requirement for QMSs was being removed and, therefore, they were not done. He later received clarification on this issue. The facility's action plan listed numerous activities related to this item. The target date for completion of all QMSs was 8/12/12. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL Many of the documents reviewed were not updated, signed, or dated. <u>Integrated Progress Notes</u> Physicians documented in the IPN in SOAP format. The notes were usually signed and dated. Vital signs were usually not included in the notes. Pre-hospital notes were often not found and post hospital documentation was very inconsistent. That is, individuals who were hospitalized, sometimes for prolonged periods, had very little documentation of follow-up once they retuned to EPSSLC. Examples are provided in the case examples. <u>Physician Orders</u> Physician orders were overall signed, timed, and dated. Nonetheless, many problems were identified with physician orders. There were missing indications, or had indications that were inappropriate. This is discussed further is section N1.	

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		Consultation Referrals The consults and IPNs for 8 individuals were requested. A total of 50 consults completed after January 2012 (including those from the record sample) were reviewed: • 47 of 50 (94%) consultations were summarized by the medical providers in the IPN o 32 of 47 (68%) consultations were documented in the IPN within five working days The vast majority of the consults were reviewed by the contract physicians who worked in the clinic. Generally, providers summarized the recommendations of the consultants, but there was no statement of agreement or disagreement. The summary frequently was limited to one or two lines that would be of limited helpfulness to the IDT. In fact, none of the consultation documentation reviewed included any comments on referring information to the teams for review or further discussion. Consultation referrals are discussed further in section G2. **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 yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. Databases were developed to track a number of clinical measures, such as cancer screenings, seizure data, diabetes, and osteoporosis. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: Preventive Care Flow Sheets For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 7 of 10 (70%) forms were updated, signed, and dated Immunizations • 10 of 10 (100%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations The status of immunity against varicella, zoster, and some other immunizations could not be determined for many individuals. The PCFS listed "no history" for several immunizations. This was noted in previous reviews and no improvement was observed during this review. The monitoring team requested a copy of the facility's immunization database, however, this data set was largely incomplete. The facility had identified	

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		individuals who lacked immunizations that were recommended by the CDC and it was reported that corrective actions had been implemented. During the next review, the monitoring team will expect to find firm evidence of improvement with the implementation of corrective action. Screenings • 8 of 10 (80%) individuals received appropriate vision screening • 9 of 10 (90%) individuals received appropriate hearing testing Prostate Cancer Screening • 2 of 7 males met criteria for PSA testing • 2 of 2 (100%) males had appropriate PSA testing A list of males greater than age 50, (African American males greater than age 45), was provided. The list included 28 males: • 23 of 28 (82%) males had current PSA results documented • 2 of 28 (7%) males had no PSA results documented • 3 of 28 (11%) males were overdue for PSA testing The medical director will need to review the accuracy of this PSA list submitted. Individual #15 and Individual #90 were not included. Breast Cancer Screening • 2 of 3 females met criteria for breast cancer screening • 2 of 2 (100%) females had current breast cancer screenings (completed in 2011/2012) A list of females age 40 and older was provided. The list included the names of 35 females, the date of the last mammogram, and explanations for any lack of testing: • 33 of 35 (94%) females completed breast cancer screening within the past 12 months • 2 of 35 (6%) females did not complete breast cancer screening due to guardian refusal Cervical Cancer Screening • 3 of 3 females met criteria for cervical cancer screening • 1 of 3 (33%) females had current cervical cancer screening A list of females age 18 and older was provided. The list included the names of 53 females, the date of the last pap smear, and explanations for lack of testing:	

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		• 26 of 53 (49%) females completed cervical cancer screening between April and June 2012 • 3 of 53 (6%) females refused <u>Colorectal Cancer Screening</u> • 4 of 10 individuals met criteria for colorectal cancer screening • 4 of 4 (100%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 52 individuals: • 47 of 52 (90%) individuals had completed colonoscopies • 2 of 52 (4%) individuals did not have colonoscopies due to guardian refusal • 3 of 52 (6%) individuals completed colonoscopies under the age of 50 for diagnostic purposes <u>Additional Discussion</u> The facility will need to examine the accuracy of the database information. Inconsistencies were found in several areas. Diabetes audits were completed on individuals who did not appear on the diabetes listing. The GERD listing included the names of only six individuals. The monitoring team identified six individuals with the diagnosis in the record sample alone. As noted above, the PSA listing was also not accurate. The monitoring team also observed that the facility's lab matrix was not consistent with state issued guidelines for colonoscopies, PSAs, BMD, etc. The medical director will need to review the lab matrix and update as required. **Disease Management** State office issued numerous multidisciplinary clinical guidelines. At the facility level, EPSSLC had developed guidelines for urinary tract infections and upper respiratory tract infections. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below. <u>GERD</u> • 4 of 10 individuals had the diagnosis of GERD • 4 of 4 (100%) individuals received appropriate medical management	

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		A list of individuals with the diagnosis of GERD was provided. The list contained only six names and, therefore, the accuracy of the list was questionable. <u>Diabetes Mellitus</u> The facility completed an audit of individuals with diabetes mellitus. The results of the facility's reported key audit data is presented below: • 5 of 6 (83%) individuals had adequate glycemic control • 4 of 6 (67%) individuals had yearly EKG • 4 of 6 (67%) individuals had annual eye examinations • 6 of 6 (100%) individuals had annual foot examinations • 6 of 6 (100%) individuals received the yearly influenza vaccination **Case Examples** Individual #28 • The individual was hospitalized in July 2012 for a surgical procedure and was discharged on 1/30/12. The receiving physician gave a verbal order to continue "previous medications." The individual's medical evaluation occurred three days following return to the facility. The IPN entry corresponding to that evaluation was the only medical documentation found in the record, was relatively brief, and lacked a complete set of vital signs. • The individual also suffered from chronic constipation. A QDRR completed in April 2012 made the recommendation to review the bowel management program, but no significant changes were made to the individual's bowel management plan. The IPN documentation showed frequent and cyclical administration of suppositories due to a lack of bowel movements. • This individual also had significant weight issues. • Abdominal films in March 2012 and April of 2012 showed the presence of left nephrolithiasis. This was noted in the diagnostic portion of the April 2012 AMA. Nonetheless, the AMA failed to list this as a problem resulting in a lack of a plan. This was an important failure because the individual received treatment with topiramate which is associated with the development of kidney stones. The facility's lab matrix did not include screening for the presence of kidney stones. Individual #162 • This individual was seen on 7/5/12 in the medical clinic due unsteady gait. Labs were obtained and carbamazepine toxicity was noted. The medication was held and the individual was seen again on 7/9/12. The level remained elevated and the individual was transferred later that day and admitted to the	

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		hospital with the diagnoses of pneumonia and UTI. Upon return to the facility on 7/12/12, the medical provider documented a history of melena and noted that the individual required hospital admission for GI evaluation of melena. This did not occur. In fact, there was no documentation of further medical evaluation until 7/16/12. This was the last available medical note and it indicated that the history of CBZ toxicity, pneumonia, and melena would be evaluated. Individual #90 • This individual was hospitalized for prolonged period due to a cervical spine fracture. The annual assessment was completed on 2/8/12, but did not mention the prolonged hospitalization for the cervical spine fracture. The APL did not include the diagnosis of cervical spine fracture nor did it include the important update of the gastric tube placement. Again, this is important should this individual require transfer to a medical facility that is unaware of the history of a cervical spine fracture (and the APL and AMA do not document this information), the individual could become exposed to procedures that are potentially dangerous. • The individual had fever and agitation for two days and never had documentation of a physician evaluation. The weekend physician ordered that the individual be sent to the emergency department for evaluation. The individual returned to EPSSLC, but was again transferred back to the acute care facility, admitted to the hospital with a bowel obstruction, and underwent a colectomy. Over a 48-hour period, this individual should have been evaluated by a physician at EPSSLC who could have communicated with the hospital physician pertinent information that impacted the initial evaluation. Individual #2 • This individual appeared to have chronic nutritional issues with low albumins and pre-albumins consistently documented. • Nursing documentation on 3/9/12 indicated that the IDT met to discus transition from enteral nutrition to oral feedings. There was no medical documentation of this discussion and it was not clear if oral feeding was started. On 3/15/12, psychology documented that the individual appeared to have pain. The medical evaluation on the same day documented no indication of pain, but stated PT/OT would be asked to assess for skin breakdown. On 3/20/12, nursing documented that the individual had a low-grade temperature of 99. Acetaminophen was administered several hours earlier at 4 pm, but that temperature was not documented. The individual's oxygen saturation was lower than baseline. There was no documentation of any assessment by a	

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		medical provider. On 3/21/12, at 8:25 am there was an order to transfer the individual to the emergency department. There was no documentation of evaluation by a medical provider. The individual was admitted to the hospital, diagnosed with pneumonia, and subsequently expired. During the 24 hours prior to transfer, the individual experienced a deterioration in status, but the records reviewed documented no medical evaluation. Individual #104 • This individual was noted to have increasing SIB on 4/29/12. On 5/1/12, the individual was seen in the medical clinic due to multiple episodes of emesis and was noted to have a slightly distended abdomen. The vital signs were not recorded and no rectal exam was documented. The individual was noted to have an elevated temperature an hour later. Shortly before midnight, the individual was transferred to the hospital and diagnosed with a bowel obstruction requiring a colon resection and colostomy. • The annual assessment completed upon return to EPSSLC provided little information on the individual's history of bowel obstruction and history of weight loss (occurred prior to surgery). The individual remained under the desired weight range at the time of completion of the assessment. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 88 individuals. The list was reported to be current as of 12/15/11. The following data regarding AED use were summarized from the list provided: • 11 of 88 (13%) individuals received 0 AEDs • 32 of 88 (37%) individuals received 1 AED • 28 of 88 (32%) individuals received 2 AEDs • 11 of 88 (4%) individuals received 3 AEDs • 3 of 88 (3%) individuals received 4 AEDs For the 88 individuals diagnosed with seizure disorder: • 1 of 88 (1%) individuals experienced status epilepticus • 7 of 88 (8%) individuals required transport to an acute care facility due to prolonged seizure activity • 7 of 88 (8%) individuals had VNS implantation • 57 of 88 (65%) individuals had refractory/intractable seizure disorder o 1 of 57 (2%) individuals was being evaluated for VNS placement None of the individuals with refractory disorder were being followed by an	

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		epileptologist. The medical director reported that this resource was not available in the community. 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. The number of neurology clinic appointments is summarized in the table below Neurology Appointments 2012 Jan 22 Feb 22 March 16 April 25 May 41 June 6 Total 132 The total number of appointments was reasonable given the number of individuals with the diagnosis of seizure disorder who actually received medications. The monitoring team requested neurology consultation notes for 10 individuals. These individuals are listed in the above documents reviewed section. The following is a summary of the review of the 10 records: • 10 of 10 (100%) individuals were seen at least twice over the past 12 months • 10 of 10 (100%) individuals had documentation of the seizure description • 7 of 10 (70%) individuals had documentation of current medications for seizures and dosages • 7 of 10 (70%) individuals had documentation of recent blood levels of antiepileptic medications • 4 of 10 (40%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 10 of 10 (100%) individuals had documentation of recommendations for medications • 0 of 10 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The clinic notes for 10 individuals were reviewed along with all neurology clinic notes included in the record sample. The consults were extremely difficult to read due to the legibility of the handwriting. One important and noteworthy improvement, however, was a change in the neurology clinic template. The top half of the consultation referral form now provided information on the MOSES and DISCUS evaluations, medications, seizure activity, last seizure, and VNS information. The MOSES and DISCUS information was limited to the dates of the evaluations and not a summary of the assessments.	

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		Nonetheless, it was encouraging to see that the revision would prompt inclusion of additional information that is needed in management of individuals with complicated seizure disorder. Overall, the content of the notes had improved in terms of data related to drug dosages, severity of seizures, date of last seizure, and the adverse effects of drugs. The monitoring team attended the neurology-psychiatry clinic. It appeared to be an effective means of integrating neurology and psychiatry services. Finally, the facility must assess the services it is providing to individuals with seizure disorders as it had an unusually high percentage of individuals who appeared to have refractory disease. This type of data should have been called to the attention of the quality department and resulted in further review and corrective actions. Those individuals with the most difficult cases will need to bee referred for evaluation by an epileptologist. This may require special arrangements with the local university health sciences center. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included two individuals with Level III DNRs meaning that no resuscitative measures were to be performed. During the January 2012 review, three individuals had DNRs in place. The DNR for Individual #161 was rescinded and treatment for a non-terminal condition was implemented. DNRs for Individual #52 and Individual #34 remained in place. As noted in the previous report, Individual #34 had a DNR order implemented on 8/5/11. The reason for the DNR order 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." No additional information, other than the physician order, was provided for this review and the document request simply stated no documentation was available. Two emails sent from the QDPP to the medical director were reviewed. The QDPP noted that per policy, DNRs required review by the Ethics Committee. Subsequent to the emails, the medical director requested a meeting of the Ethics Committee be schedule for July 2012. The medical director reported that DNRs were rescinded for Individual #107 also. This individual was not reported to have a DNR in place at the time of the last onsite review.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>L2</td><td>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.</td><td>
<u>Medical Reviews</u>
An external medical reviewer, from a sister SSLC, conducted Round 5 of the external medical reviews in 2012. A five percent sample of records was examined for compliance with 30 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were eight 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. External reviews were conducted every six months while internal audits were done quarterly. The facility's last external review was completed in February 2012. External medical management reviews were not completed. An internal audit was completed in April 2012. The results of the reviews completed are represented below.

<table>
<tr><td colspan="4">External and Internal Medical Reviews 2011 -2012</td></tr>
<tr><td></td><td></td><td>Essential</td><td>Nonessential</td></tr>
<tr><td>Sep 2011</td><td>Round 3</td><td>50</td><td>41</td></tr>
<tr><td>Nov 2011</td><td>Round 4</td><td>76</td><td>68</td></tr>
<tr><td>Feb 2012</td><td>Round 5</td><td>91 (93)</td><td>96 (94)</td></tr>
</table>
*(Internal)

Based on these data, there was improvement in the provision of medical services. As noted in previous reports, however, these reviews focused entirely on <u>processes</u> and did not provide any measure of clinical <u>outcomes</u>. Medical management audits were scheduled to be included in the next round of audits. As with all external audits, the QA department developed corrective action plans and tracked compliance with the plans.

<u>Mortality Management at EPSSLC</u>
At the time of the review, all death reviews were completed. Since the last onsite review, there were two deaths. Information for those deaths is summarized below:

The average age of death was 59 years with an age range of 49 to 69 years.
The causes of death were: (1) diffuse alveolar damage of the lung secondary to complications of abdominal surgery for intestinal obstruction (2) respiratory failure and bilateral pneumonia
Autopsies were performed on both individuals.
Both individuals died in the hospital.

The facility's contract physician reviewed each death and generated a report that was considered during clinical death reviews. There were no recommendations generated by either clinical death review. Moreover, the monitoring team was not clear on how
</td><td>Noncompliance</td></tr>
</table>

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		the facility used the reports of the contract physician when completing the clinical death reviews. The monitoring team met with the medical director, chief nurse executive, and facility director to discuss mortality management at EPSSLC. The mortality management interview is conducted with every onsite review with the intent of discussing death reviews and corrective actions related to any deaths and/or death reviews that occurred since the previous review. Neither the medical director nor the facility director was prepared to discuss the findings of the most recent clinical and administrative reviews. Therefore, little additional information was obtained.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility did not have a structured medical quality program. A comprehensive set of measures had not been identified. State office developed a set of disease management audits to serve as one component of the medical quality program. EPSSLC had not completed internal or external disease management audits The medical director appeared to be aware of the draft of the recently revised state medical policy which included a section on data collection and analysis. SSLCs were required to collect data on key areas, such as mortality, aspiration pneumonia, seizure disorders, and infectious diseases; analyze and trend these data; and take appropriate corrective actions. The facility had not outlined a plan or system to implement such a program. In response to a request for data on the facility's medical quality program, the medical department submitted data on GYN exams. This is discussed in the preventive health section above. The medical director explained that the contract physician, who specialized in infectious diseases, also developed guidelines for treatment of upper respiratory tract infections. He also conducted a review of urinary tract infections at the facility, completed a report, and developed clinical guidelines. The medical director also completed an audit of individuals with the diagnosis of diabetes mellitus. The presentation book included the audit tools for six individuals. The documents included, however, were not for the same six individuals identified in the facility's diabetes mellitus listing, indicating that there were more than six individuals with the diagnosis of diabetes mellitus. There was no information provided on sampling methodology. This audit was completed with the April 2012 internal audits, but independent from the medical management audits as it utilized a different tool. There was also no summary of the data and there was no analysis of the data to indicate if the facility was meeting its goals. The monitoring team identified areas of concern in five of six of the audits reviewed. Those areas are identified in section L1 above. The medical director should review the findings to ensure that the diabetes care for all individuals is	Noncompliance

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		appropriate. In moving forward with this provision, the medical director should review the various indicators discussed in provision L1 and the guidelines on data collection and analysis included in the state draft medical policy. The facility will need to develop a comprehensive set of indicators that includes, at a minimum, a mix of process and outcome indicators in order to move towards substantial compliance with this provision item. Moreover, the facility will need to demonstrate that indicator data are collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology should be utilized to ensure remediation is achieved.	
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.	State office issued a series of clinical guidelines and protocols. During the January 2012 review, these guidelines had not been localized or implemented. Aside from the clinical guidelines on urinary tract infections and upper respiratory tract infections, the facility had not developed any other local policies related to the state issued guidelines. The medical department's policy and procedure manual did not include any local policies related to state issued protocols prompting the monitoring team to make an additional request for a complete copy of the medical policy and procedure manual. This did not reveal any additional policies or procedures related to the state issued clinical guidelines. The facility's action plan listed 8/1/12 as the start date for activities related to this provision item. While it appeared that clinical protocols were shared with some of the medical staff, there was no documentary evidence of inservicing on the various protocols and guidelines. Moreover, the monitoring team also noted that there were inconsistencies among the various policies, procedures, and protocols, as noted in various aspects of this report. The medical director needs to develop a process to ensure that all policies and processes are consistent and congruent with state issued guidelines. Moreover, the medical department must ensure that all clinical medical staff, employees, and contract physicians are appropriately trained on medical policy, procedures, and protocols. The medical department must maintain documentation of such training.	Noncompliance

Recommendations:

1. The distribution of the caseload at EPSSLC should be reviewed to determine if the board-certified APRN should have more clinical involvement in the management of the care of the individuals (L1).

2. The medical director should ensure that weekend on-call physicians assess individuals who are in need of evaluation and provide appropriate record documentation (L1).

3. The medical director should ensure that all AMAs include all relevant information and diagnoses (L1).

4. Quarterly Medical Summaries should be completed by the primary care physicians in accordance with state issued medical policy (L1).

5. The Preventive Care Flow Sheets should be signed and initialed when updated by providers (L1).

6. Medical providers should provide consistent documentation on individuals who have returned from the hospital. It would be reasonable to consider a minimum of three consecutive days of follow-up or more if needed.

7. The medical director must ensure that the contract physicians are aware of the requirements for documentation of consultations in the IPN:
    a. Summarize the recommendations of the consultants
    b. Indicate agreement or disagreement with the recommendations of the consultants
    c. Determine if the recommendations require referral to the IDT

8. The monitoring team recommends that for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult.

9. Medical providers must write complete and clear physician orders.

10. The facility must take immediate and definite corrective action with regards to the immunization status of the individuals at EPSSLC. Each individual must have a clear immunization history with regards to those immunizations recommended by the Centers for Disease Control. The history should be easily identified in the individual's record (L1).

11. The facility must localize bowel/constipation management guidelines issued by state office. Given the number of individuals with bowel management issues this should be considered a priority (L1).

12. The medical director should work with consulting neurologists to ensure that clinic notes contain key data related to seizure management. Recommendations for additional testing and medication management should be specific as should timelines for follow-up appointments (L1).

13. Individuals with refractory seizure disorder should be referred to a qualified epileptologist for evaluation. The facility should utilize a variety of resources to achieve this, such as an association with the local university health sciences center (L1).

14. The monitoring team has recommended continues to recommend that the facility review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy (L2).

15. The medical director should review the databases currently in place to determine why the various problems with accuracy of data are occurring. The medical department must develop a process collecting and validating data to ensure its accuracy (L3).

16. The facility must develop a quality program based on a comprehensive set of process and outcome indicators in addition to the quality audits that are occurring (L3).

17. The facility must demonstrate that indicator data are collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology must be utilized to ensure remediation is achieved (L3).

18. The medical director must develop local policies and procedures based on the clinical guidelines issued by state office. All staff should be appropriately trained and documentation of training maintained. This should be approached with some sense of urgency (L4).

19. The medical director should review the various policies, procedures, and guidelines and ensure that all are consistent with state issued guidelines (L4).

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Active Record Order and Guidelines o Map of facility o An organizational chart, including titles and names of staff currently holding management positions. o New staff orientation agenda o For the Nursing Department, the number of budgeted positions, staff, unfilled positions, current FTEs, and staff to individual ratio o EPSSLC Nursing Services Policies & Procedures o EPSSLC Self-Assessment, Plan of Improvement, and Nursing Care Action Plan (updated 6/29/12) o Presentation book for Section M o Alphabetical list of individuals with current ISP, annual nursing assessment, and quarterly nursing assessment (due) dates o Nursing staffing reports for the last six months o The last six months, list of all individuals admitted to the Infirmary, length of stay, and diagnosis o The last six months, minutes from the following meetings: Infection Control, Environmental/Safety Committee, Specialty Nurses Meeting, Nurse Manager Meeting, Pharmacy and Therapeutics, Medication Variance Committee Meeting, o The last six months infection control reports, quality assurance/enhancement reports o List of staff members and their certification in first aid, CPR, BLS, ACLS o Training curriculum for emergency procedures o The last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plans o Emergency Drill Checklists 3/1/12-6/30/12 o Locations of AEDs, suction machines, oxygen, and emergency medical equipment o Infection control monitoring tools o Policies/procedures addressing infection control developed/drafted/finalized 1/1/12 – 7/17/12 o Table of contents of “Purple Binders” o List of redundant documentation eliminated from the uniform record o Lists of RN case managers’ barriers to focusing on their main tasks o List of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation, dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight o List of individuals and weights with BMI > 30 o List of individuals with weights with BMI < 20 o List of individuals on modified diets/thickened liquids o Documentation of annual consideration of resuming oral intake for individuals receiving enteral nutrition

	o Last six months peer reviews for Nursing Department o Last six months mortality reviews and QI Death Reviews for Nursing for individuals who died o "Day of the Week" nurses' schedule for 7/15/12 – 7/20/12 o For the last six individuals who transitioned to the community, their completed nursing discharge summary o Employee Education files of 10 randomly selected nurses o List of dates and outlines of Nursing Department's Specialized Inservices Re: Documentation o Treatment protocols for urinary tract infections, soft tissue infections, and upper respiratory infections o New diabetes mellitus flow sheet o Records of: • Individual #32, Individual #61, Individual #63, Individual #45, Individual #123, Individual #25, Individual #77, Individual #92, Individual #89, Individual #99, Individual #73, Individual #59, Individual 125, Individual #34, Individual #114, Individual #128, Individual #1, Individual #115, Individual #148, Individual #146 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Mary Ann Clark o Nursing Operations Officer/Hospital Liaison, Martha Manriquez o Infection Control Nurse, Margaret Amada o QA Nurse, Elaine Lichter o Nurse Educator, Irania Korb o PNMT RN, Cynthia Diaz o Director of Habilitation, Susan Acosta o Nurse Manager, Segrid Maynez o Family Nurse Practitioner, Denise Jones o PNMT Dietician, Donna Rice o Consultant Dieticians, Adriana Ascon and Melissa Prado <u>Observations Conducted</u>: o Visited individuals residing on all units o Medication administration on selected units o Enteral feedings on selected units o 7/16/12 ISPA for Individual #99 o 7/17/12 Medication Variance Committee Meeting o 7/18/12 Infection Control Committee Meeting

	Facility Self-Assessment: EPSSLC submitted its self-assessment, which was updated on 6/29/12. Since the prior review, although EPSSLC continued to use the self-assessment format it had developed for that prior review, the Chief Nurse Executive (CNE), Center Lead for section M, completely overhauled what was presented the last time. In that regard, the CNE ensured that the self-assessment process resulted in a much more comprehensive, meaningful, and accurate portrayal of the activities and outcomes for each provision item. The most important next step for the CNE is that she makes sure that the self-assessment includes everything that the monitoring team looks at by provision item. This can be done by going through the monitoring team's report and also by reviewing the extensive notes that were taken during the CNE's meeting with the monitoring team when all topics pertaining to section M were reviewed and discussed at length. For example, during the monitoring team's meeting with the CNE, the outline of the monitoring report for section M was reviewed, and it was reaffirmed that it will continue to be important for the self-assessment to line up with the topics in the monitoring team's reports. Of note, even though more work was needed, the monitoring team wanted to acknowledge the efforts of the CNE to successfully move the self-assessment process forward. The facility rated itself as being in noncompliance with all provisions of section M. The monitoring team agreed with all of these ratings.
	Summary of Monitor's Assessment: The monitoring team was pleased to report that under the leadership of the CNE, who was appointed six months ago during the prior review, the Nursing Department made significant progress in many areas across the provisions of section M. The positive changes were initially noted during the review of the facility's document submission, self-assessment, action plan, and provision action information, which was completed at a level of competence beyond what was submitted for all prior reviews. The review of the document submission also revealed that the CNE had responded to, and acted upon, all recommendations put forward in the monitoring report. Although it was clear throughout the review that the CNE and her nursing leadership team would have preferred to have been further along in the process toward achieving substantial compliance with the Settlement Agreement and the provisions of section M, there were a number of positive steps taken by the Nursing Department and definite progress toward compliance. For example, since the prior review, several key positions within the Nursing Department were filled. The Nurse Educator and Infection Control Nurse positions were filled with two nurses who immediately began to develop their roles and responsibilities and re-establish the functions of education and infection prevention and control. The Nurse Hospital Liaison began to assist the CNE with carrying out and improving nursing operations and added a level of integrity and perseverance that was invaluable to the facility.

	The Nursing Department continued to maintain good working relationships with other departments, most notably the quality assurance and pharmacy departments. This had been, and continued to be, a very positive finding. For example, despite the sometimes challenging and sensitive nature of the QA Nurse's assignments, which usually resulted in a number of findings and recommendations for the Nursing Department, the CNE and her leadership team remained open to the QA Nurse's findings, welcomed her recommendations, and took actions that benefitted the individuals and their receipt of improved health care services. Notwithstanding these positive findings, the results of the facility's self-assessments, audits, monitoring tools, etc. continued to reveal low scores across most provisions of section M. These findings were consistent with the findings of the monitoring team. Notably, however, the CNE and her leadership team were aware of these problems and were up to the task of improving the delivery of nursing care at the facility and ensuring that EPSSLC's nursing practices comported with standards of care, the Settlement Agreement, and the Health Care Guidelines.

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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.	Since the prior review, EPSSLC reported that they reviewed the Nursing Department's stability and staffing needs, case manager caseloads, nurse managers' recommendations, and management meeting minutes. The Nursing Department also continued to conduct reviews of medical emergency equipment checklists and the data analyst's reports from four selected monitoring tools – infection control, chronic respiratory distress, skin integrity, and documentation. According to the facility's self-assessment, "for the first time since the monitoring tools were adopted statewide, a true baseline is reported for the EPSSLC Nursing Department." On the basis of the low scores, which ranged from 27% to 67% compliance, and "because a consistent, well-established response to changes in health status is not fully operational and/or supported by sufficient data [and] a need for a valid process of monitoring compliance of the hospitalization, transfer, and discharge protocol and response to acute illness, injury, [and] change of status was identified," EPSSLC reported, "this provision remains rated as noncompliant." The monitoring team agreed with the facility's finding of noncompliance, and based its rating on findings that failed to reveal evidence of the presence and adequacy of assessment, reporting, documenting, planning, communicating, monitoring, and evaluating significant changes in individuals health status sufficient to help ensure that the changes were readily identified and addressed. During the conduct of the monitoring review, all presentation books and all documents submitted by the facility were closely examined, all residential areas were visited, daily observations of nursing care were made, 16 nurses were interviewed, and 20 individuals' records were reviewed.	Noncompliance

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		Consistent with the findings and conclusions in the facility's self-assessment, the monitoring review revealed that there continued to be problems ensuring that nurses' adequately identified health care problems, performed complete assessments, implemented planned interventions, conducted appropriate follow-up, and kept appropriate records to sufficiently and readily identify and address the significant changes in individuals' health status and needs. Thus, a rating of noncompliance was made in this area. <u>Staffing, Structure, and Supervision</u> Since the prior review, the CNE, with assistance from other members of the nursing leadership team, completed analyses of the department's current deployment of staff members, staff minimums, and staff ratios by residential unit and in accordance with indicators of acuity of health needs and risks. In addition, the CNE prepared monthly staffing reports that kept EPSSLC's administrative officials aware of existing vacancies in key nursing positions and provided status updates on progress made toward filling vacancies, which included current and previous efforts in hiring and retaining nurses. This was a notable accomplishment, and its undertaking provided both the Nursing Department and the facility administration ample evidence of where, when, and what level of nursing staff members were needed across the facility in order to best meet the health needs of the individuals. A review of the organizational chart of the Nursing Department revealed that almost all vacant positions were filled. In addition, the chart depicted reasonable configurations of lines of authority and supervision across the Nursing Department. Also, a review of the monthly Nursing Staffing Reports revealed that use of agency nurses was minimal and closely scrutinized, campus nurse supervisors worked weekend shifts to ensure adequate supervision of nursing staff members and to assist and oversee new nurse employees and graduate nurses, and the Nurse Operations Officer (NOO) occasionally worked evening and weekend shifts to ensure administration oversight and supervision of the nursing staff members. All of the aforementioned activities were significant, positive changes in the organization, management, and leadership of EPSSLC's Nursing Department. The next step for the CNE and her leadership team was to help nurse managers develop more effective and efficient use of their time and leadership skills to mentor and model good nursing practices for nurses on the residential units.	

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		Recordkeeping and Documentation As noted in the prior review, all individuals' records were organized in a unified form/format. The format of nurses' notes was mostly in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format, which was consistent with the state's standardized protocol. However, consistent with the facility's self-assessment and as noted in all prior reviews, there continued to be significant problems with nurses' documentation. The content as well as signature/credentials appearing in a number of nurses' notes were not legible. Some nurses' notes failed to have the time of the entry documented on the note, which made it difficult, if not impossible, to know when critically important nursing assessments and interventions were delivered. Some notes were written on the margins of the IPNs rather than new IPNs, and some nurses continued to document oblique references to individuals' health needs and risks, such as "[Individual's] bowel pattern is more regular," '[Individual] sitting in w/c kinda groggy," "[Abnormal tissue] is larger than the last time I saw this tissue," etc. Nurses also continued to incorrectly identify errors in their documentation. Rather than striking through and initialing the incorrect entry, they obliterated record entries by writing over the incorrect entries one or more times. In addition, there were no IPNs for Individual #25 and Individual #148 for the period of 5/4/12 – 7/18/12. Although the monitoring team notified the facility of this finding and reiterated the request for the individuals' IPNs, none were provided. (Also see section V of this report, on recordkeeping.) During the facility's opening meeting and presentation for section G, it was reported that the "Data Committee has revealed a reduction of redundant documentation of 30%." Upon clarification of this report by facility administration, it was revealed that a number of documents, primarily behavior data sheets, ADL sheets, etc. that were primarily documented by the direct care staff members and duplicative of other documents, were removed from the individuals' unified records. Furthermore, it was reported that direct care staff members recorded and filed some of the individuals' health status in "purple binders," which were kept on the residential units for one month and until filed in the individuals' unified records. A review of several of the facility's purple binders revealed that direct care staff members usually completed individuals' ADL sheets and wheelchair cleaning/maintenance tracking logs. However, data pertaining to tracking and recording individuals' intake and output, vital signs, and weight were often incomplete. In addition, there were many blank entries for nurses' and case managers' reviews of the aspiration trigger data. Hospitalization and Hospital Liaison Activities According to the state's 5/11/11 Nursing Services Policy, "The State Center Nursing Department will ensure continuity of the planning, development, coordination, and evaluation of nursing/medical needs for all individuals admitted to or discharged from the hospital to the infirmary or moving between facilities. The hospital liaison will make	

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		periodic visits to a hospitalized individual to obtain as much up- to-date information as possible from the hospital nurse responsible for care of the individual. Information gained will include, but not be limited to diagnosis, symptoms, medications being given, lab work, radiological studies, procedures done or scheduled with outcomes, and plans for discharge back to the State Center." Five of the 20 individuals selected for in-depth review were hospitalized one or more times during the period of 2/1/12 – 7/18/12 for treatment of significant changes in their health. In accordance with the state's clear policy directives and the provisions of the Settlement Agreement, all of the individuals who were hospitalized had Hospital Liaison Reports filed in their records. These reports revealed evidence that throughout the individuals' hospitalizations, the NOO/Hospital Liaison visited the individuals and kept in regular contact with the individuals' tertiary care providers throughout their hospitalizations. In addition, the NOO/Hospital Liaison thoroughly reviewed individuals' hospital records, interviewed tertiary care providers, and reported to interdisciplinary team members the hospitalized individuals' health status, response to treatment, and progress toward discharge. The monitoring team review revealed that individuals who were sent to the hospital benefitted from the oversight and advocacy of the NOO/Hospital Liaison. For example, a review of Individual #63's record revealed that throughout his protracted hospitalization for treatment of a complicated pneumonia, lung abscess, empyema, and decortication of his left lung, the Hospital Liaison regularly collaborated with the tertiary care professionals, his family members, and other EPSSLC clinical professionals. In addition, she helped to ensure Individual #63's continuity of care during his transfers from the hospital's intensive care unit, to its telemetry unit, to its isolation room, etc. Also, upon Individual #63's discharge from the hospital to EPSSLC, the NOO/Hospital Liaison helped Individual #63's IDT learn about his new health risks related to his significantly deconditioned status. Of note, within approximately 72 hours of Individual #63's return to EPSSLC, he was thoroughly evaluated by the facility's PNMT RN, who collaborated with the NOO/Hospital Liaison and communicated her findings and recommendations to Individual #63's IDT who assumed the management and oversight of his care. <u>Wound/Skin Integrity</u> According to the state's 5/11/11 Nursing Services Policy, "Individuals will be provided with nursing services in accordance with their identified needs...[and] nursing services includes participation in a Skin Integrity Committee that includes medical, dietary, nursing, specialized therapy, pharmacy, quality assurance, and residential services staff. The committee reviews data related to skin integrity issues, analyzes data for patterns, and formulates recommendations for preventative measures and management."	

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		Although EPSSLC reported that the results of their monitoring revealed an average of only 42% compliance with the provisions of the Settlement Agreement and Health Care Guidelines that pertained to skin integrity, there were no references to specific actions taken by EPSSLC since the prior review to address nurses' participation in a Skin Integrity Committee and/or processes to identify and address issues, patterns, and trends in individuals' who suffered alteration in skin integrity in either the action plan, provision action information, or self-assessment for section M. In addition, a review of the documents submitted by the facility revealed that since the prior review, on 5/24/12, only one Skin Integrity Committee meeting was held. A review of the 5/24/12 meeting's minutes compared to the prior meeting's minutes, which were documented on 12/14/11, indicated that many more individuals were identified with acute and/or chronic wounds and skin infections on 5/24/12 than were identified on 12/14/11. In addition, all of the individuals with alteration in skin integrity who were identified on 5/24/12 were reportedly at various stages of healing; all were recommended to receive various treatments/follow-up interventions; and, as of the review, all interventions were either "in progress" or "scheduled." Due to the absence of aggregate data, the status of these individuals' alteration in skin integrity was unknown. In addition, despite the 5/24/12 meeting's report of "no improvement in reducing the [facility's] rate of fungal infections," the "Round Table Discussion" of the 5/24/12 meeting was identical to the discussion that reportedly occurred months earlier at the 12/14/11 meeting and was limited to two cryptic phrases - "data gathering and action plan on fungal infection" and "follow-up of action plans on individuals discussed." There was no evidence that assertive actions were planned implemented to prevent and/or address the infections, thus, the frequency of the infections increased and responses to treatment decreased. For example, it was reported that several individuals who were diagnosed with fungal infections had suffered reoccurrences of these infections on their buttocks, armpits, and/or under their breasts. During the onsite review, the monitoring team met briefly with the facility's nurse practitioner. During this meeting, it was learned that the nurse practitioner had only recently assumed responsibility of the oversight of wound and skin integrity from the CNE. It was reported that the nurse practitioner was in the process of developing a committee that reviewed data related to skin integrity issues, analyzed data for patterns, and formulated recommendations for preventative measures and management. According to the nurse practitioner, she was trying to "include as many nurses" and "get as many case managers as possible" involved in the oversight and treatment of alteration in skin integrity. To date, the nurse practitioner had not developed a system to track and record the facility's management of individuals' skin integrity problems, but she reported that she was planning to work with the Infection Control Nurse to do so.	

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		Infection Control According to EPSSLC's action plan, provision action information, and self-assessment, which were updated on 6/29/12, since the prior review, several actions were reportedly taken to address the prior review's findings related to this provision - an Infection Control Nurse was recruited and hired, the Infection Control Nurse, CNE, and Medical Director met to discuss the development of an infection control data tracking system, a baseline infection control surveillance tool was developed and used to capture information by which baseline performance measurements would/could be obtained, and some infection data were entered into an infection control database. Nonetheless, the facility reported that there continued to be "instability in the infection control department [that] has prevented the establishment of a foundation," which could effectively address and measure EPSSLC's infection control needs. Notwithstanding the facility's self-assessment of instability in their infection control, the monitoring team's review showed that the facility's infection control program was on its way to being on track for meeting the provisions of the Settlement Agreement and Health Care Guidelines. For example, an Infection Control Nurse was on board, and she was committed to developing a quality infection prevention and control program. Although the Infection Control Nurse had been at the facility for only two short months, she had already developed a working relationship with the facility's infectious disease medical consultant, implemented an infection flow sheet for tracking individuals' infections, conducted Infection Control Committee Meetings, and developed a proposal for Tdap vaccines to be administered to all individuals who needed immunization. In addition, the Infection Control Nurse was working her way through the state's and facility's policies and procedures pertaining to infection prevention and management to ensure that they were reviewed, revised, and updated as needed. The Infection Control Nurse was also working closely with local public health officials to ensure that whenever an employee's and/or individual's PPD test converted from negative to positive that proper procedures were followed. One of the single largest tasks facing the facility and Infection Control Nurse was "getting on the same page" with ensuring that individuals' received all of the correct infection screening tests with their results properly documented in their immunization records. During the onsite review, the monitoring team attended a meeting of the Infection Control Committee. The meeting was well attended by all departments. At the meeting, the status of infection control policies and procedures was reviewed, employee health issues were raised, and the incidence of individuals' infections and prevalence of fungal infections were presented and discussed. There was some talk of interventions and recommendations to address the patterns and trends of infections, but this aspect of the	

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		meeting was limited and in need of further development. A review of 20 sample individuals' records revealed that, since the prior review, a number of individuals suffered one or more infections, some individuals were placed on contact precautions, and at least one individual had an unknown history of disease, immunization, and vaccination. It was not surprising that given the Infection Control Nurse's brief tenure at the facility, there was little evidence of her involvement in the planning and delivery of nursing services and supports to individuals who suffered infections and/or were at heightened risk of infection. Nonetheless, these individuals presented health problems and risks that should have been addressed. For example: • Over the past six months, one-third of the 20 individuals selected for in-depth review suffered one or more urinary tract infections. There was no evidence that the facility's Infection Control Nurse and/or Infection Control Committee conducted an investigation of the environment for sources of infection and provided the direct care staff members with training on appropriate hygiene practices to prevent infection, as called for by the facility's 10/6/11 "Urinary Tract Infection Interdisciplinary Protocol." • On 1/6/12, Individual #152 was admitted to the facility. Prior to her admission, she lived in Juarez, Mexico with her mother. According to nursing assessments, "She had measles/chickenpox during her childhood," but there were "No immunization records available." Thus, there was no information in Individual #152's nursing assessment pertaining to her infection and immunization history, no evidence that attempts were made to obtain her vaccination, immunization, and history of disease, and no evidence that blood tests were completed to determine her infectious/communicable disease status, save for the PPD test. • For many months, Individual #67 was prescribed and continued to receive antibiotics to treat her "stable, recurrent cellulitis." When the monitoring team asked the facility's infectious disease medical consultant for his opinion regarding the care and treatment of Individual #67's skin infection, he stated, "She probably does not have an infection." There was no evidence that either the Infection Control Nurse or the infectious disease medical consultant to the facility were involved or had participated in planning or reviewing her care and treatment to ensure that it was adequate or appropriate to meet her needs. • From April 2012 through July 2012, Individual #25 was treated for an eye infection. During the early stages of Individual #25's infection, it reportedly "looked better" now and then. However, after three months of Individual #25's infection's failure to respond to treatment, her eye discharge was cultured and it tested positive for MRSA. Although Individual #25 was placed on "contact precautions," it was reported during the 7/18/12 Infection Control Committee meeting that she was "all over Dorm C." Although it was recommended that Dorm C should receive "enhanced housekeeping," there were no other	

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		recommendations or plans made to ensure that the infectious disease medical consultant's recommendation for "cleanliness more than anything else" would be ensured and that the vulnerable individuals who shared Individual #25's living areas, would be protected from the spread of drug-resistant infection. <u>Emergency Response</u> A review of the state of medical emergency equipment at EPSSLC continued to reveal ongoing efforts to improve upon the serious problems noted during the prior reviews. The additional AEDs, which were purchased many months ago, were available for use, the emergency medical equipment for Dorms A, B, and C continued to be stored in one central location, and, across all cottages, emergency medical equipment was clean, organized and stored on carts in the record rooms. Notwithstanding these positive findings, there continued to be problems related to enforcing the facility's expectations for its nurses to make sure equipment was in working order and ensuring follow-up to recommendations made by the facility's Safety Committee and the Special Task Force, which was created to address the "critical and complex issues" of oxygen use and equipment at the facility. For example, during the onsite review, there were no residential areas where the logs revealed that daily checks were consistently done during the period of 7/1/12-7/16/12. The failure to ensure the presence and availability of functioning medical emergency equipment placed individuals' health and safety at risk. Also, although the presentation book for section M indicated that, since the prior review, the Safety Committee recommended that a checklist be developed to better monitor staff members' response to actual medical emergencies. There was no evidence of follow-up to this recommendation. In addition, as noted during the prior review, on the cottages, emergency medical equipment was kept locked in the record rooms. This situation continued to be a concern to the monitoring team because immediate access to emergency medical equipment could be delayed by their storage in locked rooms. Also, since the prior review, the facility reported that they convened a Special Task Force to address the "critical and complex issues" of oxygen use and equipment at the facility. A review of the documents submitted by the facility revealed that, on 6/19/12, 13 issues were identified as needing "immediate resolution through new and/or revision of policy/protocols." These issues ranged from safety issues in oxygen storage, to cleaning, repair, maintenance, and requisition of equipment, to the need for development of inservice training and disciplinary action for noncompliance with policies/procedures. During the onsite review, the QA Nurse showed the monitoring team a completed inventory of equipment present and/or in use at the facility, as well as several comprehensive guidelines, protocols, and procedures related to oxygen use, equipment,	

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		and storage that she had drafted several weeks prior to this review. Despite the urgent nature of the issues, there was no evidence that the facility administration had either reviewed or approved the draft policies, procedures, and guidelines. A review of Emergency Drill Checklists for 3/1/12-6/30/12 revealed that approximately 156 drills were conducted during the four-month period. However, as noted during all prior reviews, although nurses continued to participate in the drills, in accordance with the state's and EPSSLC's policies, other clinical professionals, who were in direct contact with the individuals served by the facility, failed to participate in over 85% of these drills. <u>Significant Changes in Individuals' Health Status</u> According to the Health Care Guidelines, <u>all health care issues must be identified and followed to resolution</u>. In addition, documentation of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate and recovery underway until such time as the problem is resolved. In addition, the state's Nursing Services Policy stipulated that nursing staff members must document <u>all health care issues</u> and must 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. <u>Diet, Nutrition, and Weight</u> During the onsite review, the monitoring team identified serous problems with the management of individuals' diets, nutrition, and weight. Prior to the onsite review, EPSSLC submitted to the monitoring team document XII.21.g, entitled, "Individual With Unplanned Weight Loss of >= 10% Over Six Months: June 2012," which was a list of eight individuals who had suffered significant, unplanned weight loss during the six-month period of January 2012 through June, 2012. During the onsite review, 10 more individuals, who appeared to have lost significant amounts of weight since the prior review or were reported to the monitoring team by their family and/or facility staff members to have lost significant amounts of weight, were added to the list. During the offsite review of 20 sample individuals' records, nine more individuals were added to the list of EPSSLC individuals who had suffered serious problems with their diet, nutrition, and/or weight status since the prior review. The monitoring team met with the facility's dieticians and other clinical professionals and reviewed 19 of the 27 individuals' records to learn more about the issues pertaining to their significant, unplanned weight loss, undesirable weight gain, abrupt and severe weight fluctuations, meal refusals, and compromised nutrition status. Listed below are some examples of the seriousness of the problems revealed during the monitoring team's meeting with the facility's clinical professionals and reviews of individuals' records.	

