United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: March 18 – March 22, 2013

Date of Report: May 28, 2013

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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 offsite 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. The recently appointed facility director, Laura Cazabon-Braly, supported the work of the monitoring team, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. The Settlement Agreement Coordinator, Priscilla Munoz, again did an outstanding job, ensuring that the monitoring team was able to conduct its activities as needed.

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, including frequent questions about what it would take to come into substantial compliance. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist EPSSLC in doing so.

Third, two topics warrant commentary; both in follow-up to the previous monitoring report.

- Administrative and management: There was a marked and palpable change in the tone and tenor of service provision on campus that was noticed by all monitoring team members. Staff, at all levels, were more focused on the individuals and the provision of services than they were during the last review. It seemed that the new senior administration played the key role in enacting, and now maintaining, this change.

- Weight loss: During the prior review, the monitoring team found many issues regarding the way individuals' weights, diet, and nutrition were managed. Since that time, the facility focused on addressing this serious problem, such as holding a weight management committee meeting each week. More detail is in sections G, M, and O of this report. The facility should be sure, however, to ensure that these activities are also measuring the desired outcomes of these activities, that is, that individuals weight, nourishment, and overall health are improving and maintaining.

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.

Restraint

- The facility made minimal progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. Staff were not consistently completing required restraint documentation, making it impossible to determine if restraints were implemented and monitored in compliance with state policies. A recent reorganization of the psychology department may have contributed to the temporary lack of progress towards meeting compliance with the provisions of section C.
- There were 10 restraints used for crisis intervention between 7/1/12 and 2/28/13 and an additional four restraints from 3/1/13 through 3/13/13. There were 58 instances of dental/medical restraint including pretreatment sedation from 7/1/12 through 1/25/13 involving 26 individuals.
- Action taken by the facility to address compliance with section C since the last monitoring visit included:
    - Developed a restraint discussion checklist to use when reviewing restraint incidents.
    - Revised the function and purpose of the Restraint Reduction Committee.
    - Began NEO training on the new restraint policy.
    - Director of Behavioral Service trained QDDPs on new restraint policy and IDT discussion following restraint incidents.
- It was very good to see that a very small number of restraints were implemented at EPSSLC. Thus, the monitoring fully expects the facility, under the leadership of facility management, to meet substantial compliance with all of section C when the facility is next reviewed by the monitoring team.

Abuse, Neglect, and Incident Management

- The facility made substantial progress in addressing compliance with section D, though minimal progress had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility.
- There was 1 confirmed case of abuse and 13 confirmed cases of neglect between 8/1/12 and 1/31/13. Overall, DFPS conducted investigations of 41 cases involving 100 allegations at the facility. An additional 21 other serious incidents were investigated by the facility, all involving serious injuries.
- There were 861 injuries reported between 9/1/12 and 2/28/13, including 8 serious injuries resulting in fractures or sutures. Some of the serious injuries were preceded by similar incidents, not adequately addressed.
- The incident management department should take an integral role at the facility in looking at both systemic issues that contribute to incidents and individualized supports and services that place individuals at risk.

Quality Assurance

- The QA program at EPSSLC continued to improve since the last onsite review. The QA plan narrative at the facility was current, complete, and adequate. The QA data list/inventory continued to improve, but the QA department should now ensure that important types of data (i.e., key indicators) are included in the data list/inventory (as well as in the QA matrix) for each of the Settlement Agreement sections.
- The QA director and the department section leaders should work towards improving their self-monitoring tools, especially regarding content/validity, adequate instructions, implementation, and regular review by the QA department.
- Data from the QA plan matrix for the self-monitoring tools for 17 of the 19 (89%) sections of the Settlement Agreement (not section E) were summarized and graphed showing trends over time, however, there was a need to review the content of many of these tools.
- Meetings between the QA director, SAC, and department head were beginning to occur. The schedule content, format, and expectations for these meetings were still in development. A section leader meeting and a monitoring committee were two groups whose activities were also related to the QA program at the facility.
- The QA report continued to improve. The QAQI Council meeting observed by the monitoring team was improved since the last onsite review.
- A number of work groups, special committees, and special projects were occurring at EPSSLC (e.g., weights, meal improvement, level of supervision). The QA department should keep track of these groups and ensure that their work and data are part of the QA program at EPSSLC.
- More work needed to be done across all aspects of the CAPs system, from development, definition, and assignment, through implementation, review, and modification.

Integrated Protections, Services, Treatment, and Support

- Though considerable progress was noted, the facility was not yet in compliance with any of the provisions of section F. The ISP planning and development processes had been revised. EPSSLC QDDPs and other team members had been provided training on the new process by statewide consultants. IDTs began implementing the newly developed process in October 2012.
- There had, however, been some positive steps forward with the new ISP process.
    - The facility received training and technical assistance on the new ISP process from state office consultants.
    - The QDDP Coordinator continued to attend ISP meetings and to provide coaching and feedback to QDDPs based on results from the facilitation skills assessment tool.
    - The facility had begun using the new ISP Preparation Meeting process to identify preferences and needed assessments prior to the ISP meeting.

    - A process was developed to gather assessment submission data.
    - The QDDP Coordinator had begun presenting findings from the section F monitoring tools at monthly QDDP meetings.
    - Home supervisors had begun monitoring the implementation of all plans.
- The monitoring team observed two annual ISP meetings in the new format. The IDTs were following the format of the new ISP process and team members were holding a more integrated discussion. Team meetings were very lengthy and the IDTs struggled with how to integrate the risk discussion into the ISP meeting. The facility was moving in a positive direction, though additional training was still needed to help team develop meaningful plans through this process. The new process, thus far, was not resulting in adequate supports and measurable outcomes.

Integrated Clinical Services

- Notwithstanding the complete absence of an organized plan, the concept of integration of clinical services had permeated into various clinical departments over time. To