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		• The locus of control for all food services and nutrition at EPSSLC was a Program Specialist I, who supervised the dieticians and fielded and processed all requests and orders for dietary consultations. • Two dieticians provided only 25-30 hours of services per month to the individuals at EPSSLC. • EPSSLC employed only one Diet Technician. Reportedly, he/she was assigned the responsibility to ensure that the dieticians' consultation and evaluation reports were obtained from the "shared folder," printed, and filed in the individuals' records. In addition, the Diet Technician was usually the only diet/nutrition staff member who attended and/or participated in individuals' IDT meetings. Thus, his/her participation was critical during ISPAs held as a result of significant changes in individuals' weight. o Of note, the monitoring team attended an ISPA for Individual #99. At several points during the meeting, the Diet Technician, who was unprepared for the meeting, incorrectly reported Individual #99's diet, meal substitutes, food preferences, etc. The Diet Technician was immediately interrupted and corrected by the individual's sister, who was also attended the ISPA. • Four individuals' physicians' orders for diet/nutrition consultations were not carried out, and one individual's physician's order was significantly delayed. • Four individuals who suffered serious untoward health events that significantly negatively impacted upon their diet/nutrition/weight status failed to have these events referenced by their dieticians during their quarterly/annual reviews. o Individual #34's dietician failed to reference her bilateral mandible fractures as a health event that occurred during the quarterly review period that actually and potentially affected her diet/nutrition/weight status. o This was also true for Individual #63 who suffered a complicated pneumonia, lung abscess, and empyema and was diagnosed with a lung mass. o Individual #32 suffered a blow out fracture of his eye orbit and had surgery (ORIF). • Seven individuals' physicians' orders for calorie counts and/or strict measuring of their intake/output to assess their adequacy of nutritional intake were not carried out, and one individual's physician's order was only partially implemented. • One individual's physician's order that stated that he/she "agreed with the dietician's recommendations" resulted in no changes to the individual's diet until over one month later when the individual's physician repeated his/her order to change the individual's diet to a high calorie diet. Thus, there was over	

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		one month's delay in providing the individual with additional caloric intake. • The two dieticians differed in their calculations of the same individuals' IBW ranges. So, for example, one dietician calculated Individual #114's IBW as 93-114 pounds and the other dietician calculated his IBW as 88-108 pounds. There were no explanations provided for the differences in their calculations, which varied across the individual's quarterly diet/nutrition reviews. This was significant because individuals' clinical professionals often cited that the reason for not identifying, reporting, and intervening to address diet/nutrition/weight problems was because the individual was "still within [his/her] IBW." • Regardless of the changes in individuals' diet/nutrition/weight status, none of the 19 individuals' records had diet/nutrition reports/summaries/etc. that were generated outside of their regularly scheduled quarterly/annual nutrition reviews. • It was not uncommon to find that individuals' weights fluctuated by 10 or more pounds from one month to the next without any verification/validation of the changes in individuals' weights. For example, it was recorded in Individual #63's record and reported as fact during his post-hospitalization ISPA meeting with his IDT members, the state's Medical Services Coordinator, and his family that he gained 31 pounds in one month. This implausible finding was not verified and/or validated before it was reported at the meeting as a fact. In addition, not one attendee at the ISPA questioned the validity of this 31-pound weight gain and/or asked for verification of the measurement. • It was also not uncommon to find that a number of individuals' weight gains and/or weight losses occurred at an exceedingly rapid pace and without evidence of planned and consistently implemented healthy changes in their lifestyle. • There was no evidence that consistent attempts were made to identify and address problems at mealtime, obtain food preferences, and/or offer meal substitutes, other than Ensure, etc., to individuals who frequently refused meals. The following principles were applied during the above review regarding weights, diets, and nutrition: • When data were recorded they must be complete. • Calorie counts were not considered as merely a record of percentages of unknown quantities of food. Even if the calories served were known, simply recording a percentage of food consumed (e.g., 65%) failed to indicate calories consumed. For example, if 35% of the meal were uneaten, it could have been the most caloric rich/nutrient dense food item(s) served. A record of percentages of intake was not, and it not, equivalent to counting calories consumed to assess adequacy of nutritional intake.	

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		• "Strict I and O" means just that, and, by definition, would include a record of amount of fluid taken "in" and put "out" during the review period. "Strict I and O" would include fluids consumed with medications, as well as meals, as well as between meals, etc. "Strict I and O" also means that all fluids put "out" must be measured. This would include measurement of urine output, vomitus, etc. and would not be merely a record of "X1," "X2," etc. • The regularly scheduled Nutrition Quarterly/Annual reviews that just happened to occur after the physicians' order (albeit weeks, if not months, after the order) and were not contemporaneous with the physicians' orders were not considered and implementation of the physician's order for a dietary consultation. In the weeks following the onsite review during which these issue were identified by the monitoring team, the facility, under direction and leadership from state office, submitted a one and a half page narrative describing the facility's immediate actions and longer-term plans to address these weight-diet-nutrition problems on a facility-wide basis and to address the specific individuals identified during this review. The document described reasonable activities, however, most important will be the facility's immediate attention to individuals and to system issues. This must include adequate assessment of outcome (i.e., fixing of the problems). <u>Other Significant Changes in Individuals' Health Status</u> Across the 20 sample individuals reviewed, there was evidence that their physicians usually responded to nurses' notifications of significant changes in their health status and needs and/or when the individuals needed to be seen by their doctor. However, as noted in prior reviews, it was the direct care staff members who continued to be the first responders and reporters of health care problems and concerns to the LVNs. Thus, there continued to be a heavy reliance upon the direct care staff members to readily identify problems, and on the LVNs to promptly respond to the direct care staff member's report, review the individual and situation, and report their findings to RNs for assessment, monitoring, and referral to the physician. A review of 20 sample individuals' records showed that the facility failed to ensure that its nurses consistently identified, implemented, and documented their interventions to address individuals' health care problems and changes in health status, and/or conducted at least daily follow-up until resolution of the significant changes in individuals' health status occurred. This problem manifested itself in different ways, such as the failure of nurses to consistently and completely document "Sick Call Reports" to help ensure that accurate information was relayed to the treating physicians and/or the nurse practitioner. Oftentimes, important information, such as the onset and duration of the problem, aggravating and alleviating factors, and accompanying signs and symptoms were not documented. As a result, proper diagnosis and treatment of	

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		individuals' significant changes in health status were at risk of delay. For example, Individual #59's physician noted that he was "Sent for R eye. No other Hx. Pt unable to respond." Absent any other information or relevant history, Individual #59's physician prescribed the individual an antibiotic for an eye infection. Across all records reviewed, there were also many examples of nurses who failed to ensure proper and complete follow-up to significant changes in individuals' health status. The following examples represented the seriousness of this problem at EPSSLC. • On 6/6/12, Individual #63's physician noted that he reviewed his labs and chest x-ray, which revealed a persistent nodule on the left upper lobe of his lung. His physician ordered a CT scan of his chest, additional blood tests, and vital sign measurements and neurologic checks every shift for seven days. There was no evidence that the vital sign and neurologic checks were carried out as ordered. • Over the past several months, Individual #99 suffered significant change in gait, head injury, bout of insomnia, episode of vomiting, and a skin rash. Although these significant changes in his health status were identified as such by his nurses, there was no evidence of follow-up nursing assessment and monitoring to ensure that the significant changes in his health were addressed and resolved. • Individual #77 was diagnosed with constipation. Her nurse noted that she was straining at stool and administered a suppository. Although Individual #77's nurse noted that she was only able to pass a small, watery stool, which was a sign of impending impaction or obstruction, her nurse referred her to the charge nurse for further evaluation. Notwithstanding this significant change in Individual #77's health status, neither the charge nurse nor the direct care nurse conducted follow-up assessment or treatment.	
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.	In accordance with the provisions of the Settlement Agreement, the DADS Nursing Services Policy and Procedures 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 and the Post-Hospital/ER/LTAC Assessment forms in use at EPSSLC would reference the collection, recording, and analysis of a complete set of health information that would lead to the identification of all actual and potential health problems, and to the formulation of a complete list of nursing diagnoses/problems for the individual. In addition, a review of the state's guidelines for completing the quarterly/annual comprehensive nursing assessments revealed that they clearly required the comprehensive nursing assessments to be completed prior to and in anticipation of the individuals' annual and quarterly ISP meetings. Thus, making it imperative that the Nursing and QDDPs/ISP Coordination Departments closely coordinate, communicate, and collaborate with each other.	Noncompliance

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		The presentation book for section M showed evidence of memoranda and ongoing activities to "assure all necessary discipline assessments are completed and available in the active records for the IDT to review prior to the annual IDT." The review of 20 sample individuals' records revealed that all had quarterly and annual nursing assessments that were conducted in a timely manner and proximate with the individuals' annual IDT meetings. This was an improvement from the findings of prior reviews. At EPSSLC, RNs and LVNs alike continued to document IPNs by exception without the support of care pathways and templates for IPNs. Of note, since the prior monitoring review, the EPSSLC RNs completed phase two of the RN physical assessment course, which continued to help improve their knowledge and training in identifying and evaluating variance in health status indicators. Also, EPSSLC recently distributed the state's "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. Nonetheless, documentation by exception, as implemented by EPSSLC nurses, continued to have significant problems that stymied many of the CNE and her nursing leadership team's efforts to obtain substantial compliance with the provisions of section M. 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. The facility's self-assessment of their performance in this area ranged from 75% to 95% compliance, as measured by the Nursing Department. It was unclear, however, whether these results, which were labeled "Assessment of the Assessment Results," were evaluations of timeliness, content, and/or quality of the nursing assessments. The monitoring team's review of 20 sample individuals, however, revealed that, although there were significant improvements made in the timeliness of completion and some improvements made in the content of the individuals' quarterly and annual nursing assessments, all nursing assessments reviewed failed to provide a complete, comprehensive, and accurate 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	

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		interventions to achieve outcomes were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. As noted during the prior review, the significant discrepancies between the facility's self-assessments of compliance and the findings of the monitoring team review were of concern, because the bases for the facility's relatively positive self-findings were not evident throughout the monitoring review of this provision item. In addition, the facility's self-assessments of its compliance across the other aspects of nursing care, such as skin integrity, seizure management, chronic respiratory distress, etc., which provided the foundation upon which complete, accurate, and comprehensive nursing assessments were developed, scored relatively low, with average scores of less than 50% 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. In addition, it was not uncommon to find that the 2012 nursing assessments referenced the individuals' physicians' 2010 lists of "current, active problems." • The majority of nursing assessments failed to show meaningful reviews of individuals' response to and effectiveness of all of their medications and treatments. Individual #1 was a good example of this problem. o It should be noted, however, that there were several nursing assessments, such as Individual #73's and Individual #146'sassessment, where nurses very thoughtfully and completely evaluated the individuals' response to their medications and treatments. • Dates and results of mealtime monitoring for several sample individuals who resided in the Systems building were blank. This problem was identified during the prior review, and, given the extensive number of meal monitoring forms completed, and almost always perfectly scored by the facility, it was not expected. • 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 when an individual suffered significant, abrupt, and/or unplanned weight loss and his/her nurses failed to take assertive actions because the individual still happened to be within his/her IBW (IBW is merely a calculation of weight believed to be maximally healthy for an individual; it can be affected by factors such as gender, age, frame, muscular development, etc.). • Tertiary care reviews were incomplete. • Individuals' significant histories of chronic and acute conditions, including, but	

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		not limited to, respiratory illnesses and infections, heart disease, skin breakdown, and medication side effects were not completely identified and evaluated. • Nursing assessments that indicated that individuals had pain management problems failed to reference complete evaluations of the location, intensity, onset, duration, quality, etc. of the individuals' pain, and what alleviated and/or aggravated 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. In addition, it was not uncommon to find lists of nursing problems/diagnoses carried over from one nursing assessment to the next regardless of changes in the individuals' health problems, needs, and risks. • Nursing summaries continued to need improvement. In general, they were not the concise recapitulations of the individual's health status over the review period. Rather, they continued to be difficult to read and understand the main points, run-on lists of orders, order changes, discrete events, lab test results, etc., which always left the reader wondering how all of the various health events, treatments, interventions, risk reduction activities, etc. impacted the individual. The following examples from this sample indicated the seriousness of this problem at EPSSLC. • Individual #63's comprehensive quarterly nursing assessment, completed three weeks after his protracted hospitalization for treatment of pneumonia, lung abscess, and empyema, failed to portray his severely debilitated and deconditioned health status or his newly diagnosed lung mass. Rather, the assessment blithely noted, "He recuperated his stable health condition." • Despite Individual #125's change in health status, problems, and needs over the past year, his comprehensive nursing assessments failed to reference his current, active medical problems. In addition, his nursing assessment failed to review the results of his lab tests and the effectiveness of his medications and treatments. Also, despite significant changes in his intake, sick call reports for meal refusals, and physician's orders to "push fluids" and "encourage to drink as much as possible," the past 10 meal intake monitoring reports listed in his nursing assessment failed to provide any similarity to a nursing assessment. For	

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		example, there were no evaluation of his mealtime behavior, the assistance he required, or his tolerance of food/fluids, etc. Rather, the 10 reports reiterated: "No choking or aspiration. Adaptive equipment used. Following PNMP." • Over the past six months, Individual #59's nursing assessment indicated that he suffered increased seizure activity, change in VNS settings, changes in his seizure medications, and changes in his cardiac and psychotropic medications due to metabolic acidosis and hypotension. Notwithstanding the potential impact of these significant problems and needs on Individual #59's health and wellbeing, his nursing assessments failed to reference his actual and potential responses to his untoward health events.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of interventions. In addition, the state's 12/30/11 guidelines for the routine responsibilities of the RN case managers reaffirmed that, with regarding to planning, they must actively participate in ISPA meetings and IDT meetings to discuss and formulate plans of care to address the health risks, as well as other chronic and acute health needs or issues as they arise, for the individuals served by the facility. The guidelines also indicated that RN case mangers were not to provide RN coverage for the unit/campus on any shift, not to be scheduled to work or provide RN coverage for the unit/campus on weekends or holidays, not to work as a campus RN, RN supervisor or Officer on Duty, and not to provide supervision to other nurses. Thus, while the guidelines confirmed expectations for RN case managers, they also sought to ensure that RN case managers would be afforded adequate time and attention to focus on their main task – the quality, clinically optimal, and cost-effective management of the health care status and health care needs of individuals on their assigned caseloads. During the review, the RN case managers at EPSSLC prepared comprehensive lists of the barriers that continued to prevent them from focusing on their main tasks. Remarkably, all seven RN case managers' lists referenced many of the same barriers. The top six barriers were unavailable and incomplete active records, running errands to and for the medical clinic, completing the weight gain/loss notification forms, significant delays in response and/or unavailability of staff members from medical and psychiatry clinics, last minute unscheduled meetings, and carrying out direct care nursing duties. In addition, the RN case managers reported that most of the barriers that prevented them from	Noncompliance

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		focusing on their main tasks occurred on a weekly, if not daily, basis. These obstacles must be addressed by facility administration, as well as the Nursing Department, in order to achieve substantial compliance with the provisions of section M. According to the facility's presentation book for section M3, since the prior review, the RN case managers and direct care RNs evaluated the current process of revising the HMPs and ACPs to reflect changes in the individuals' health status, maintained participation in the IDT meetings to ensure adequate discussion and planned interventions to address changes in individuals' health and risk status, implemented a new case manager job description, and identified the NOO as the RN case managers' supervisor. Currently, the monitoring review of 20 individuals' records revealed that all 20 individuals failed to have specific, individualized nursing interventions developed to address all of their health care needs, including their needs associated with their health risks. As a result, a rating of noncompliance was given to this provision item. However, it should be noted that there were improvements in certain HMPs for some individuals. For example, there were obvious attempts made to make certain that the HMPs for Individual #128 and Individual #34 were more complete, accurate, individualized, and appropriate. The HMP developed to address Individual #34's pain related to her bilateral mandible fractures with ORIF was also a good example of the RN case manager's formulation of a plan that described specific observations and interventions to both recognize and respond to the individual's indicators of pain. Some general comments regarding the 20 sample individuals' care plans are below. Of note, all of the findings were consistent with the findings from the prior reviews. • Generic, stock, mini-plans with various dates and time frames, some of which were reviewed at least quarterly, many of which were not, continued to be the pattern of health care planning at EPSSLC. o A number of the interventions put forward in the stock care plans were not consistent with the state's health and nursing care protocols. • Almost identical HMPs were used to address health problems regardless of the individual's co-morbid conditions and/or the precursors, nature, scope, and intensity of the problem. • Several of the 20 sample individuals were diagnosed with poor oral hygiene. And, at least one individual's oral hygiene was so poor that she suffered multiple caries and heavy bleeding upon brushing her teeth. However, not one individual had a HMP to address oral hygiene needs. • Some individuals HMPs referenced other individuals' names. Of note, these	

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		HMPs were signed and dated as "reviewed" by their nurses, which raised question regarding the veracity of the review process. • ACPs were not consistently developed in response to emergent health problems and/or resolved in a timely manner, if at all. • Not one of the 20 individuals records contained plans that addressed all of the current health needs of the individuals at all times. • There were many examples of when the implementation of care plan interventions was not borne out by documentation of IPNs. For example, the IPNs in Individual #25's record failed to reveal evidence that the interventions referenced in her HMP for pica, such as monitoring her bowel movements daily, eliminating non-food items, providing alternatives to pica, charting at least once a shift during the acute phase, etc. were carried out. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #63 was a 40-year-old man who was hospitalized from 4/9/12 to 5/7/12 for treatment of a complicated pneumonia. During his hospitalization, he was also diagnosed with a lung mass. His 1/31/12 HMPs were not reviewed and appropriately revised. In addition, there was no HMP developed to address his urgent need for better strength and endurance and no HMP to address his actual and potential responses to his newly diagnosed lung mass. • Although Individual #115, a 60-year-old man, had HMPs to address several of his acute health problems, there were no planned interventions to address most of his chronic health needs and risks. For example, he had an ACP to address his urinary tract infection, but it was a generic plan that failed to reference any specific interventions to address his chronic, long-standing health needs, which were that of an uncircumcised male with phimosis who was at risk of failure to maintain good genital hygiene and urinary tract infections. • Individual #148, since his recent admission, suffered a significant, unplanned, 22-pound weight loss and a MRSA infection on his scalp. Despite these health problems, a review of Individual #148's record revealed that he failed to have an HMP to address his weight loss, and his HMP to address his MRSA and scalp abscess was clearly not adequately reviewed by the nurses who signed it because it erroneously referenced Individual #148 as "her" and referenced interventions to address "leg cellulitis" rather than his scalp abscess.	

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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.	Of the six provisions of section M, M4 has the broadest scope. This provision item clearly ties assessment and reporting protocols to outcomes, and it requires rigorous implementation to achieve substantial compliance. More specifically, this provision item demands that each component of the nursing process is in place and put into practice, such that the health needs of the individuals served by the facility are met. This means that, when properly implemented, the assessment and reporting protocols should produce results, that is, expected outcomes. Expected outcomes will depend on the individual and his/her situation, and they may include maintaining or attaining health or achieving end of life goals. The facility's self-assessment indicated that, since the prior monitoring review, the facility's nursing education program was "enhanced" vis a vis (1) developed a schedule for training and a database for tracking, trending, and monitoring nurses' compliance with competence-based training, (2) implemented strategies to address identified issues, (3) filled the vacant Nurse Educator position, and (4) developed an effective education referral process to address nurses' competency issues. The CNE reported, however, that based upon the findings from the facility's self-assessments, "this provision [was] noncompliant because instability in the Nurse Education department prevented progress with required competency training and educational opportunities." The monitoring team was in agreement with the self-rating of noncompliance due to the findings of numerous problems in the facility's training of its nurses and their implementation of the nursing assessment and reporting protocols specifically developed by the state (and some developed by the facility) to improve nursing practice and ensure consistent application of the nursing process. Since the prior review, the CNE, who had been in her position for only six months, had made very significant strides toward improving the level of performance and accountability of nurses across the Nursing Department. Starting with the completion of a much-improved action plan, provision action information, and self-assessment, and extending to the CNE's performance of multiple roles and responsibilities over the past six months, she demonstrated a higher level of leadership, direction, motivation, and support for the facility's nurses than what was found during prior reviews. With the addition of a NOO, Infection Control Nurse, and Nurse Educator, the CNE was able to establish a baseline of performance upon which she and her leadership team immediately began improving the delivery of nursing care at the facility. One of the ways in which delivery of nursing supports and services was improved was through the recruitment and retention of a reasonably stable nursing workforce, who were deployed across the campus, in accordance with the levels of individuals' acuity and needs for nursing services. This was a noteworthy improvement over the prior method of	Noncompliance

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		assigning nurses to the Systems Building and cottages without first evaluating and discerning the individuals' needs for nursing care. Notwithstanding these positive findings, it was clear that there was work to be done in this area in order to build a stable and competent Nursing Department. Since the prior review, the newly hired Nurse Educator was integral to the department's endeavor to build up the Nursing Department and ensure that the state's and the facility's nursing policies, procedures, and protocols were properly implemented. For example, the Nurse Educator had developed a database to identify nurses who had completed and/or needed to complete areas of competency-based training. Notably, a review of the data revealed that there were a significant number of nurses who had not completed at least annual, competency-based training across all required training areas. In addition, when the Nurse Educator was asked how she established and maintained direct care staff members competence in two areas of delegated health care duties – colostomy care and blood pressure and vital signs, she replied that she was not involved in this aspect of training and/or ensuring direct care staff members' competence to carry out the aforementioned delegated health care duties. Absent the involvement of the Nurse Educator, it was unclear whether and how direct care staff members' competence in carrying out these delegated health care duties was ensured. A review of the competency/skill and on-the-job training records for 10 of the most recently hired nurses revealed problems documenting and maintaining accurate and complete evidence that nurses actually received the orientation and training that was reported to the monitoring team, and that the nurses were truly evaluated and deemed competent to carry out their duties prior to their assignments. For example, almost all records had blank entries for the assessment and verification of their competence/skills by the nurses' Nurse Managers, several records failed to have verification of their skills/competence in a number of areas, and at least one nurse failed to turn in any of his/her competency tests. These problems were significant because they were indicative of gaps and lapses in three of the most important areas of nursing education – performing training, evaluating competence, and verifying skill levels of nurses who cared for the individuals. During observations on the units, no nurses were observed to have the state's protocols on laminated cards on their person and/or in their workstations. Although EPSSLC reported that they had implemented and distributed the state's nursing protocols, there was no evidence in either the IPNs, comprehensive assessments, or HMPs that the protocols were consistently and/or correctly used to guide and direct nursing interventions during episodes of acute changes in health, ensure that adequate and	

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		appropriate nursing assessments and monitoring of health status changes were completely carried out, and trigger the parameters and time frames for the reporting of signs and symptoms of significant changes in health to the individuals' physician and/or other clinical professionals, as indicated. This failed to corroborate the facility's report that they had actually implemented the nursing protocols. For multiple individuals, their records revealed the following: • Multiple individuals who were sedated for procedures failed to have evidence of implementation of the protocol developed to address pretreatment and post-sedation/anesthesia. Thus, there were significant lapses in close monitoring of individuals who were recovering from various medical procedures. At least one individual (Individual #123) who was sedated stopped breathing. She required emergency medical procedures, and was transported to the hospital. • Individuals who suffered frequent episodes of nausea, vomiting, and diarrhea failed to have evidence of implementation of the protocols developed to address these problems. Thus, individuals suffered complications, such as dehydration and fluid/electrolyte imbalance. • Individuals who suffered episodes of constipation failed to have evidence of implementation of the protocol developed to address this problem. Thus, these individuals suffered repeated use of ineffective interventions, delayed treatment, and heightened risks of impaction and obstruction. • Several individuals who suffered head injuries were not assessed or monitored, in accordance with the head injury protocol. This was especially significant for individuals who suffered more than minor head injuries and were not closely and completely assessed and monitored, as indicated by the protocol. • Individuals who ingested inedible objects failed to have evidence of implementation of the protocol developed to address their pica. As a result of failure to monitor the individuals' stool, there were at least two individuals for whom passage of the objects was not confirmed. • There were uniform failures to implement the SOAP documentation protocol. Thus, there were numerous occasions when there was no evidence that significant changes in individuals' health status were adequately assessed, acted upon, and monitored until resolution. Although it was apparent to the monitoring team that adherence to the protocols was a work in progress, it was not apparent what actions the Nursing Department planned to take, apart from increasing the number of monitoring tools, to help ensure that their nurses would consistently implement the nursing protocols. Since the prior review, the Quality Assurance Nurse continued to provide extensive	

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		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 four areas of nursing care - documentation, skin integrity, infection control, and chronic respiratory distress. She submitted her data/findings to the facility's QA data analyst for analysis and reporting to the Nursing Department. Also see comments in section E of this report. Despite the QA Nurse's challenging job and the occasionally sensitive nature of her findings and recommendations, she continued to make it her business to identify and follow-up to resolution problems observed during her monitoring of individuals at meals and during medication administration, as well as when staff members' responded to the calls for Code Purple. Thus, the QA Nurse's sharp eye, keen ear, and astute recommendations were invaluable to the Nursing Department's strategies to achieve substantial compliance with section M and to the facility's desire to deliver quality care. For example, the QA Nurse recently stepped forward to help the Nursing Department address problems that were identified in the storage, maintenance, and availability of oxygen equipment. A review of the QA Nurse's drafted guidelines, policies, procedures, and protocols revealed a thoughtful analysis of the problem and a much-needed, comprehensive plan for resolution. However, as of the review, no actions had been taken by facility administration to review and/or approve the plan. Since the prior review, the QA Nurse also completed two clinical death reviews of nursing care, both of which were very comprehensive, complete, thoughtful, appropriately critical, and well documented. They 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 either "pending" or not done. 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	At the time of the monitoring review, EPSSLC had completed almost two years 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 monitoring review, there was a focus on improving the area of infection prevention and control. In addition to the expectation that nurses would actively participate in activities to reduce individuals' risks of infections, nurses were required to review the clinical indicators of health risks and maintain their participation in unit meetings, medical rounds, and IDT meetings to	Noncompliance

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	reviews as indicated by the health status of the individual.	ensure that adequate and appropriate discussions of individuals' health risks occurred. According to the self-assessment, this provision was rated, "noncompliant because the Nursing Department does not currently have an effective method of utilizing or assessing the use of clinical indicators in developing nursing interventions." The monitoring team was in agreement with the facility's finding of noncompliance, however, its finding was based upon observations during an ISPA meeting and reviews of 20 sample individuals' records that revealed that the facility failed to develop and implement a reasonable system of assessing, documenting, reviewing, and revising, as appropriate, the health and behavioral risks of individuals served by the facility. One of the most direct ways that the Nursing Department would improve its performance and compliance with the risk assessment and planning processes would be through improving its nurses' assessment and documentation of individuals' indicators of risk and their attendance and participation in the IDT and ISP processes. During the conduct of the review, the monitoring team attended one IDT meeting, for Individual #99. The members of his team and his guardian, who was his sister, attended the meeting. The individual was not present at the meeting, and it was unclear why he failed to attend and/or what efforts were made to encourage and support his attendance. What was clear, however, was that Individual #99's sister was a staunch advocate of his health and safety. At several points during Individual #99's team's discussion of his health risks, his sister voiced her concern, and, occasionally, her frustration over his team's failure to know and report exactly what and how much he ate versus a reiteration of his diet order, whether or not his bowels were regular versus what laxative he received, the results of his diagnostic tests versus technical name(s) of the procedure(s), etc. Although there were several opportunities for the RN case manager to take a lead role in clarifying Individual #99's health status and directly answering his sister's questions and forthrightly responding to her concerns, this failed to occur. The QDPP who chaired the meeting was respectful and undoubtedly well intentioned, but she had been on the job for only one month and was in need of additional training, mentoring, and supervision by a more experienced QDDP. Although the actual assignment of ratings across the specific risk categories was not a focus of the meeting, opportunities to explore and ascertain Individual #99's health and behavioral risk issues were prevalent throughout the meeting. Nonetheless, neither the QDDP nor the RN case manager seized the chance to allay his sister's fears and respond to her challenge of, "It's up to you to tell me what needs to be done to keep him safe." 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	

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		revealed that more than half of the 20 sample individuals failed to have risk ratings that accurately and appropriately referenced the status of their health and behavioral risks. In addition, there were a number of individuals' records that 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 completely follow-up with QDDPs and/or IDT members to ensure that individuals' health risks were addressed in a timely way such that the likelihood of negative health outcomes were reduced, (2) failed to serve as the individual's "health advocate" during the ISP process, and (3) failed to ensure that the health risks that they identified during their nursing assessments were consistently addressed vis a vis health care/risk action plans. Therefore, this provision item was rated as noncompliance. Examples included the following: • Since Individual #148's recent admission to EPSSLC, he lost 22 pounds and was below the lower limit of his IBW range. Nonetheless, there was no evidence that his team met to review his health risks related to his weight loss and subsequent MRSA infection. In addition, his 5/8/12 risk assessment and risk action plan had not been reviewed or revised. Rather, Individual #148's risk assessment continued to reference that his health risks related to his "weight" were "low." • Individual #59 was diagnosed with hypertension. Over the past months, his cardiac medications were changed due to problems with metabolic acidosis and hypotension, and he suffered episodes of orthostatic hypotension. His 11/7/11 risk assessment and risk action plan, however, were not reviewed and revised. • Individual #77's risk assessment and risk action plan were dated 7/18/11. Since that time, she suffered tooth extraction, significant weight loss and weight gain, escalated target behaviors, multiple episodes of constipation, and incontinence. Despite these changes, there was no evidence that her risk assessment and risk action plan had been reviewed or revised.	

#	Provision	Assessment of Status	Compliance
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the prior review, the facility's action plan indicated that the Nursing Department continued to monitor, record, track and trend, analyze, and report indicators of compliance related to medication administration. Prescribing and dispensing errors were now included in the tabulation of medication variances, and corrective action plans were developed as needed. In addition, nurses were provided remedial education and training as needed. The facility's processes related to the administration of medication and the management of the medication administration system continued to improve. In addition, for the first time, the monitoring review revealed that significant improvements in nursing practices were made. 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 standards of care and the Health Care Guidelines, the facility had taken more steps toward improving their procedures for the administration of medications, in accordance with current, generally accepted standards of care. Notwithstanding these positive findings, this provision item was rated as being in noncompliance because there continued to be serious problems in nurse documentation of medication administration records across 19 of the 20 individuals reviewed. During the review, observations of medication administration and enteral administration of medications and nutrition were conducted in the systems building and in the cottages. Two of the four observations of nurses' administration of medications, which were delivered via oral and enteral routes, were administered in accordance with current, accepted standards of practice. The other two observations of medication administration revealed some positive findings, but were still in need of improvement in order to meet accepted standards of practice. • It should be noted that none of the serious problems noted during prior reviews, were observed during the current review. Nurses were much more cognizant of individuals' needs for assistance and support during medication administration and more observant of safe and sanitary administration practices. It was apparent that the Nursing Department's decisions to more closely and critically observe nursing practices and correct deficiencies was working. 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. Nonetheless, there continued to be problems with the accountable administration of medications. The review of 20 sample individuals 6/1/12 - 6/3/12 MARs revealed that 19 of the 20 individuals had multiple missing entries in	Noncompliance

#	Provision	Assessment of Status	Compliance
		their MARs, which indicated numerous potential medication errors in the administration of seizure medications, laxatives, psychotropics, calcium/vitamin D, diabetes medications, anti-hypertensives, eye drops, etc. These problems were not improved from the prior review and continued to raise question over whether, or how, these potential medications errors were reconciled, identified, analyzed, and reported by the Medication Error Committee in their Medication Error Trend reports. During the onsite review, the monitoring team attended the 7/17/12 Medication Error Committee meeting. As noted in prior reviews, the facility continued to implement a strict system of accountability of medication variance. Their analyses, explanations, and responses to medication variances continued to be comprehensive, creative, and complete. According to the monthly data and trend analyses presented at the meeting, as a result of adding prescribing and dispensing errors to the calculation of the facility's total medication variance, the measure temporarily increased. However, the most current data reflected that the total medication variance was, again, on the decline. As noted during all prior reviews, EPSSLC reported that the department responsible for contributing the largest percentage of medication variance to the total variance was the Nursing Department. The most common medication errors continued to be the omission of medications and the administration of the wrong dosages of medications. During the Committee's discussion of these findings, recommendations for follow-up actions and corrections to nursing practices were made. Notwithstanding these positive findings, the results of the Pharmacy Department's monthly audits of bulk stock liquids were, again, striking. The Pharmacy Department's audit revealed that levetiracetam liquid medication prescribed for several individuals lasted from several days to three weeks longer than they should, if administered as ordered. As noted in prior reviews, although the Pharmacy and Nursing Departments immediately took action to address this serious finding, 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. The Pharmacy Department planned to continue to convert as many bulk, stock medications as possible to unit-dose. 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 ways to audit bulk items such as topical preparations, eye drops, etc. • Review, and possibly revise, the current manner in which the severities of the medication errors were determined.	

#	Provision	Assessment of Status	Compliance
		• Select three nurses to be specially trained to conduct medication observations and audits. As of the monitoring review, the above-referenced initiatives were pending further review by the committee.	

Recommendations:

1. Continued assistance from the facility's senior management to support the CNE's development of a strategic plan to effectively utilize the nurses in leadership and management positions to achieve substantial compliance with the provisions of section M (M1-M6).

2. Continue to bring administrative and clinical supports to bear on the facility's nursing education and infection control and management programs and processes to ensure that they fully develop into functioning programs/departments (M1- M6).

3. Consider developing focused, real-time interventions to address the pandemic problem of nurses' documentation, or the lack thereof (M1-M6).

4. Ensure that the position of Nurse Hospital Liaison is filled as soon as possible so that the NOO may be able to fully embrace her role and responsibilities and assist the CNE with planning and implementing initiatives to achieve substantial compliance (M1-M6).

5. Consider ways to reward nurses' positive performance (M1–M6).

6. Consider ways to remove or diminish the barriers to the RN case managers' ability to focus on their main tasks (M2, M3, M5).

7. Ensure administrative follow-up review and finalization of the drafts of guidelines, policies, and procedures for oxygen use and storage (M1).

8. Consider clarifying expectations for nurses in leadership and management positions to lead by example and become regularly involved in the daily delivery of nursing care on the homes (M1-M6).

9. Develop ways to help all nurses understand how they should be using the standardized nursing protocols during their daily routines. (M1–M6).

10. Continue to work on ensuring that nurses consistently document health care problems and changes in health status, adequately intervene, notify the physician(s) in a timely manner, and appropriately record follow-up to problems once identified (M1, M4).

11. Ensure that nursing assessments are complete and comprehensive and conducted upon significant change in individuals' health status and risks (M1, M2, M5).

12. The facility should consider re-evaluating the current healthcare planning approach including the overreliance on standardized, stock care plans versus the development and implementation of person-centered health care plans, interventions, and goals (M3).

13. Consider developing additional strategies to continue to improve the collaboration and cooperation between the Nursing and Habilitation Departments, and especially with the PNMT RN, to improve the coordination of individuals' health care (M1-M6).

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 #009.2: Medical Care, 4/19/12 o EPSSLC Self-Assessment for Section N o EPSSLC Action Plan Provision N o EPSSLC Provision Action Information o EPSSLC Organizational Charts o EPSSLC Prospective Review of New Medication Orders, Revised 2/2012 o Anticoagulation Therapy Protocol, 11/2010 o EPSSLC Quarterly Drug Regimen Reviews, 10/2011 o Physician Orders, December, January – June 2012 o Pharmacy and Therapeutics Committee Meeting Minutes, 2012 o Medication Variance Review Committee Meeting Notes, 2012 o Polypharmacy Committee Meeting Minutes, 2012 o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations, 2012 o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #49, Individual #189, Individual #25, Individual #6, Individual #67, Individual #155, Individual #3, Individual #34, Individual #175, Individual #196, Individual #77, Individual #78, Individual #188, Individual #24 Individual #79, Individual #73, Individual #63, Individual #79, Individual #24, Individual #188, Individual #76, Individual #76 o MOSES and/or DISCUS evaluations for the following individuals: • Individual #162, Individual #15, Individual #104, Individual #32, Individual #161, Individual #191, Individual #28, Individual #90, Individual #2, Individual #63, Individual #46, Individual #44, Individual #40, Individual #70, Individual #1, Individual #126, Individual #10, Individual #13, Individual #69, Individual #18, Individual #57, Individual #80, Individual #13, Individual #61 Individual #195 Individual #119, Individual #127, Individual #27, Individual #77, Individual #157, Individual #76, Individual #96, Individual #100 Individual #52, Individual #60, Individual #89, Individual #67, Individual #54, Individual #113, Individual #83, Individual #79, Individual #12, Individual #7, Individual #3, Individual #74, Individual #56, Individual #116, Individual #123, Individual #8, Individual #39, Individual #37, Individual #51, Individual #108 Individual #82, Individual #36, Individual #31

	Interviews and Meetings Held: o Amista Salcido, PharmD., Pharmacy Director o Giovanna Villagran, PharmD., 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, Chief Nurse Executive o Elaine Lichter, RN, Quality Enhancement Nurse o Veronica Bahner, RN, Clinic Nurse Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Error Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Unit Team Meeting o Pharmacy Department o Tour of pharmacy
	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. The pharmacy director expanded the self-assessment by including additional activities and outcomes. Some of the activities did not directly link to the Settlement Agreement, such as the PAR levels and the Medicare rejection rates, though these were of interest to facility management and QAQI Council. Most activities aligned with a data point or outcome. These data were used to determine a self-rating of substantial compliance or noncompliance. It will be essential for the self-assessment to include everything that the monitoring team evaluates. This can be achieved by reviewing, paragraph by paragraph, the report below, and by including all of those topics in the self-assessment tool. The facility rated itself in substantial compliance with provision items N1, N2, N4, N5, N6, and N7. For provision items N3, and N8, the facility rated itself in noncompliance. The facility remained in substantial compliance with provisions N2, N4, and N7. The monitoring team found the facility in noncompliance with provisions N1, N3, and N6. The facility did not maintain substantial compliance for provision N5.

	Summary of Monitor's Assessment: Progress continued to be seen in most areas of this provision as noted throughout this section of the report. Communication improved between the clinical pharmacists and the medical staff as did documentation of the communication, but the facility had yet to demonstrate a reliable methodology for reviewing the need for additional laboratory testing and ensuring that it was completed prior to issuing medications. Quarterly Drug Regimen Reviews were competed in a timely manner, although the monitoring team identified some problems with the system and the recommendations being generated. The facility continued to have problems in the area of polypharmacy, most notable was the fact that the incorrect definition of polypharmacy was being used. Drug Utilization Evaluations were completed in a timely manner, but the P&T minutes did not always document the discussion of these. More important, the minutes did not provide definitive closure for the corrective actions of deficiencies that were identified with the DUES. The facility continued to struggle with the adverse drug reaction reporting system. Very few reactions were reported and most were initiated by the clinical pharmacist. The intense case analysis was completed by the clinical pharmacist and presented to the P&T instead of being referred to committee for review. The facility continued to make progress with regards to the medication variance system. Over a period of two years, a series of changes were implemented that resulted in decreased omissions and increased accountability with medications. Nonetheless, the CNE believed that the facility had yet to prove that all of the process changes had resulted in sustainable improvements. Finally, the monitoring team is concerned that some practices which benefitted the pharmacy department were discontinued. The pharmacy director believed that data analysis regarding physician prescribing patterns was no longer necessary (N1) and the self-assessment stated follow-up on recommendations related to QDRRs was no longer needed for provision N4. The monitoring team believes that the facility should approach change with a high degree of caution, particularly when the process was one that resulted in measures of success. The monitoring also believes that the pharmacy department will continue to move forward in the achievement of substantial compliance ratings and this will be evident during the next onsite review.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.</td><td>The facility continued to have a well-organized and well-run pharmacy managed by Amista Salcido, Pharm.D. She made good use of the available space and resources within the pharmacy. For example, frequently, infrequently, and mid-frequency prescribed medications were stored in an efficient and thoughtful manner.

The pharmacy director reported that prospective reviews were completed for all new orders through the WORx software program. The program checked the standard parameters, including therapeutic duplication, drug interactions, and allergies.

The policy Prospective Review of Medication Orders was revised in February 2012. The policy outlined the steps used in the process and summarized the dispensing process in a flowchart:
1. The clinic faxes order to pharmacy.
2. The pharmacist performs initial prospective review of order.
3. The pharmacist calls clinic for order clarification and completes medication variance form if necessary. Additional steps for psych meds if required.
4. The pharmacist enters information into the WORx software.
5. The label is printed and order filled by pharmacy technician.
6. The pharmacist reviewed all orders entered by the technician and initials the label.

The monitoring team requested copies of all clinical interventions documented since the last onsite review. A summary of the types of interventions is presented below.

<table>
<tr><th colspan="6">Pharmacy Interventions 2012</th></tr>
<tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th></tr>
<tr><td>Missing Indications</td><td>18</td><td>13</td><td>4</td><td>9</td><td>12</td></tr>
<tr><td>Incomplete Indications</td><td>2</td><td>3</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Inappropriate Indications</td><td>--</td><td>2</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Dosing</td><td>7</td><td>6</td><td>1</td><td>2</td><td>1</td></tr>
<tr><td>DDI</td><td>5</td><td>5</td><td>1</td><td>7</td><td>4</td></tr>
<tr><td>Duration</td><td>2</td><td>3</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Formulation</td><td>4</td><td>4</td><td>1</td><td>--</td><td>1</td></tr>
<tr><td>Duplication</td><td>2</td><td>3</td><td>1</td><td>--</td><td>1</td></tr>
<tr><td>Other</td><td>--</td><td>3</td><td>5</td><td>3</td><td>5</td></tr>
<tr><td>Route</td><td>1</td><td>3</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Not Avail</td><td>2</td><td>--</td><td>2</td><td>2</td><td>1</td></tr>
<tr><td>Non Formulary Drug</td><td>3</td><td>1</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Allergies</td><td>1</td><td>1</td><td>--</td><td>--</td><td>1</td></tr>
<tr><td>No Stop Dates</td><td>--</td><td>2</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Wrong Drug</td><td>--</td><td>1</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Legibility</td><td>--</td><td>1</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Total</td><td>47</td><td>52</td><td>15</td><td>23</td><td>26</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

		Observations, interviews, and document reviews indicated that the medical staff maintained a very good working relationship and communicated frequently with the clinical pharmacists. In the past, the pharmacy director maintained a log summarizing the types of interventions, but this practice was abandoned. The monitoring team did not understand this decision because a specific recommendation was made to maintain data on physician performance and share this with the medical director for the purpose of performance improvement. The pharmacy director responded that pharmacy interventions were not necessarily bad. As seen in the table above, however, many of the pharmacy interventions documented were related to issues that required correction, including incomplete orders, duplicate orders, dosing issues, orders lacking indications, allergy issues, and inappropriate indications. During the conduct of the review, copies of orders received in the pharmacy for the first seven days of the months of January 2012 through June 2012 were also requested. The pharmacy only kept the annotated pharmacy orders for two and maximally three months, per state pharmacy board requirements. In response to the monitoring team's request, the facility submitted a set of orders in which the first four months were reconstructed from emails sent from the medical clinic. These orders did not contain the pharmacy annotations needed for review by the monitoring team. Due to the reconstruction of these orders, it was not certain that the submission accurately captured all orders that were submitted to the pharmacy during the first seven days of the month. 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." Following the onsite review, the pharmacy director submitted additional evidence in order to support substantial compliance. Although the pharmacy director submitted documents following the review, during interviews with the monitoring team, there was no evidence of a clear plan that would support compliance with this component of the provision. Aside from Clozaril and warfarin, the department did not have a definite list of drugs that were monitored prospectively prior to dispensing each order and the pharmacy was not aware of the list of drugs involved in the pilot at other facilities. The pharmacy did not provide any documentary evidence or log to demonstrate that it checked labs on each individual for any certain class of drugs prior to dispensing. There were a few emails provided, but all were dated late June 2012 and July 2012, resulting in	

		the monitoring team's inability to cross-reference these emails to intervention documentation forms. Moreover, the monitoring team could not substantiate this through the review of original orders. It should also be noted that the facility's self-assessment did not provide any data relative to monitoring of prospective lab ordering and none of the Pharmacy Intervention Forms submitted addressed lab monitoring. QDRRs provided evidence that medications were dispended even when labs were not monitored in accordance with that lab matrix.	
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.	Forty QDRRs were reviewed to determine if the facility remained in substantial compliance with this provision item. Overall, the QDRRs were completed in a timely manner. The facility reported 78% compliance with timely physician completion and 83% compliance with timely completion by the psychiatrist. The clinical pharmacists commented on many clinically relevant issues. The monitoring team made several recommendations in the January 2012 report with regards to the content of the actual QDRR report. The QDRR Report, <u>not</u> the worksheets, is the official document that that provides information to the IDT on information related to medication regimens. It is retained in the permanent record. The monitoring team made the recommendation that relevant information, such as monitoring parameters and lab values are included in the report. Throughout this review, the monitoring team observed some element of regression with regards to the quality of the QDRRs. Problems were identified with the process as well as the content of reviews. The following are examples of some general issues which the monitoring team believes the facility must review and remediate: • The QDDRs did not address every drug for which there was a monitoring parameter included in the lab matrix. This new format of generalized documentation was not consistent with the guidelines outlined in the facility's Quarterly Drug Regimen Review Policy as stated in Attachment 2. • Several medication indications (drug profiles) were outdated or inappropriate and there was no recommendation or request to change the indications. • The physicians agreed with every recommendation made by the clinical pharmacists, but it was not evident that the physicians thoroughly reviewed these recommendations. In some cases, the pharmacists repeated recommendations that were actually not necessary and the physicians agreed. The monitoring team found examples where BMDs, eye exams, etc. were recommended on repeat QDRRs, but those studies had already been done. As previously mentioned, there were clinical issues that required attention and/or remediation. There was evidence that some labs were not ordered in a timely manner and	Substantial Compliance

		when ordered, they were not obtained. In some instances, obtaining labs was delayed by months. Required monitoring parameters were not found on several QDRRs and sometimes the required labs or parameters were not documented in the worksheets. The following are a few examples of clinical issues that surfaced through review of the QDRRs: • Individual #195, 5/17/12: This individual was noted to have iron deficiency anemia, erosive gastritis, and thrombocytopenia and was treated with ferrous sulfate. The QDRR Report did not mention the use of ferrous sulfate and did not comment on the individual's Hb and Hct. Rather, it stated that all other routine monitoring parameters were appropriate. The most recent CBC on the worksheet appeared to be February 2012 and it indicated a significant anemia. A follow-up CBC and iron studies would have been warranted given the clinical scenario of erosive gastritis, blood loss, and iron deficiency anemia. The QDRR Report had no comments on this. • Individual #73, 5/25/12: The QDRR Report documented a lithium level of 1.21, but no other information regarding of toxicity was provided in the report. Given that the level was elevated, it would have been appropriate to include notes on the individual's clinical findings during that time. In addition, none of the other lithium parameters were highlighted in the report, such as the EKG and the renal function, and this should have been done. • Individual #175, 5/17/12: The clinical pharmacist noted that the last TSH was 8/26/11 and a recommendation was made to repeat the TSH. The monitoring team did not find a clinical intervention form corresponding to this recommendation and noted that the medication was dispensed without having record of a current TSH. The individual also appeared to need a repeat BMD in 3/12, but no recommendation was made to obtain the study. • Individual #25, 4/30/12: The clinical pharmacist noted "Order to repeat Vit D level written on 8/2/11, results not noted in chart, follow-up on vitamin D level especially due to multiple AEDs and weekly vitamin D dosing." It appeared that the clinical pharmacist believed it was important to have follow-up up on the lab values, yet the medication continued to be dispensed for eight months (August 2011 to April 2012) without this information. • Individual #24, 5/25/12: The individual received olanzapine. According to the lab matrix, weights, waist circumference, and blood pressure were to be monitored. The QDRR Report did not include any of this information. It was also not found on the worksheet, which was a cumulative document. • Individual #79, 5/25/12: The individual received treatment with olanzapine and quetiapine, as well as two antihypertensives. The individual also had a lipid disorder. This individual was at high risk for cardiovascular disease and metabolic syndrome, yet the QDRR simply stated the blood pressure was at goal and labs due: FLP last 8/31/11. There was no statement with regards to the individual's risk for metabolic syndrome.	

		• Individual #63, 3/9/12: The individual had osteoporosis and vitamin D deficiency. The vitamin D level was 24 in December 2011. The individual was treated with weekly vitamin D and subsequently received monthly vitamin D, but the QDRR contained no recommendation to repeat the level and no follow-up vitamin D was noted in the records. It is unknown if the individual's treatment was adequate. • Individual #162, 7/9/12: This individual received carbamazepine and multiple other AEDs. The lab matrix required that a CBC be obtained every six months. Three QDRRs (January, April, and July of 2012) were reviewed and none reported the results of the CBC. • Chlorhexidine was dispensed for daily use although dental policy specifically indicated it was to be used for only the first 14 days of the month. The pharmacy director was not aware of this. The MARs indicated it as used on a daily basis and it was refilled on a monthly basis indicating it was used or not being reconciled appropriately. This was seen on all MARS reviewed and went unnoticed across all clinical disciplines. Finally, the lab matrix continued to lack important monitoring parameters that are consistent with the generally accepted professional standard of care. Important examples include monitoring for complications of metabolic acidosis for individuals who received topiramate, appropriate monitoring of renal function for those receiving lithium, and inclusion of the requirement for eye exams for those receiving quetiapine. The laboratory matrix also included diabetes guidelines that did not correctly interpret the ADA guidelines. Moreover, the matrix cited the 2010 ADA standards. Since 2010, the ADA has released the 2011 and the 2012 standards. The 2012 standards were available at the time the lab matrix was revised. Finally, the revision of the lab matrix continued to include medical guidelines that were not consistent with state issued policy. In fact, the guidelines for colonoscopies, PSAs, and other screenings were not consistent with those found in the facility's Preventive Care Flow Sheet. The facility should consider removal of preventive care guidelines from the laboratory matrix and utilize the preventive care flowsheet to track these requirements. In order for this provision to remain in substantial compliance the following information will need to be noted on the QDRR Report: • The QDRR Report should comment on every medication that is included in the lab matrix, even if it increases the length of the report. The exact value should be provided with the date as well as an indication of the range of values. • The lab matrix must be updated to reflect current practice standards, such as the requirement to complete eye examinations when receiving quetiapine.	

N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications were documented in the QDRRs. For each use, there was a comment related to the indication. The use of prn meds is discussed further in section J. <u>Polypharmacy</u> The facility continued to monitor the use of polypharmacy through the Polypharmacy Oversight Committee and P&T Committee. At the time of the onsite review, the facility was utilizing the wrong definition of polypharmacy rendering inaccurate data. This is discussed in detail in section J. <u>Anticholinergic Monitoring</u> Each of the QDRRs commented on the anticholinergic burden associated with drug use. The risk was stratified as low, medium, or high. Generally, there were no recommendations made on how to further minimize the burden, but overall, attention was given to this issue. <u>Monitoring Metabolic and Endocrine Risk</u> The facility monitored individuals for the metabolic risk through the QDRRs that were completed quarterly. The laboratory matrix included several monitoring parameters, including glucoses, HbAlc1, weight, lipid panels, waist circumference, and blood pressure. A review of QDRRs showed that, in many instances, these monitoring parameters were not applied on a consistent basis. The monitoring team has made the recommendation that pertinent information, such as monitoring parameters and lab values, are included in the report. The QDRR reports reviewed did not include information, such as waist circumferences, weights, and blood pressures. Moreover, the worksheets also did not include the waist measurements. Specific examples are discussed in N2. Overall, the monitoring team did not believe that the QDRRs adequately assimilated the information on monitoring the risk for the endocrine and metabolic risk for use of the new generation antipsychotic medications. This information may have been included in psychiatric documents.	Noncompliance
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the provider's responses to both prospective and retrospective reviews. Based on the documentation provided, the providers accepted the recommendations made by the pharmacists during the prospective and retrospective reviews. The medical director and psychiatrist agreed with 100% of the recommendations made by the clinical	Substantial Compliance

	and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	pharmacist. The self-assessment stated, "100% of recommendations were accepted during this rating period, therefore, no other follow-up was needed." Throughout the conduct of this review, the monitoring team saw evidence that recommendations were accepted, but there was no appreciable action on the part of the physician. This was particularly noted when recommendations were made to make changes in bowel management plans (discussed in section L). The monitoring team, therefore, disagrees with the approach that no follow-up is needed because all recommendations were accepted. In order for the facility to maintain substantial compliance with this provision item, the monitoring team must find unequivocal evidence that the physicians continue to accept and implement the recommendations of the clinical pharmacists. The pharmacy director must maintain some data related to this provision item as was done for previous reviews. The pharmacy director will need to maintain some data showing that the primary provider and psychiatrist not only accepted, but also implemented, the recommendations of the clinical pharmacist.	
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.	A sample of the most recent MOSES and DISCUS evaluations submitted by the facility in addition to the most recent evaluations included in the active records of the record sample was reviewed. The findings are summarized below: Thirty-eight MOSES evaluations were reviewed for timeliness and completion: • 38 of 38 (100%) were signed and dated by the prescriber 35 of 38 (92%) documented no action necessary • 3 of 38 (8%) documented actions taken, such as drug changes and monitoring Forty-five DISCUS evaluations were reviewed for timelines and completion: • 45 of 45 (100%) were signed and dated by the prescriber • 45 of 45 (100%) indicated no TD Although the psychiatrist completed the required sections of the evaluations, it appeared that there was a significant decline in how this process occurred. Little attention appeared to be devoted to completion of the forms. For example, when scores were noted to increase and numerous relevant comments were made by the evaluator, the psychiatrist simply noted "no action necessary." The self-assessment also documented that 22% of the evaluations completed in 2012 were "noted as overdue" because they were waiting for signatures from the physician before being placed in the record. The Neurology clinic template added the MOSES and DISCUS dates to the templates. None of the neurology clinic notes reviewed included any actual information on the scores or data.	Noncompliance

		All documents reviewed were completed by the psychiatrists at EPSSLC. Reviews of documents, such as Annual Medical Assessments, neurology clinic notes, and integrated progress notes indicated that primary providers and neurology consultants were not utilizing information captured in these side effect rating tools when making treatment decisions. The facility must demonstrate that the evaluations are completed in a timely manner, are adequately completed, and are utilized in clinical practice. Providing adequate training to healthcare practitioners on the value, use, and requirements for completion of these tools may be helpful in achieving these goals. The clinical pharmacist also noted in the QDRR that the consulting neurologist indicated that the DISCUS evaluations for one individual could be discontinued since the offending medication was no longer used. The monitoring team recommends continued DISCUS evaluations for some period of time (minimum of six months) in those cases where medications can mask symptoms of tardive dyskinesia. The decline in the quality of the physician reviews and the facility's self-identification of overdue evaluations resulted in loss of substantial compliance for this provision item.	
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 maintained a system for reporting adverse drug reactions. Training was provided to nursing, direct care professionals, psychology, and habilitation staff. This represented good progress. Notwithstanding increased training, reporting of ADRs remained limited, with a total of 10 ADRs reported from January 2012 to June 2012. Record reviews indicated many suspected ADRs could have been reported, including weight changes, anemia, thrombocytopenia, elevated liver enzymes, acidosis, kidney stones (topiramate), and carbamazepine toxicity. In addition to the overall general sense of under reporting, the monitoring team identified a series of issues with the facility's ADR system: • The majority of the reporting was completed by the pharmacy staff. 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 recognize and report adverse drug reactions. The medical staff will need to become fully engaged in this process, recognizing ADRs and initiating reporting of ADRs in a timely manner. The ADR form should clearly identify who is reporting the ADR. The ADR form needs revision to avoid confusion related to initiation versus submission (see recommendations). • The January 2012 monitoring report recommended that the policy be revised, such that an intense case analysis could be performed for cases other than those that required hospitalization. The wording of the current policy did not appear to change that approach. There are circumstances under which severe and/or fatal	Noncompliance

		ADRs occur and those must be reviewed quickly. Therefore, it would not be appropriate to await the return of an individual from a hospitalization if prolonged. The ADR policy must provide a definite and appropriate risk management approach to deciding which ADRs will be investigated. It must also clearly outline the timeframes for review, and the participants. o An intense case analysis should be conducted as a multidisciplinary review with participation by the CNE, pharmacy director, QA department, and medical director, as well as an appointee of the facility director. The findings should be presented in a written report. A corrective action plan should be developed, implemented and followed through to completion. The Pharmacy and Therapeutics Committee and Quality/ Risk Management Committee should both monitor the outcome of this process. Facility policy should assign definitive oversight to one committee. The facility self-rated this provision item as being in substantial compliance. In the self-assessment, the pharmacy director reported on the number of staff trained, the ADR policy and form, and the accessibility of the ADR form to staff. The self-assessment also commented on a review of the ADR forms, indicating that two intense case analysis were completed. The monitoring team, however, found this provision to be in noncompliance because: 1. ADRs were under reported. 2. ADRs were reported primarily by the pharmacist and should be reported by all clinical staff. The medical staff must report ADRs as they see individuals and observe ADRS/suspected ADRs (e.g., carbamazepine toxicity, nephrolithiasis secondary to topiramate) 3. An appropriate risk strategy for identification and management and review of serious cases was not implemented.	
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	The facility completed one DUE each month. Since the last onsite review, DUEs were completed on acetaminophen, statins, dilantin, Keppra, topiramate, and colonoscopy preps. The acetaminophen DUE was performed in response to an FDA safety announcement regarding the increased risk of hepatotoxicity associated either APAAP use. The facility's data showed 81 individuals received the limit of 4 gm/day and the recommendation was made to place a limit of the 3 gm/day. The March 2012 P&T minutes documented June 2012 as the projected completion date for corrective action, but subsequent minutes never documented closure of this corrective action. The statin DUE was conducted in response to the FDA's revision of guidelines for monitoring of liver enzymes. As a result, the facility removed the requirement for	Substantial Compliance

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<td>standards of care with regard to this provision in a separate monitoring plan.</td>
<td>monitoring LFTs and adding Hba1c monitoring.

The facility should cautiously approach the removal of monitoring parameters for the individuals living at the facility because many individuals are not capable of verbalizing complaints of illnesses in the same manner as the general population.

As a general principle, the facility must always take into consideration, state issued guidelines and protocols prior to altering local policy, particularly when making protocols less stringent. The medical director should always ensure that the facility is utilizing the most current guidelines. The pharmacy director referred the monitoring team to the 2010 ADA standards. Two additional iterations have been released with the current version being 2012.

While it is not mandatory that DUEs be completed on a monthly basis, in order to maintain substantial compliance, DUES must be completed in accordance with the Health Care Guidelines and facility policy. There must be adequate documentation in the Pharmacy and Therapeutics Committee meeting minutes of discussion of the DUEs and there must be an appropriate plan of correction for deficiencies identified during the conduct of the evaluations. Specific concerns were noted in the January 2012 review and recommendations were made with regards to the need to have an adequate system for implementing correction actions and follow-up when deficiencies were identified.
The P&T minutes of the April 2012 meeting documented no DUE discussion, but reported that two DUEs were discussed last month. There did not appear to be a March 2012 P&T meeting and the February 2012 meeting minutes documented only the acetaminophen DUE discussion. The May 2012 minutes covered the Keppra DUE and the June 2012 meeting addressed topiramate.

In order for the facility to maintain substantial compliance for this provision item, DUEs will need to be completed in accordance with policy and procedure and the P&T minutes will need to clearly document a discussion of the DUE. Corrective action plans will need to be developed (identified in the minutes) and closure must also be identified in the P&T minutes.</td>
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<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 are summarized in the table below.

<table>
<tr><th colspan="6">Medication Variances 2011 - 2012</th></tr>
<tr><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td></tr>
<tr><td>56</td><td>69</td><td>60</td><td>84</td><td>131</td><td>112</td></tr>
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The fluctuations in the number of variances likely represented the changes in reporting</td>
<td>Noncompliance</td>
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		practices. The facility began reporting all errors including prescribing errors. Over a period of two years, many processes were implemented that contributed to safer medication practices at EPSSLC: • Multiple checkpoints and reconciliations produced a significant decrease in the number of omissions and bin omissions. • Many bulk liquids were converted to unit doses. • There was collaboration between medical, SLP, and pharmacy to reduce prescribing errors. • Several respiratory medications were converted to unit doses to increase accountability. During discussion with the CNE and pharmacy director, both believed that positive changes had occurred and that the facility was headed in the right direction. The CNE was quite frank in stating that the medication database had just been implemented and the facility did not have adequate data at the time of the onsite review to support a rating of substantial compliance.	

Recommendations:

1. The facility will need to take a number of steps in order to move towards compliance with Provision N1. The monitoring team offers the following recommendations for consideration:
    a. The pharmacists should continue to document communication with prescribers as required by facility policy. The outcomes of the interventions should be documented.
    b. There should be clear documentation of the prescriber who is contacted and the time of contact.
    c. The pharmacy director will also need to have a process for tracking prescriber responses and making referrals to the medical director when appropriate. This would involve having some ability to track the acceptance of recommendations.
    d. The pharmacy director, in conjunction with the medical director, should seek addition guidance from state office on development of the drug list for completion of the prospective reviews.
    e. The facility will need to determine how it will provide documentation that drug monitoring occurs.
    f. The pharmacy director and clinical pharmacist should ensure that the prospective reviews are appropriately connected with other pharmacy monitoring systems, such as the ADR monitoring and reporting system, such that a pharmacy intervention that identifies an ADR appropriately triggers the ADR system.

2. The following actions should be taken into consideration with regards to the QDRR:
    a. The QDRR Report should comment on every medication that is included in the lab matrix. The exact value should be provided with the date as well as an indication of the range of values.
    b. The lab matrix must be updated to reflect current practice standards such as the requirement to complete eye examinations when receiving quetiapine.

3. The clinical pharmacist/pharmacy director should follow-up on the most critical recommendations before the next quarterly QDRR (N4).

4. The facility must ensure that employees (medical and nursing) have adequate training on completion of the MOSES and DISCUS evaluations. Documentation of training and attendance should be maintained (N5).

5. The medical director must ensure that the MOSES and DISCUS evaluations are completed in accordance with state medical policy. The PCP must complete the MOSES evaluations. The evaluations should be provided to the neurologist for review and three must be evidence that these assessments are being utilized in clinical decision making. (N5).

6. The facility should take multiple actions with regards to the ADR reporting and monitoring system:
    a. The ADR policy should specify how the reporting form is completed.
    b. ADRs should be reviewed by the primary provider, clinical pharmacist, and medical director. All three should be required to sign the ADR reporting form.
    c. The form should indicate who initiated it (two staff cannot submit it).
    d. The facility must ensure that all medical providers, pharmacists, nurses, 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
    e. The facility should review ADRs in accordance with facility policy and procedure (N6).

7. The facility must conduct DUEs in accordance with facility policy and procedure. Discussion of DUEs must be documented in the P&T minutes. Corrective action plans must be developed and followed through to completion. (N7).

8. The clinical leaders of the facility, medical, nursing and pharmacy, must ensure that staff are reporting all medication variances, actual and potential, in accordance with state policy (N8).

9. The pharmacy director should ensure that appropriate reconciliation of all liquid medications is being completed and documentation is being maintained in a format that can be retrieved and reviewed (N8).

10. The medical, nursing and pharmacy departments should continue their collaborative efforts to ensure that proactive steps occur to improve medication practices at the facility (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o EPSSLC client list o Admissions list o PNMT Staff list o PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section-Physical Nutritional Management o EPSSLC PNMT Process (2/10/12) o PNMP Review Process (2/23/12) o Protocol for Passing Competency NEO and Refresher March 2012 o Competency-Based Training Steps for Validation Group o SSLC Policy 012.2 Physical Nutritional Management (4/23/12) o PNM/PNMT spreadsheets and trend summary reports submitted o PNMT Assessment template o Other PNM assessment templates submitted o HOBE template o List of PNMT Meetings (1/2/12 to 5/31/12) o PNMT Meeting documentation (1/2/12 to 5/31/12) o Individuals with PNM Needs o Risk Action Plan Audit findings o At Risk PSP Review Tool o PNM Monitoring tool templates o Completed Individual PNMP Monitoring Forms submitted (5/12) o Individual Mealtime Monitoring Forms submitted (5/12) o Completed IDT Mealtime Monitoring Forms submitted (5/12) o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o List of PNMP monitoring completed in the last quarter o List of hospitalizations/ER visits/Infirmary Admissions o Summary List of Individual Risk Levels (6/4/12) o Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o Poor Oral Hygiene o Pneumonia 6/1/11 to 6/10/12 o Individuals with Choking Incidents and related documentation

	o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown/Pressure Ulcers in the Last Year and Active Pressure Ulcers o Skin Integrity Meeting Minutes (5/24/12) o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Wheelchair seating assessments/documentation submitted o Individuals Who Use Ambulation Assistive Devices o Orthotic Devices o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPS submitted o Preventative Maintenance Spreadsheet (12/11 – 3/12) o Maintenance Log o ISPA for PNMT meeting for Individual #115 (7/17/12) o PNMT Assessments, Risk Assessments, Action Plans and ISPs/ISPAs: • Individual #52, Individual #9, Individual #120, Individual #90, Individual #46, Individual #178, Individual #191, Individual #115, Individual #28, Individual #39, Individual #93, Individual #161, Individual #63, Individual #100, Individual #74, Individual #32, Individual #162, Individual #59, Individual #109, Individual #112, Individual #155, and Individual #38 o APEN Evaluations: • Individual #90, Individual #161, Individual #113, Individual #93, Individual #71, Individual #162, Individual #92, Individual #155, Individual #10, and Individual #57 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #67, Individual #70, Individual #191, Individual #32, Individual #112, Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 o PNMP section in Individual Notebooks for the following: • Individual #67, Individual #70, Individual #191, Individual #32, Individual #112,

	Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: • Individual #67, Individual #70, Individual #191, Individual #32, Individual #112, Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 <u>Interviews and Meetings Held</u>: o Susan Acosta, PT, Clinical Coordinator o Cynthia Diaz, RN o Eric Herrera, PT o Jennifer Ochoa-Evers, MOT o Karin De La Fuente, MS, CCC/SLP o Donna Rice, RD/LD o Denise Jones, FNP o Adrian Rascon, RD o Melissa Prado, RD o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs (on and off-site) o PNMT meeting o Meeting with Dietitians and FNP
	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. Susan Acosta, PT, the Clinical Coordinator, had outlined specific assessment activities, some of which were based on the previous reports by the monitoring team. She attempted to quantify each and presented findings in the self-assessment report as well as supporting documentation that demonstrated specific accomplishments or steps. The Presentation Book provided extensive information related to actions taken, data presented to illustrate elements assessed and an analysis of the findings, accomplishments, and work products. The most important next step for Ms. Acosta is to minimally revise the existing audit tool for section O. While it contained some elements that would be useful to assessing compliance with this provision, others clearly were not. A revised/new version of this tool may be used in addition to the other indicators identified by Ms. Acosta.

	The activities for self-assessment listed for each provision were numerous and will not be listed here. The findings were presented in narrative form and it may be useful to supplement that with data in a graph or table format to illustrate change and improvements over time. Further analysis in a brief narrative or list format and to identify barriers to achieving compliance may be easier to prepare and review. An action plan to address identified issues can illustrate how Ms. Acosta intended to proceed with continued progress toward compliance. Evidence contained in the Presentation Book may not need to be so extensive, but rather provide simple examples to supplement the self-assessment or action plan items. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the clinicians and Ms. Acosta and believes that the facility was continuing to proceed in the right direction. Ms. Acosta is commended for her thorough and detailed approach to this process. The data used for self-assessment was generally meaningful, but a streamlined approach to the presentation that is clear and precise would be helpful (e.g., graphs). That information would then be used to guide actions for subsequent months. Even so, while these were appropriate self-assessment activities, they were not the only activities necessary to self-assess substantial compliance. Careful review of the monitoring report will provide additional insight into essential measures for self-assessment. The monitoring team discussed approaches to self-assessment with the Ms. Acosta and it is hoped that this provided a clear direction for the future. The facility self-rated itself as noncompliant with all four items of O (O1 through O8). While actions taken were definite steps in the direction of substantial compliance, the monitoring team concurred with this finding.
	Summary of Monitor's Assessment: There was a clear and definitive difference between where the Habilitation Therapies were now relative to a year ago. Susan Acosta, PT, Clinical Coordinator was meeting the challenges enthusiastically and was continually seeking ways to improve the supports and services provided by the department. She established a strong and comprehensive infrastructure and, if anything, should now be able to hammer down on specific areas to fine tune, such as streamlining documentation, training, and monitoring. There needs to be a simplification of the many tracking systems in place and focusing on the elements of the Settlement Agreement by evaluating outcomes now that processes and systems were in place. There was a fully-constituted PNMT, including a full time nurse. While the team met twice each week, attendance was less than adequate for the nurse, though this should be now remedied with the addition of Cynthia Diaz, RN, to the team. A meeting observed during this review showed significant improvement since the last review. Ms. Diaz was seen as a competent leader, appeared to understand PNM and the team process, and was a good facilitator of the meeting. It is recommended that the team consider revising their methods of documentation to be more concise, while clearly identifying outcomes and team actions. The action plan should not be separate, but rather

	built into the IDT action plans. The QDDPs attended these meetings inconsistently, though future routine attendance and participation should permit better integration. There were concerns with issues related to weight loss/low weight for approximately 25 individuals that had not necessarily been identified by the IDTs. It was not acceptable to overlook significant weight loss because an individual continued to fall within his or her calculated ideal body weight range. There were issues identified related to nutrition services in previous reports by the monitoring team and these continued to be of concern. Contract hours, availability for ISPs and ISPAs, communication, and timeliness of actions should be examined. Forty to 60 hours a month was not sufficient to effectively address the nutritional needs of 126 individuals. There may be other trends that require attention from a systems approach as well as from an individual-specific perspective. There continued to be concerns related to mealtimes and position and alignment, though both areas were improved. There should be a focus on the less complicated seating systems because many were in poor condition and did not provide proper support and alignment. The therapists would benefit from continuing education in the area of wheelchair seating assessment and selection. QAQI Council should carefully examine issues around staff competency-based training and compliance monitoring. There was a tremendous amount of training and monitoring being done, yet staff could not and/or did not fully comply with their responsibilities related to implementation of PNM plans. It is likely that there were many issues that influenced this problem, one of which would be the disjointed approach to training and monitoring across departments. It must also be understood that achieving compliance with this section depends on the cooperation and collaboration of all EPSSLC staff.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of	Core PNMT Membership: The current core team members of the PNMT were Cynthia Diaz, RN, Eric Herrera, PT, Jennifer Ochoa-Evers, MOT, Karin De La Fuente, MS, CCC/SLP, and Donna Rice, RD/LD. There was no physician core team member. Alternates were assigned for the all positions except the nurse, who was the only full time dedicated team member. Mr. Herrera, Ms. Rice, and Ms. De La Fuente were part-time at EPSSLC, but their primary assignment at the time of this review was to the PNMT. With the exception of Ms. Diaz, all team members were assigned to the PNMT during the previous review, while she began this assignment on 4/3/12. She was a state employee while all other team members were contract. The OT was full time at EPSSLC, serving on the PNMT and was assigned a caseload on the systems therapy team (36 individuals). Additional participants on the team included PNMT technician, nurse case managers, QDDPs, direct support professionals, home managers, and other IST members of the individuals reviewed as indicated. The PNMT did not function independently of the IDT.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	<u>Continuing Education</u> Continuing education was documented for each of the core members of the team in the last six months and some included the alternates as well. Team members had participated in webinars, Introduction to PNMT in August 2011, and attended PNMT training in August 2011. The 2012 Annual Habilitation Conference sponsored by DADS was scheduled for 9/20/12-9/21/12 and there were plans to support team members to attend this key training. Additional continuing education was documented related to PNM included the following and attended by one or more core team members: • Lower Extremity Ulcers: Arterial vs. Venous • Vestibular Rehabilitation in the Military Setting • Effective Neurological Management of Sensory Processing Disorders • Management of Dysphagia Across the Lifespan • Optimizing Nutritional Intervention in Surgery • Demystifying Fats • Fatty Acids and Inflammation • Addressing Dementia and Alzheimer's Disease in a Community Based Organization Serving Individuals with Developmental Disabilities: Focus on Nutrition • Impact of Nutrition on Acute Ischemic Stroke Outcome • Dysphagia – A Perspective on Sensory and Behavior Problems • Rifton Inservice-Intervention with Adaptive Equipment • Cognitive Rehabilitation Therapy This level of continuing education was adequate. It is critical that this team continue to achieve and maintain the highest possible knowledge and expertise in the area of PNM. Consideration of continued PNM-related continuing education opportunities for all team members, in addition to the state-sponsored conferences/webinars, should be a priority. As stated in section P below, an important focus for continuing education should be in the area of wheelchair seating assessment in the very near future. <u>Qualifications of Core Team Members</u> Ms. Diaz practiced as a RN since 2006 with previous experience as medical/surgical nurse and a peritoneal dialysis nurse prior to starting at EPSSLC in 2008. Background and experience for the other team members was reported in previous reviews. The facility submitted verification of current licensure for each core team member. <u>PNMT Meeting Frequency and Membership Attendance</u> There were generally twice weekly meetings held from 1/3/12 through 5/31/12, 43 listed in total. This frequency was appropriate. Attendance during that period was: • RN: 67%, no alternate designated	

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		• PT: 100% with alternate • OT: 98% with alternate • SLP: 95% with alternate • RD: 93% no alternate designated • PNMPT Technician: 81% • MD: 2% • Psychiatrist: 5% • FNP: 5% • QDDP: 95% • RN Case Manager: 47% • Home Manager: 0% • Psychologist: 21% • Other (nurse, OT, PT, SLP, administrators, not otherwise designated as alternates): 86% On average, attendance by the core team members was acceptable with the exception of the nurse. There had been a significant lag in the availability of a nurse, though Ms. Diaz was now full time. There was no designated alternate as yet for this position. Alternates did not consistently attend meetings in the absence of the core team members for the SLP or RD. Attendance by a physician was minimal. Attendance by the core PNMT members was generally consistent since 4/3/12. It is critical that all core team members participate in each meeting because this is key to the provision of appropriate and adequate services. <u>Role of the PNMT: Facility PNMT Policy</u> A policy PNMT process (revised 2/10/12) outlined the referral process, assignment of Levels of Involvement, and PNMT member responsibilities. Appropriate referrals included individuals at high risk who were not stable and/or for whom the IDT required assistance in the development of an intervention plan to address PNM concerns. This included the IDT, of which the PCP was a member, and self-referrals by the PNMT based on review of key clinical indicators. Self-referrals were generated through PNMT nurse attendance at the unit meeting. She emailed information gathered at these meetings and individuals with hospitalizations and other issues were placed on the agenda for discussion and/or referral as indicated. The PNMT was to meet within five days to assign a Level of Involvement determined by review of existing assessments and interventions in place with the IDT.	

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		Levels of Involvement (LOI) were defined as follows: • Level 1/High Risk (LOI1): Individuals at high risk and for whom the team needs extra assistance. These individuals were formally served by the PNMT. • Level 2 (LOI2): Individuals at medium or high risk or who had a change in status, had a diagnosis of aspiration pneumonia within one year, and those who received enteral nutrition and determined to require assistance from the PNMT. This included, but was not limited to, hospital transition planning, risk assessment with rationale, action plan development and monitoring. • Level 3 (LOI3): Individuals identified or suspected of change or potential change in status and/or risk, either formally or informally. These were also individuals who had transitioned to the IDT for primary care from LOI1 or LOI2 requiring minimal assistance from the PNMT. A comprehensive PNMT assessment was completed only for individuals determined to be LOI1. An Action Plan was developed by the PNMT and integrated into the ISP within five days of this LOI assignment. Once the Action Plan was finalized in conjunction with IDT, it was implemented in no more than 14 days. When the individual had met all stated objectives and the issues for which the individual was referred were stabilized, the plan was placed back with the IDT for primary responsibility with oversight provided by the PNMT. AT LOI2 the PNMT completed a PNMT-IDT Assistance and Integration Assessment and Plan within five days of this LOI assignment to review and update risk ratings, action plans, Aspiration Pneumonia and Enteral Nutritional Evaluations (APENs), PNMPs, additional assessments, and to define roles and responsibilities for PNMT/IDT members. When the Action Plan was determined to be adequately implemented to reduce and stabilize the concerns for which the individual was referred, the individual was transitioned to LOI3. At LOI3, the PNMT outlined recommendations in the Primary IDT Management Plan within five days of this LOI assignment. This LOI consisted of meetings with the IDT and a brief summary report.	
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	<u>PNMT Referral Process</u> Since 1/3/12, the PNMT had reviewed a large number of individuals who were identified as active cases at LOI1 or LOI3 and others who were scheduled for discussion only. There was no one designated as LOI2. The PNMT reviews were as follows: • LOI1: seven individuals (Individual #93, Individual #115, Individual #191, Individual #113, Individual #90, Individual #39, and Individual #28). • LOI3: 13 individuals (Individual #39 was transitioned to this level from LOI1).	Noncompliance

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	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.	• Discussion only: 24 individuals not also with a designated LOI. Others included referrals requiring no action: • Individual #109, Individual #47, Individual #9, Individual #120, Individual #46, Individual #178, Individual #18, Individual #43, Individual #56, Individual #108, Individual #38, Individual #112, and Individual #59. There were 13 individuals who were transitioned to their IDT after receiving supports from the PNMT: • Individual #161, Individual #155, Individual #21, Individual #103, Individual #71, Individual #92, Individual #113, Individual #10, Individual #74, Individual #40, Individual #52, Individual #28, and Individual #107. It could not be readily determined how many individuals had received a comprehensive PNMT assessment since the previous onsite review by the monitoring team. Assessments completed in the last two months were requested and submitted. Additional assessments were also submitted as part of the individual records for the sample selected. Assessments were reviewed for Individual #191 (9/12/11 and 5/24/12), Individual #39 (2/23/12), Individual #115 (9/13/11), Individual #28 (5/10/12), Individual #93 (12/20/11), and Individual #90 (12/20/11 and 4/5/12). Only Individual #28 was referred by the IDT, while each of the others was self-referred by the PNMT. In addition to these comprehensive assessments, there was extensive documentation, but while it was thorough, it was not very user friendly. The monitoring team appreciated the efforts by the PNMT to ensure that all actions were well-documented; but the current system appeared to be excessive and may be difficult to sustain. Most importantly, it was difficult for others to locate what was probably very important information. A referral to the PNMT (self-referral, or from the IDT) and a LOI1 assignment meant that there was an urgent need for specialized supports and services and, as such, the assessment process should be completed in a timely manner, that is, in a month or less. Upon referral, the PNMT Referral Form and Level of Involvement Assessment document was completed that documented IDT actions, RN physical examination, and a rationale for the LOI assignment. The assessment was driven by the Assessment Plan developed that assigned specific tasks and due dates. This system was very good to ensure that all issues were addressed for inclusion in the assessment report. Action plans were developed for each though these were generally developed after the assessment was completed. Due to the urgency of a condition warranting referral, actions	

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<tr><td></td><td></td><td>to address identified needs should be implemented as indicated during the assessment process rather than waiting for the finalized plan.

The EPSSLC PNMT developed a PNMT Action Plan in conjunction with the IDT that outlined responsibilities related to PNMT recommendations and actions from the PNMT assessment, rather than integrating these into a revised IDT Action Plan (which they may want to consider in the future). It is likely that there was already an existing plan for risk issues not addressed by the PNMT and this would prevent there being multiple plans. As with the other plan, the QDDP would be responsible for ensuring that all aspects of the plan were implemented appropriately and in a timely manner as outlined in the plan. This information is a key element to the effective provision of services by the PNMT and should be tracked and analyzed. Actions outlined in the plan were reviewed at the PNMT meetings and follow-up/outcomes were documented for each. In the case that an individual was hospitalized, the PNMT RN completed a post-hospitalization assessment of status to ensure that the individual's needs were clearly identified and met. Comprehensive assessments submitted were completed as follows:

<table>
<tr><td>Name</td><td>Date of Referral</td><td>Assessment Date</td></tr>
<tr><td>Individual #93</td><td>11/29/11</td><td>12/20/11</td></tr>
<tr><td>Individual #115</td><td>8/30/11</td><td>9/13/11</td></tr>
<tr><td>Individual #39</td><td>2/16/12</td><td>2/23/12</td></tr>
<tr><td>Individual #191</td><td>9/8/11</td><td>9/12/11</td></tr>
<tr><td>Individual #191</td><td>9/8/11</td><td>5/24/12 (re-eval)</td></tr>
<tr><td>Individual #90</td><td>1/17/12</td><td>1/19/12</td></tr>
<tr><td>Individual #90</td><td>1/17/12</td><td>4/5/12 (re-eval)</td></tr>
<tr><td>Individual #28</td><td>4/18/12</td><td>5/10/12</td></tr>
</table>

All were completed in less than one month and most in less than two weeks, with the exception of the re-evaluations.

<u>PNMT Assessment and Review</u>
The eight assessments listed above for individuals identified as LOI1 were reviewed. These were generally of a similar format, though the more current assessments were more thorough in content. These included an extensive review of individual risk levels by the IDT at the time of the assessment and rationale for each. It was not clear if these were the rationales reported by the IDT or only as reported by the PNMT. Most of the documentation appeared to be from extensive record review.

There were clinical assessments in the following areas: nursing physical assessment, nutritional health, oral hygiene and oral care, medication administration, mealtime</td><td></td></tr>
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		strategies, dysphagia evaluation, positioning and mobility status, behavioral challenges, medical issues related to PNM risks, and physical clinical indicators. Most of these did not indicate a hands-on assessment as little clinical data were reported other than in the nutritional section and in the functional mobility sections. Though it was stated that a mealtime observation and dysphagia assessment were conducted, the information documented was minimal (e.g., Individual #28). While health and medical history were necessary to gain perspective on the individual's current status, it was critical that hands-on assessment of current status be documented by all team members. • It was also important the PNMT gain a new and perhaps different perspective on issues for the individuals they review. If only the existing information was used, it would be unlikely that a new, improved plan would be developed to address serious PNM health issues as indicated by the reasons for referral. • Other aspects of the written report did not consistently reflect use of the data presented, particularly the analysis section. • There were a number of recommendations buried in the body of the report and not carried through to the recommendations section and, as such, could be lost as a result (Individual #90). The assessments reviewed generally followed the state-established PNMT assessment template with some appropriate modifications. The assessments consistently recorded the referral source, date of referral, and reason for referral. The assessments reviewed the IDT assigned risk levels in each category and the rationales established by the IDT. There was no clear evidence that the team made any judgment as to the accuracy of these levels in the assessment, though it was reported that they often met with the IDTs to re-assess risk levels with the IDTs. The analysis should capture the PNMT's opinions. Head of bed evaluations were consistently completed as indicated and often were a primary finding by the team. The analysis of findings was weak and did little to present the clinical reasoning used to interpret the primary issues and to select specific interventions and supports. The recommendations were scattered throughout the report and were not compiled at the end to ensure that they were included in the Action Plan. Finally, the clinical indicators were not defined, such as established thresholds, baselines, or clinical criteria. This IDT meeting for individual #115 was observed by the monitoring team. The meeting was well-managed by the Cynthia Diaz, the PNMT nurse. All participants were well-prepared and this resulted in meaningful discussion and plans for additional actions required. An ISPA was prepared by the QDDP to reflect the findings, actions and recommendations from the meeting, which was reported to be a routine practice.	

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		Unfortunately, as described above, the system of documentation by the PNMT, while thorough, was excessive and difficult to track for those not directly involved in the process. This primarily pertained to the discussion logs and action plans. For example, the plans for Individual #90 (2/2/12 – 4/12/12 and revised 4/12/12 – 5/24/12) and Individual #191 (10/18/11 – 1/10/12 and revised, 1/10/12 – 5/31/12) were in excess of 15 pages (Individual #90) and over 40 pages (Individual #191). Again, while the PNMT is commended for its efforts and dedication to complete and accurate documentation, the monitoring team challenges them to evaluate the current system to identify ways to streamline the process and resultant documentation. There were no individuals classified as LOI2, so documentation of this level of supports was not possible. For those classified as LOI3, documentation consisted of the Recommendations for IDT Action Plan and the PNMT Individual Discussion log. Again, the action plans were separate from the one developed by the IDT, and it was difficult to determine how the two were integrated (e.g., Individual #161). There was a concern regarding individuals at the LOI3 level of intervention because the PNMT appeared to focus on the identified reason for referral only, rather than on an integrated comprehensive approach. The purpose of the PNMT was to look beyond what may be examined by the IDT to find the root cause of problems, examine antecedents and the interrelationship of health risk concerns to design, and implement effective intervention plans. An example involved Individual #32. He was self-referred to the PNMT on 12/15/11 due to frequent falls. This was identified via the hospital report reviewed that indicated he had a broken nose after a fall on 12/13/11 with sutures needed after a fall on 11/22/12 and possible mandible fracture after a fall on 10/7/11 (x-ray negative). He had experienced 12 falls since 1/1/11, six of which resulted in injuries. The PNMT reviewed Individual #32 with a focus on the falls only from the time of referral through 7/26/12. During the time that these reviews were being conducted, Individual #32 had also experienced significant weight loss. He had shown a steady weight loss from 171 pounds in May 2011, perhaps due to an 1800 calorie diet implemented on 3/31/11. At that time he was considered overweight with a BMI of 25.9. His weight history since that time was as follows: • September 2011: 162 pounds • December 2011: 153 pounds • January 2012: 155 pounds • February 2012: 142 pounds • March 2012: 141 pounds • June 2012: 138 pounds	

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		The evidence of continued weight loss should have triggered assessment in at least February 2012 when he had lost more than 5% of his weight in one month. While there were ISPAs held related to his falls, none mentioned weight loss. When discussing weight issues with staff at EPSSLC, the repeated response was that the individual was within his ideal weight range. It is standard to be concerned with unplanned weight loss of 5% in one month or 10% in six months. Certainly, with any ongoing weight loss, careful monitoring was indicated to address undesired weight loss and to determine if there were other mitigating issues. The PNMT did not examine any key clinical indicators per the documentation so also missed this potentially critical health concern for Individual #32. This was one example of many weight loss or low weight concerns for individuals living at EPSSLC identified by multiple members of the monitoring team during the week of this onsite review (Individual #114, Individual #112, Individual #172, Individual #25, Individual #99, Individual #73, Individual #63, Individual #2, Individual #104, Individual #28 Individual #118, Individual #154, among others). Of the approximately 25 individuals with weight concerns identified by the monitoring team, only five were identified at high risk for weight and another two were identified as medium risk. All others were considered to be at low risk, including Individual #32 described above. There were 11 individuals (9% of the census) with a BMI under 18, considered to be underweight and eight individuals (6%) listed with unplanned weight loss of 10% over six months as of June 2012. There were six others with a BMI less than 20, which while they may be considered to be at a normal weight, would suggest that these individuals were in the low end of their weight ranges. With any additional weight loss, these individuals would be at greater risk for related health concerns and diligent monitoring was required. There were17 individuals with BMIs greater than 30, in the obese range. Clearly the IDTs did not fundamentally understand the purpose of assessing risk in an ongoing, comprehensive manner with full IDT representation to examine the interrelationship between risk categories and all health, medical, and behavioral indicators and findings. A meeting was held with the Adrian Rascon and Melissa Prado, the clinical dietitians, the PNMT nurse, Cynthia Diaz, the PNMT dietitian, Donna Rice, Clinical Coordinator, Susan Acosta, PT, and Denise Jones, FNP to discuss this and barriers they experience as very part-time contractors at the facility (only 20-30 hours a month each). Time available, communication, timely notification, and follow-up were cited as concerns. It is critical that the facility examine these issues promptly and effectively to ensure health and safety and minimize risk of harms related to nutritional concerns. Only the diet technician was available for ISP meetings, another significant concern to the monitoring team.	

#	Provision	Assessment of Status	Compliance
		Risk Assessment Risk rating tools and action plans were submitted for the 16 of 17 individuals (88%) in the sample for whom individual records were requested, though both documents were not available for Individual #32, Individual #15, Individual #34, Individual #90, Individual #61, Individual #112, and Individual #74. These tools were to be completed by the IDT at the time of the annual ISP with routine review after post-hospitalization or other changes in status. An action plan was developed to manage or mitigate identified risks. There were a number of inconsistencies in the risk ratings for a number of individuals. Though improved since the previous review, there was no rationale provided for a particular rating in some cases and ratings were often inconsistent with clinical indicators. Some examples are below. • Individual #61 was identified at low risk for diabetes, largely because she had no personal history of this disease. This completely discounted that her maternal grandmother and aunt had diabetes and she was in the obese range, BMI of 33.3. • Individual #90 was identified as low risk for diabetes with the rationale that he did not have a history of this disease rather than identifying whether he presented with any conditions that would predispose him to diabetes. He was also identified at high risk for fractures with a rationale that he had previous fractures and not that he had a diagnosis of osteopenia. • Individual #32 was identified at low risk for weight though it was reported that he had experienced a six pound weight loss in one month per his risk assessment. • Individual #112 was identified at low risk for weight though it was reported that he had a weight loss of three pounds per month over a four month period. It was stated that this may have been planned as he was on a lower calorie diet. It was of great concern that none of the team members who participated in this assessment knew if weight loss was intended and that, if they did not, they did not seek that information from the dietitian. He was also identified at low risk for diabetes, but did have a positive family history of the disease. • Individual #63 was identified at high risk for weight (5/10/12) as it was reported that he lost 35.4 pounds since April post hospitalization. He was eating only about 50% of his meals at the time of the assessment. His action plan indicated that he should receive a nutritional assessment. A quarterly review note (5/24/12) by the dietitian indicated that he weighed 171.8 in April 2012 with a seven pound weight loss since February 2012. At that weight and a BMI of 25.36, he was considered to be borderline overweight. It was of concern that the dietitian did not follow-up regarding reported weight loss to obtain a more current weight for May 2012.	

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		The action plans associated with the risk rating tools generally contained only routine care and protocols for the risk identified rather than individualized and/or more aggressive interventions. Referrals to the PNMT were not made appropriately by the IDT, but rather the PNMT self-referred individuals as they deemed necessary.	
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> It was reported that at all individuals living at EPSSLC (126) had identified PNM needs and were provided PNMPs. Comments below relate only to the 17 PNMPs submitted for the individuals in the sample. Improvements in the format and content were noted and the plans were generally very good. They were each written in first person language, which was a positive feature. Audits of these plans had been completed on a monthly basis to address consistency with content, format and first person language. Improvements in the implementation of the plans were also observed. • PNMPs for 17 of 17 individuals in the sample (100%) were current within the last 12 months. • PNMPs for 17 of 17 individuals in the sample (100%) were of the same format and consistent with the most current state-established format that included risk levels, triggers and outcomes. • PNMPs for 17 of 17 individuals in the sample (100%) included a list of risk areas, but did not specify the actual risk level as high, medium, or low. Each of those listing the risk areas also provided a brief rationale. • In 17 of 17 PNMPs (100%), photographs of positioning and/or adaptive equipment were included. The photographs were generally large and easy to see,. A few of the black and white copies were difficult to see (Individual #104, Individual #25, Individual #63, Individual #99, Individual #112, Individual #34, and Individual #125, among others). For that reason, only color copies should be made available for staff reference in all locations. The size of the photographs also varied across plans. • In 17 of 17 PNMPs (100%), positioning was addressed. • In 10 of 11 PNMPs (91%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included, though generally minimal. • In 17 of 17 PNMPs (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 17 of 17 PNMPs (100%), the PNMP had a distinct heading for bathing instructions. • In 2 of 17 (12%) of the PNMPs, toileting instructions were provided. In some other plans there was a reference to toileting, but assistance instructions were not clearly stated.	Noncompliance

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		• In 17 of 17 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning or the individual was listed as independent. • In 17 of 17 PNMPs (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • There were 2 of 17 individuals who had feeding tubes. The PNMPs indicated nothing by mouth as indicated for these individuals (100%). • In 15 of 17 PNMPs (88%), dining position for meals or enteral nutrition was provided via photographs. • 15 of 15 individuals who ate orally (100%) had Dining Plans current within the last 12 months contained in the individual record or book. • In 15 of 15 PNMPs (100%) for individuals who ate orally, diet orders for food texture were included. • In 15 of 15 PNMPs for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 15 of the 15 PNMPs for individuals who ate orally (100%), dining equipment was specified in the dining equipment section or that none was prescribed. • In 17 of 17 PNMPs (10%), a heading for medication administration was included in the plan. • In 17 of 17 PNMPs (100%), a heading for oral hygiene was included in the plan. • 17 of 17 PNMPs (100%) included information related to communication, specifically the optimal communication strategies. Though three individuals were listed with talking photo albums (Individual #70, Individual #67, and Individual #25), only one, Individual #70, had specific instructions for its use in his PNMP. <u>Integration of the PNMPs in the ISPs/ISPAs</u> There were 17 ISPs submitted for the 17 individuals included in the sample selected by the monitoring team. Only 16 of those were current within the last 12 months (Individual #15's plan expired on 6/20/12). ISP meeting attendance by the following team members was as follows for the current ISPs included in the sample for whom signature sheets were present in the individual record (also see section F above): • Medical: 18% • Psychiatry: 35% • Nursing: 100% • RD: 0%, a diet technician attended 76% • Physical Therapy: 41% • Communication: 47% • Occupational Therapy: 41% • PNMPC/Therapy Technician: 12% • Psychology: 88%	

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		• Dental: 71% It would 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 by the IDTs. The Physical Nutritional Management Plan was referenced in 12 of the 17 current ISPs (71%). The sections varied as well as the content. Actual review of the PNMP by the IDT was indicated in the new format ISPs. In some cases, specific strategies were included and the required changes identified. In others, it was mentioned only that the individual had a PNMP. In some cases, the discussion appeared to relate to edits in wording of the instructions rather than a substantial discussion and review of the efficacy of the strategies included in the plan. This did, however, reflect a significant improvement in this area since the previous review by the monitoring team. Training for QDDPs was conducted to address this issue, with an annual and quarterly review of the PNMP documented in each document. A follow-up audit had not yet been conducted to determine if this was being adequately implemented.	
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>PNMP Implementation</u> PNMPs and Dining Plans were developed by the therapy clinicians with variable input by other IDT members. Attendance by PNM-related professionals at the ISP meetings was limited and, as such, discussion and input would be limited. There was evidence of ISPAs for required changes in the PNMPs. Unfortunately, these documents were not readily available to all staff, rather only the annual ISP document was included in the individual notebooks, thereby, creating a potential gap in information for direct support staff. Continued efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should improve 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. Wheelchair positioning instructions were generally not individual-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 NEO and in individual-specific training provided by the therapists and PNMPCs.	Noncompliance

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		Observations There was clear improvement related to mealtimes in the homes observed by the monitoring team and, as before, this was most notable in the systems area dining room. All individuals observed in both the systems and the cottage areas, however, had current dining plans. No food texture, liquid consistency, or adaptive equipment errors were observed. Instructions on several dining plans, however, were not in the sequence of implementation which may be confusing to staff, but otherwise were improved. A few notable concerns related to implementation as well as continued snack time issues are presented below: • Individual #40: During a snack in the day program area, staff offered her pudding using a breakable plastic spoon. The PNMP indicated that she should use a brown unbreakable spoon because she bit down on the spoon. She was also supposed to have an adaptive bowl and long spouted cup. None were available. Her PNMP indicated that she was to eat with hand-over-hand assistance using a universal cuff for the spoon. If she refused then staff could help her. The staff did not offer her the opportunity to do this. The staff reportedly was a senior employee, working at EPSSLC for many years. There was evidence of training on Individual #40's dining plan on 8/19/11, 4/25/12, and 5/25/12. None of this appeared to be competency-based, but rather only informational related to changes in the dining plan (equipment changes). o Issues pertaining to positioning for snack time in this home were noted in the previous monitoring review as well. Special seating was provided for those who needed it and stools for staff to sit on were provided in response to the concerns identified at that time. It would be important for clinicians to examine the entire environment in the day program areas, both on and off campus. • Individual #191: Instructions for independent eating were not included on the most current Dining Plan. He was not provided a beverage throughout his meal, though staff reported that they came by periodically to ask him if he wanted a drink or they waited for him to call out to ask. No staff stayed with him throughout his meal. It was noted that staff did not offer one until prompted to do so. There were no instructions related to this in his Dining Plan. • In home 513, concerns were again noted related to the proper implementation of Individual #52's plan. The staff again left a full pitcher of thin liquids, unsupervised, on Individual #52's table. This created a risk of her pouring out this liquid, drinking it and aspirating. This happened during previous observations by the monitoring team and recommendations were to ensure a safe environment during the meal. Individual #52 was prescribed thickened liquids. These were provided to her.	

#	Provision	Assessment of Status	Compliance
		• In home 510, there were 11 individuals with only two staff, including two individuals who required one to one assistance to eat and drink. The other individuals in the home were milling about with no focused activity. The staff reported that they frequently had difficulty keeping one individual from leaving the home. Positioning and alignment were also improved over previous onsite reviews, though not always consistent with the plans. As before, staff attention to detail was lacking. Every individual was screened for ergonomic mealtime chairs and these were provided to those who needed them. Rolling stools had been provided for some homes, but these was a notable omission in other homes where staff continued to stand to assist at meals. It was noted that many of the less complex wheelchairs were in poor condition and did not provide adequate support and alignment. Individuals with this type of seating system should become a focus for assessment, modifications, and/or new systems as needed. Several of these were also noted by Susan Acosta and she concurred that this required attention. The majority of staff struggled to verbalize the rationale for the strategies in the plans and to answer questions related to individual health risks. It had been recently determined that the previous questions asked of staff were rote and practiced and did not reflect assimilated knowledge related to their role in the provision of PNM supports and services. The questions were to be changed every three months in an attempt to address this issue. <u>Choking/Aspiration Events</u> There was one choking incidents since the previous review (Individual #57, 3/20/12). He required abdominal thrust to clear a piece of sausage. This was the second such incident of him grabbing sausage in four days. Individual #57 was to take nothing by mouth and all nutrition and hydration was by enteral tube. This was deemed a supervision issue and the IDT implemented changes in his plan to address this. Unlike in the previous review when it was noted that choking incidents were not reviewed by the PNMT (Individual #39, 1/2/12 and multiple others previously), this case was reviewed on several occasions. The PNMT had referred Individual #39, completed a PNMT assessment, implemented an action plan with his IDT, and did routine follow-up. He had not had a subsequent choking event, but will require ongoing supports from the PNMT. Both men were listed at HIGH risk for choking.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure	<u>New Employee Orientation</u> There was extensive staff training provided across each of the key content areas related to PNM supports and each of these was competency-based. In most cases, the training was provided by licensed professional staff with the exception of dysphagia and	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	communication. This was of concern to the monitoring team and the facility should evaluate this practice. The materials submitted were clear, well-organized and very thorough with regard to content. Of course, the effectiveness of any training depended on the instructor's ability to accurately and clearly present the content in a manner that is fun and interesting for adult learners with sufficient opportunities for practice. All competency-based training clearly stated outcomes and expectations for performance. EPSSLC met these standards in most areas. In the past, significant concerns were identified by the monitoring team related to content and instructional methods in some aspects of the training provided. The content areas appeared to have been corrected and were generally excellent. Though it was not possible to observe any training during this onsite visit to assess instructional methods, this will be a priority for the subsequent review. Training materials were submitted for the PNM training for NEO. New employees participated in NEO classroom training prior to their assignment in the homes and completed initial competency check-offs for specific skill sets related to PNM and communication. PNM/OT/PT topics were conducted across four full days, an increase from six month ago. The training materials had been updated to reflect changes in processes since the previous review and the checklists had been revised as well. Staff were required to sign an acknowledgement that they had been trained on the following: • Fundamentals of the PNMP and dining plans and their content • Responsibilities to review these prior to working with an individual • Responsibility to review the Dining Plan before every meal and snack • Documentation associated with the PNMP • Expected that when asked they understood that they had been trained on these things It could not be determined from the materials submitted, however, if there were sufficient opportunities for active practice of the skills necessary for appropriate implementation of PNM plans, particularly related to the mealtime aspect of the training. Previous observations of the physical management aspects confirmed that these were largely hands-on practice. Detailed checklists for practice as well as assessment competency check sheets and written tests were used for each of these curricula across numerous content areas for each aspect of PNM training, including: • Stand-pivot transfer • Two-person transfer • Repositioning • Mechanical lift transfer • AFOs (orthotics)	

#	Provision	Assessment of Status	Compliance
		• Gait belt • Gait Trainer • Mealtime positioning • Palm protector • Adaptive dining equipment • Food texture • Liquid consistency • Communication competencies were outlined in Section R of this report These were detailed and appropriate depending on who was conducting the competency check-off for staff. Successful completion of these check-offs established competency for foundational PNM skills. In the case that a DSP did not pass competency skills in three attempts, that employee's name was to be sent to the Director of CTD and deemed "not suitable" for hire. These procedures became effective as of March 2012. After attending NEO training and completing the initial competency checks, each DSP reported to the assigned home supervisor and completed validation of home-specific competencies within seven days of assignment. This was conducted prior to completion of the shadowing period and before being assigned a caseload in the home. Validators (PNMPCs and home supervisors) were identified by Habilitation therapists and were also validated to complete this process initially and for two consecutive quarters. Re-validation of validators was completed annually. The same process for establishing ongoing competencies for these areas was applied to refresher training in that if an existing employee did not pass within three attempts, he or she would be referred to the Director of CTD for corrective action and would not be permitted to work with individuals until passing the competency check offs. Additional staff training was also provided since the previous review. These included pre-survey training for DSPs reviewing transfers, repositioning, wheelchairs, the PNMP and risk levels, mealtime and the dining plan, and communication strategies. Training for Mealtime Coordinators (described below) for all residential supervisors and back-up supervisors and Communication Moment training (described in Section R) was provided to administrators, DSPs, QDDPs, therapists, psychologists, and nurses. Both of these were provided in March 2012 (May 2012 for the nurses). Additional training for the PNMPCs and habilitation therapy technicians was provided on a monthly basis related to PNMPs, theme-based education, photography for support plans, AAC, wheelchair positioning, monitoring, competency-based training, communication with difficult people, mealtime coordinator and mealtime assistive equipment. Theme-based informal training included gait belts, re-positioning, communication	

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		Individual-Specific PNMP Training A professional staff audit of PNMPs and Dining Plans was conducted after the last review. It was identified that there were 29 plans requiring specialized non-foundational training of staff for appropriated implementation of the plans. Individual-specific inservice training for PNMPCs and the direct support professionals was provided by licensed professional staff upon the introduction of a new strategy or plan or if there were major changes made in an existing plan (non-foundational as taught in NEO). There were approximately 36 individuals with PNM needs whose staff required this type of training to effectively implement their PNMP and/or dining plan. In the case that there was a change in implementation, competency-based training was provided. If the change was minor or was a clarification, an inservice was provided without check-off. If further staff training was required, the therapists established competency of the PNMPC and home supervisors who then completed cascade training for the additional staff. By report, the trainers required demonstration with a skills-based check-off to establish the competency of staff. There was extensive evidence that this system was in place for each program change for training the DSPs. Again this will be a focus of future reviews by the monitoring team. It was policy that staff were not to work with an individual at high risk until they had been trained and checked off. Per the monitoring results, it was common for staff to report that they had not been trained to implement an individual's PNMP. Pulled staff were required to review all aspects of the PNMP. Pulled staff were required to request needed training and clarification from supervisors and/or Therapy Services as necessary. Training of these staff was not listed as role for the Mealtime Supervisors in each home. It was of concern that training for pulled staff relied on them merely reading the plans and being expected to ask questions. It was of concern because these staff could be assigned to an individual with high risk health concerns.	
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	Monitoring Staff Competency and Compliance A system of Mealtime Supervisors (or designated and trained back-ups) had been developed in that they were assigned to be on duty during meals in each home. These staff had participated in a competency-based training regarding their roles. These staff, who were already acting supervisors, were able to serve as an additional level of monitoring for staff and individuals. Their responsibilities included the following: • Check the dining room environment • Ensure that equipment and supplies were readily available	Noncompliance

#	Provision	Assessment of Status	Compliance
	plans.	• Ensure that dining plans were present • Ensure that diet textures, liquid consistencies and adaptive equipment were correct as per the plans and diet cards • Assist individuals to get or be served their food • Monitor for proper positioning, independence, etc. • Assist staff with positioning before, during and after meals, providing seconds and refilling beverages, replacing utensils as needed, assist in cleaning the area, securing assistance form DSPs, professional staff, nursing as needed • Ensure that dining plans were implemented properly and that aspiration triggers were recognized and documented • Notify the proper staff of any concerns Monitoring of staff competency and compliance was documented on a variety of monitoring forms. Ongoing compliance monitoring was tracked by individual name rather than staff name, so it was not known if all staff were monitored. Frequency of this monitoring, conducted largely by the PNMPCs, was reported to be based on individual risk levels established by the IDT. Individuals at high risk in an area were monitored by the PNMPCs at a prescribed frequency. There was a database related to monitoring and findings, with consistent review and analysis. These findings should be reviewed and used for the self-assessment, as well as to drive corrective actions and training. Monitoring findings based on the completed forms submitted for May 2012 (62) were as follows: • PNMP (90) o 100% (17) o 90% (12) o 80% (27) o 70% (4) o 60% (8) o No score (22) Approximately 62% of the PNMP monitorings had a finding of compliance (80% or above) for this month. It was noted, however, that 39% of the forms had one or more "no" findings documented, but only six of these (18%) had any documentation of action taken related to correcting a problem identified, training provided to staff or steps need for follow-up.	

#	Provision	Assessment of Status	Compliance
		• Mealtime (87) o 100% (46), one of these had a "no" finding and should have been scored at 71% (Individual #128) o 90% (15) o 80% (6) o 70% (3) o 60% (0) o 50% (2) o No score (15) 77% of the PNMP monitorings had a finding of compliance (80% or above) for this month, based on the forms submitted and reviewed by the monitoring team. It was noted, however, that 78% of the forms reviewed had one or more "no" findings documented. Only five of these (7%) had any documentation of action taken related to correcting a problem identified, training provided to staff or steps need for follow-up. • Home Mealtime Monitoring o "No" answers =0 (64) o "No" answers =1 (27) o "No" answers =2 (10) o "No" answers =3 (1) o "No" answers =4 (5) o "No" answers =5 (2) o "No" answers =7 (3) It appeared that a number of these were duplicates. There were 112 forms submitted with the findings as listed above. There were 15 forms that documented a need for staff re-training, though the monitor had marked "yes" for all indicators, indicating that there were no issues identified. There were 11 forms also documenting a need for retraining or interventions required related to the issues identified by the monitor, three others indicated training was provided, but was unrelated to the issues documented by the monitor. Four other forms identified issues that would require follow-up, but there was no way to determine if this had been done. For example, there were not enough stools for staff to sit on to be able to sit at eye level (Home 512). In one case, there were not enough staff to assist at the meal (B dorm). The monitor notified that Mealtime Supervisor and educated them on their roles and responsibilities. Follow-up training and monitoring would be necessary in this case. An extensive tracking system was in place.	

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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: The current monitoring system for implementation compliance and staff competency was to be based on individual risk levels. While this type of monitoring focused on staff performance, it was tracked per individual rather than by staff. This was different than monitoring that focuses on the individual's health status and the impact of supports and services on health, function and risk levels. Thus, there was a need for greater focus on individual status monitoring and review of triggers, in addition to compliance monitoring. Individual status was generally evaluated routinely and effectively for individuals followed by the PNMT, but compliance monitoring data were not utilized. The monitoring team discussed this with the PNMT during their meeting. The potential links between the two should be identified via routine trend analysis. There was little evidence of this type of review conducted for individuals not served by the PNMT. Effectiveness Monitoring: Effectiveness monitoring of the PNMPs was conducted at least quarterly as well as through compliance monitoring and through validation monitoring. There was no mechanism to clearly report this, however. These forms were not a part of the individual record, so this information remained separate. Consideration for how this could be addressed was needed. Equipment and supports were reviewed for implementation, but often stopped short of actually assessing or analyzing the impact on function, health, or risk levels. In most cases, the effectiveness of interventions and supports were not consistently and specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians. A similar approach should be incorporated into the quarterly/monthly reviews. Similarly, this kind of analysis should be incorporated into routine, consistent documentation of other direct and indirect interventions. Effectiveness monitoring and additional staff training would be indicated related to changes in environments for homes, day programs, and work environments. For example, an excellent effort was made to integrate a select group of individuals to participate in community-integrated day programming. It was reported, however, that some EPSSLC staff at these programs had not received individual-specific training related to their PNM needs and risk issues. This was due, in part, to many of these staff not being the regular staff typically assigned to the individuals and would not likely have been trained beyond the training provided in NEO and annual refreshers. It is critical during the planning of these exciting projects that issues, such as training, are worked out and that those responsible for training be notified in a timely manner so that they could evaluate and provide what was needed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There were 20 individuals who attended the community multi-purpose center five mornings a week, nine individuals who attended the senior citizen program three mornings a week, and 35 individuals who attended on a rotating basis (four at a time) two mornings a week. Approximately 17% of the individuals attending required individual-specific, non-foundational competency training for transfers, wheelchair positioning, gait belt assistance, or splint application. By report, the regular staff assigned to these individuals had received this training, but it would not have been provided to pulled staff unless requested. These programs should be monitored to identify any issues requiring assistance from the therapists and to identify any needed training. <u>Validation of Monitoring by PNMPCs:</u> Inter-rater reliability observations of the PNMPCs were accomplished via regularly scheduled validation monitoring conducted by the licensed clinicians. This complemented the competency-based training provided to ensure continued effectiveness and accuracy of the PNMPCs in conducting their job responsibilities. <u>Trend Analysis:</u> Information gathered from the various types of monitoring was entered into a database with monthly analysis and reporting by the Clinical Coordinator. Trends or concerns identified were addressed via corrective action plans within the department and collaboratively with other departments if determined to be more systemic in nature.	
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.	<u>Individuals Who Received Enteral Nutrition</u> There were 15 individuals listed who received enteral nutrition. Only Individual #90 was listed as having received a new tube placement since the previous review. Individual #191 and Individual #161 received oral intake for nutrition, hydration, and medications. All others were NPO (nothing by mouth). Four individuals who received enteral nutrition were also listed with poor oral hygiene (Individual #71, Individual #155, Individual #103, and Individual #1). The list submitted that identified individuals with pneumonia in the last 12 months included six incidences for six individuals from 6/1/11 to 6/10/12. Two of those individuals received enteral nutrition (Individual #63 and Individual #90) and Individual #191 ate orally. Individual #191 and Individual #90 were considered to be at High risk for aspiration. Those listed with aspiration pneumonia included Individual #191, Individual #63, and Individual #90. Of these, Individual #191 and Individual #90 were assessed by the PNMT and Individual #63 was reviewed at LOI3.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There were three other cases of pneumonia (Individual #57, Individual #74, and Individual #39) that should not necessarily be ruled out as aspiration. Individual #57 was considered to be at High risk for aspiration. Each of these was also assessed (Individual #39) or reviewed by the PNMT (Individual #74 and Individual #39). Individual #191 was classified as high risk for GI problems and constipation/bowel obstruction. Individual #90 was listed as high risk for respiratory compromise. These may further increase their potential for acquiring aspiration pneumonia. Of the 15 individuals who were identified with enteral nutrition, there were 10 for whom APEN assessments were submitted for review. While it was positive that these assessments were completed, many did not actually provide a sufficient rationale for continued enteral tube use. The monitoring team does not specifically challenge that any of these individuals should not have a tube or receive enteral intake, but improvements in documenting the rationale for this were indicated based on the assessments reviewed. <u>APEN Assessments</u> A sample of APEN assessments was requested and submitted for at least 10 individuals for whom these were completed since the previous review and 10 were submitted. Each of these assessments was completed and current from 12/13/11 to 5/24/12. Per the policy, each individual who received enteral nutrition and each individual who was diagnosed with aspiration pneumonia should receive one of these assessments completed by the IDT on an annual basis (Individual #90, Individual #161, Individual #113, Individual #93, Individual #71, Individual #162, Individual #92, Individual #155, Individual #10, and Individual #57). Each of these individuals received enteral nutrition. Only Individual #90 was listed with aspiration pneumonia, though Individual #162 was listed with pneumonia, ruled out. Several of these individuals also received oral intake and attempts to return others to some level of oral intake were reported (Individual #71 and Individual #93), though they were returned to NPO status for a variety of reasons. These reports documented an extensive medical history. There was great variability in the content of the analysis of findings. Most were minimal and the rationale was not clearly stated. It was absent in two of the reports (Individual #162 and Individual #113). The initial rationale for enteral eating was identified early in the report, but there was limited evidence that all clinical information was used to determine if enteral nutrition continued to be appropriate and medically necessary at the time of the assessment. Measurable outcomes were outlined in the separate Risk Action Plan and attached. In two cases, that plan indicated that there should be follow-up to further explore potential for oral intake (Individual #161 and Individual #92). It was not clear that this follow-up had occurred in a timely manner.	

#	Provision	Assessment of Status	Compliance
		PNMPs All individuals who received enteral nutrition in the selected sample had been provided a PNMP that included the same elements as described above.	

Recommendations:

1. Evaluate the many tracking systems and simplify these focusing on the elements of the Settlement Agreement by evaluating outcomes now that processes and systems are in place (O1 – O8).

2. It is recommended that the PNMT consider revising their methods of documentation to be more concise, yet clearly illustrate outcomes and team actions. The action plan should not be separate but rather built into the IDT action plans. The QDDPs attended these meetings inconsistently, though routine attendance and participation should permit better integration (O1).

3. Incorporate pertinent findings into the analysis as rationale for recommendations and interventions. Many recommendations were scattered throughout the report and care should be taken capture these at the end of the report in a single list (O2).

4. Define clinical indicators to guide the IDT to recognize the need for specific actions such as referral back to the PNMT as in established thresholds, baselines or clinical criteria, for example. Access the existing data system for risk, and occurrence of key clinical indicators and/or diagnoses to drive better identification of a need for PNMT review. This should effectively impact the referrals from the IDT as well as for self-referral (O2).

5. The facility should carefully examine the contract hours for the dietitians to ensure improved availability for ISPs and ISPAs, communication with other team members and timeliness of actions. Forty to sixty hours a month of nutrition services is not sufficient to effectively address the nutritional needs of 126 individuals (O2).

6. Consideration of continued PNM-related continuing education opportunities for all team members, in addition to the state-sponsored conferences/webinars should be a priority. As stated in Section P below, an important focus for continuing education should be in the area of wheelchair seating assessment in the very near future (O1).

7. The PNMT should review their current system of documentation to ensure that it is thorough yet concise and useful to the full IDT (O2).

8. Take steps to better integrate the PNMT Action Plan with the IDT plan. Ideally this should be a single plan developed in collaboration with both teams (O2).

9. Focus assessment efforts on individuals with off-the-shelf seating systems for modifications, and/or new systems as needed (O3).

10. Report monitoring data in assessments and use this information during meetings to better evaluate the effectiveness of interventions, supports and plans, as well as staff competency and compliance (O7).

11. Evaluate training and monitoring needs of the off-site day programs (O5).

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o EPSSLC client list 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 QA/QI Report January 2012 and April 2012 o PNMP Review Process (2/23/12) o Protocol for Passing Competency NEO and Refresher March 2012 o Competency-Based Training Steps for Validation Group o Settlement Agreement Section P: OT/PT Audit forms submitted o PNM spreadsheets and trend summary reports submitted o List of Individuals Who Received Direct OT and/or PT Services o List of SAPs/Indirect OT/PT Services o OT/PT/SLP Assessment template o Other PNM assessment templates submitted o HOBE template o Risk Action Plan Audit findings o At Risk PSP Review Tool o PNM Monitoring tool templates o Completed Individual PNMP Monitoring Forms submitted (5/12) o Individual Mealtime Monitoring Forms submitted (5/12) o Completed IDT Mealtime Monitoring Forms submitted (5/12) o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o List of PNMP monitoring completed in the last quarter o List of hospitalizations/ER visits/Infirmary Admissions o Summary List of Individual Risk Levels (6/4/12) o Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o Poor Oral Hygiene o Pneumonia 6/1/11 to 6/10/12 o Individuals with Choking Incidents and related documentation o Individuals with BMI Less Than 20

	o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown/Pressure Ulcers in the Last Year and Active Pressure Ulcers o Skin Integrity Meeting Minutes (5/24/12) o Fractures o OT/PT/SLP Assessment Audit results o Tracking log of OT/PT/SLP assessments completed o Assessment Referral Spreadsheet o Individuals with PNM Needs 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/SLP Assessments for individuals recently admitted to EPSSLC: Individual #146, Individual #148, Individual #147, and Individual #13 o OT/PT/SLP Assessments, ISPs, ISPAs, SAPs/SPOs and other related documentation for the following individuals: • Individual #28, Individual #195, Individual #16, Individual #113, Individual #161, Individual #80, Individual #157, Individual #59, Individual #8, Individual #78, Individual #134, Individual #109 o OT/PT/SLP Assessments and Audits for the following: • Individual #107, Individual #24, Individual #184, Individual #89, Individual #16, Individual #4, Individual #77, 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),) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #67, Individual #70, Individual #191, Individual #32, Individual #112, Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 o PNMP section in Individual Notebooks for the following:

	• Individual #67, Individual #70, Individual #191, Individual #32, Individual #112, Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #67, Individual #70, Individual #191, Individual #32, Individual #112, Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 <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, DPT o Rocio Alvarenga, OTR o Sandra Moreno, PTA o Frank Diaz DeLeon, COTA) o PNMT members o PNMP Coordinators o Various supervisors and direct support staff o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs (onsite and offsite)
	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. Susan Acosta, PT, the Clinical Coordinator, had outlined specific assessment activities, some of which were based on the previous reports by the monitoring team. She attempted to quantify each and presented findings in the self-assessment report as well as supporting documentation that demonstrated specific accomplishments or steps. The Presentation Book provided extensive information related to actions taken, data presented to illustrate elements assessed and an analysis of the findings, accomplishments, and work products. The most important next step for Ms. Acosta is to minimally revise the existing audit tool for section P. While it contained some elements that would be useful to assessing compliance with this provision, others clearly were not. A revised/new version of this tool may be used in addition to the other indicators identified by Ms. Acosta.

	The activities for self-assessment listed for each provision were numerous and will not be listed here. The findings were presented in narrative form and it may be useful to supplement that with data in a graph or table format to illustrate change and improvements over time. Further analysis in a brief narrative or list format and to identify barriers to achieving compliance may be easier to prepare and review. An action plan to address identified issues can illustrate how Ms. Acosta intended to proceed with continued progress toward compliance. Evidence contained in the Presentation Book may not need to be so extensive, but rather provide simple examples to supplement the self-assessment or action plan items. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the clinicians and Ms. Acosta and believes that the facility was continuing to proceed in the right direction. Ms. Acosta is commended for her thorough and detailed approach to this process. The data used for self-assessment was generally meaningful, but a streamlined approach to the presentation that is clear and precise would be helpful (e.g., graphs). That information would then be used to guide actions for subsequent months. Even so, while these were appropriate self-assessment activities, they were not the only activities necessary to self-assess substantial compliance. Careful review of the monitoring report will provide additional insight into essential measures for self-assessment. The monitoring team discussed approaches to self-assessment with the Ms. Acosta and it is hoped that this provided a clear direction for the future. The facility self-rated itself as noncompliant with all four items of P. While actions taken were definite steps in the direction of substantial compliance, particular with P1, the monitoring team concurred with this finding.
	Summary of Monitor's Assessment: Significant progress continued to be made related to this provision. The level of staffing for OT and PT clinicians remained consistent, though low for the number of individuals with identified needs. The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services. Assessments were reviewed, and consistency for content were found to be improved since the last review. the Clinical Coordinator completed audits of assessments that were completed by clinicians. The reviewed assessment was to be corrected by the therapist prior to submitting to the IDT, but there was no mechanism in place to ensure that this was done. The audit system was thorough, but was not conducted in a manner to establish and maintain competence, but rather was primarily an editing process. Some slight modifications to the system would permit this and would be of benefit to the clinicians. P1 was very close to substantial compliance and the monitoring team anticipates this achievement with the next review with attention to the recommendations in this report and onsite discussion.

	A number of individuals were listed with direct OT and/or PT as well as programs designed for implementation by DSPs or integrated into other SAPs. Documentation, however, was inconsistent and there was insufficient rationale provided to continue or discharge from services. These interventions were not well integrated into the ISP process. The department continued to need to move forward to the implementation of interventions beyond the PNMP with involvement in the home and day program areas to enhance the meaningfulness and functional activities that meet PNM needs, but also address preferences, interests, and potentials for skill acquisition, engagement and participation in the daily routine.

#	Provision	Assessment of Status	Compliance
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> Susan Acosta, PT, continued to serve as the Clinical Coordinator for Habilitation Therapies. OT/PT staffing was consistent with that found during the previous review. There were two therapy teams, one for the cottages and one for the systems area. These teams included two physical therapists, Heather Rodriguez, DPT, and Jessica Cordova, MPT (contract). The occupational therapists were Rocio Alvarenga, OTR, and Jennifer Ochoa-Evers, OTR (contract). There was also a PT Assistant, Sandra Moreno, PTA, and an OT Assistant, Fred Diaz Deleon, COTA. Jessica Cordova, PT, practiced as a PT since 2008 in inpatient and outpatient settings as well as home health and worked at EPSSLC since 2009 and was currently full time. She was currently working toward a Doctorate in Physical Therapy with expected graduation in March 2013. Heather Rodriguez, DPT, practiced as a PT since 2009 in inpatient neuro-rehabilitation and a skilled nursing facility. She completed a Doctorate of Physical Therapy program last year. She was full time at the present time. Jennifer Ochoa-Evers, OTR, practiced as an OT since 2010 in a skilled nursing facility setting since that time until her employment at EPSSLC in October 2011. She was full time. Rocio Alvarenga, OTR, practiced OT since 2010 working in pediatrics until starting at EPSSLC in March 2011. Sandra Moreno, PTA, practiced as a PTA since 2009 with previous work experience in a falls risk clinic, outpatient wound care, geriatrics, and outpatient rehabilitation with an orthopedic surgery group. She worked at EPSSLC since 1996. Alfredo Diaz DeLeon practiced as a COTA since 1998 with experience in a psychiatric setting, outpatient pediatrics, and nursing homes before coming to work at EPSSLC in 2003. • 5/6 (83%) therapy clinicians were verified with current licenses to practice in the State of Texas. There was no finding online for the license listed for Rocio Alvarenga. This should be verified immediately by the facility. There was one vacant position each for occupational therapy and physical therapy. There were two RTT4s serving as OT and PT technicians and two RTT3s serving as therapy technicians, one with the cottages team and the other with the systems team. There were five PNMPCs at the time of this review. The census at EPSSLC was 126 individuals per the list submitted and all were listed with	Noncompliance

#	Provision	Assessment of Status	Compliance
		PNM needs. It was reported that the ratios for OT and PT were 1:42. This was calculated by including the therapy assistant positions, but, as such, was inaccurate. The assistants were not licensed to complete assessments and design interventions supports and should not be included in these ratio calculations. Their roles were critical, however, in that they were to provide training, supervision of technicians and PNMPCs, assist with data gathering, provide monitoring, and provide direct/indirect supports. The systems area served 36 individuals and the cottage area served 90 individuals. This division of responsibility created a caseload of 1:36 for the OT and PT serving systems and 1:90 for the OT and PT serving the cottages. These actual ratios, were moderately high to ensure adequate provision of necessary and effective supports and services as reported in the subsequent sections of this report. <u>Continuing Education</u> Four of the six clinicians reported participation in continuing education outside of onsite inservice training during the last six months, and five listed participation in courses during the last year. Ms. Rodriguez had completed her Doctorate in Physical Therapy within the last year so additional continuing education would not be expected. Topic areas included: • Coursework for a Doctorate in PT (Ms. Cordova) • DADS Webinars related to PNMT • AAC for Children • Effective Neurological Management of Sensory Processing Disorder • Orthopedic Massage Techniques for Cervical Pain • Pathology of Chronic Conditions for Massage • DADS Annual Habilitation Therapies Conference (October 2011) • School Based Therapy Intervention with Adaptive Equipment • Dysphagia A Perspective on Sensory and Behavioral Problems EPSSLC is encouraged to support at least annual educational opportunities for all clinicians beyond just those offered by the state to ensure that they continue to expand their knowledge and skills. Participation in ongoing continuing education is critical and should be encouraged throughout the year. A particular focus on wheelchair assessment is recommended to ensure competence of all clinicians in this area. The RTT4s, RTT3s, and PNMPCs also had participated in training specific to their responsibilities since 1/1/12. There was a curriculum designed with courses provided at least monthly, or as needed, related to AAC, wheelchair positioning, competency-based training, PNMPs, lifting and transfers, monitoring, mealtimes, taking photos for plans, and communicating with difficult people. This had been a recommendation by the monitoring team in the past and the facility is commended on its consistent attention to the training	

#	Provision	Assessment of Status	Compliance
		needs of these key staff members. New Admissions Three individuals were listed as admitted to the facility since the last onsite review. Samples of new admission assessments were submitted. A fourth assessment was submitted for an individual readmitted to EPSSLC since the previous review. Each of the assessments for individuals newly admitted was completed within 30 days of admission. OT/PT Assessments The OT/PT assessments were written per the Habilitation Therapy Comprehensive Assessment OT/PT/SLP format dated 5/1/12. There were no instructional guidelines for completion to guide content for consistency per the document submitted. The state format instructions indicated that the assessment should provide a current picture of the individual's status, in terms of functional abilities, health risks, and potential for community placement. An Assessment of Current Function had been developed by the state, but was not in place at EPSSLC. No template for any other updates was submitted. Per the state format guidelines, the assessment findings were to address health conditions and clinical data reflecting the individual's function and guide provision of supports. Historical data and information gleaned from record review were to be pertinent to the assessment and provide an analysis of relevance to clinical findings and recommendations. Therapists were instructed to analyze the clinical information as each section was completed so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated. These guidelines indicated that recommendations for supports and activities, other than direct therapy requiring a licensed professional, should be incorporated into the ISP so they may be integrated throughout the individual's daily routine. This was of significant concern to the monitoring team because all aspects of supports and services should be included in the ISP. Per the guidelines, the comprehensive assessment was to be completed within 29 days of admission and an update was to be completed at least annually to address services provided to the individual during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was to be included in the written report. The content guidelines for each of these areas were extensive and comprehensive in nature. The EPSSLC assessment format was consistent though did not appear to utilize the written content guidelines, as these were not submitted with the most current template.	

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		The five most current assessments for each clinician (10), new admission assessments (4), and the OT/PT assessments for the each of the 17 individuals in the sample selected by the monitoring team were submitted for review. ISPs were also requested and submitted for each individual except those who were newly admitted (26). The ISP for Individual #67 was submitted twice for each sample. Though 31 assessments were submitted, one was duplicated in multiple requests (Individual #67), two others were missing the first page in the copies submitted (Individual #112 and Individual #39), and two were expired at the time of this onsite review (Individual #34 and Individual #99). Three others were not of the most current format as they were completed in August 2011 and September 2011 (Individual #57, Individual #74, and Individual #32). None of these were included in the sample selected for review. Thus, there were 23 unique assessments reviewed and all were in the Habilitation Therapy Comprehensive Assessment OT/PT/SLP format. Comments are below: • 100% (23/23) were identified as comprehensive assessments. • 0 of 23 individuals had comprehensive assessments that contained each of the 23 elements outlined below, though at least 65% of the elements were present in each of the 23 assessments reviewed. • Overall, the assessments were very good and were considerably improved since the previous review. The elements listed below were the minimum basic elements necessary for an adequate comprehensive OT/PT assessment by the monitoring team. The current state assessment format and content guidelines generally required that these elements be contained within the assessments. The percentage of assessments (23) that contained each element are listed below: • Signed and dated by the clinician upon completion of the written report (91%). All were signed copies of the original, though two had undated signatures. The date of the assessment was identified in the heading of these two assessments, but it was not possible to determine when the report was finalized and signed and, thereby, available to the IDT for review and integration into the ISP. Five assessments had signatures dated prior to the date of the assessment listed in the heading, suggesting that these were signed before the assessment was completed. • Dated as completed 10 days prior to the annual ISP (100%), though five were completed less than 10 days prior to the ISP (Individual #63, Individual #125, Individual #70, Individual #70, Individual #25). The state required these to be completed 10 working days prior to the ISP per the ISP meeting guide. Two others were identified as completed prior to the ISP, but since the signatures were not dated, it could not be determined if they were actually available 10 days before the ISP.	

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		• Diagnoses and relevance to functional status (100%). • Individual preferences, strengths, interests, likes, and dislikes (100%). • Medical history and relevance to functional status (100%). • Health status over the last year (100%). • Medications and potential side effects relevant to functional status (74%). Some assessments listed only the purpose of the medications; others provided an extensive list of potential side effects. It would be useful to report if any of these were experienced by the individual. • Documentation of how the individual's risk levels impact performance of functional skills (100%). The assessments contained two sections that reported health risk levels that were associated with PNM supports. The first section identified the current levels and rationales assessed by the IDT at the time of the comprehensive assessment, while the second section identified changes needed to existing risk levels with the rationale and supports and/or service needs. There was no consistency noted across assessments as to which risk areas were reported by the clinicians. Some reported high and medium risks (Individual #15) and others also reported low risk PNM-related areas (Individual #70). It appeared that the format had changed somewhat per the self-assessment, and may have contributed to these differences. It would be important to address all areas of risk relevant to PNM to determine if the current ratings were accurate, if changes were necessary based on findings and to ensure supports and services sufficiently addressed these needs. • Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day (100%). • Description of the current seating system for those requiring a wheelchair (12 individuals) with a rationale for each component and need for changes to the system outlined as indicated also with sufficient rationale (67%). Issues identified with the wheelchair were stated in the locomotion section of the assessment, but were not consistently translated to recommendations with the potential for those items to be overlooked (Individual #128, 4/24/12). There was no evidence of a work order for the recommended repairs noted in the maintenance log submitted through 6/8/12. In two cases (Individual #115 and Individual #195), the wheelchair was described, but there was no indication that it adequately met the individuals' needs. Individual #90's assessment did not provide an adequate description of his wheelchair, rationale, or effectiveness. • Evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work) (0%). Though it was clear in most cases that the clinicians had made observations in the homes, particularly for ADL skills, it was not evident that they had conducted any observations during day programs or in work environments.	

#	Provision	Assessment of Status	Compliance
		• Evidence of discussion of the PNMP as well as the effectiveness of the current version of the plan with necessary changes as required for individuals with PNM needs (100%). • Discussion of the expansion of the individual's current abilities (74%). While each assessment discussed potential for expansion of current abilities, a number provided the rationale for not providing supports of this nature due to the individual's regression and/or cognitive deficits, neither of which would be acceptable in this setting. • Discussion of the individual's potential to develop new functional skills (70%). While each assessment discussed potential for skill acquisition, a number provided the rationale for not providing supports of this nature due to the individual's regression and/or cognitive deficits, neither of which would be acceptable in this setting. • Discussion of the current PNMP and other supports and services provided throughout the last year and effectiveness, including monitoring findings (0%). While each presented an extensive discussion of supports and services provided over the last year, none incorporated findings from the monitoring conducted related to compliance with implementation and effectiveness monitoring. • Comparative analysis of health and impact on functional status over the last year (100%). • Comparative analysis of current functional motor and activities of daily living skills with previous assessments (100%). • Addressed the individual's foundational PNM and functional skill needs including clear clinical justification and rationale (100%). Most provided a sufficient rationale for the interventions and supports recommended. A tremendous amount of data were reported that were not consistently used in the analysis. • Identify need for direct or indirect OT and/or PT services (100%). • Reassessment schedule (100%). • Monitoring schedule (100%). In some cases, the frequency of PNMP monitoring did not appear to match the identified need (Individual #195). • Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs (74%). • Factors for community placement (100%). • Manner in which strategies, interventions, and programs should be utilized throughout the day (100%). This was generally accomplished via the PNMP and mobility skills. While most of the elements listed above were addressed by the current state assessment format and guidelines, the clinicians should consider each of these as specific content in the proposed headings to ensure assessments were comprehensive as required by the	

#	Provision	Assessment of Status	Compliance
		Settlement Agreement. Additional prompts or cues in the form of guiding questions may be helpful to ensure that key elements are addressed in each assessment. Additional findings: • Each of the assessments identified preferences, likes, and dislikes as per the PFA Supports section of the report. These were important for establishing contexts for communication opportunities, but there was no clear link between these and functional participation in the daily routine. Observations in the natural environments would also provide important clues as to preferences as well as individual potentials for enhancing or expanding existing functional skills • Measurable objectives were most often related to staff actions rather than learning objectives for the individual. Only six assessments presented measurable learning objectives for the individual. In three cases, the objective was to develop a SAP rather than the actual learning objective (Individual #146, Individual #25, and Individual #147) and, in two other cases, the objective was to provide direct therapy, but without a measurable functional goal(s) designated as an outcome of the intervention (Individual #90 and Individual #161). • There were 67 assessments completed from 1/1/12 to 6/30/12. Of these, four were for individuals newly admitted and these were completed within 30 days of admission/readmission. All of the others were completed prior to the ISP, though three were dated less than 10 working days prior to the ISP as required by the state guidelines. o It could not be determined how many individuals had not yet received an OT/PT assessment using the current format, though by report, all individuals will be provided one at the time of their annual ISP prior to October 2012. o It was not known if EPSSLC would adopt the Assessment of Current Status format recently developed as an update version of the comprehensive assessment. It would be appropriate and desirable to conduct a modified assessment that was based on the original comprehensive assessment, primarily adding changes in status and the effectiveness of supports and services over the previous year with recommendations for the next year based on a sound rationale, rather than duplicating the extensive format of the comprehensive assessment. ▪ This would permit more time for therapists to focus on the delivery of supports and services rather than on assessment. ▪ Of course, a repeat comprehensive assessment would continue to be indicated in cases of a significant change in status and for individuals newly admitted to the facility. • There were a significant number of discipline-specific assessments to address referrals and special concerns, such as the delivery of orthotics and mealtime	

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		equipment. It appeared that many of these could have been documented in the IPNs rather than as stand-alone assessments. Most of these did not have marker notes to alert others to the assessment located in the Habilitation Therapy section of the individual record (Individual #99). These were tracked by the Clinical Coordinator with referral date, source/reason for referral, discipline and date assessment was completed, generally within a few days of the referral. • The therapy clinicians generally completed discipline-specific post-hospitalization assessments rather than comprehensive or combined OT/PT assessments, though some of these were noted as well (Individual #63, 5/8/12). In most cases each of these was also a separate document filed in the Habilitation Therapies tab of the individual record, and while some had marker notes in the IPNs (PT for Individual #74), most did not (OT for Individual #74, OT/PT for Individual #63 and PT for Individual #90). o As in previous reviews, the facility is commended for consistency in the practice of providing these assessments. But, if the assessment is not to be included in the IPNs as a notation, a marker note is necessary to direct other IDT members to the information. Ideally, whenever possible, recommendations should also be included in the IPNs to ensure timely implementation and/or integration with other supports and services. The post-hospitalization assessments were also tracked in the referral log described above. For the ISPs (23): • 96% (22/23) of the ISPs submitted were current within the last 12 months. The ISP for Individual #15 was expired at the time of this onsite review. ISPs were not requested for the new admission assessments. The ISP for Individual #115 did not have an attached signature sheet. • 50% (11/22) of the current ISPs with signature pages submitted were attended by OT and 50% (11/22) were attended by PT. In four of these cases both OT and PT attended the meeting. In most cases only one or the other was present. Five ISPs were attended by a SLP only and, in one case, a therapy technician attended in the absence of a licensed clinician. It was of concern to the monitoring team that an unlicensed technician was assigned to represent all therapy disciplines at the ISP meeting. In one case there was no OT/PT representation. Audits were completed by the department director for assessments completed by clinicians for editing and teaching purposes to improve the quality, but not specifically to establish competency of each therapist. These audits were detailed and thorough with a quantifiable score calculated related to content and format, though only the following elements were used for self-assessment of this provision: • PNM Health Risks	

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		• Analysis of PNM Health Risks The assessment reviewed was to be corrected by the therapy team prior to submitting it to the IDT. These were conducted one time a month for each team, but were not random as the therapy teams were informed which evaluation was to be audited prior to beginning it. The score was established per team rather than per individual clinician, so it was not possible to establish competency for each using this system. The findings from these audits reflected compliance above 80% in 90% of the assessments audited, though the sample size was only 10 across five months because the system was implemented in March 2012. These scores and the review conducted by the monitoring team reflected a significant and consistent improvement in the quality of the assessments completed by the clinicians. The current audit system was very thorough, but also very time consuming for the Clinical Coordinator. Additionally, there was no mechanism to establish competence for individual clinicians, but rather by team only. Specific feedback was provided with tracked comments in the original document and the therapy team was expected to make the necessary corrections prior to submission of the assessment to the IDT. There was no evidence that trends identified by the audit process were targeted for staff training. This system was dependent on the abilities of the Clinical Coordinator to conduct these audits in a competent manner and to provide adequate oversight and direction to the clinicians for corrective actions. Areas to focus on over the next six months would be modifying the system to establish competency and to incorporate findings into staff training opportunities (possibly via case study format, for example) to enhance overall performance. These findings would be useful to report and trend on a monthly basis. Corrective strategies could be developed as needed to address issues as indicated both for individual clinicians and teams.	
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	<u>OT/PT Interventions</u> The primary intervention provided was the PNMP. These were addressed in detail in section O above. Additional services included the following: • Direct PT services: Individual #31, Individual #63, Individual #104, Individual #109, Individual #70, Individual #72, and Individual #70. • Direct OT services: Individual #112, Individual #78, Individual #161, Individual #148, and Individual #70. • GIFT program by PT: 17 individuals, though this program had recently been discontinued. The focus was sitting posture, standing balance, postural control, ambulation, and gait training. Most included a functional measurable objective.	Noncompliance

#	Provision	Assessment of Status	Compliance
	required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	• GIFT program by OT: 18 individuals, also recently discontinued. The focus of these was upper extremity reaching, grasp/release, and range of motion. Most included a functional measurable objective. • Other PT-designed SAPs: Individual #127, Individual #59, Individual #24, Individual #60, Individual #8, and Individual #32. • Other OT-designed SAPs: Individual #117 and Individual #134. Each of these was intended as a skill acquisition program, though many were not included in the action plans of the individual ISPs or identified in the ISPAs (for those for whom ISPs and ISPAs were available). Some exceptions noted included Individual #70, Individual #63, Individual #161, Individual #90, and Individual #32. None of these was addressed in a consistent manner. None stated specific measurable objectives in the plans. There was limited evidence of SAPs in the documents submitted. There were also concerns pertaining to the documentation related to progress or status of interventions provided for any of these individuals. Some examples included: • Individual #78 was listed as receiving direct OT related to sensory processing issues. An IPN dated 10/11/11 indicated that she would have continued direct OT. There was no further documentation until an OT reassessment dated 3/6/12-3/29/12. Three goals were listed that had not been previously documented. Only one of these was specific to Individual #78, while the others were staff actions. A training objective was also listed that stated she would be provided direct OT services rather than specific training outcomes. • Individual #78 was also listed as receiving direct OT related to acute hand swelling in January 2012. There was no further documentation in the IPNs by OT regarding this issue. On 1/23/12, the OT wrote a discharge summary which stated a goal that was not measurable or functional. • Individual #109 was listed as provided direct PT from October 2011 to March 2012. He was referred to PT for a temporary wheelchair to support his leg due to a knee immobilizer. There was no baseline assessment data and no objectives in measurable terms. A SAP Strategy Sheet detailed the elements of the direct interventions with a stated goal, though different from that included in the progress notes. Baselines were not consistently established in the assessments. Establishing baseline is a very basic and key standard of practice for both OT and PT. Further, there was insufficient justification documented in the assessment to initiate or terminate therapy. Measurable goals for direct OT or PT were not included in the ISP or addendum. Documentation of interventions was inconsistent at best. Most notes were typed at one time then entered later into the IPNs or were filed in the Habilitation Therapy tab only. While the clinicians were clearly making a commendable effort to provide therapeutic	

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		interventions, the documentation of these interventions was not consistent with basic standards of OT and PT practice.	
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 section O above.	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 section O above. Recommended frequency of monitoring was included in the OT/PT assessments, though findings of the monitoring conducted were not reported at this time. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT was included in the routine monitoring done by the PNMPCs as well as during quarterly reviews by wheelchair technicians, as described above in section O. There were routine quarterly maintenance checks documented to assess the working condition, PNMP monitoring conducted by PNMPCs checked all equipment for working order, but cleanliness was not included as an element reviewed. A weekly nighttime cleaning audit, however, was conducted to address this. The self-assessment indicated that condition and needs for repair of adaptive equipment was an issue frequently identified in PNMP monitoring. A log of work orders was generated and tracked for completion and timeliness with orders generated through routine PNMP monitoring, random checks, and reports by direct support and home management staff. This was monitored closely by the Clinical Coordinator with weekly meetings held with the fabricators to ensure that maintenance and fabrication of new systems and modifications were completed in a timely manner.	Noncompliance

Recommendations:

1. The data used for self-assessment was generally meaningful, but a streamlined approach to the presentation that clearly outlines essential measures in a precise and concise manner (e.g., graphs). That information would then be used to guide actions for subsequent months (P1-P4).

2. Modify audit system to establish competency for clinicians related to assessments and documentation of interventions and effectiveness monitoring (P1 and P4).

3. Improve consistency of the system of documentation. Ensure that the rationale was clearly stated to continue or discharge from services. These interventions were not well integrated into the ISP process. The department continued to need to move forward to the implementation of interventions beyond the PNMP with involvement in the home and day program areas to enhance the meaningfulness and functional activities that meet PNM needs, but also address preferences, interests, and potentials for skill acquisition, engagement and participation in the daily routine (P2).

4. Clearly establish baselines in the OT/PT assessments as the foundation for interventions and measurable, functional outcomes (P1).

5. Include measurable performance criteria in the objectives for interventions and refer to these in all documentation (P2).

6. Areas to focus on over the next six months regarding the assessment audits would be modifying the system to establish competency and to incorporate findings into staff training opportunities (possibly via case study format, for example) to enhance overall performance. These findings would be useful to report and trend on a monthly basis. Corrective strategies could be developed as needed to address issues as indicated both for individual clinicians and teams P1).

7. Increase consistency of documentation and better integrate it with the IPNs (P2).

8. Explore ways in which attendance at the ISPs/ISPAs is improved (P1).

9. Include a discussion of the current PNMP and other supports and services provided throughout the last year and effectiveness, including monitoring findings. While each presented an extensive discussion of supports and services provided over the last year, none incorporated findings from the monitoring conducted related to compliance with implementation and effectiveness monitoring (P1).

10. Participation in ongoing continuing education is critical and should be encouraged throughout the year, beyond just that offered by the State. A particular focus on wheelchair assessment is recommended to ensure competence of all clinicians in this area (P1).

11. 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).

12. Consider including oral hygiene status in OT/PT assessments. Consider strategies to address sensory issues that may negatively impact the effectiveness of oral hygiene care (P1).

13. Results and findings from PNM monitoring during the last year should consistently be reviewed and summarized (P1).

14. Documentation of direct therapy services should state a clear rationale to initiate, continue the service, modify the plan, or discharge. Measurable goals should be clearly stated and integrated into the ISP. Data collected should link to the expected outcomes and progress notes should summarize progress. Close the loop (P2).

15. Implementation of coaching and skills drills with staff 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).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o EPSSLC Policy: Dental Services, 4/29/11 o EPSSLC Organizational Charts o EPSSLC Self -Assessment Section Q o EPSSLC Action Plan Section Q o EPSSLC Provision Action Plan o Presentation Book, Section Q o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams 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 Listing, Individuals Receiving Pretreatment Sedation January – June 2012 o Documentation of strategies for dental refusals the following individuals: • Individual #5, Individual #39, Individual #65, Individual #32 o Complete Dental Records for the Prior Three Years: • Individual #120, Individual #65, Individual #111, Individual #117, Individual #39, Individual #71, Individual #28, Individual #195 Interviews and Meetings Held: o Howard Pray, DDS, Facility Dentist o Raquel Rodriquez, RDH o Jennifer Pacheco, RDH o Amista Salcido, PharmD, Pharmacy Director Observations Conducted: o Dental Clinic o Provision of prophylactic dental services to Individual #120 and desensitization session for Individual #83 o Informal observation of oral hygiene regimens in residences o Pretreatment Sedation Meeting o Clinical Integration Meeting

	Facility Self-Assessment: There was no onsite dental director. The part time dentist played a role in the overall provision of dental services, but his primary responsibility was to do clinical work and provide direct dental care (which he did very well), not to develop and oversee a system of dental care at EPSSLC. As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) provision action information. The self-assessment was an expansion of the document utilized during the last review. It was more reflective of the assessment conducted by the monitoring team. The dental director described for both provision items, a series of activities engaged in to conduct the self –assessment. For each activity, a result or data point was if was used to help determine an overall compliance rating. For the most part, the assessment did a good job of assessing what the monitoring team assesses. The facility will need to invest time in exploring data accuracy. To take this process forward, the monitoring team recommends that the dental director continue this type of self-assessment, but expand upon it by adding additional metrics that are specific to clinical outcomes in dentistry. In that regard, the dental peer review will be of great assistance. The facility rated itself in noncompliance for both provisions. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: The dental clinic made progress in that additional individuals completed assessments and planned treatments and received dental services. As a dental system, however, there was not a great deal of progress. Many of the issues that surfaced in the January 2012 review were not addressed. The facility did not develop strategic plans to address oral hygiene or missed appointments. The facility now reported that there were minimal refusals and no failed appointments. This was an odd finding, because numerous desensitization/SAP plans were developed for individuals who refused to go to or cooperate in dental clinic, though it may be that some of the individuals did not tolerate long procedures and, as a result, the dentist could not complete the exam. Overall, it appeared that individuals received appropriate care to the extent that it could be delivered given a limited number of dental hours. The use of general anesthesia continued at EPSSLC, as did referral to the community hospital for dental work to be performed under general anesthesia. Since the last visit, the facility still had not implemented a policy on suction toothbrushing. A work group had drafted a policy, but it was not approved. Individuals received preventive care and emergency care. Very few individuals had restorative work completed and the number of visits for extractions far exceeded the visits for restorations. Although there

	may be reasons for these extractions due to prior poor care (e.g., tooth or bone loss that was not restorable), the need for continued work on improved oral hygiene was evident. The percentage of individuals with poor oral hygiene increased, however, the rating period was changed, making the comparison difficult. The facility utilized the services of a contract dentist who was capable of providing the clinical services needed. His role was that of a clinician and not an administrator and his hours at the facility had been decreased. The clinic had no onsite dental director or administrative leadership. Many of the tasks that need to occur to achieve compliance with the Settlement Agreement will require administrative leadership and guidance. Finally, data continued to be problematic and, at times, the problems were so obvious it appeared as though there was no oversight of the data. Oral hygiene ratings were dated December 2011 and the very first data element in the self-assessment was reported as 125%. Many of the document requests were simply not fulfilled or fulfilled incorrectly. The increased presence of administrative leadership may help to improve these problems.

#	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.	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with all members of the clinic staff. The monitoring team also attended several meetings in which the dentist and dental hygienist were active participants. The review to some extent was limited due to a lack of records. Although the dental tab of the active records was requested, it was not included for several individuals in the record sample. <u>Staffing</u> A part time dentist and two full time dental hygienists staffed the dental clinic. Dental clinic was operational five days a week. The number of dentist hours was reduced to less than three days a week. Of these, two days each month were devoted to outpatient general anesthesia and one day to paperwork. A community anesthesiologist came to EPSSLC on the outpatient general anesthesia days. There was no onsite dental director. The part time dentist played a role in the overall provision of dental services, but his primary responsibility was to do clinical work and provide direct dental care (which he did very well), not to develop and oversee a system of dental care at EPSSLC. <u>Provision of Services</u> Dental clinic was conducted five days a week and provided basic dental services, including prophylactic treatments, restorative procedures, such as resins and amalgams, and x-rays. The total number of clinic visits and key category visits are summarized	Noncompliance

#	Provision	Assessment of Status	Compliance
		below. | | Jan | Feb | Mar | Apr | May | Jun | | --- | --- | --- | --- | --- | --- | --- | | Preventive Care | 34 | 49 | 35 | 16 | 23 | 4 | | Restorative | 1 | 0 | 0 | 0 | 3 | 0 | | Emergency Care | 3 | 2 | 2 | 2 | 1 | 1 | | Extractions | 3 | 0 | 4 | 4 | 5 | 0 | | Total Clinic Appointments | 43 | 53 | 41 | 23 | 23 | 5 | Five other appointments occurred off-campus for individuals who had multiple extractions under general anesthesia. <u>Emergency Care</u> Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dentist by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary. In order to assess emergency care, the IPN notes were requested. This allows the monitoring team to assess the dental entries as well as overall management of the individual. The IPN entries were not provided as requested. The monitoring team will review this during subsequent reviews. <u>Oral Surgery</u> There were no referrals to the oral surgeon. The sample of records reviewed did not indicate any outstanding needs for referral. This will continue to be monitored during subsequent reviews. <u>Oral Hygiene</u> The facility did not track oral hygiene on a quarterly basis. The document request contained data dated 12/10/11. The self-assessment presented the following oral hygiene ratings for 68 individuals from January 2012– May 2012: • Good: 18% • Fair: 44% • Poor: 36 % The ratings reported for good, fair, and poor for January 2012 were 14%, 48%, and 33% respectively. The facility continued to have a significant percentage of individuals with poor oral hygiene, which in many cases is reflective of the oral care provided in the home environments. For example, an IPN entry dated 3/11/12 for Individual #6 stated, “Oral hygiene was poor. Oral hygiene had not been provided in a while from looking at the condition of his mouth.”	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Eleven individuals received treatment with suction toothbrushing and chlorhexidine. The facility did not have a separate policy for this procedure, although a workgroup had convened to develop such a policy. The plan was to have facility training for nurses and direct support professionals once the policies were approved. During interviews with the pharmacy director, the monitoring team noted that the pharmacy was dispensing chlorhexidine for use on a daily basis. This was discussed with the dental hygienists who stated that the policy was for 14 day use. Record reviews showed that orders did not specify 14 days of chlorhexidine use but stated, “suction toothbrushing with chlorhexidine.” The MARS contained in the records reviewed showed that suction toothbrushing was being performed two to three times a day with chlorhexidine each day of the month. The continuous use of chlorhexidine is associated with adverse events necessitating the 14 day use cycle.

<u>Staff Training</u>
All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn.</td><td></td></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</td><td><u>Policies and Procedures</u>
The facility maintained a dental services policy. As previously noted, a suction toothbrushing policy had been drafted but was not approved.

<u>Annual Assessments</u>
In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months along with the date of previous annual assessment was requested. Assessments completed by the end of the anniversary month were considered to be in compliance. The available data were used to calculate compliance rates that are summarized below.

<table>
<tr><td colspan="7">Annual Assessments 2012</td></tr>
<tr><td></td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td></tr>
<tr><td>No. Exams</td><td>26</td><td>13</td><td>11</td><td>9</td><td>6</td><td>4</td></tr>
<tr><td>Compliant Exams</td><td>24</td><td>13</td><td>11</td><td>9</td><td>5</td><td>3</td></tr>
<tr><td>% Compliance</td><td>92</td><td>100</td><td>100</td><td>100</td><td>83</td><td>75</td></tr>
</table>

<u>Initial Exams</u>
The facility submitted data for three individuals admitted since the last onsite review. All of the individuals completed initial dental evaluations.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	assessment of the use of sedating medications and dental restraints.	Dental Records Dental records consisted of initial/annual exams, annual dental summary, dental progress treatment records, and documentation in the integrated progress notes. Providers documented in the integrated progress notes. An entry was also made in the dental treatment record. IPN entries were written in SOAP format and were generally dated, timed, and signed. Copies of the complete dental record for the prior three years for eight individuals seen in the dental clinic were reviewed. The following is a summary of those records: • 8 of 8 (100%) records included current annual examinations • 8 of 8 (100%) records included periodontal charts • 8 of 8 (100%) records included Annual Dental Summaries • 8 of 8 (100%) records included treatment plan records During the January 2012 visit, issues were identified with documentation in the dental clinic. This appeared to be an ongoing problem, but could not be fully evaluated because many documents were not provided as requested. The annual examinations found in the dental treatment records were often four lines. The clinic record did not appear to include a copy of the note that was placed in the record. The current Health Care Guidelines require documentation in the IPN. The exact formulae for achieving that had not been prescribed. The dentist should work with the dental director to determine the most suitable format. Options include a brief entry in the IPN that provides adequate information to the IDT with full documentation in the dental treatment section. Another option is a detailed IPN entry that is copied and placed in the permanent dental record. The final documentation selection must include adequate detail of the examination and treatment. Failed Appointments The facility reported data on refusals and missed appointments only. Those data are summarized in the table below:	

Failed Appointments 2011 - 2012						
	Jan	Feb	Mar	Apr	May	Jun
Missed	1	1	0	1	0	0
Refused	1	1	0	0	0	0
Total Failed	2	2	0	1	0	0
Total Visits	43	53	41	23	32	5
% Failed	5	4	0	4	0	0

#	Provision	Assessment of Status	Compliance
		The facility reported failed appointments as zero. The monitoring team questioned the hygienists about this data particularly due to the number of SAPs for individuals who had problems cooperating and refusing treatment in clinic. None of these individuals appeared to be captured by these data. Moreover, based on these data, only one individual in the facility missed dental clinic due to illness or hospitalization, which is possible, but rather unlikely. The monitoring team was also provided a list that included a brief statement for four individuals who missed or refused appointment. In each case, it was stated that the appointment was refused or the individuals was referred to the community for treatment under general anesthesia: • Individual #5 missed an appointment and was rescheduled. • Individual #39 had a history of pneumonia and was rescheduled to have work done under general anesthesia. • Individual #65 refused treatment, was referred to the community, and completed treatment under general anesthesia. • Individual #32 refused treatment and was rescheduled. <u>Dental Restraints</u> The facility reported very little use of chemical restraints for dental clinic. The number of individuals receiving pretreatment sedation and general anesthesia is summarized below.	

Individuals Requiring Sedation and General Anesthesia
2012

	Jan	Feb	Mar	Apr	May	Jun
Oral Sedation	0	1	0	0	0	--
General anesthesia	7	0	7	6	6	--
General anesthesia (community)	0	0	0	1	2	2

TIVA was not used at EPSSLC. 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.

<u>Strategies to Overcome Barriers to Dental Treatment</u>
The facility reported very few refusals, yet there appeared to be a need for several desensitization plans. It may be that some were for individuals who did not tolerate long procedures and the dentist could then not complete the exam. The monitoring team was provided with a list of 19 individuals who had current dental desensitization plans. The

#	Provision	Assessment of Status	Compliance
		medical director chaired a committee that developed an assessment process, which resulted in the development of two formal desensitization plans and 17 skills acquisition plans. The plans were reviewed and all appeared individualized however, it was not clear if any progress was made because most of the documents were essentially blank. The monitoring team observed two individuals in the dental clinic. One was one of the 15 or so cooperative individuals at the facility. He received his regular prophylactic treatment (Individual #120). Individual #83 was observed having her teeth brushed and receiving a positive reinforcer (watching a short music video) after being cooperative with the procedure. Overall, dental staff interacted positively and professionally with both individuals. The monitoring team suggests that when barriers to the provision of dental treatment are identified, consideration should be 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. This is an ongoing process that must occur on a daily basis and not weeks prior to monitoring reviews.	

Recommendations:

1. The facility needs administrative leadership in the form of a dental director or other designated lead (Q1).
2. The dental director should examine the oversight of the suction toothbrushing program to ensure that it is adequate (Q1).
3. The facility must evaluate the oral care that is provided in the homes to determine the cause of the high percentage of poor oral hygiene scores in the facility (Q1).
4. The facility must ensure that those with poor oral hygiene have adequate plans in place to assist in improvement of oral health. Individuals who demonstrate deterioration in hygiene status should also have development of a plan (Q1).
5. The dental director should review the current documentation system in the clinic to assist in selecting the most feasible method of documentation with duplication (Q2).
6. The facility needs to evaluate the data that is being reported on refusals and missed appointments to determine the accuracy and why SAPs and plans are needed if there are essentially no refusals (Q2).
7. The various SAPs should be updated to reflect any progress or success that has occurred. If there had been no progress, the IDTs must consider another plan of action that will lead to a successful outcome for the individual (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 list, Section I 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 Facility Operational Communication services Policy (4/11/11) o Speech Language Communication Assessment template o AAC-related spreadsheets and summary reports o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o List of individuals with PBSPs o PBSP Behavior Support Plan Checklists submitted o List of individuals with AAC o List of common area AAC devices o List of individuals receiving direct speech services o QAQI Report January 2012 and April 2012 o PNMP Review Process (2/23/12) o Protocol for Passing Competency NEO and Refresher March 2012 o Competency-Based Training Steps for Validation Group o Communication Card Process o Communication Moment Process o List of SAPs/Indirect Communication Services o OT/PT/SLP Assessment template o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o List of PNMP monitoring completed in the last quarter o Assessment Tracking Log o Assessment audits submitted o PNMP Monitoring sheets submitted o Individual Communication Forms submitted o Communication Assessments, ISPs, ISPAs, and communication and AAC-related documentation for the following: • Individual #195, Individual #117, Individual #19, Individual #4, Individual #103, Individual #105, Individual #5, Individual #84, Individual #189, Individual #12, Individual

	#92, Individual #119, Individual #102, Individual #128, Individual #80, Individual #157, Individual #115, Individual #49, Individual #78, Individual #28, Individual #113, Individual #75, Individual #52, Individual #16, and Individual #44 o Communication Assessments and ISPs for individuals recently admitted to EPSSLC: • Individual #146, Individual #147, Individual #148, and Individual #13 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 (<u>not submitted</u>), 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, and Nutrition tab, for the following: • Individual #67, Individual #70, Individual #191, Individual #32, Individual #112, Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 o PNMP section in Individual Notebooks for the following: • Individual #67, Individual #70, Individual #191, Individual #32, Individual #112, Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: • Individual #67, Individual #70, Individual #191, Individual #32, Individual #112, Individual #25, Individual #63, Individual #104, Individual #99, Individual #90, Individual #184, Individual #61, Individual #57, Individual #74, Individual #39, Individual #15, and Individual #125 <u>Interviews and Meetings Held</u>: o Susan Acosta, DPT, Habilitation Therapies Clinical Coordinator o Valerie Villegas, MS, CCC/SLP o Jacqueline Lopez, MS, CCC/SLP o Karin De La Fuente PNMP Coordinators o Various supervisors and direct support staff o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs (onsite and offsite)

	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. Susan Acosta, PT, the Clinical Coordinator, had outlined specific assessment activities, some of which were based on the previous reports by the monitoring team. She attempted to quantify each and presented findings in the self-assessment report as well as supporting documentation that demonstrated specific accomplishments or steps. The Presentation Book provided extensive information related to actions taken, data presented to illustrate elements assessed and an analysis of the findings, accomplishments, and work products. The most important next step for Ms. Acosta is to minimally revise the existing audit tool for section R. While it contained some elements that would be useful to assessing compliance with this provision, others clearly were not. A revised/new version of this tool may be used in addition to the other indicators identified by Ms. Acosta. The activities for self-assessment listed for each provision were numerous and will not be listed here. The findings were presented in narrative form and it may be useful to supplement that with data in a graph or table format to illustrate change and improvements over time. Further analysis in a brief narrative or list format and to identify barriers to achieving compliance may be easier to prepare and review. An action plan to address identified issues can illustrate how Ms. Acosta intended to proceed with continued progress toward compliance. Evidence contained in the Presentation Book may not need to be so extensive, but rather provide simple examples to supplement the self-assessment or action plan items. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the clinicians and Ms. Acosta and believes that the facility was continuing to proceed in the right direction. Ms. Acosta is commended for her thorough and detailed approach to this process. The data used for self-assessment was generally meaningful, but a streamlined approach to the presentation that is clear and precise would be helpful (e.g., graphs). That information would then be used to guide actions for subsequent months. Even so, while these were appropriate self-assessment activities, they were not the only activities necessary to self-assess substantial compliance. Careful review of the monitoring report will provide additional insight into essential measures for self-assessment. The monitoring team discussed approaches to self-assessment with the Ms. Acosta and it is hoped that this provided a clear direction for the future. The facility self-rated itself as noncompliant with all four items of R (R1 through R4). While actions taken were definite steps in the direction of substantial compliance, the monitoring team concurred with this finding.

	Summary of Monitor's Assessment: Staffing levels were increased at the time of this review, with significant efforts made to hire two full time speech language pathologists. The existing clinicians appeared to be strong in their knowledge and skills, though the variety of AAC and communication programs were limited to optimal communication strategies included in the PNMPs, communication cards provided to all individuals, and communication books and sheets. Only a small number of other systems were provided. As always, the SLPs were responsible for communication supports and mealtime supports for all of the individuals living at EPSSLC, though primary responsibilities for the PNMT were assigned to a single contract SLP. The current ratio for caseloads in the cottages and the systems areas continued to be moderately high. An existing COTA position had been allocated to a Speech Assistant position. This was a very good idea and the facility is strongly urged to actively pursue hiring for this key position. While the assistant would not be licensed to conduct assessment, he or she would provide very valuable supports related to direct therapy and indirect supports for modeling, training, and monitoring. There was no specific Master Plan, though the staff were working through the completion of new comprehensive assessments for all individuals living at EPSSLC and were on track to accomplish this by the end of this calendar year. There continued to be individuals who were considered to have priority needs related to communication who had not yet received this new assessment. It was of concern, however, that while it appeared that the clinicians were doing a good job of outlining specific communication strategies for use throughout the day, in PBSPs, and in SAPs, few other communication systems had been developed. It was anticipated that over the next six months with strong, consistent professional staff, this would be a focus and greater progress would be made. Integration of communication strategies and AAC systems should not be the sole responsibility of direct support and day program staff. Engagement in more functional skill acquisition activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be an ongoing 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 these programs for individuals and groups. Overall, the monitoring team was very encouraged by the current strategies and infrastructure for staff training and monitoring in place to address communication supports for individuals living at EPSSLC and looks forward to continued progress.

#	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.	Staffing: At the time of this review, there was two full time SLPs, Valerie Villegas, MS, CCC/SLP and Jacqueline Lopez, MS, CCC/SLP. Each of these clinicians provided communication supports and services at EPSSLC. A part-time contract SLP, Karin De La Fuente participated as a member of the PNMT. Per the list submitted to the monitoring team, there were three budgeted positions for SLPs. This list indicated that there were two positions filled, one contractor and one unfilled position. Each was listed as full time with a ratio of 1:42. This was not accurate because Ms. De La Fuente was contracting part-time only and provided services only related to the PNMT. Thus, the actual current ratio was 1:63. Qualifications: CVs were submitted for each of the clinicians working at EPSSLC. Ms. Villegas had graduated from the University of Texas at El Paso in 2010 with two years of experience in pediatric and skilled nursing facility settings. She began her employment at EPSSLC in February 2012. Ms. De La Fuente had practiced as a speech language pathologist since 1988 with varied experience in pediatrics and adult rehabilitation. She provided contract services at EPSSLC from 2005 to 2008 and again from 2010 to the present time. Ms. Lopez had also completed a degree in Speech Language Pathology from the University of Texas at El Paso in 2010 with experience in early childhood intervention. • 3 of 3 SLPs (100%) were licensed to practice in the state of Texas. • 3 of 3 SLPs (100%) were certified with the American Speech and Hearing Association to practice speech-language pathology. Evidence that the facility consistently verified both state licensure and ASHA certification for each clinician will be requested prior to the next compliance review. Continuing Education: Evidence of participation in communication-related continuing education was limited, particularly for the two newly hired clinicians. All clinicians participated in an online course "Functional Augmentative and Alternative Communication (AAC) Approaches for Severe Aphasia" that was not included in the list of continuing education submitted. It was reported in the Presentation Book. The monitoring team anticipated that each of the clinicians would be supported to participate in further communication-related continuing education courses over the next year to enhance their knowledge in skills in the provision of services to individuals living at EPSSLC. This is critical to ensure improved clinical assessment and program development skills for AAC and language for individuals with developmental disabilities.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility, however, did not provide an adequate number of speech language pathologists or speech assistants with specialized training or experience as evidenced by noncompliance with R2 through R4 below. <u>Facility Policy:</u> A local policy existed (Facility Operational Communication Services Policy, 5/1/11), but generally merely reflected the language contained in section R of the Settlement Agreement rather than clear operationalized guidelines for the delivery of communication supports and services. The following components were included in this policy: • Outlined assessment schedule: Only stated that there would be a system to monitor status, condition of assistive equipment, effectiveness of interventions, and implementation of programs. The policy did not outline any guidelines. • Timelines for completion of new admission assessments (within 30 days of admission or readmission): This was specifically stated in the policy. The following components were not included in this policy: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.) • Frequency of assessments/updates • Timelines for completion of comprehensive assessments (within 30 days of identification via screening, if conducted) • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT) • A process for effectiveness monitoring by the SLP • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment • Methods of tracking progress and documentation standards related to intervention plans • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution Though a number of these elements were referenced, the content was limited to policy statements. Details for implementation were not outlined, nor were there any specific procedural guidelines associated with this policy. This provision item was not considered to be in substantial compliance due to the diminished staff ratios for communication-related supports and services during most of	

#	Provision	Assessment of Status	Compliance
		this review period. The two recently hired clinicians did not have sufficient work history established at EPSSLC to evaluate their competence in the provision of services as required in this provision. The contract SLP was assigned to the PNMT and, as such, was not primarily responsible for communication-related issues.	
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.	<u>Assessment Plan:</u> There was no Master Plan submitted with the document request. Instead, communication assessments were being completed for all individuals living at EPSSLC per the annual ISP schedule without prioritization based on need. This was not necessarily an inappropriate approach because of the relatively low census at the facility as long as each individual was on schedule to receive an appropriate comprehensive assessment in a timely manner. Per the tracking log, at least 67 individuals were listed with a new comprehensive communication assessment since 11/27/11. Four of these were identified as newly admitted to EPSSLC. It was not possible to determine who continued to need a comprehensive communication assessment, though it appeared that the only individuals who had not yet received a communication assessment were those with and ISP scheduled for July 2012 through December 2012. Based on this schedule, all individuals should receive a new comprehensive assessment by December 2012. The Communication Services Tracking Log had no due dates identified, though annual ISP dates were listed. It would be expected that all assessments would have been submitted 10 working days or more prior to the ISP. Based on review of the Tracking Logs and other documents submitted: • 3 of 4 individuals (75%) admitted during the last six months had received a communication screening or assessment within 30 days of admission or readmission. • Comprehensive communication assessments were provided to all individuals newly admitted to EPSSLC rather than only a screening. • 50 of 63 individuals (79%) had communication assessments completed within 10 or more days of their annual ISP. This excluded those newly admitted listed above. <u>Communication Assessments:</u> Communication assessments were requested and submitted as follows: • Individuals in the sample selected by the monitoring team (17/17 were submitted) • Five of the most current assessments by each speech clinician (10 were submitted for two SLPs) • Individuals newly admitted to EPSSLC (four were submitted)	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individuals who participated in direct communication intervention, SAPs, were provided AAC, had PBSPs, and/or presented with severe language deficits (assessments for 21 individuals were submitted) There were six duplications included in these requests (Individual #67, Individual #157, Individual #15, Individual #195, Individual #104, and Individual #16) and a number of multiple year assessments were submitted for others. Only the most current was included in the sample for review. Also, the most current assessments for four individuals were completed more than 12 months ago though annual assessments/updates would be expected for each based on need (Individual #92, Individual #49, Individual #44, and Individual #84). All totaled, there were 42 unique assessments available for review. A template for the Speech-Language Communication Comprehensive Assessment was submitted as requested. Eight of the 42 assessments were completed using a different format than the one submitted as current. Seven of these had been completed prior to October 2011 when the assessment format was revised. The assessment for Individual #117 was completed on 11/15/11 using the previous format. The other 34 assessments generally matched the newer format. Six assessments that were completed by clinicians no longer employed at the facility and one assessment (Individual #67) was missing pages, so these were not included in the sample for review. Thus, 27 assessments were selected. These were the most current assessments from the two clinicians across each of the requests of the monitoring team (current assessments, new admission assessments, and assessments for individuals with PBSPs, severe language deficits, AAC use, direct communication therapy and/or SAPs). Of these, 14 assessments (11% of the current census) were included in the analysis that follows (Individual #5, Individual #161, Individual #115, Individual #104, Individual #13, Individual #148, Individual #15, Individual #103, Individual #19, Individual #119, Individual #52, Individual #189, Individual #113, and Individual #4). • 0 of 14 individuals had comprehensive assessments that contained each of the 22 elements outlined below. These were considered to be the minimum basic elements necessary for an adequate comprehensive communication assessment. Many of these elements were missing or they were addressed in inadequately. The current state assessment format and content guidelines generally required that these elements be contained within the assessments.	

#	Provision	Assessment of Status	Compliance
		The elements most consistently included were: • Dated as completed 10 days prior to the annual ISP: The monitoring team evaluated this only on 10 calendar days rather than 10 business days as identified in state policy. • Individual preferences, strengths, interests, likes, dislikes: This was based solely on the information presented in the Personal Focus Assessment and the information was not utilized to design individualized AAC systems or programs to build on strengths and interests. • Reassessment schedule. • Monitoring schedule: This appeared to be standardized rather than individualized. • Factors for community placement • Recommendations for services and supports in the community: This section of the assessments reviewed provided suggestions for general supports only. The need for services from a SLP related to communication was not outlined for any individual. • Manner in which strategies, interventions, and programs should be utilized throughout the day: The Optimal Communication Strategies identified for individuals was one of the strongest aspects of the assessments reviewed. These were to be integrated throughout the day via communication cards, PNMPs and PBSPs. The percentage of assessments that did <u>not</u> include each element are listed below: • Dated as completed 10 days prior to the annual ISP (7%). • Diagnoses and relevance of impact on communication (14%). Some assessments merely listed the diagnoses. • Individual preferences, strengths, interests, likes, and dislikes (7%). • Medical history and relevance to communication (100%). No medical history from the previous year was reported in any assessment reviewed. • Medications and side effects relevant to communication (100%). The side effects were general and not specific to the potential impact on communication. No assessment reported that an individual presented with any of the side effects listed and whether it impacted functional communication. • Documentation of how the individuals' communication abilities related to their health risk levels (100%). Only challenging behaviors and seizures were mentioned even though individuals presented with additional risk concerns. • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day (36%). While each assessment provided this information, a number provided only general statements as to skills rather than specific functional examples observed by the	

#	Provision	Assessment of Status	Compliance
		clinician or reported by staff. • Evidence of observations by SLPs in the individual's natural environments (day program, home, work) (43%). There were a few statements that implied that the clinician observed some communication behaviors reported, but there was no clear evidence that they had actually observed the individual in natural environments to identify communicative efforts, interactions with peers and others, or potentials for additional skill acquisition or support needs. • Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal (93%). The clinicians did not provide examples of information included in the dictionaries, did not routinely discuss if these were still accurate and effective, and did not discuss specific changes needed. Some of the statements were merely rote descriptions of how a communication dictionary could assist staff. • Discussion of the expansion of the individual's current abilities (36%). Though there was a section for this in the assessment format, the adequacy of content varied greatly. • Discussion of the individual's potential to develop new communication skills (36%). Though there was a section for this in the assessment format, the adequacy of content varied greatly. • Effectiveness of current supports, including monitoring findings (100%). This was not consistently present in the assessments reviewed and none presented findings from monitoring conducted throughout the last year. • Addressed the individual's AAC needs including clear clinical justification and rationale as to whether the individual would benefit from AAC (64%). Though there were report headings to guide the clinician, this was not a strong component of the assessments reviewed. In addition, most of the supports provided continued to be limited to optimal communication strategies, communication sheets and dictionaries. While each of these were valid and important as an aspect of communication supports, additional types of supports were limited. • Comparative analysis of health and functional status from the previous year (100%). • Comparative analysis of current communication function with previous assessments (100%). • Identify need for direct or indirect speech language services (79%). It was implied in most cases that direct speech services were not recommended, but was not clearly stated. • Reassessment schedule (0%). • Monitoring schedule (14%). As stated above many recommendations for	

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		monitoring did not appear to be individualized based on specific needs. • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits (57%). Many of the individuals were identified with significant communication deficits yet supports to expand or improve existing skills or promote new skill acquisition were very limited. Many assessments stated that the optimal communication strategies and communication dictionaries were all that was needed. • Factors for community placement (7%). The clinicians offered general communication based supports only. • Recommendations for services and supports in the community (14%). One assessment indicated that skilled speech services were not needed in the community though specific communication supports were recommended. None of the others outlined specific service needs in the community. • Manner in which strategies, interventions, and programs should be utilized throughout the day (7%). The optimal communication strategies were functional and could be applied throughout the day. This was considered to be a strength of the assessments reviewed. Additional findings: • 1 of 14 assessments contained five or fewer of the elements outlined above. • 3 of 14 assessments contained six to 10 of the elements outlined above. • 10 of 14 assessments contained 11 to 15 of the elements outlined above. • None of the 14 assessments contained more than 15 of the 22 elements outlined above. • Augmentative/Alternative Communication and Assistive Technology: Content in this section varied across assessments, though most demonstrated an improvement in this area. • The only risk areas addressed were related to Challenging Behaviors or seizures. It was not clear why these were the only areas reported. The clinicians did not consistently report the existing risk levels nor did they provide recommendations for changes in the existing risk levels based on assessment findings. • Clinical Impressions: The analysis sections of these reports were somewhat improved, though most provided insufficient rationale for the recommendations identified. These were scattered throughout the assessment and the current assessment format did not promote a clear statement of the rationale and plan related to communication supports for each individual. • The assessments did not generally identify important life activities or inventory ways for greater meaningful participation in them.	

#	Provision	Assessment of Status	Compliance
		• Most assessments identified preferences, likes, and dislikes as per the PFA Supports section of the report. These were important to establishing contexts for communication opportunities, but there was no clear link between these and functional participation in the daily routine. Observations in natural environments would also provide important clues as to preferences as well as individual potentials for enhancing or expanding existing communication skills • The Optimal Communication Strategies were functional and meaningful ways in which staff could successfully interact with the individual, though there was little focus on specific programs to expand or enhance existing skill levels. • Skill acquisition programs were recommended for only six of the individuals for whom assessments were reviewed (Individual #19, Individual #119, Individual #115, Individual #161, Individual #4, and Individual #148), though all had communication needs. • Measurable objectives were generally related to staff actions rather than learning objectives for the individual. • Many of the above findings were consistent with the findings in the previous report submitted by the monitoring team. There were 64 individuals listed with severe or profound language deficits and only 33 (49%) of them had received a communication assessment using the current format. These individuals had the greatest need for communication supports, yet they had not been prioritized via a Master Plan to be provided an adequate communication assessment. While they appeared to be on track to receive one prior to the end of this calendar year, this should have been provided in a more timely manner. <u>SLP and Psychology Collaboration:</u> There were 51 individuals with PBSPs and replacement behaviors related to communication. Overall, only 29 individuals or 57% of those on this list had received a communication assessment during the last year. It appeared, however, that any of the individuals with ISPs prior to July 2012 had already received a new communication assessment and it would be expected that all others would receive one prior to 2013. As stated above, these individuals should have been prioritized based on their needs for a comprehensive assessment in a timely manner. The communication assessments identified optimal communication strategies which were provided to the psychologists via email for integration into behavior programming developed. It was not clear that assessment and/or program design was conducted collaboratively by speech and psychology staff. A number of individuals for whom communication assessments were submitted also had PBSPs. These were reviewed to determine if the communication strategies identified as	

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		optimal were integrated into these plans. • Individual #39: There were very clearly stated communication strategies outlined in his PBSP, but they were not the same ones clearly outlined in his communication assessment. The psychologist also prompted staff to encourage him to use his communication book or wallboards, though neither was identified in his communication assessment. • Individual #61, Individual #25 and Individual #67: The optimal communication strategies were exactly copied into the PBSP. While in these cases this was appropriate, it would be more desirable to integrate the strategies in a thoughtful manner that was useful to staff rather than necessarily merely cut and paste into the plan. Even more desirable would be that these strategies would be developed collaboratively by the SLP and psychologist. • Individual #104: The optimal communication strategies were integrated into the teaching/supporting alternative or replacement behavior section of his PBSP. This was a good example of integration of the optimal communication strategies into his plan. Again it would be most appropriate if these strategies were developed collaboratively by the SLP and psychologist. • Individual #99 and Individual #191: The strategies outlined in the PBSP and the communication assessment were not the same. While they were not generally conflicting, the collective strategies from both plans were extensive and staff would have to refer to each plan to capture all of these. Collaboration between the SLP and the PBSP would more effectively address this issue. • Individual #112: The PBSP was referenced in the optimal communication strategies, but the other specific strategies were not clearly referenced in the PBSP. • Individual #70 and Individual #74: There was no clear integration of communication strategies from the communication assessment into the PBSP. Behavior Support Committee meeting minutes for the last six months were requested. Signed PBSP Checklists were submitted with signatures of the committee members for the following dates 4/17/12, 5/1/12, 5/22/12, 5/29/12, 6/12/12, and 6/19/12. This committee had met regarding nine individuals to review assessments and PBSP strategies. A SLP had signed the PBSP checklist for each of these and, by report, her contribution was important and meaningful. This documentation, however, did not reflect collaboration other than attendance by the SLP. The current communication assessment format presented a section titled Behavioral Considerations, which indicated that the individual had a PBSP and the types of behaviors noted during the assessment. Each of these was steps toward compliance in this area. The quality of content of this section varied greatly across assessments, however, and did not appear to be used in the analysis of assessment findings for the design of communication supports and services	

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		recommended. <u>Assessment Audits</u> An audit tool was used by the Clinical Coordinator to assess the communication assessments. A sample of one individual per month was selected by the Clinical Coordinator, though the therapist was told which assessment would be audited prior to the due date so this was not a true random sample. The Clinical Coordinator also indicated that there was no system to review an audited assessment for the appropriate corrections prior to the therapist submitting the assessment to the IDT, though this was an expectation for the therapist audited. The audit tool was more comprehensive, but the self-assessment only addressed a limited number of those elements. The self-assessment identified that while improvements were noted, there continued to be a need for improved identification of individuals who would benefit from AAC systems. Per the self-assessment for this section, staffing ratios continued to be a barrier to compliance. Though progress had been made with the hiring of two full time clinicians and with the completion of improved communication assessments, there continued to be issues with the adequate provision of individualized supports and services to enhance existing skills and promote new skill acquisition for individuals with identified communication needs. There was, however, a marked improvement over previous reviews, though actual content elements required continued improvement as described above and per the facility's own self-assessment. The department was clearly examining its performance in this area. This provision of section R of the Settlement Agreement was not considered to be in substantial compliance due to the documented weaknesses in the existing assessments as reviewed. It is appropriate that all individuals were receiving new assessments and these were clearly much improved over previous monitoring reviews.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication	<u>Integration of Communication in the ISP:</u> Based on review of the sample of ISPs, the following was noted: • 15 of 17 ISPs reviewed (88%) were current within the last 12 months. • In 7 of 17 ISPs reviewed (41%) for individuals with communication needs, an SLP attended the annual meeting. • In 2 of 17 current ISPs reviewed for individuals with AAC and/or communication supports (12%) the specific type was identified for individuals listed with AAC. Most listed one type of AAC, though each individual was listed with more than one system. The newer style ISPs for Individual #104, Individual #191,	Noncompliance

#	Provision	Assessment of Status	Compliance
	interventions that are functional and adaptable to a variety of settings.	Individual #112**,** and Individual #67 did a better job of addressing AAC, though not all systems were included. In fact, the communication book was identified as not appropriate for Individual #112 and Individual #90, though they were still listed as having one. In the case of Individual #25, the talking photo album provided to her was included in the PNMP section, but was not identified in the communication section of the ISP. • 9 of 17 ISPs reviewed (53%) included a description of how the individual communicated, including the AAC system if he or she had one. Most of these descriptions were minimal or were limited to professional jargon reported in the communication assessment rather than a functional description of how the individual communicated as well as ways staff could effectively communicate with them. More of the new format ISPs contained this information, so this was an improvement since the previous review. A number of these included the optimal communication strategies outlined in each of the communication assessments. These were generally written in first person language and in layman terms. • 0 of 17 ISPs reviewed (0%) contained skill acquisition programs specifically related to communication skills. <u>AAC Systems:</u> All individuals living at EPSSLC were provided communication cards, optimal communication strategies, and communication books. In some cases, communication books were recommended to be discontinued, but were still in use (Individual #63). There were 16 individuals with talking photo albums, seven individuals with environmental control switches, and 58 individuals with picture communication sheets. Other devices included a sound amplifier, soma sensory device, sign language book, photo menu, Ablenet sound generating device, picture choice board, picture communication book, and a monitor, for eight individuals. Though there was evidence of communication dictionaries provided to some individuals, this was not included as a type of AAC in the lists provided. There were few individualized AAC systems available to individuals with identified communication needs, many of whom would benefit from AAC systems. • In the case of Individual #63, it was reported that he had a Hip Talker device, but did not use it for communication purposes. There was no evidence that any training had been provided to encourage its use in a functional manner during meaningful activities for communication purposes. • Individual #34 was identified with potential to use a speech-generating device to make choices, make requests, and social comments. This assessment was completed after her ISP and none of the recommendations were integrated into	

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		her annual ISP dated 8/5/11, nor was there evidence of an ISPA to address this recommendation. Her ISP indicated that she had started to use more words in the last year. It was unfortunate that these additional supports were not implemented to promote even greater advances in her communication skills. It is a generally accepted principle that AAC use does not discourage verbal speech, but rather enhances and encourages it. Communication strategies were essentially staff instructions for optimizing communication with the individual based on unique qualities about their needs and abilities. These were generally excellent and the use of cards, inclusion of these in the PNMP, sharing of these strategies with psychology and program developers, as well as, specific staff training were methods applied to ensure these were integrated throughout the day and across environments. These tended to be ways to enhance existing communication efforts, but there was little provided to promote new skill acquisition. Communication cards were to be carried by the primary communication partner and passed to subsequent caregivers at workshops, day programs, therapy interventions, and at shift changes. When there were changes to the strategies, Habilitation staff were to make the changes to the cards and the PNMPs, as well as provide staff training as indicated. Another method intended to promote greater communication opportunities for individuals was the implementation of the "communication moment" (4/1/12). The communication partner was to review the strategies with the individual prior to initiating any activity as well as use those strategies throughout the activity. These strategies were also to be reviewed with others during appointments or meetings. Staff were supposed to redirect others to use the appropriate strategies identified as most effective for the individual whenever necessary. The staff were to be prepared to discuss these strategies with anyone who asked about them. While this was commendable, integration of these strategies would not always be intuitive for direct support professionals. There was still a significant need for staff to work with professional staff who modeled the functional integration of these strategies into the daily routine throughout the day. This was also needed to appropriately provide skill acquisition programs intended to promote the potential for learning new communication skills during functional activities that were meaningful and interesting. In some cases, AAC was summarily dismissed when an individual failed to activate a switch during an assessment, for example, rather than incorporated into meaningful activities to prompt use or specific training to address use. Additionally there are many effective formats available for application of pictures or actual objects for AAC systems other than the picture sheets, books and albums used as standards at EPSSLC.	

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		EPSSLC appeared to be focused on supports that addressed natural communication modalities identified through the assessments. This was an excellent and much needed first step, but is more of a staff training focus rather than an individual-specific one. Staff need to understand their role in being effective communication partners to capitalize on individual's existing skills to the fullest extent possible. It is important, however, that the assessment process step out beyond this to identify potentials for individual learning for skill acquisition. There were no written communication plans or instructions with photographs that included the use and care of AAC submitted for individuals. There were a number of general use devices located in various environments, including seven homes, the workshop, and activity rooms. Picture wallboards continued to be available in nine homes and an activity room. There was evidence of some instructions related to their use in individual notebooks. Consistent implementation was an ongoing concern and, as such, meaningful and functional use by the individuals often did not occur and was not observed by the monitoring team. <u>Direct/Indirect Communication Interventions:</u> Generally accepted practice standards for documentation by the SLP related to communication interventions included the following: • Current communication assessment identifying the need for intervention with rationale. • Measurable objectives related to functional individual outcomes included in the ISP. • Routine IPN or other SAP documentation contained information regarding whether the individual showed progress with the stated goal. • Routine IPN or other SAP documentation described the benefit of device and/or goal to the individual. • Routine IPN or other SAP documentation reported the consistency of implementation. • Routine IPN or other SAP documentation identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. Direct communication-related interventions were identified as provided for two individuals in the last six months (Individual #19 and Individual #195). Each was provided through the GIFT program. Communication assessments were submitted for	

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		each individual, dated 2/27/12 and 4/10/12, respectively. Recommendations for these interventions were included in the assessment and ISP for Individual #195 only. The measurable objective was related only to participation in the program rather than an actual learning objective to promote improved communication skills. Documentation for 0 of 2 individuals (0%) was adequate as per the indicators outlined above. As such, the provision of these interventions did not meet basic minimum standards of practice for speech services. No documentation for communication-related SAPs was submitted for review in the samples requested. <u>Competency-Based Training and Performance Check-offs:</u> New employees participated in NEO classroom training prior to their assignment in the homes and completed initial competency check-offs at that time for specific skill sets related to PNM and communication. The schedule indicated that there was a one hour session related to deaf awareness and an additional three hour session related to AAC, each on day nine of the NEO training schedule. The provision action steps for section R indicated that the combined sessions for dysphagia and communication in NEO were expanded from four to six hours and the refresher was expanded from one hour 30 minutes to three hours for both content areas. The curriculum "Communication- It's More Than Words was revised on 6/10/12 and "Alternative and Augmentative Communication (AAC) Devices" was revised in February 2012. These training curricula appeared to be comprehensive, though it was not clear during what time frames each of these was taught. There was a significant amount of content in these curricula and it could not be determined if any aspect of this training took place during the PNMP training blocks on day nine or ten. Staff were required to sign an acknowledgement that they had been trained on the following: • Fundamentals of communication strategies in the PNMP • Use of both universal and individualized AAC devices • Documentation associated with implementation of the PNMP It could not be determined from the materials submitted, however, if there were sufficient opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. However, there were competency check sheets and written tests for each of these curricula and included the following: • Adaptive switch competency assessment and practice checklists • Communication competency assessment and practice checklists • Picture Communication Board competency assessment and practice checklists • Picture Communication Sheets competency assessment and practice checklists	

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		• Put 'Em Around competency assessment and practice checklists • Sound Generating Device competency assessment and practice checklists • Talking Photo Album competency assessment and practice checklists These were well-detailed and appropriate depending on who was conducting the competency check-off for staff. Successful completion of these check-offs established competency for foundational PNM skills. In the case that a DSP did not pass competency skills in three attempts, that employee's name was to be sent to the Director of CTD and deemed "not suitable" for hire. These procedures became effective as of March 2012. The steps for validating competency were outlined in a procedure dated 2/8/12 and submitted with the document request. After attending NEO training and completing the initial competency checks, each DSP reported to the assigned home supervisor and completed validation of home-specific competencies within seven days of assignment. This was conducted prior to completion of the shadowing period and before being assigned a caseload in the home. Validators (PNMPCs and home supervisors) were identified by Habilitation therapists and were also validated to complete this process initially and for two consecutive quarters. Re-validation of validators was completed annually. Staff training related to communication was included as an aspect of annual retraining along with dysphagia and was offered monthly for existing staff. The same process was applied for refresher training in that if an existing employee did not pass within three attempts, he or she would be referred to the Director of CTD for corrective action and would not be permitted to work with individuals until passing the check-offs. A new foundational training course was added related to communication moments and was included in NEO, but also provided also to administrators, DSPs, QDDPs, therapists, psychologists (3/19 to 3/23/12), and nurses (5/2/12). Additional training was provided to all DSPs on 5/16/12 and 5/17/12 related to communication and communication moments. Individual-specific inservice training was provided to PNMPCs, home supervisors, and the direct support professionals for non-foundational skills (those not taught in NEO) by the SLPs upon the introduction of a new communication system/plan or if there were major changes made in the plan. If further staff training was required, the SLP established competency of the PNMPC and/or home supervisors who then in turn completed further training for the other direct support professionals. By report, the trainers required return demonstration with a skills-based check-off to establish the competency of staff. Evidence of this process was not requested for review by this will be a focus for future reviews by the monitoring team.	

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		The current system for training staff regarding the implementation of communication programs and the effective use of AAC throughout the day appeared to be sound, however, as stated above, the existing communication supports were very much limited, the strongest of which were the optimal communication strategies. While these were excellent and had the potential to be well integrated into other training programs, there were very few programs designed specifically to increase communication skill acquisition. The use of AAC was also very limited beyond those standards provided to everyone, though it appeared a number of individuals could benefit from these supports. The current systems provided were a continuation of the weaknesses identified in previous reviews by the monitoring team. It was expected with new speech staff and continuing education opportunities that a more creative and individualized approach would be forthcoming over the next six months. While the interactions of staff with 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. Staff were observed talking to the individuals, but most did not appear to understand how to facilitate better engagement and participation with the individuals, despite the communication strategies, cards and moments. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology where appropriate), should continue to be a priority. This will only be possible when the clinicians are sufficiently available to routinely model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. Rather than merely co-designing programs and providing formal training, actual implementation should be collaborative with demonstration in real time activities. As stated above, many of the strategies outlined or the ability to incorporate assistive technology is not naturally intuitive for direct support professionals. Group and individual activities should be routinely co-directed by speech clinicians and DSPs in the homes, work, and day program environments so that the clinicians can model how to appropriately use these strategies during the activities to expand and enhance staff's partnering skills as well as to expand and enhance active participation of the individuals via communication. Also partnering with OT and PT in this capacity will further promote functional and meaningful activities for individuals.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>R4</td><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.</td><td><u>Monitoring System:</u>
Monitoring of communication supports was provided using the validity tier system and based on the health risk assessment ratings. The Communication Monitoring Form was used to evaluate staff knowledge regarding the required supports, the presence and condition of the supportive equipment, and the appropriate implementation of the supports. Staff drills included specific questions, such as:
1. Who are the individual's Communication Partners?
2. Who is the Primary Communication Partner?
3. What is a Communication Moment and when do you practice it?
4. Were you trained on this individual's communication strategies?

The monitor was to provide immediate feedback and correction to the DSP related to identified concerns. The drill questions were to be changed every three months to enhance staff learning and prevent rote responses. Findings were entered into a tracking database. Findings and analyses were reported to the QAQI Monitoring Committee on a monthly basis by report. A weekly monitoring system to review the presence, working order of general community-use AAC devices, as well as individual devices(electronic), had been developed and was implemented the last couple of months.

While this was a good approach, the clinical coordinator was also encouraged to structure monitoring based on prioritized communication needs as well. The frequency of monitoring was included in the communication assessment format, though this did not appear to be individualized and no rationale for the recommended frequency was stated in the assessments reviewed.

There was no local policy related to monitoring of communication supports.

Completed monitoring sheets (101) were submitted for approximately 60 individuals for May 2012. Results were as follows:

<table>
<tr><th>100%</th><th>90%</th><th>80%</th><th>70%</th><th>60%</th><th>50%</th><th>40%</th><th>30%</th><th>No score</th></tr>
<tr><td>39</td><td>0</td><td>26</td><td>10</td><td>3</td><td>2</td><td>0</td><td>2</td><td>19</td></tr>
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While the overall percentage of compliance was above 80%, there were some deficiencies in the process that suggested that was not an accurate reflection of staff performance and implementation as well as the efficacy of communication supports provided.
• There were 25 forms that did not specify which communication system(s) were monitored, so actual staff implementation was questionable.</td><td>Noncompliance</td></tr>
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		• As the majority of the communication supports provided were limited to strategies, individual books, and picture sheets, there was virtually no issue related to being in good working condition, one of the elements of the monitoring process. • The PNMPCs were asked to make a judgment as to whether the pictures and symbols were appropriate and individualized. This would be a function of assessment for which these non-licensed staff were not qualified to provide. • Since there were virtually no formal programs, the element of staff demonstrating or describing the features and use of the communication systems was also left to the discretion of these non-licensed staff. • There was also no method to document if communication was actually observed or were merely described by staff as stated on the form. For example in the case of Individual #25, she was listed with communication strategies, a card, sheets, and a talking photo album. The monitor on 5/31/12 documented that staff followed all communication and AAC equipment/systems instructions on the PNMP. There was no reference to the photo album on the monitoring form, so it was not known if it worked or was used as instructed. Further, there were no instructions in her individual notebook regarding this device and none in her PNMP. Her individual notebook had picture sheets and references to using a wall board, but it was not known if these were monitored by the PNMPC. There was not one entry in the integrated progress notes related to communication and no other evidence of effectiveness monitoring by the SLP in the last 12 months beyond the annual assessment. Licensed clinicians should conduct routine reviews of the efficacy of the communication supports provided and observe and validate consistent implementation of all AAC systems and Communication Dictionaries. A tracking system was developed to track monitoring by the PNMPCs and to track identified issues and follow-up. This was documented on a monitoring form, but it did not appear that the findings were documented in the individual record or integrated with the ISP review process. The SLPs did not reference these findings in their annual assessments. Monitoring of communication programs and systems should be based on level of need 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.	

Recommendations:

1. Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal should be addressed in the communication assessment and reviewed routinely throughout the year (R2).

2. The assessment process should reflect the clinicians should clearly describe communication abilities and opportunities in a variety of settings as observed by the therapist. The daily activities should be observed for potentials for communication partners to facilitate participation. For example, encouraging an individual to look toward their wheelchair before a transfer or blinking or vocalizing for "go" to initiate the transfer are ways in which the individual can participate in a way that is communication-based. Holding a self-care object, like a toothbrush, while the DSP brushes their teeth is another way in which opportunities can be captured during routine activities throughout the day. These activities must be observed however to capitalize on those potentials (R2).

3. Continue efforts to acquire full time SLPs and/or Speech Assistants to ensure that the facility is able to meet the identified needs of individuals and meet the requirements of the Settlement Agreement in a timely manner. There was an insufficient number of skill acquisition plans to promote increased communication and language skills (R1).

4. 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 (R3).

5. Expand supports beyond the optimal communication strategies to include AAC and SAPs. Effectiveness monitoring for each should be conducted routinely (R3-R4).

6. 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).

7. Continued staff training and modeling are indicated to ensure appropriate and consistent implementation of recommended AAC systems (R3).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u> o Individual Support Plan (ISPs) for: • Individual #28, Individual #66, Individual #157, Individual #39, Individual #148, Individual #61, Individual #49, Individual #31, Individual #70, Individual #147, Individual #120, Individual #84, Individual #175, Individual #38, Individual #60, Individual #152 o Skill Acquisition Plans (SAPs) for: • Individual #49, Individual #31, Individual #70, Individual #147, Individual #120, Individual #84, Individual #175, Individual #38, Individual #60, Individual #152 o SAP data for: • Individual #49, Individual #31, Individual #70, Individual #147, Individual #120, Individual #84, Individual #175, Individual #38, Individual #60, Individual #152 o Quarterly reviews of SAP progress for: • Individual #152, Individual #60, Individual #38, Individual #175, Individual #84, Individual #120, Individual #147, Individual #70, Individual #31, Individual #49 o Dental desensitization plans for: • Individual #70, Individual #33, Individual #19, Individual #83, Individual #126, Individual #84, Individual #169, Individual #82, Individual #57, Individual #51 o Multi-purpose Center and Hilos de Plata Senior Citizen Center Monitoring Sheet, dated March 2012 o Skill Acquisition Program/Monitoring-Documentation Checklist, undated o Section S Presentation Book, undated o Inventory of all data collected at the facility, dated 6/12/12 o Provision Action Information, dated 6/29/12 o Corrective Action plans in the last 6 months o Minutes of QAQIC, PET, and PIT meetings in the last 6 months o Engagement data sheet, dated 3/28/12 o Active Treatment Schedule, undated o Section S Self-assessment, dated 6/29/12 o Section S Action Plans, dated 6/29/12 o Draft policy and procedures for Habilitation, Training, Education, and Skill Acquisition Programs, dated 5/10/12 o A summary of community outings per residence/home for the past six months o A list of individuals who are employed on- and off-campus, undated o Description of on-campus work programs, undated o A list of skill training provided in the community, undated o Desensitization Evaluation of Individuals, dated 2012

	o PowerPoint EPSSLC Skill Acquisition Plan Training o List of individuals who attended public school (four individuals, two of whom graduated in June 2012) o ISPs, ARD/IEPs, and EPISD progress notes for: • Individual #69, Individual #35, Individual #134 o School and home social story book for seizures for Individual #69 <u>Interviews and Meetings Held</u>: o Cynthia Martinez, QDDP Coordinator o Martha Pena, Program Developer; Beatriz Rivera, Program Developer; Susan Abbott, Program Developer o Guadalupe Azzam, Active Treatment and Day Programs Coordinator o Alex Euzaragga, Rosa Renteria, QDDPs <u>Observations Conducted</u>: o Active Treatment Meeting o Pre-Sedation/Desensitization Planning Committee Meeting o Community day program o Observations occurred in various day programs and residences at EPSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals.
	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. Overall, the self-assessment included many relevant activities in the "activities engaged in" sections. For example, S1 included a review of SAPs that focused on many of the same components that the monitoring team reviews. Not all activities described in the self-assessment, however, were consistent with what the monitoring team reviewed. For example, for S1 the self-assessment reported that the facility reviewed the section S tool which included some measures that were similar to those described in the report below (e.g., SAPs with all the components necessary for learning), however, it did not appear to address the need for a clear rationale and desensitization plans, that have been consistently included in S1 reports. Finally, the quality of the plans for maintenance and generalization did not appear to be addressed in the S-tool. The monitoring team suggests that the facility 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 department 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, and the monitoring teams report.

	EPSSLC's self-assessment indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas. The 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 recommends that the facility establish, and focus its 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: Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, there were improvements since the last review. These included: • Development of a SAP checklist to monitor SAP content (S1) • Initiation of an interdisciplinary team to develop plans to decrease dental/medical sedation (S1) • Expansion the new SAP format (S1) • Re-initiation of graphed quarterly SAP data (S3) • Evidence of data-based decisions for the continuation, discontinuation, or revision of SAPs (S3) • Initiation of day programming in the community (S1, S3) • Continued positive working relationship with the local public school district, with good outcomes for individuals (S1) The monitoring team suggests that the facility focus on the following over the next six months: • Ensure that the rationale for each SAP clearly states how acquiring this skill is related to the individual's needs/preference (S1, S2, S3) • Ensure that each SAP has a plan for maintenance and generalization that is consistent with the definitions below (S1) • Document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2). • Conduct additional training on the implementation and data collection of SAPs (S3) • Collect and track SAP integrity measures (S3) • Develop a system to separately track recreational activities and training in the community (S3) • Establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved (S3)

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	<u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at EPSSLC had multiple skill acquisition plans; the average number of skill acquisition plans (SAPs) per individual sampled by the monitoring team was 5.3. Skill acquisition plans at EPSSLC consisted of training objectives, and were referred to as 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). As discussed in the last report, an important component of effective skill acquisition plans is that they are based on each individual's needs identified in the 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. The facility recently modified the SAP format to include a rationale for each specific acquisition plan. This appeared to be a very direct way to ensure that SAPs were developed to address individual preferences and needs. During the last onsite review (January 2012), the facility had only five SAPs in the new format for the monitoring team to review. During this review, however, the new SAP format had been expanded to the majority of skill acquisition plans across the facility. In the monitoring team's sample, only one (Individual #120's SAP of self-administration of medication) of the 53 SAPs reviewed (2%) was in the old format. In 23 of the 52 SAPs in the new format reviewed (44%), the rationale appeared to be based on a clear need and/or preference. For example: • The rationale for Individual #31's SAP of wiping the table was that she was a candidate for moving to the community and, therefore, she would benefit from acquiring independent living skills that she would use in the community. • The rationale for Individual #84's SAP of using a liquid soap dispenser was that he enjoyed touching and exploring his surroundings, and using the soap dispenser was the first step toward him learning to wash his hands. In 29 of the 52 new format SAPs reviewed (56%), however, the rationale was not specific enough for the reader to determine if it was practical and functional for the individual. For example: • The rationale for Individual #60's money management SAP was that she would benefit from a program teaching her to identify the different US bills • The rationale for Individual #152's dressing skills SAP was that he enjoyed looking nice when he goes out	Noncompliance

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		EPSSLC 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. This can most directly be accomplished by indicating how preference, strengths, skills, and needs impacted the selection of this particular SAP (see S2). Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology The new SAP training sheets contained all of the above components. As discussed in the last report, the maintenance and generalization plans, however, did not consistently reflect the processes of maintenance and generalization. A generalization plan should describe how the facility plans to ensure that the behavior occurs in appropriate situations and circumstances outside of the specific training situation. A maintenance plan should explain how the facility would increase the likelihood that the newly acquired behavior will continue to occur following the end of formal training. Overall, 36 of the 52 SAPS reviewed (69%) in the new format included a plan for generalization that was consistent with the above definition. Thirty of the 52 SAPS reviewed (57%) included a plan for maintenance that was consistent with the above definition. An example of a good generalization plan was: • The plan for generalization in Individual #120's leisure skills SAP stated that he should be encouraged to participate in leisure activities on campus and out in the community. • The plan for generalization in Individual #152's toothbrushing SAP stated that	

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		he be encouraged to brush his teeth when he goes home and visits his family. An example of an unacceptable plan for generalization was: • The plan for generalization in Individual #60's SAP of propelling her wheelchair stated that staff should always follow PNMP and BSP plans when working with her. An example of a good maintenance plan was: • The plan for maintenance in Individual #31's SAP of putting on her seat belt stated "Make sure to continue offering… the opportunity to fasten her seat belt after training…" An example of an unacceptable maintenance plan was: • The plan for maintenance in Individual #147's SAP of dressing stated that she will be encouraged to perform dressing in a timely manner whenever changing clothes. It is recommended that all SAPs contain generalization and maintenance plans that are consistent with the above definitions. The facility continued to use different training methodologies, including total task training and forward and backward chaining. As discussed in the last report, however, much more training and monitoring of SAPs at EPSSLC was necessary to ensure that they were implemented and documented as written (see S3). <u>Desensitization skill acquisition</u> The facility continued to make progress in this area. Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. 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. Since the last review, EPSSLC established an interdisciplinary team to develop plans to decrease dental/medical sedation. A list of dental desensitization plans developed indicated that 19 plans were developed since the last onsite review. A review of 10 dental desensitization plans indicated that the plans were not in the new SAP format. It is recommended that compliance and dental desensitization plans be incorporated into the new SAP format. Outcome data (including the use of sedating medications) from	

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		desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail in future site visits. Replacement/Alternative behaviors from PBSPs as skill acquisition 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. Communication and language skill acquisition Several of the replacement behavior SAPs targeted the enhancement or establishment of communication and language skills (see K9). None of the 53 SAPs reviewed by the monitoring team, however, involved teaching new or improved methods of communication. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (also see section R). 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 past reviews, the monitoring team was encouraged by the general positive interaction of staff and individuals, and the addition of activity schedules and materials at	

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		EPSSLC. The overall observation of engagement during this review, however, was mixed. In some homes visited (e.g., 509), 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. In still other homes individuals were not engaged when the monitoring team entered the area, but soon after arrival, activity materials were brought out and staff began to engage individuals. The table below documents engagement observed in various settings throughout the facility. The average engagement level across the facility was 50%, about the same as that observed during the last three reviews (i.e., 49%, 50%, and 51%), 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. The monitoring team was encouraged by two recent developments at EPSSLC that will potentially result in improvements in individual engagement. One was the appointment of a new active treatment coordinator who appeared to have a good understanding of individual engagement, and was committed to improving it. The second positive development was the establishment of day programming in the community. This appeared to be a natural way to build and reinforce meaningful individual engagement. The monitoring team anticipates seeing improvement in engagement in activities in the next review. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
Dorm B and C	3/9	3:9
Dorm A	2/3	1:3
Cottage 506	2/5	2:5
Cottage 513	0/4	1:4
Cottage 513	2/3	1:3
Cottage 512	2/5	2:5
Cottage 507	1/3	1:3
Cottage 507	0/3	1:3

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Cottage 515 (day program)	0/7	3:7
Cottage 515	2/7	3:7
Cottage 515	2/3	1:3
Cottage 515	2/2	1:2
Vocational Workshop	11/24	3:24
Cottage 506	3/5	2:5
Cottage 507	5 /9	3:9
Cottage 513	4/5	3:5
Cottage 513	2/2	2:2
Cottage 513	2/3	2:3
Cottage 511	1/6	2:6
Cottage 511	3/6	2:6
Cottage 510	2/4	2:4
Cottage 510	2/4	2:4
Cottage 508	1/3	2:3
Cottage 508	4 /4	2:4
Cottage 509	3/4	2:4
Dorm A	2/6	3:6
Dorm C	2/3	3:3

Educational Services

Four students continued to attend public school over the past six months. Two graduated in June 2012, so only two students were scheduled to be in school at the beginning of the next school year. Overall, the relationship between EPSSLC and El Paso Independent School District (EPISD) remained extremely positive and, if anything, had improved even further since the last onsite review.

The monitoring team met with the two QDDPs responsible for working with EPISD. They reported that excellent communication continued. They cited graduation activities for

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		the two students who finished their educational services, and participation in a sports team with both of the EPISD school teachers. The public school program was adequately identified in the one new EPSSLC ISP (Individual #69). Collaborative work continued in the development of the ARD/IEPs in that the QDDPs reported that they attended all ARD/IEP meetings contributed to the objectives chosen in the ARD/IEP. In addition, they also reported some joint work, such as choosing the same training words for home that were being taught at school (Individual #134) and working on the same storybook about seizures in both settings (Individual #69). Extended school year summer school continued to be offered. This year it was for six weeks, four half days per week. The QDDPs noted that they read EPISD progress reports and put them into the scanned folder on the shared drive. They reported that any issues were discussed by the IDT. The monitoring team was satisfied with the educational services component of this provision item and has no further recommendations other than for the QDDPs to their collaborative work with EPISD.	
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 continued to struggle with the documentation of how this information impacted the selection of skill acquisition plans. The monitoring team will continue to review the specific assessments utilized by EPSSLC, however, this rating of noncompliance is based on the absence of documentation that assessments were consistently used to develop SAPs. At the time of the onsite review, the facility was completing the transition from the use of the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). FSA appeared to be an improvement over the PALS in that it provided more information (e.g., necessary prompt level to complete the skill) regarding individual's skills. EPSSLC also used the preference assessment survey and, at the time of the onsite review, began to use a new vocational assessment. No assessment tool is going to consistently capture all the important underlying conditions for all skill deficits. Therefore, to guide the selection of meaningful skills to be trained, assessment tools often need some individualization. The FSA, for example, may identify the prompt level necessary for an individual to dress himself, but to be useful for developing SAPs, one may need to consider additional factors, such as context, necessary	Noncompliance

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		accommodations, motivation, etc. For example, the prompt level necessary for getting dressed may be dependent on the task immediately following getting dressed (i.e., is it a preferred or non-preferred task), and/or the type of clothes to be donned, whether the individual chooses them or not, etc. Similarly, surveys of preference can be very helpful in identifying preferences and reinforcers, however, there is considerable data that demonstrates that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. Thus, in summary, there was no documentation of the use of individualization of assessment tools to identify SAPs. Additionally, review of ISPs did not consistently document how assessments impacted the development of programs. The following were typical: • Individual #49's ISP discussed her vocational assessment, preferences, and communication assessment, but concluded that she will have a bathing and money recognition SAP without any discussion of her FSA, or discussion of any assessment data that led to the conclusion that those skills were practical and functional for her, or that other skills were less important. • Individual #120 had a recycling SAP, but no mention in his ISP of any assessment results (e.g., vocational assessment, preference assessment) that suggested that recycling was a practical SAP for Individual #120. • Individual #31's ISP discussed the fact that she did not like loud noise. Additionally, the vocational assessment concluded that she did very poorly with a shredding job due to the noise of the machine. Her ISP, however, identified a new SAP for shedding paper. The director of QDDPs and program developers were able to discuss, in general terms, how they have used various assessments of individual preference (including an example of a systematic preference assessment) and strengths and skills (as identified in the FSA and other assessment tools) to develop meaningful skill acquisition plans and vocational programming. They could not, however, provide the monitoring team with documentation of how these various assessments resulted in individualized skill acquisition programs. The director of QDDPs discussed developing a tool to better guide the team, and more clearly demonstrate the effects of assessments and preference on the selection of individual programing. The monitoring team looks forward to reviewing that tool.	

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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	There was improvement in this provision item, however, more work in the areas of integrity of the implementation and recording of SAPs is necessary before this item can be rated as being in substantial compliance. At the time of the onsite review, QDDPs at EPSSLC summarized SAP data monthly and presented those data at quarterly meetings. Ten quarterly reviews representing the outcome data of 53 SAPs were reviewed to determine compliance with this provision item. During the onsite review, QDDPs graphed SAP outcome data for nine of the 10 quarterly reviews (90%) examined by the monitoring team (Individual #84 was the exception). This represented an improvement from the last review when none of the quarterly data were graphed. Additionally, there were several examples (e.g., Individual #120, Individual #60, and Individual #31) of SAPs being modified or discontinued as a result of the absence of progress. For example, the quarterly review of Individual #31's community awareness SAP stated that, due to her recent poor performance, the SAP was revised. This also represented progress from the last review when there was no evidence of decisions concerning the continuation, discontinuation, or modification of SAPs being based on outcome data. Finally, 24 of the 53 SAPs reviewed (45%) showed progress or the achievement of sustained high levels (i.e., above 90%) of SAP performance. This represented a decrease in SAP progress from the last report when 79% of SAPs showed progress. As in past reviews, the monitoring team observed the implementation of SAPs in the day programs and cottages during the onsite review to evaluate if they were implemented as written. Additionally, SAP data sheets were reviewed to evaluate if data were completed as scheduled. The results from those observations were discouraging. For example: • Individual #69 was working on his engagement in leisure activities SAP. The SAP coversheet indicated that the SAP consisted of three steps. The SAP data sheet, however, only had one step. The DCP indicated that he did not know how	Noncompliance

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		to record the data. • The monitoring team asked five DCPS across five different cottages if they could be observed conducting a SAP. Three of those DCPs reported that they did not know what a skill acquisition plan/SAP was. • Current data for scheduled skill acquisition plan implementation were present in four of seven SAP data sheets reviewed (57%). This was a decrease from the last review when 70% of SAPs reviewed had currently data, and is consistent with the facility's self-assessment, which indicated that 40% of SAPs were missing data. The newly developed community day program (see S1) appeared to be a wonderful opportunity to provide a model for training skills in the community. The monitoring team looks forward to seeing how this new, exciting program is utilized by the facility to achieve both meaningful individual engagement (S1) and community training (S3b). These observations suggested that SAPs were not consistently conducted as scheduled, or implemented as written, and that additional training and monitoring of DCPs is needed. The only way to ensure that SAPs are conducted as scheduled and 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 scheduled and written.	
	(b) Include to the degree practicable training opportunities in community settings.	As noted in the last review, many individuals at EPSSLC enjoyed various recreational and training activities in the community. In order to achieve substantial compliance with this provision item, the facility needs to develop a data system to track recreational activities and training in the community, establish acceptable levels of each, and demonstrate the that those levels are consistently achieved. The self-assessment indicated that from 1/1/12 to 5/31/12 EPSSLC conducted 1203 community outings. Additionally, the facility provided the monitoring team with several examples of training activities that occurred in the community (e.g., Individual #195's identifying an accessible restroom in the community). As discussed in the last review there was, however, no way evaluate how often SAP training occurred in the community, or how many individuals at EPSSLC had skill training in the community. It is recommended that recreational and skill training activities in the community be separately recorded so that trends could be tracked. Additionally, acceptable levels of both activities should be established. At the time of the review, no individuals at EPSSLC worked in the community.	Noncompliance

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 the above definitions (S1).

3. Compliance and dental desensitization SAPs should be written in the new SAP format (S1).

4. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (S1).

5. The facility should ensure that assessments are consistently used and documented to determine individual skill acquisition plans (S2).

6. Additional monitoring and training of DCPs in the implementation and recording of SAPs is needed (S3).

7. A plan should be developed to collect and graph integrity data to ensure that SAPs are conducted as scheduled and written (S3).

8. The facility should develop a data system to track recreational activities and training in the community, establish acceptable levels of each, and demonstrate the that those levels are consistently achieved (S3).

9. Revise the self-assessment so that it includes the topics that the monitoring team commented upon in the report (self-assessment).

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, attachments, January 2012 o EPSSLC facility-specific policy, Most Integrated Setting Practices, 5/11/12 (same as the state policy, 018.1) o EPSSLC organizational chart, undated, but probably June 2012 o EPSSLC policy lists, undated, but probably June 2012 o List of typical meetings that occurred at EPSSLC, undated o EPSSLC Self-Assessment, 6/29/12 o EPSSLC Action Plans, 6/29/12 o EPSSLC Provision Actions Information, most recent entries 6/29/12 o EPSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/16/12 o Community Placement Report, last six months, 1/1/12 through 7/19/12 o List of individuals who were placed since last onsite review (3 individuals) o List of individuals who were referred for placement since the last review (9 individuals) o List of individuals who were referred and placed since the last review (0 individual) o List of total active referrals (12 individuals) o List of individuals who requested placement, but weren't referred (4 individuals) • Documentation of activities taken for those who did not have an LAR (1 individual) o List of individuals who requested placement, but weren't referred due to LAR preference (2 individuals) o List of individuals who were not referred solely due to LAR preference (10 individuals) o List of rescinded referrals (2 individuals) • ISPA notes regarding each rescinding • Special Review Team minutes for each rescinding o List of individuals returned to facility after community placement and related ISPA documentation (0 individuals returned during this period) 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, and a brief narrative for each case (7 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 under alternate discharge procedures and related

	documentation (0 individuals) o APC weekly reports, five, 6/1/12 through 7/13/12, these were detailed referral and placement report for senior management o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, February 2012 • Community tours, 1/12/12 through 5/23/12 (9) and ISPAs for some (0) • Meetings with local LA (2) • Training for LA and SSLC staff, 6/1/12 • New employee orientation, January 2012 through June 2012 • Sessions with Facility staff (QDDPs, residential managers, activity coordinators, 2/29/12 through 7/5/12 • Email of most integrated setting practices policy to managers, 5/10/12 o Self-advocacy meeting, 5/30/12 o Family association meetings, 5/19/12 o Signs posted around campus regarding community living o CLOIP and permanency plan tracking documents, and completed CLOIP forms, January 2012 through May 2012 o APC statewide monthly scan call agendas, January 2012 through June 2012 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 List of individuals who had a CLDP completed since the last review (3 individuals) o Completed checklists used by APC regarding submission of assessments for CLDP that were <u>not</u> within the CLDP (none) o DADS central office written feedback on CLDPs (3 individuals, 100% of the CLDPs) o For the three statewide monitoring tools for section T: • Blank tools • Completed tools: Review of living options (6, of which 4 were on an older tool) • Corrective Action Plan regarding interobserver agreement o Self-monitoring tool for T2b o Total count of obstacles by category, 85 total, 6/11/12 o State obstacles report and EPSSLC addendum, October 2011 o PMM tracking sheet, undated, but likely June 2012 (incomplete) o Daily log with ENE support checklist, from Draco services o Transition T4 materials for: (none) o ISPs and assessments in the September 2011 style for: • Individual #69, Individual #36, Individual #66, Individual #157 o ISPs in the January 2012 style for: • Individual #15, Individual #88 o CLDPs for: • Individual #53, Individual #55, Individual #110

	o Draft CLDP for: (none) o In-process CLDPs for: • Individual #195, Individual #123, Individual #61 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of any IDT meetings that occurred after each review, conducted since last onsite review for: • Individual #132: 90, post-90 • Individual #68: 45, 90, post-90 • Individual #53: P, 7, 45, 90 • Individual #55: P, 7, 45, 90 • Individual #110: P, 7 <u>Interviews and Meetings Held</u>: o Antonio Ochoa, Admissions and Placement Coordinator o Alice Villalobos, Post Move Monitor o Helen Alvarez, Fernando Fraga, Transition Specialists o Eileen Short, DADS central office coordinator of transition specialists o Gisel Hita, program director, Ericka Vasquez and Gracie Orozco, managers, Draco Services, Inc. o Family of Individual #76 <u>Observations Conducted</u>: o CLDP Meeting for: (none) o CLDP assessment review meeting for: (none) o Statewide APC scan call, 7/19/20 o ISP Meeting for: • Individual #77, Individual #102 o Community group home and community day program visits for: • Individual #110: 7-day post move monitoring, 7/16/12 and 7/17/12 o Self-advocacy meeting, 7/19/12 o Community living activity room, day program area, 7/17/12
	Facility Self-Assessment EPSSLC continued to use the self-assessment format it developed for the last review. The APC had further developed what he presented last time by including additional activities and outcomes. In that regard, he made progress in that he was trying to look at actual activities and outcomes for each provision item. The most important next step is for the APC to make sure that he includes everything in his self-assessment that the monitoring team looks at. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in the self-assessment (and perhaps in a new self-assessment tool, too). It is possible that new tools might include everything that comprises the self-

	assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. The current three tools used by the APC had numerous problems in content and in implementation (see T1f). Again, it will be important for the self-assessment to line up with the topics in the monitoring team's reports. For example, provider fair information has been, for many consecutive reviews, monitored in T1b2. In the self-assessment, it was in T1a. In addition, there was only one sentence about the determinations of professionals in the APC's self-assessment of T1a ("6 of 7 revealed that the transfer/referral is consistent with the determination of professionals that community placement is appropriate"), however, the monitoring team assessed professional determinations in much more detail than that by also looking at ways that professional determinations were provided in assessments, during the meeting, and in the final ISP document. Not everything, however, requires a tool. For example, for T2a, when assessing whether post move monitoring occurred within the required timelines, the APC could easily look at the entire list of post move monitorings (because there were only 12) rather than only using the three for which a post move monitoring self-monitoring tool was implemented. The APC correctly acknowledged problems in some of the self-assessment data for T1c2, T1c3, and T1d. The PMM was interested in self-assessing T2b. To that end, she asked the monitoring team to look at three pages of audit data of post move monitoring and one page of graphs. This appeared to be, however, self-assessment of T2a, that is, whether post move monitoring was conducted as required. T2b looks at the PMM's adequate implementation of post move monitoring while it is occurring. Thus, the items should be more about her actual conduct while doing the onsite reviews, such as whether the PMM was thorough, asked all of the questions, interviewed every staff member, spoke with the LAR/family, interacted with the individual, actually looked at evidence rather than merely asking staff about evidence, walked through the home, examined closets and refrigerator, allowed staff to answer questions rather than providing leading questions, was assertive and professional, pursued any problems uncovered, and so forth. The completed written post move monitoring report should correspond with what occurred during the onsite review. T2b might be self-monitored if the APC should conduct any observations of the PMM while she is completing an onsite post move monitoring. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the APC and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in substantial compliance with six provision items: T1c2, T1c3, T1d, T1e, T1h, and T2a. The monitoring team agreed all of these, except for T1e. In addition, the monitoring team rated T2b as being in substantial compliance and did not rate T4 (because there were no transfers).

	Summary of Monitor's Assessment EPSSLC continued to make progress towards substantial compliance. The specific numbers of individuals who were placed remained stable, but at a low annual rate of approximately 5%. On the other hand, since the last review, 9 individuals were referred and 12 individuals were now on the referral list, the most at any one time since monitoring began. Opinions and determinations of professionals regarding community placement were being addressed more so than at the time of the previous review, however, more work was needed so that this is done in an adequate, thorough, and consistent manner. In reading the professionals' opinions, the monitoring team noted different "approaches" to these comments. The monitoring team recommends that the facility and state office consider providing more direction to the professionals, so that there is a consistent approach to this requirement. The CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that training objectives were considered and developed based upon the individual's referral to the community. Obstacles to referral and placement at the individual level were not identified or addressed in a consistent manner. There was no indication if the identification of these obstacles led to a plan to address them. EPSSLC was engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. Most progress was seen in the organization and conduct of tours of community providers. CLDPs were rated as not being developed in a timely manner. This was due primarily to there having been many long-standing referrals. It is likely to not be a problem going forward. IDT members continued to be very involved in the placement activities of the individuals. IDT meetings occurred after post move monitoring visit, even if there were no problematic issues. The CLDPs identified the need for training for community provider staff. The CLDPs included some descriptions of the content of what was to be trained, but more detail was needed regarding this training. The sets of CLDP assessments were all completed within 45 days prior to the individual leaving the facility. The assessments need to focus more upon the individual moving to a new residential and day setting. The lists of ENE supports was much improved. Some additional work was needed to ensure implementation of supports were adequately included in the list of ENE supports and that evidence of implementation was adequately defined. The monitoring team recommends that the APC create a self-assessment specifically for the ENE supports. Since the last review, 12 post move monitorings for 5 individuals were completed. This was 100% of the

	post move monitoring that was required to be completed. All (100%) occurred within the required timelines. All (100%) were documented in the proper format, in line with Appendix C of the Settlement Agreement. Of the 5 individuals who received post move monitoring, 4 (80%) transitioned very well, appeared to be happy, and were having a great life. This was well reflected in the detailed post move monitoring reports. Many of the post move monitoring reports also noted that families were very happy to have their loved one in these new placements (one individual was now living with his family). One individual, however, had difficulty in his placement, likely due, at least in part, to inadequate support provided by the provider.

#	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 continued to make progress towards substantial compliance with the items of this provision. Tony Ochoa, the facility's Admissions and Placement Coordinator (APC) continued as the lead for this provision. He continued to be assisted by the post move monitor (PMM), Alice Villalobos. Two new transition specialists were hired. They participated in some of the monitoring team's activities during the onsite review. The transition specialists worked under the direction of a central office coordinator, however, the APC said that he expected for them to be fully included in all community living related activities at EPSSLC. The APC and the PMM were very responsive to many of the suggestions and recommendations made in the last monitoring report and during the last onsite review. The specific numbers of individuals who were placed remained stable, but at a very low rate, approximately 5% of the census. On the other hand, the number of individuals on the active referral list was almost 10%, the highest since monitoring began at the facility. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 3 individuals were placed in the community since the last onsite review. This compared with 4, 1, 1, 3, and 1 individuals who had been placed during the periods preceding the previous reviews, respectively. o This demonstrated a stable trend. o Individuals were placed in community group homes or with a family member. • 9 individuals were referred for placement since the last onsite review. o This compared with 6 who were newly referred at the time of the previous review. o 0 of these 9 individuals were both referred and placed since the last	Noncompliance

		onsite review. • 12 individuals were on the active referral list. This compared with 8, 9, 10, 4, and 7 individuals at the time of the previous reviews, respectively. o This was the largest number since monitoring began. o 3 of the individual were referred for more than 180 days. Activities, however, were continuing towards their placements. This compared to 1 and 6 individuals who were referred for more than 180 days during previous monitoring reviews. • 4 individuals were described as having requested placement, but were not referred. This compared with 3 and 2 individuals at the time of the previous reviews, respectively. o 2 were not referred due to LAR preference, 1 was not referred due to medical issues, and 1 was not referred due to legal citizenship reasons. o A review had been held for the individual not referred due to legal reasons (see last monitoring report). o Although a review should have been held for the individual not referred due to medical problems (as recommended in the previous report), the APC now reported that the individual's mother was wanting to have the individual move home with her, and that the IDT supported this transition. At this time, they were waiting for some of his medical problems to stabilize. Therefore, the monitoring team does not think a special review is necessary, however, the APC should ensure that he is following facility policy in this regard. • The list of individuals not being referred solely due to LAR preference contained 10 names (compared to 58 individuals at the time of the previous reviews). o The APC had done a nice job in creating a list that was more accurate than any previous listing at EPSSLC. The 10 names were individuals whom the IDT would refer, except for LAR preference. • The referrals of 2 individuals were rescinded since the last review. This compared to 2 and 2 at the time of the previous reviews, respectively. o Each individual's IDT met and an ISPA report was issued that provided information indicating to the monitoring team that the decision to rescind was reasonable and done thoughtfully. The rescindings were due to the individual's choice and to an increase in medical and behavioral problems. o A special review team meeting was also held for each of these rescinded referrals. o As recommended in previous reports, however, the APC should 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. Note that the ISPA and	

		the SRT notes provided a lot of detail regarding the decision to rescind. The purpose of the APC review is to assess the referral and placement processes. o Note, however, that the new ISP process may result in an increase in referrals and, as a result, an increase in the number of rescinded referrals. If this occurs, it should not necessarily be viewed as an increase in failure by the facility. • 0 individuals were returned to the facility after community placement. This compared with 0 individuals at the time of the previous reviews. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, or who had run away from their community placements were available for the first time, another positive action taken by the APC. The APC initiated a simple spreadsheet database with a section for each of the individuals who had moved over the past year. In each section, the APC described any of these untoward outcomes or events. Data were readily available through the first 90 days due to post move monitoring. The APC and the monitoring team discussed the facility obtaining these data for one year post-move. A simple phone call to each provider at 12 months appeared to be a reasonable and relatively easy way to obtain this information. o 7 individuals had one or more of these incidents occur since the last onsite review. o The most serious involved psychiatric hospitalization for one woman and a change in residential provider for one man. o A detailed review/root cause analysis should be conducted for any of these or similar types of significant post-move events in order to assess the referral and placement processes. • 0 individuals had died since being placed since the last onsite review. • 0 individuals were discharged under alternate discharge procedures (see T4). The monitoring team again recommends that each of the above bullets should be graphed separately. 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). <u>Other activities</u> None described. <u>Determinations of professionals</u> This aspect of 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 was	

		discussed at length in previous monitoring reports. Primary responsibility for meeting this fell to the QDDPs and the professionals. Thus, the monitoring team looks for indications in each professional's assessment, during the conduct of the annual ISP meeting, and in the written ISP that is completed after the annual ISP meeting. EPSSLC had made a lot of progress and, as a result, professional opinions and determinations were more often sought and discussed in ISP meetings and in the ISP document than six months ago. First, however, for the written assessments (for a sample of annual ISPs reviewed by the monitoring team), there was little change since the last monitoring review. That is, only the nursing, habilitation, and educational assessments routinely stated the professional's determination. This was probably due to the template for the assessment providing a prompt for the professional to make this determination. Second, in the two ISP meetings observed during the week of the onsite review, community living was discussed at various times during the meeting. Professionals were asked to give their opinions. For Individual #77, the QDDP asked the participants, "How do you feel? I read the assessments and you guys feel that she could live in the community. No barriers." Although it was good to see an acknowledgement by the meeting facilitator (i.e., the QDDP), no further discussion took place and no professional members of the IDT made any other comments. For Individual #102, the LAR was adamant about there not being a referral. Perhaps as a result, the QDDP did not discuss professional opinions about referral. Third, in the sample of completed ISP documents (representing the work of five different QDDPs), there was discussion of living options in every one of them. Moreover, there was a statement or paragraph about each of the professional's and his or her determination and opinion. This was good to see (e.g., Individual #66). The format of this presentation of the professionals' determinations, however, was very different across the ISPs and should be done in a more consistent manner. In one of the newer written ISPs (Individual #15), the QDDP noted that the ISP consultant stated that they were no longer going to ask each professional at the ISP meeting and instead were going to rely on the content of the written assessments. The monitoring team, however, has found this one-by-one statement to be of value in the ultimate decision-making of the entire IDT. The monitoring team remains open to further discussion with DADS and the DADS consultant regarding this component of the ISP meeting.	

		The monitoring team has noted different "approaches" to way professionals give their determinations and opinions. The monitoring team recommends that the facility and state office consider providing more direction to the professionals, so that there is a consistent approach to this requirement. It may be that all three of these aspects of the professional's opinion should be addressed (that is the recommendation of the monitoring team). 1. A description of what supports that individual would need if he or she lived in the community. This, alone, was not really an adequate indication of the professional's opinion. 2. A statement of whether needed supports could be provided in the community, based upon the professional's knowledge of available community supports. 3. A specific declarative statement regarding whether the professional believed the individual should be referred and whether the individual was likely to do well in the community. <u>Preferences of individuals</u> The preferences of individuals continued to be sought and met by EPSSLC IDT members. <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 APC's improved data regarding IDT and LAR decisions about referral was an improvement from the previous review. <u>Senior management</u> The APC continued to complete the detailed weekly report discussed in the previous monitoring report. This was good to see because it contained good information, especially regarding the status of each referral. The APC emailed this document each week to senior management. The monitoring team again recommends that this be presented orally to senior management, too, perhaps at the beginning of an IMRT or other meeting that was already occurring. In addition, the APC should give periodic updates on the successes and challenges for some of the individuals who had moved so that senior management becomes more knowledgeable about life in the community for individuals who previously lived at the facility.	
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,	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 completed and the DADS state office was expecting to disseminate it very soon. The APC reported that the facility followed the state's policy. The facility-specific policy was unchanged since the last onsite review and any comments from previous monitoring	Noncompliance

	procedures, and practices shall require that:	reports were still applicable. The APC regularly disseminated (emailed) the policy to management and clinical staff. As noted in previous reports, the three monitoring teams had a number of concerns related to the DADS draft policy and, on 5/16/11, submitted comments for the state's consideration. It was anticipated that the state would address the monitoring teams' concerns in the revised version of the policy. Further, at the parties' meetings in July 2012, the parties agreed that the rating for T1b would be based solely on the development of adequate state and facility policies. The sections T1b1 through T1b3 would be considered stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b. The state and facility had not yet finalized adequate policies related to transition and discharge processes, therefore, the facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The new-style ISP process described in the previous report had been brought to EPSSLC. This new process was designed to address the many items that were required by the Settlement Agreement, ICF regulations, and DADS central office. Further, the new ISP was to include items that had been missing from previous ISP formats, such as professional's opinions (T1a), the identification of protections, services, and supports (T1b1), and the identification of individual obstacles (T1b1). EPSSLC implemented this new process over the past six months. Recently (mid-June 2012), EPSSLC received new training that involved additional modifications to the ISP and ISP processes. More training on the at-risk component of the ISP was still to come. <u>Protections, Services, and Supports</u> The reader should see sections F and S of this report regarding the monitoring team's findings about the current status of ISPs and the IDT's ability to adequately identify the protections, services, and supports needed for each individual. Recently, DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was also found for these three provision items of section F: F1d, F2a1, and F2a3 The three CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that skill acquisition programs were considered and developed based upon the individual's referral to the community. The monitoring team recommends that, upon referral, the APC seek out the IDT, and the QDDP coordinator to talk about what SAPs might be considered now that the individual	Noncompliance

		was referred for placement. This should be documented in the CLDP. If this type of discussion occurred during the ISP meeting in which the individual was referred, it should be explicitly documented in the ISP, too. <u>Obstacles to Movement</u> There was progress seen in identifying and addressing obstacles to referral and placement. This was evident in the ISP meetings observed and in the completed ISP documents. Clearly, attention was paid to this aspect of this provision item since the last onsite review. As with many aspects of the new ISP process at EPSSLC, the way in which obstacles were addressed in the ISP documents and in the ISP meeting varied across QDDPs and ISPs. Sentences about obstacles appeared in different places in the ISPs and the amount of discussion varied greatly. In some ISPs, obstacles were not identified or the descriptions were minimal. An example of a good description was in the ISP for Individual #36. It contained a paragraph in a section called living option determination about obstacles and what might be done to address them. Overall, at EPSSLC, this needs to be done in a more consistent manner. The APC kept some data on obstacles, but it was not complete and it addressed the requirements of section T1g more so than this aspect of T1b1. The monitoring team recommends that the next revision to the facility's self-monitoring tool for section T contain a determination of whether the ISP identified obstacles to referral and placement, and if the ISP included a plan to overcome any identified obstacles. These data could then be incorporated into the data set described in T1a above.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	The monitoring teams, DADS central office, and DOJ recently agreed on the specific criteria 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 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 (the closed and open bullets) followed by EPSSLC's status for each. The bulleted lists can be used for the facility's next revision of its self-assessment. These lists were also presented in the previous monitoring report. <u>Individualized plan</u> • 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. <u>EPSSLC status</u>: There was some progress towards developing an individualized plan.	Noncompliance

		For example, the ISP for Individual #15 described the plan for his sister to visit some community providers with the individual. Prompts within the first part of the ISP helped the QDDP work towards an individualized plan, however, all three of the above bullets were not included. In many ISPs, an action plan related to community living was included (e.g., Individual #88). The QDDP coordinator and the APC should get together and ensure that the above three bullets are explicitly addressed in each ISP. This may require an additional prompt in the ISP or standard expectations about what is in an action plan for community living. <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>: A semi-annual provider fair was held in February 2012. It continued to be held in the manner described in the previous report (i.e., one provider at a time). This seemed to work well for EPSSLC and the monitoring team's positive comments in the previous report still apply. The APC collected survey data from participants that included their satisfaction with the fair and ways it might be improved. The APC had not yet analyzed the data from February 2012, even though the next semi-annual fair was coming up in the next month. He should be sure to do so, and he should analyze data from the August 2012 fair, too. The analysis from both fairs should be presented to the monitoring team during the next onsite review. <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. Quarterly meetings (two since the last onsite review) were occurring as scheduled. Topics appeared to be relevant. The APC raised a point at the recent meeting about the inadequacy of the LA's participation at ISP meetings. Provider attendance at the quarterly meeting was minimal, however, this was not the responsibility of the facility. The quarterly meeting was important for the ongoing collaborative work between EPSSLC and the LA. The annual inservice with the LA had occurred on 6/1/12 and appeared to be adequate. Overall, EPSSLC was engaged in activities at the required criterion for this aspect of this provision item. <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 EPSSLC status: EPSSLC had not yet started to address this activity. The APC should consider summarizing the data from all of the CLOIP reviews, including the recommendations made by the LA CLOIP workers. 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 continued to do a good job in managing the system of tours of community providers. Two tours occurred most months and many individuals participated. The APC planned these tours each quarter along with the QDDPs. There was a one-page report for each individual that was completed by the facility's staff. In addition, the APC now ensured the information about each individual got to the IDT, so that it could be used by the team for planning purposes. He did so by putting it into the shared drive folder so that the QDDP had access to it. The monitoring team recommends that the APC develop a tracking system so that he knows if all individuals for whom a tour is appropriate indeed went on a tour. Thus, there should be (at least) two pieces of data related to tours: number of tours, number of different individuals who went on tours, and percentage of individuals for whom a tour was appropriate who went on a tour. These data could then be included in the facility's QA program and included in the set of data described in T1a. Visit friends who live in the community EPSSLC status: EPSSLC was not yet implementing this activity in any organized manner. 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 maintained the good progress and activities described in the previous report. During this period, he presented to the self-advocacy group and the family association. He also posted two different signs around campus regarding community living. A plan for staff to learn more about community options • management staff • clinical staff	

		• direct support professionals EPSSLC status: The APC maintained the good progress and activities described in the previous report. This included presentations at new employee orientation, periodic meetings (often quarterly) with many of the discipline departments and the QDDPs, and an emailing of the most integrated setting policies to all management and clinical staff. 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.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed during the living options discussion at the annual ISP meeting, or at any other time if requested by the individual, LAR, or IDT member. The QDDP had primary responsibility for this process. In addition, a listing was given to the monitoring team showing every individual, the individual's preference, and whether the IDT referred the individual for community. 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 referral for community placement in their annual assessments. o Progress was observed, as noted in T1a, but this was not yet being done for all assessments. • 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. o This was not yet occurring regularly and consistently. • Living options for the individual were thoroughly discussed during the annual ISP meeting. o Discussion of living options to occurred during every ISP, however, the depth and breadth of these discussions varied greatly across ISPs. This was evident during the two ISP meetings observed at EPSSLC. • Documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the	Noncompliance

		individual, as well as the decision regarding referral of the entire team, including the individual and LAR o Although there were statements at the end of the ISP, in a section titled Living Option Determination, these were not yet written adequately or in enough detail, in many cases. o The living options discussion for Individual #66 was a good example. o The recommendation for one individual contained a statement that he should continue to reside in his current home due to his medical status and it <u>also</u> contained a statement that there was no obstacle to placement (Individual #15).	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The APC submitted three CLDPs to the monitoring team for individuals placed since the last review. This was 100% of the CLDPs completed since the last review. One of the three was in draft form at the time of the last review during which the monitoring team attended the individual's CLDP meeting and discussed the CLDP with the APC. Therefore, of most interest to the monitoring team was the facility's performance in regards to CLDPs completed since then (i.e., two). <u>Timeliness</u>: Both individuals were referred in the Fall of 2010, thus, their placements took much longer than 180 days. Even so, a CLDP could still be considered to be timely because there are many reasons for delays that are not due to lack of activity by the APC, IDT, or provider. In both of these cases, however, there were long gaps (i.e., months) where it was not clear what, if anything, was occurring regarding their referrals. Some of these gaps occurred prior to the current APC taking on the job of APC. The monitoring team believes that the APC was keeping up on new CLDPs and, therefore, this was unlikely to continue to be an issue. <u>Initiation of the CLDP</u>: Rather than waiting until right before the individual moved, the CLDP document should be created at the time of referral. This was now occurring at EPSSLC, usually at a meeting called the APC-PMM-IDT meeting. This typically occurred at the ISP meeting (if a referral occurred then) or within a week or so after the referral. The CLDP contents were then developed and completed over the months during which referral and placement activities occurred. All 12 individuals on the referral list had a CLDP. They were initiated in a timely manner. Three of these in-process CLDPs were reviewed. They were for referrals that occurred approximately 30, 90, and 120 days. These CLDP contained relevant information. The amount of information corresponded with the length of time since the CLDP was developed. All three (100%) were initiated within a couple of weeks of the referral.	Noncompliance

		IDT member participation: IDT members continued to be very involved in the placement activities of the individuals. The types of examples presented in the previous report were also evident this time. Team members thoughtfully evaluated the homes and day programs being explored by the individual. By being highly involved, and with the leadership of the APC, every one of the placements was individualized and the path that each individual took to placement was based around his or her needs and preferences. To accomplish this, there were many visits to providers, overnight trials, and IDT meetings to review and discuss. The two individuals visited many of the El Paso providers (there were only six total). Both individuals ended up being referred to the same provider, Draco Services, under the local leadership of Gisel Hita. The IDTs noted that Draco Services seemed best able to meet the individuals' needs. The IDTs can also indicate that one additional reason for provider choice was that they had a good working relationship and a good history of successful placements with Draco Services in El Paso. Two new transition specialists were recently hired. They were likely to help assist IDTs in identifying the strengths and weaknesses of each of the providers. CLDP meeting prior to move: A CLDP meeting was not scheduled during the week of the onsite review. Therefore, this aspect of this provision item could not be rated. The monitoring team spoke with the APC about ways to ensure that the monitoring team can assess a CLDP for the next onsite review. Post post-move monitoring IDT meetings: IDT meetings occurred after post move monitoring visit, even if there were no problematic issues. The monitoring team was given documentation for 10 of the 11 post move monitoring visits conducted since the last review (also see T2a). One of the completed post move monitorings submitted to the monitoring team was for the observation conducted during the week of the onsite review (see T2b) and, therefore, the IDT team meeting was not yet expected to have occurred.	
	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 CLDPs developed and completed since the last onsite review 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 LA and community provider. Some comments regarding the actions in the CLDP are presented below. Note that EPSSLC had made progress in all of these areas. • The CLDPs identified the need for training for community provider staff. The CLDPs included very good descriptions of the content of what was to be trained, including bulleted points, agenda topics for the training, handouts, and sign in sheets. To move forward with this aspect of this provision item, the APC should	Noncompliance

		address the following: o All of the specific community provider staff who <u>needed to</u> complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff) were not identified. Note that the documentation did report on who <u>actually did</u> attend training. o The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP. There were some indications of provider staff doing observations at the facility, such as staff observing medication administration prior to Individual #110's move. o Training should have a competency demonstration component. Many of the descriptions of inservicing now noted that staff were to be required to give a verbal description and to answer questions, or to answer a multiple choice paper quiz (e.g., regarding food textures). o In the CLDPs, it was merely noted that, "Draco staff participated in the training." • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. • 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. The assigned staff person, and the completion of these activities also need to be documented. DADS central office continued to conduct reviews of CLDPs at EPSSLC. Feedback was given for all three of these CLDPs. Feedback from central office had been very helpful to the facility and should continue. The comments on the CLDP for Individual #110 were very detailed.	
	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 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 and LAR review. Individuals and their LARs were very involved in the process. The monitoring team was impressed with this aspect of EPSSLC's referral and placement program. Again, as noted in the previous report, although none of these three 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 assessment of needs and supports within 45 days prior to the individual's leaving.	The APC continued the process that was in place at the time of the last review, that is, in preparation for the CLDP meeting, assessments were updated and summarized. It seemed that the APC held an IDT meeting prior to the CLDP meeting to review assessments and determine which disciplines needed to provide new or updated assessments. This was called a pre-CLDP meeting. Usually, approximately 12-15 assessments were identified as needing to be updated for the transition. The monitoring team's review of the three CLDPs indicated that these sets of assessments were all completed within 45 days prior to the individual leaving the facility. Even so, there were problems with the assessments and the way they were written for the individual's transition and the way in which they were handled in the CLDP. These must be corrected or this item will not remain in substantial compliance. • The assessments need to focus more upon the individual moving to a new residential and day setting. All of the staff who wrote assessments were well aware of where the individual was moving (as evidenced in the CLDP meeting), however, their assessments usually made little reference to the new home or day program. Further, the assessments, for the most part, did not place any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. Perhaps they were primarily assessments that were updated from the standard annual ISP assessment. o The monitoring team recommends that the assessment updates have prompts to the writer, such as "Instructions to provider" and/or "Recommendations in the community setting." These sections can help focus the professionals on the individual's specialized needs in his or her upcoming new home and day settings. The APC and his staff should thoroughly look at these recommendations to ensure that they are sufficiently future-oriented. • In the assessments section of the CLDP, the entire assessment was cut and pasted. Instead, the summary/update for the individual's upcoming move should be in the CLDP, with the full assessment attached to the CLDP. This was also noticed and noted by the DADS CLDP reviewer on page 25 of Individual #110's CLDP review. • In each subsection of the assessment review section of the CLDP, deliberations (discussion) that occurred <u>during</u> the CLDP meeting, and recommendations that came <u>out of</u> the CLDP meeting need to be clearly described. o If a recommendation in an assessment does not make it into the list of ENE supports, it should be documented as to why.	Substantial Compliance

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.	EPSSLC made more progress than ever before in adequately identifying essential and nonessential (ENE) supports. This was evident by the monitoring team's review of the two newest CLDPs. Even so, the monitoring team and the APC and PMM again discussed the development of ENE supports at length because some needed protections, services, supports, and preferences did not make their way into the list of ENE supports. The primary areas for the APC to work on are to: • Ensure that all topics included in training have a corresponding ENE support for implementation. For example, some adaptive equipment needs and preferred activities were important enough to include in staff training, but not in the list of nonessential supports (e.g., shower chair, gait belt). • Clearly describe the ways the PMM should evidence the occurrence of the implementation of supports by the provider. This needed to be done more thoroughly. During the onsite post move monitoring, the PMM and the monitoring team worked with the provider to develop a checklist that might be one way to accomplish some of this. The provider, Draco Services, developed a very simple, though very useful, checklist the very next day. They began to use it that next day, too. It can serve as a model to other providers, as well as for future transitions of individuals to Draco Services. Further, the monitoring team suggests the APC do an ENE support self-assessment prior to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted below. • Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. • All safety, medical, and supervision needs were addressed. • What was important to the individual was captured in the list of ENE supports. • The list of supports thoroughly addressed the individual's need/desire for employment. Many individuals are excited to move to the community and do not fully understand that it may take months, if not longer, to find a job. • Positive reinforcement, incentives, and/or other motivating components to an individual's success procedures were included in the list of ENE supports. • There were ENE supports for the provider's implementation of supports. That is, 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. • Any important support identified in the assessments or during the CLDP meetings that was not included in the list of ENE supports should have a rationale. • Every ENE support included a description of what the PMM should look for when doing post move monitoring (i.e., evidence).	Noncompliance

		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. The PMM might consider bringing an IDT member along as well. Each review indicated that each essential support was in place. • Each of the nonessential supports should have an implementation date. All of them did. • Some facilities hold an IDT meeting immediately following the pre-move site review before the individual moved. EPSSLC might consider this.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	The APC appeared to understand the importance of this provision item. He and the post move monitor and the QA department all engaged in many activities that took many hours towards conducting quality assurance activities. This included attending ISP meetings, meeting with QDDPs, and working on inter-observer agreement. The APC even initiated and completed a corrective action plan to improve IOA with the QA department on their reviews of living option discussions in the ISP meeting. This was good to see. Some evidence was provided that showed poor IOA in August 2011 and good IOA in April 2012. Unfortunately, however, overall, these activities bore little fruit towards meeting this provision item. Comments are below. First, as self-noted by the APC, the quality assurance process for section T needs to be planned out and included in the facility-specific policy for most integrated setting practices. The monitoring team recommends that this be a separate facility-specific policy. Second, at this time, the APC was only applying quality assurance activities to the living options discussion that occurred during the ISP meetings. Thus, the APC and PMM attended full ISP meetings (two to three hours each) in order to observe, collect information, and provide feedback to the QDDP. The feedback process appeared to be meaningful. The data collected, however, were not. Therefore, in planning a full quality assurance process for section T, all aspects must be included (e.g., CLDP development, CLDP content, ENE supports, CLDP implementation, post move monitoring). Third, new tools need to be developed. At this time, the APC and the PMM used two different tools (a sample was reviewed by the monitoring team). Both tools seemed inadequate for assessing the living options discussion. The tool used by the PMM was not always fully completed, however, she added a detailed narrative paragraph that described, and somewhat critiqued, the way living options and community referral were discussed (or not discussed) at the meeting. The narrative was thorough, interesting,	Noncompliance

		and might be useful to the APC, PMM, and QDDP. The tool used by the APC had boxes with the topics the APC hoped would be discussed, but the tool did not allow the reader to have any sense of the meeting discussion. A new tool is needed, as is one for the CLDP and post move monitoring. The APC conducted training sessions with the QDDPs on the tool's contents. Without an adequate tool, training of the QDDPs will be a waste of time. Giving verbal feedback after the ISP meeting, however, is a good use of time. Fourth, data graphs should be created. To create a more organized (and thereby more effective and useful) process, the state office and APCs should align their activities with the content of the Settlement Agreement and with the content of the monitoring team's report. That is, the APC, when self-assessing provision T, should be looking at the same activities and documents that the monitoring team looks at. The APC should then judge both the occurrence/presence and the quality of those activities and documents. This means that the department will need to self-assess its performance on every provision item by observing, collecting data, reporting data, and making changes based upon these data. Please also see the comments at the beginning of this section of the report in Facility Self-Assessment. The APCs had a monthly forum (scan call) that included all of the APCs from all of the facilities and the DADS central office coordinator for section T. The monitoring sat in on this monthly forum during the onsite review and appreciated having the opportunity to do so. This scan call could provide one forum for discussion and the ultimate development of more valid, useful, user-friendly, and reader-friendly tools.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most	The same state and facility report that was discussed in the previous monitoring report was again submitted. It was an annual report. The new report was due sometime in October 2012. Because this was the same report, please refer to the previous monitoring report for discussion. The APC, however, created a new one-page listing of the obstacles identified for 85 individuals (68% of the individuals) spread across nine different obstacles. It was good to see the APC starting to create a database that might be helpful to facility management, state office, and the APC when he writes the facility-specific portion of the next state report. The monitoring team's understanding was that only one obstacle could be chosen for each individual, even if there was more than one obstacle. Important information might be lost by doing it this way. The facility should also consider a data system that needs to be able to separate out the difference between an obstacle to referral and an obstacle to placement.	Noncompliance

	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.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 1/1/12 through 7/19/12. 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 in T1a, the APC had created this list; it should be included in this report, too. It contained 10 names.	Substantial Compliance

	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 indicated, notifying the appropriate MRA or regulatory agency.	EPSSLC maintained substantial compliance with this provision item. Moreover, the competency of the PMM was also evidenced by the state office request for her to participate in the training of other PMMs at their meeting in Austin in June 2012. <u>Timeliness of Visits</u>: Since the last review, 10 post move monitorings for 5 individuals were completed. This was 100% of the post move monitoring that was required to be completed. All of these were completed by the PMM, Alice Villalobos. All 10 (100%) were reviewed by the monitoring team. In addition, the PMM conducted 2 post move monitorings after the 90-days because unresolved issues remained. Both of these were also reviewed by the monitoring team for a total of 12 post move monitoring reports. All (100%) occurred within the required timelines. The PMM visited both the residential and the day program sites. The PMM maintained a spreadsheet indicating each individual, the deadline for completion of each post move monitoring, and the actual date of completion of each post move monitoring. Surprisingly, the list was incomplete (it only contained two of the five names). This list should be kept up to date and be complete. As discussed with the APC, a simple review should be done of all placements to find out if any serious incidents occurred for the period of one year following placement. As noted in T1a, a simple phone call would be an easy way to obtain this information. The APC was keeping this set of data. <u>Content of Review Tool</u>: All 12 (100%) post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. • Post move monitoring report forms were completed correctly and thoroughly. Good information was included. • Detail was provided regarding the training provided for each of the training-related essential supports (though see T1c1 above). • The PMM added comments into the evidence reviewed box, so that this tool described not only what she was to look at, but also what she did look at. This was good. o Often, the PMM looked at more things than were in the evidence to be	Substantial Compliance

		reviewed box. This demonstrated the PMM's thoroughness. Now that she was experienced in what types of evidence made sense, she should participate more in the development of this aspect of the CLDP, that is, in completing the evidence to be reviewed box. This would also have an educational/training effect for IDTs, the APC, and the new transition specialists. • The monitoring team also very much liked that the PMM wrote detailed comments throughout the report. For example, there were close to three full pages of details describing the status of Individual #55's nonessential supports. • There were various statements throughout the report, such as there being no further issues or concerns, or that the provider, Draco Services, had done a good job in supporting the individual. This helped provide a broader picture of the PMM's overall opinion of the placement. Please continue to provide this. • The monitoring team also liked that the PMM completed the checklists in a cumulative format, that is, she scored each item as yes/no for the current review, but she kept her comments (with dates) from any previous reviews in all of the boxes on the form. Thus, the 90-day checklist became a single cumulative document showing every visit from pre-move through the 90-day. This made it very easy for read to follow the individual through his or her first 90 days in the community. • All staff were interviewed. • The PMM made appropriate lists of follow-up activities/actions for the PMM at the end of each report. • The PMM continued to be assertive in her monitoring and in her follow-up. Substantial compliance was maintained by EPSSLC. Even so, the following comments should be considered as the PMM and APC move forward with post move monitoring: • The individual's psychiatric diagnoses, psychiatric medications, and medical conditions might be inserted right into the post move monitoring form within the series of additional questions. This will make it easier for the PMM as well as for the reader to understand the individual's issues and what it is that the provider staff were expected to be informed about. Of the 5 individuals who received post move monitoring, 4 (80%) transitioned very well, appeared to be happy, and were having a great life. This was well reflected in the detailed post move monitoring reports. Many of the post move monitoring reports also noted that families were very happy to have their loved one in these new placements (one individual was now living with his family). One individual, however, had difficulty in his placement, likely due, at least in part, to inadequate support provided by the provider (Individual #132), including absence of thorough staff training and absence of good collaboration with the individual's public school. Due to the PMM's follow-up, a	

		number of problems were fixed that would have likely remained unaddressed. Even so, after the completion of all post move monitoring, the individual's LAR had him transferred to a different provider. This was not surprising to the monitoring team, which had visited this provider during the last onsite review. This is an example of a referral that should be revised by the APC as to what might have been done differently during the referral and placement process. <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. The PMM did a good job of following up when there were problems. The PMM did additional post move monitorings past 90 days if there were unresolved issues (e.g., Individual #68 for incomplete MARs and staff knowledge of his needs). Issues were readily resolved. IDT meetings were held following 10 of the 11 post move monitoring visits (the 12th, for post move monitoring done during the onsite review week, was not yet due/scheduled). This was good to see and IDT meetings to review each post move monitoring were now scheduled to continue to occur.	
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.	EPSSLC maintained substantial compliance with this provision item. The monitoring team accompanied the PMM on a 7-day post move monitoring visit to the home and day program of Individual #110. Also present were the DADS central office transition specialist coordinator, and the facility's two new transition specialists. Draco Services was the provider. As the monitoring team has come to expect, Draco Services were very good, including the niceness of the settings, individualized home and bathroom modifications, staff professionalism, and management quality. Gisel Hita was the program director. She was extremely knowledgeable about the individual, including her programming and support needs. Ms. Hita and the other managers, including Ericka Vasquez and Gracie Orozco, met with the PMM and the monitoring team. They all were committed to making the individual's transition a success. Moreover, they were receptive to all comments and suggestions from the PMM and from the monitoring team. The individual lived in a beautiful home with three other individuals who transitioned from EPSSLC. The day program was open, bright, and with center- and community-based activities. The individual appeared to have settled in very well and was happy. Provider direct care staff were knowledgeable about her needs, preferences, and routines. The PMM was thorough, that is, she covered all of the ENE supports, asked a lot of	Substantial Compliance

		questions, and looked for evidence. She interviewed all three direct care staff, interacted with the individual, and examined all of the home, including for example, the refrigerator, bedroom closet, and backyard. The PMM went through, in detail, all of the sections and items in the post move monitoring tool. The monitoring team then reviewed the completed post move monitoring report. The content corresponded with what the monitoring team observed.	
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	There were no discharges during this review period that met the criteria for this provision item.	Not Rated

	protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

Recommendations:

1. Do a detailed review (i.e., root cause analysis) of each rescinded referral and any other untoward post move serious incidents to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring (T1a, T2a).

2. Determine how to use the information/suggestions from these root cause type reviews in the standard procedures used by the APC and transition specialists (T1a).

3. Each of the bullets in T1a should be graphed separately, and included as part of the facility's QA program (T1a, T1f).

4. Implement procedures so that professionals' opinions and determinations regarding community placement are in their annual assessments, in the ISP meeting discussion, and in the ISP document (T1a, T1b3).

5. The monitoring team has noted at least three different "approaches" to way professionals give their determinations and opinions. All three should be included. Provide more direction to the professionals, so that there is a consistent approach to this requirement (T1a, T1b3).

6. Do an oral presentation to senior management of referral status of those who have been referred, and the post move lifestyle status of individuals who have moved (T1a).

7. Facility-specific policies will need to be revised or perhaps totally re-written once the new state policy is finalized and disseminated (T1b).

8. Upon referral, the APC should seek out the IDT and others as noted in T1b1 to talk about what training objectives might be considered now that the individual was referred for placement (T1b1).

9. Address obstacles to referral and placement at the individual level (T1b1).

10. Attend to the detail provided in T1b2. The nine bulleted lists might be used in the facility's self-assessment process (T1b2).

11. Provide more information on the training of provider staff (e.g., to whom, method, demonstration of competency) (T1c1).

12. Collaborate with community and provider clinicians (T1c1).

13. Document completion of day of move activities (T1c1).

14. The discharge assessments need to focus upon the individual moving to a new residential and day setting (T1d).

15. In each subsection of the assessment review section of the CLDP, deliberations (discussion) that occurred during the CLDP meeting, and recommendations that came out of the CLDP meeting need to be clearly described (T1d).

16. Ensure that all topics included in training have a corresponding ENE support for implementation (T1e).

17. Clearly describe the ways the PMM should evidence the occurrence of the implementation of supports by the provider (T1e).

18. The monitoring team suggests the APC do an ENE support self-assessment prior to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted below (T1e).

19. Develop an organized QA program for section T (T1f).

20. Develop new self-monitoring tools (T1f).

21. Include in the Community Placement Report, those individuals who would be referred by the IDT if not for LAR preference (T1h).

22. Keep an accurate tracking list of post move monitoring dates (T2a).

23. Insert the individual's psychiatric diagnoses, psychiatric medications, and medical conditions right into the post move monitoring form within the series of additional questions (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Determination for Need of Guardian Priority Tool o Flow Chart For Determining Guardianship Needs o Section U Audit Form o Guardianship Training Curriculum o EPSSLC Section U Presentation Book o EPSSLC List of Individuals without LAR o EPSSLC Priority List of individuals lacking both functional capacity to render a decision regarding health or welfare and a LAR to render such a decision o List of individuals for whom an LAR had been obtained in the last six months o Documentation of activities the facility had taken to obtain LARs or advocates for individuals o Individual Support Plans and Rights Assessments for : • Individual #71, Individual #90, Individual #61, Individual #36, Individual #84, Individual #13, Individual #101, Individual #157, Individual #66, and Individual #178 Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Gloria Loya, Human Rights Officer o Cynthia Martinez, QDDP Coordinator Observations Conducted: o Observations at residences and day programs o Unit Morning Meeting 7/17/12 and 7/18/12 o Incident Management Review Team Meeting 7/16/12 o Annual ISP meetings for Individual #274 and Individual #322 o Human Rights Committee Meeting
	Facility Self-Assessment: EPSSLC submitted its self-assessment. The self-assessment was updated on 6/29/12. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct meet compliance with section U, the results of the facility self-assessment, and a self-rating for each item. The facility had implemented an audit process using the tool developed by the state office to measure compliance with the Settlement Agreement. The tool was used in conjunction additional assessment measures including observation of ISP meetings. Results of this audit were included in the self-assessment.

	The facility self-assessment described criteria used to evaluate compliance for each item and details on specific findings. For example, for item U1, the self-assessment activities engaged in by the facility included: reviewed guardianship priority tool to ensure priority list is accurate and review data from the ISP monitoring tool. The results of the self-assessment noted: 50% compliance with IDT discussion of individuals ability to give informed consent and making an accurate determination of the need to seek guardianship. The facility self-rated U1 as out of compliance based on findings of the self- assessment. The facility self-rated U1 and U2 as not in compliance. The monitoring team agreed with the facility's compliance rating for U1 and U2. The facility continued to make progress in holding a meaningful discussion regarding the need for guardianship, as noted in section U1 of this report, but this discussion was still not always adequate.
	Summary of Monitor's Assessment: Some positive steps that the facility had continued in regards to consent and guardianship issues included: • The continued efforts of sharing the guardianship process information during annual ISP meetings resulted in 17 additional referrals for guardianship. • Five family members filed for guardianship within the past six months with assistance from the Human Rights Officer. • Three applications for guardianship were filed with Lulac Project Amistad. • The guardianship process was completed for four individuals. • The Human Rights Officer provided training on the Guardianship and Advocacy Policy to IDT and family members. • The Priority for Guardianship list was updated. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The monitoring team commends the facility's continued progress in seeking guardianship for a number of individuals determined to be in need. In order to gain compliance with U1, the facility will need to ensure that all IDTs are adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility had made good progress towards compliance with section U. • IDTs need additional training and support to adequately determine the need for guardianship based on each individual's ability to capacity to make decisions. • The facility should continue to seek guardians and/or advocates for individuals with a prioritized need for assistance in making decisions.

#	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 continued to make very good progress on obtaining compliance with the requirements of section U under the direction of the Human Rights Officer. The Priority for Guardianship was updated on 5/24/12. The list now included 39 of who had been prioritized as priority 1 (high) need for guardianship, 16 prioritized as priority 2, and two as priority 3. • There were 55 individuals at the facility with guardians. • Eight individuals were in the process of obtaining LARs • Eleven individuals had been referred for advocates and advocates had been obtained. A sample of 10 ISPs was reviewed for evidence that the team had discussed the need for guardianship. Six (60%) individuals in the sample did not have guardians. There was evidence in all (100%) of the 10 ISPs reviewed that teams were at least having minimal discussion regarding the individual's functional capacity to render a decision regarding health or welfare. The teams, however, did not record a decision on the need for guardianship in all cases. The discussion of an individual's ability to give informed consent should result in a priority rating for the need for an LAR when it is determined that an individual cannot give informed consent. For example, • The ISP for Individual #71 noted that based on his functional assessments, he was unable to provide information and consent. It was further noted that his sister advocated on his behalf. The team did not make a determination on his need for guardianship. • The ISP for Individual #61 noted that she lacked the ability to give informed consent in a number of areas. It further noted that guardianship had been discussed with her mother and her mother did not wish to pursue guardianship. The team did not make a determination regarding her need for guardianship. • The ISP for Individual #90 noted stated that the IDT had determined that he was Priority 1 for the need for guardianship, but then stated that he "required an advocate rather than a guardian, because a guardian is very restrictive". • The guardianship discussion for Individual #13 focused on his father's interest in becoming a guardian rather that his need for guardianship based on his ability to give informed consent. The ISP for Individual #84 included a statement regarding his ability to give informed consent along with a determination regarding his need for guardianship. Although good progress had been made, IDTs were not consistently holding thorough discussions regarding the need for guardianship and ability to make decisions and give	Noncompliance

#	Provision	Assessment of Status	Compliance
		informed consent. Priority for guardianship should be 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 had made additional efforts to gain guardians and advocates for individuals. The facility was taking steps to pursue guardianship when deemed appropriate by the IDT. Guardians had been obtained for four individuals at the facility and six additional individuals were pending finalization. There were still 39 individuals at the facility deemed as a Priority I for guardianship without guardians. The facility began documenting efforts to obtain an LAR in the individual record when an individual was identified as being in need of an LAR. It was called "Efforts to Obtain LAR" (e.g., Individual #28). This should be a beneficial tracking tool for the IDT in identifying any barriers to obtaining guardianship. It was not yet seen in all active records. The facility did have some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human 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. Observation of the HRC process during the monitoring team's visit confirmed that the committee engaged in good discussion around rights issues for each individual. Alternative strategies were discussed prior to restricting an individual's rights in any area and the committee required strategies to be in place to reduce the need for long term restrictions when appropriate. The facility continued to offer self-advocacy opportunities for individuals at the facility, including an active self-advocacy group. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process.	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. Maintain a prioritized list of individuals that need a guardian based on IDT recommendations (U1).

3. Explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals (U2).

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o EPSSLC organizational chart, undated, but probably June 2012 o EPSSLC policy lists, undated, but probably June 2012 o List of typical meetings that occurred at EPSSLC, undated o EPSSLC Self-Assessment, 6/29/12 o EPSSLC Action Plans, 6/29/12 o EPSSLC Provision Actions Information, most recent entries 6/29/12 o EPSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/16/12 o EPSSLC facility-specific policy, Recordkeeping Practices," dated 4/28/12, though it was merely a copy of the state policy o Descriptions of the EPSSLC processes for active records, individual notebooks, master records, overflow, monitoring, and error tracking, 1-3 pages each, February 2012 o List of all staff responsible for management of unified records o Job descriptions for the two new record clerks o Unified records committee: charter, quarterly meeting minutes/agenda (two meetings) o Data reduction committee: Notes from April 2012 meeting and list of documents condensed or discontinued o Tables of contents for the active records, master records, and individual notebooks, updated February 2011 o List of other binders or books used by staff to record data (six) o Description of the EPSSLC shared drive o Two lists that showed the status of state and facility policies for each provision of the Settlement Agreement, undated, probably June 2012 o Various signature sheets for various policy trainings o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o Documentation of training of the recordkeeping department staff on each of these five processes, April 2012 o Instructions regarding IPNs, November 2009 o Instructions regarding SOAP note format, undated o Notes regarding the tracking of assessments, April 2012 o Documentation of new employee orientation sessions regarding recordkeeping, documentation and HIPPA, January 2012 through July 2012 o Documentation of annual refresher training on recordkeeping, January 2012 through June 2012 o Documentation of follow-up trainings for medical and habilitation services on IPNs February 2012,

	psychology department on ISPs June 2012, and DSP staff on documentation May 2012 o Blank tools used by the URC o List of individuals whose unified record was audited by the URC, December 2011 through May 2012 o List of medical consultations, monthly, November 2011 through March 2012 o Completed unified record audit tools for 22 individuals, from January 2012 through June 2012 (two to five per month): • Statewide self-monitoring tool • Active record and individual notebook • Master record • V4 questionnaire ▪ Monthly narrative summary of V4 questionnaire results o Emails from URC requesting corrections be made, January 2012 through May 2012 o Errors spreadsheet, along with some graphic presentations for each month o Correction follow-up spreadsheet for each month o Review of active records and/or individual notebooks of: • Individual #24, Individual #83, Individual #128, Individual #28, Individual #49, Individual #1, Individual #46, Individual #72, Individual #118, Individual #34 o Review of master records of: • Individual #148, Individual #129, Individual #108 <u>Interviews and Meetings Held</u>: o Priscilla Guevara, Interim Director of Records, and Unified Records Coordinator o Priscilla Munoz, Settlement Agreement Coordinator o Sammy Medina, DSP <u>Observations Conducted</u>: o Records storage areas in residences o Overflow and master records storage area o Unified Records Committee meeting, 1/16/12
	Facility Self-Assessment EPSSLC continued to use the self-assessment format it developed for the last review. The Medical Records Coordinator (MRC) and the Unified Records Coordinator (URC) had further developed what they presented last time by including additional activities and outcomes. In that regard, they made progress in that they were trying to look at actual activities and outcomes for each provision item. The most important next step is for the MRC and URC is to make sure that they include everything in the self-assessment that the monitoring team looks at. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in the self-assessment (and

	perhaps in a new self-assessment tool, too). It is possible that new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. For example, in V1, they looked at the quality of the unified record via the quality assurance audits, the results of statewide self-monitoring tools, and some trainings. The monitoring team, however, reported on policies for the department, relevant activities, and detail on each component of the unified record (as well as the shared drive and overflow files). For V2, they looked at any new policies. The monitoring team looked more in depth at the status of all state and facility-specific policies, and the entire system of training (how done, documentation, percentages, etc.). For V3, the MRC and URC correctly self-assessed whether the quality assurance audits were done, and whether errors were disseminated and tracked. The monitoring team also looked at the quality of the audits and resulting data. Note that the outcome of the audits is an assessment of the unified record and, therefore, is a part of the self-assessment of V1. The actual findings of the audits should not be part of the self-assessment for V3. For V4, they reported on the only two activities that were being conducted (V4 interviews and observations at ISP meetings). As noted in V4 below, there are six aspects to V4 that need to be implemented and self-assessed. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the MRC and URC and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in noncompliance with all four provision items of section V. The monitoring team agreed with these self-ratings.
	Summary of Monitor's Assessment: EPSSLC demonstrated continued progress with this provision item. In the weeks following the onsite review, Priscilla Guevara, the URC was appointed as the medical records coordinator (MRC). Two new unit clerk positions were created and filled since the last onsite review. This was a major plus for the department. There were six new succinct one- to three-page descriptions of recordkeeping processes. The MRC could consider putting these into one document with six sections and making it an official facility-specific policy. Activities of training, specialized training, and quarterly facility-wide mini-reviews continued. New activities included ISP assessment tracking, a unified records committee, and a DSP data reduction committee.

	Active records were overall maintained satisfactorily, however, there still remained numerous errors in recording, legibility, document placement, and document presence. Contents of the IPNs still needed to be resolved. Data and documents were not transferred from the individual notebooks into the active records in a timely manner. Often three or four months had gone by. Further, the individual notebooks were large. Therefore, a short term work group is recommended to assess the content/table of contents for the individual notebooks. The new pink binders need to be incorporated into the facility's recordkeeping policy and procedures, and into the monthly unified record audit processes. The master records continued to be maintained satisfactorily, however, there was still a need for a process to address missing items that should be present. The shared drive needed to be examined to determine if any unified records documents were only in the shared drive (i.e., electronic). EPSSLC did not maintain an appropriate spreadsheet or database regarding state and facility policies for each provision of the Settlement Agreement. This needed to be corrected as described in V2. Further, a system of managing, documenting, and reporting on staff training for state and facility policies was needed. Monthly quality assurance review audits continued to be done thoroughly and consistently. Unfortunately, the department did not meet the five per month requirement over the past six months. The addition of the two unit clerks should help remedy that problem. Errors were logged on a spreadsheet and an email sent to each responsible manager or clinician. The URC followed up two weeks later. Approximately 20-30 errors were reported for each unified record review. Most errors were related to legible signatures, credential entries, and signatures on verbal and telephone orders. Only about 25% were missing or outdated documents. Graphs of department activities and results of monthly audits had not been improved as recommended in the previous report. These needed to be created. Details are provided in V3. The facility continued to implement the same exact procedures for provision item V4. Thus, short interviews of staff following ISP meetings were done (that was good) and URC attendance at entire ISP meetings to observe the presence of the active record also continued (that was not good). Further, no action was taken to address the six aspects of V4 that were reviewed during the last monitoring review (and reviewed again during this onsite review).

#	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. The recordkeeping department was led by Priscilla Guevara. During the time of the onsite review, she was working in the role of interim coordinator of the recordkeeping department (i.e., medical records coordinator, MRC) as well as maintaining her duties as unified records coordinator (URC). The previous MRC, Priscilla Munoz, was appointed as SAC since the last review. In the weeks following the onsite review, Ms. Guevara was appointed as the medical records coordinator. The monitoring team wishes her good luck in her new position. Two new unit clerk recordkeeping department positions were created and filled since the last onsite review. This was a major plus for the department. The clerks' responsibilities were to include monthly unified record audits, management of the pre-ISP core list submissions, and other general recordkeeping-related tasks. State policy and facility-specific policies remained the same since the last onsite review and, therefore, no new comments are provided here. The table of contents and maintenance guidelines were updated in February 2011 and had not changed. The recordkeeping department, however, wrote six new one- to three-page descriptions of recordkeeping processes (i.e., active record, individual notebook, master record, overflow, monitoring audits, tracking errors). These succinct descriptions were on-point, useful, and used in training of recordkeeping staff (documentation was submitted to the monitoring team) and other staff at the facility. These really were local policies. The MRC could consider putting these into one document with six sections and making it an official facility-specific policy. The recordkeeping department engaged in other new activities, and continued with some old activities as noted in the previous report. Activities continued since the last report included the following: • The URC provided training in new employee orientation. • The URC provided annual refresher training to all staff. o 12 pages of sign in sheets for the annual refresher were submitted to the monitoring team. o The monitoring team requests that data showing the number of staff who should be trained, and the number of staff who were trained be provided during the next onsite review. • The URC provided specialized training as needed. o Habilitation and medical services, February 2012	Noncompliance

#	Provision	Assessment of Status	Compliance
		o Psychology staff, June 2012 o Residential staff May 2012 ▪ The residential department also did its own additional training for its own staff. • The facility-wide quarterly active record key items audit continued. This was a special review (not part of the section V3 activities). The overall outcome of these quarterly audits should be given to the recordkeeping department and shared with the monitoring team. A number of new activities occurred since the last onsite review: • The recordkeeping department began, in April 2012, to receive all assessments due prior to each annual ISP meeting. The department then documented receipt and completion. The information was maintained in what was called the assessment database. The monitoring team reviewed the data from this database, updated after the onsite visit, dated through 7/31/12. • A Unified Records Committee was initiated. The MRC wrote a description, called a charter. It began in April 2012 and its second meeting was during the onsite review. The purpose was to bring together the many facility departments (quarterly) to review the status, progress, and concerns related to recordkeeping practices. This was a good idea. The monitoring team suggests that data be shared from the monthly audits (section V3), the quarterly facility wide audits, and the assessment database. The committee might also consider its role in the management of forms at EPSSLC. • A short term work group (approximately one month) addressed the reduction of duplicative data collection that DSP staff were required to record. It was called the data committee. The recordkeeping department reported that they did not participate in this committee, though they were listed in the cover sheet of the committee. The committee appeared to have resulted in some good outcomes. One was the creation of the pink binder to contain some house-wide data sheets. This was a reasonable change. The data in these binders, however, should be considered part of the individual notebook, for purposes of audit reviews. <u>Active records</u> Overall, the active records were organized and fairly well maintained. Now that there were two new unit clerks, it is likely that much more progress will be seen at the next onsite review. The monitoring team's comments are below: • Each volume of the active record had that volume's table of contents showing when the binder was opened. This was helpful to the reader. • Overall, the IPNs and observations notes had improved in meeting the requirements of Appendix D. Entries were followed the requirements more so	

#	Provision	Assessment of Status	Compliance
		than during the previous review (e.g., spacing, legibility). Even so, there was still further improvement needed as identified in the facility's own reviews and in the monitoring team's reviews of a sample of records as per Appendix D. Much training had occurred and further progress is expected. • Frequently, there were items in the IPNs or in the observation notes that did not belong there, such as body checks, hospital discharges, and the active problem list. This should be corrected. The monitoring team recently learned that state office was preparing to disseminate specific guidelines about what can and cannot be included in the IPNs. Once that is disseminated, the facility will need to update its IPN instructions from November 2009. • Much data were missing from the active record because they were not moved from the individual notebook to the active record as per the facility's policy. This was due, in part, to there not being sufficient staff in recordkeeping (that was now corrected) and there not being clarity as to who was responsible for doing so (that still needed to be corrected). As a result, the active records were often missing observation notes and SAPs for three or four months. • Numerous items were misfiled. This included documents being in the wrong individual's active record (e.g., Individual #6's psychological update and Individual #93's aspiration trigger sheet for May 2012 were both in Individual #118's active record), missing items (e.g., no FSA or recent quarterly review for Individual #24), documents in the wrong section of the active record (e.g., Individual #128), and items in the wrong order within a section. • Consider dating all forms so that clinicians, reviewers, readers, etc. will know if they're looking at the latest one. This may require the creation of a database of all forms to be maintained by the recordkeeping department (perhaps this can be a task or project for the unified records committee). <u>Individual notebooks</u> EPSSLC continued to use individual notebooks. Staff appeared comfortable and knowledgeable about the individual notebooks (e.g., Sammy Medina, DSP I). For the most part, data in the individual notebooks were recorded up to date. There were, however, a number of topics related to the individual notebooks that need to be addressed by the facility: • Too much data and too many documents remained too long in the individual notebooks. In particular, SAP data sheets and daily observation notes were often in the individual notebooks for three or four months. These were supposed to be moved at the end of every month. As a result, the individual notebooks were larger and heavier than they needed to be. Furthermore, if the individual notebook should be lost or destroying, many months of information would be	

#	Provision	Assessment of Status	Compliance
		lost. Many of the staff interviewed for section V4 indicated that thinning of the individual notebooks was needed. • Overall, the individual notebooks contained a lot of information and were very full. The facility might consider another short term work group to assess the contents of the individual notebooks. It may be that they determine no changes are necessary, however, a review would likely be welcomed by facility staff. • One of the outcome of the data committee was to take some information out of the individual notebook and put it into the pink binder. The pink binder contained documents, such as vitals, aspiration triggers, the ADL flow sheet (blood pressure, weight, bowel movements), and pica information. o The monitoring team believes that the information in the pink binder should be considered to be part of the individual notebook and, therefore, receive the same review, auditing, and perhaps one- to two-page process description as do the individual notebooks. In other words, the contents of the pink binder should not "fall between the cracks" of the facility's recordkeeping policies and practices. o For instance, repeated from section M1 above: In these binders, data pertaining to tracking and recording individuals' intake and output, vital signs, and weight were often incomplete. In addition, there were many blank entries for nurses' and case managers' reviews of the aspiration trigger data. <u>Master records</u> EPSSLC continued the system of managing the master records that was described in the previous report. Overall, it appeared to be satisfactory and acceptable. The staff had not, however, resolved what to do about items that should be in the master record, but were not. As noted in previous monitoring reports, a process is needed and should be delineated. It may be that the staff who manage the master records indicate what actions they've taken to try to obtain the document, or indicate the rationale for why no further action is needed. <u>Shared drive</u> The shared drive was described to the monitoring team. The recordkeeping department should be aware if there are any unified record documents that only appear in the shared drive and do not ever appear in the unified record (i.e., any electronic-only documents). <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	

#	Provision	Assessment of Status	Compliance
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 presented three documents related to this provision. One was a list of updated policies and procedures since the last onsite review. This was helpful. One other was a list called Policy Title, and the other was a list called Localized Policy Title. It was unclear if one list was a subset of the other list. It was also difficult for the monitoring team to determine if all state policies for all Settlement Agreement provision items were included. EPSSLC should certainly maintain a list of all of the policies for the facility. For the purposes of the monitoring review, there should be a secondary list that only includes state policies for each provision of the Settlement Agreement, and all facility-policies that are related to each of these state policies. EPSSLC kept this type of spreadsheet last review. It should be used going forward. In addition, once re-initiating the spreadsheet, it should be expanded to include any relevant aspects of the DADS memo from the assistant commissioner, dated 2/15/12, such as, at a minimum, whether or not the facility-specific policy was reviewed by state office (though this was no longer a DADS requirement). Not all state policies were yet in place, though continued progress was evident. The facility submitted more than 60 pages of signature sheets regarding trainings on policies, but the monitoring team could not determine how these trainings fit into an overall system of managing the trainings on policies. For the next onsite review, the facility should specify for the state and facility policies for each provision of the Settlement Agreement, regarding training: • Notes the list of job categories to whom training should be provided. • Defines, for each policy o who will be responsible for certifying that staff who need to be trained have successfully completed the training, o what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and o documentation necessary to confirm that training occurred. (Some of this responsibility may be with the Competency Training Department.) • Includes timeframes for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training). Some trainings occur only once, while others require annual refreshers.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Includes a system to track which staff completed which training. • Includes data on the number of staff who are supposed to receive training on each and every policy and the number of staff who did receive training on each of these policies. Then, a percentage can be calculated. A table could be created that showed every state and facility-related policy. For example, it might be that 100 employees were required to have training on the state and facility restraint policies and 90 were trained at the time of the onsite review. A simple table could show columns for the number of staff required to be trained (e.g., 100), the number who's training was current (e.g., 90), and the resulting percentage (e.g., 90%). Each row of the table could be a state or facility-specific policy.	
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. Unfortunately, however, the five per month requirement was not met over the past six months. This was understandable given the change in management of the department and the hiring of the new unit clerks. As a result, in 2012, there were two done in January, five done in February, March, and April, three done in May, and two done in June. Again, the addition of the unit clerks makes it likely that this will not occur again. The names of the five individuals chosen for review were generated by the QA department via a random procedure. As a result, the URC re-audited two of the records (both were in June, for Individual #188 and Individual #85). Instead, the monitoring team recommends that the URC not re-audit a unified record if she had audited it within the previous 12 months. Consider that, if 5 are done each month, within a 12 month period, half of the unified could be thoroughly audited, and within 24 months, 100% could be fully audited. Once again, the reviews were done in a consistent and thorough manner. The review consisted of six components: (1) the table of contents review of the active record and individual notebook, (2) a checklist review of the master record, (3) the statewide self-monitoring tool, (4) the V4 questionnaire, (5) copies of emails showing that facility staff were notified of any needed corrections, and (6) a spreadsheet to note follow-up status for any item that needed correction. There was a lot of detail in the comments column that indicated the specific documents and their dates. There was lots of detail in the comments column showing what she found. The typical number of errors was around 15-20. The majority of these errors (about 75%) were illegible signatures and improper credentials. Many others were unsigned verbal and telephone orders. There were few missing or misplaced documents per review. This	Noncompliance

#	Provision	Assessment of Status	Compliance
		was somewhat different than what was found by the monitoring team (see V1 above). At the end of each month, the URC sent an email to the responsible department head. As recommended in the previous monitoring report, the notification now provided praise for improvement. In addition, it now asked for what would be done to make improvements going forward. The URC also sent a copy of the problematic signature, IPN entry, or observation note, so that the supervisor could see exactly what it was that was being rated. Each month, all errors were listed on a lengthy spreadsheet. Two weeks later, the URC checked to see if the correction was made. The amount of time to allow for follow-up is a decision to be made by the facility. Two weeks seemed reasonable to the monitoring team. The URC kept track of corrected and uncorrected items on a copy of this spreadsheet. In the last monitoring report, the monitoring team noted that this was a cumbersome way to manage error corrections, however, after many months of doing so, it seemed to be a system that was manageable for the URC. Below are additional comments regarding the facility moving forward towards substantial compliance: • The pink book contents (as related to the individual) need to be included in the audits of the individual notebooks. This will probably require an update to the audit tool for the individual notebooks. • If the review of the shared drive (see section V1) shows that some unified record related documents are only electronic (i.e., only on the shared drive), consider whether the monthly audit should include anything about these shared drive contents. • Interobserver agreement was obtained on the statewide tool. It should also be obtained on the table of contents tools. • Separating out those errors that need correction from those errors is recommended. The URC continued to graph data same as was being done during the last onsite review. All graphs were only for the current month. There was no month to month trending. None of the recommendations from the monitoring team were implemented. Those recommendations are updated and provided below. • 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 (the monitoring team reviewed this in detail with the URC): o Number of unified records audited o Average score on statewide self-assessment tool portion of the audit	

#	Provision	Assessment of Status	Compliance
		o Average number of errors found per individual o Average number of corrections needed per individual (because not all errors can be corrected) o Percentage of corrections needed that were corrected within a specified time period (e.g., two weeks).	
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.	During the previous review, and in the previous monitoring report, the monitoring team detailed the activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. Unfortunately, no new activity or efforts were devoted to this. The URC continued to do the V4 interviews. This was good to see, but it was only one aspect of what is required for this provision item, and was a continuation of what was being done six months ago. The monitoring team and the URC (new MRC) discussed V4 at length during the onsite review. Below, the six areas of this provision item are again presented, with some comments regarding EPSSLC's status on each. <u>Records are accessible to staff, clinicians, and others</u> EPSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Records were maintained in the home areas that medical staff had access to. Individuals were seen in the medical clinic and records were brought to clinic. Records were not available to the IDT (for review and/or documentation) for the time that individuals were away from home. This was a problem when conducting QDRRs and other types of record reviews (i.e., decreased efficiency). o This appeared to occur during all times of day – morning, afternoon, and evening and was reported to the monitoring team as one of the most significant problems that negatively affected the RN case managers ability to complete their main tasks. o Habilitation therapists generally typed up a separate note for insertion into the IPNs due their difficulty accessing the individual record as needed for documentation. As a result a number of these became late entries in the record and, as such, were not available to all team members in a timely manner. • Current ISPs were not available in 6 of 16 (27%) of the records, indicating that support staff did not have information necessary to fully implement ISPs. • Records were accessible to the psychiatrist during clinic.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual notebooks were always available. <u>Data are filed in the record timely and accurately</u> EPSSLC was somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews, however, should be summarized so that it can be used to satisfy this requirement, too. • Data from the individual notebooks were not moved to the active records in a timely manner. <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: • Up to date data were recorded in the individual notebooks and in the pink books. This was a great improvement since the last review, however, data pertaining to tracking and recording individuals' intake and output, vital signs, and weight were often incomplete. • There were blanks in 19 of 20 individuals' MARs, many missing entries in individuals' health status information, such as blood-glucose, intake, output, weekly weight, etc., which were supposed to be recorded on MARs and/or other tracking logs. • There was a pilot program in three homes regarding daily data cards that were checked for integrity more frequently. Psychology staff estimated a much greater accuracy in the new data collection process. • The PNMT reported ongoing issues with the consistent data entry with special tracking and with standard forms, such as the Aspiration Trigger Sheets. <u>IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> EPSSLC appeared to be, but wasn't really, self-assessing this. As part of the statewide self-monitoring tool, the URC answered a question related to this item, however, there was no explanation as to how she arrived at the rating. In addition, the monitoring team observed that: • Evaluations, such as the MOSES and DISCUS tools and non facility consultations, did not always appear to be fully taken into consideration when making treatment decisions. • There was little evidence that nurses' reviewed individuals' records to make care/treatment/training decisions. Usually, nurses' made these decisions based upon their assessment or evaluation of a particular situation. The IPNs failed to reveal that nurses consistently incorporated a review of the individual's history and/or prior illnesses and /or injuries as part of their evaluation and/or when	

#	Provision	Assessment of Status	Compliance
		they made care, treatment, and training decisions. • Use of the record was evident for specific issues, such as wheelchairs or orthotics. • The facility was attempting to enter relevant data on risk rating forms prior to risk discussions. Having this information for all team members will be beneficial for the IDT in making treatment decisions. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • The URC conducted a brief, but informative, interview with IDT members each month for the individuals whom she audited. She then wrote a summary page of her interpretation of these interviews. o Some of the comments were very interesting, but the results were not used in any way by the facility, other than perhaps to assist the URC in scoring the statewide self-monitoring tool question for V4. o The URC should summarize and bring forward any interesting comments or suggestions to the unified records committee and/or the QA department for consideration by QAQI Council.: • When a random sample of nurses were asked about how they used the individuals' record to make decisions, the responses ranged from that they used the record to document what they did, to that the recordkeeping department were the staff members responsible to review records. • Psychiatry clinic staff were noted to utilize other information with regard to making treatment decisions (e.g., psychology evaluations, data graphs, MOSES, DISCUS, nursing information, and other clinical data). <u>Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions</u> The URC and/or MRC continued to attend full ISP meetings only to see if the active record was present and used. As stated clearly in previous monitoring reports, this is not a good use of their time and they should discontinue doing it. It is easy to find out if the active record was present by having the QDDP, or the QDDP coordinator if he or she is present, report on it. In addition, regarding the use of the records during meetings and clinics, the monitoring team found the following: • During the monitoring team's observations of one individual's ISPA meeting, several IDT members paged through the record apparently looking for information to shed light on the discussion. Occasionally, the staff member appeared to find what he/she was looking for in the record, but most of the time it appeared as though the record failed to reveal information germane to the	

#	Provision	Assessment of Status	Compliance
		discussion. • Not all information was always readily available. For example, at the quarterly ISPA meeting for Individual #99, the team did not have relevant information regarding his diet or test results from an ultrasound recently completed. • The record was present, available, and used during psychiatry clinics. • The record was present and used during the PNMT meeting.	

Recommendations:

1. Consider making a facility-specific policy that incorporates all six of the recordkeeping processes documents (V1).

2. For recordkeeping practices refresher training, present data showing the number of staff who should be trained, and the number of staff who were trained (V1).

3. The unified records committee should review (V1):
    a. data be shared from the monthly audits,
    b. the quarterly facility wide audits,
    c. the assessment database,
    d. its role in the management of forms at EPSSLC, including perhaps putting a date on each form.

4. The pink binder should be considered to be part of the individual notebook and, therefore, receive the same review, auditing, policy/procedure, and perhaps one- to two-page process description as do the individual notebooks (V1, V3).

5. Continue to work on the Appendix D requirements, such as legibility, signatures, entries, proper filing, missing documents (though there had been much improvement since the last review) (V1).

6. Determine what should and should not be in the IPNs. State office guidance may be forthcoming. Then revise the November 2009 IPN instructions (V1).

7. Ensure documents and data get transferred from the individual notebooks to the active records in a timely manner and as required by facility and state policy (V1).

8. Consider creating a short term work group to assess what should and should not be in the individual notebooks (V1).

9. In the master record, document efforts of the URC when a document that is not optional could not be obtained (V1).

10. The recordkeeping department should be aware if there are any unified record documents that only appear in the shared drive and do not ever appear in the unified record binders (V1).

11. Use a spreadsheet that properly lays out each Settlement Agreement provision and the corresponding state and facility policies (V2).

12. Expand the spreadsheet to include relevant information from the assistant commissioner's email on 2/15/12 (V2).

13. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).

14. Provide data on the number of staff who were supposed to be trained on every Settlement Agreement-related state and facility-specific policy, and the actual number of staff who were trained (V2).

15. Conduct five unified record quality reviews each month (V3).

16. Do not re-audit a unified record within 12 months of having already audited it (V3).

17. Obtain interobserver agreement on the table of contents tool, too (V3).

18. Determine how to include the shared drive in the audits of the unified records, if needed (V3).

19. Graph important recordkeeping outcomes and include in the facility's QA program (V3).

20. Implement and monitor all of the aspects of assessing the use of records to make care, treatment, and training decisions, that is, the six areas highlighted with underlined headings in section V4 (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
AAUD	Administrative Assistant Unit Director
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABX	Antibiotics
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
ADD	Attention Deficit Disorder
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
AOD	Administrator On Duty
AP	Alleged Perpetrator
APAAP	Alkaline Phosphatase Anti Alkaline Phosphatase
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
APES	Annual Psychological Evaluations

APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
AROM	Active Range of Motion
ASA	Aspirin
ASAP	As Soon As Possible
ASHA	American Speech and Hearing Association
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
BLE	Bilateral/Both Lower Extremities
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
BPD	Borderline Personality Disorder
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BSPC	Behavior Support Plan Committee
BPRS	Brief Psychiatric Rating Scale
BTC	Behavior Therapy Committee
BUE	Bilateral/Both Upper Extremities
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CA	Campus Administrator
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan

CBC	Complete Blood Count
CBC	Criminal Background Check
CBZ	Carbamazepine
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
CEA	Carcinoembryonic antigen
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIN	Cervical Intraepithelial Neoplasia
CIP	Crisis Intervention Plan
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMA	Certified Medication Aide
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 Pharmacy Technician
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	Development Center
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DERST	Dental Education Rehearsal Simulation Training
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
DRM	Daily Review Meeting
DRR	Drug Regimen Review
DSHS	Texas Department of State Health Services
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
FLACC	Face, Legs, Activity, Cry, Console-ability
FLP	Fasting Lipid Profile
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
GB	Gall Bladder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
GI	Gastrointestinal
GIFT	General Integrated Functional Training
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
HOBE	Head of Bed Evaluation
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
ID	Intellectually Disabled
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
LOI	Level of Involvement
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 Plan
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)
NPR	Nursing Peer Review
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OC	Obsessive Compulsive
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill
ODD	Oppositional Defiant Disorder
ODRN	On Duty Registered Nurse
OIG	Office of Inspector General
ORIF	Open Reduction Internal Fixation
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
PAI	Provision Action Information
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
Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
PHE	Elevated levels of phenylalanine

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
PMRQ	Psychiatric Medication Review Quarterly
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
QMS	Quarterly Medical Summary
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RML	Right Middle Lobe
RN	Registered Nurse
RNCM	Registered Nurse Case Manager
RNP	Registered Nurse Practitioner
RO	Rule out
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
SAMT	Settlement Agreement Monitoring Tools
SAP	Skill Acquisition Plan
SASH	San Antonio State Hospital
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
SIDT	Special Interdisciplinary Team
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOTP	Sex Offender Treatment Program
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
UD	Unauthorized Departure
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
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs

WBC	White Blood Count
WFL	Within Functional Limits
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old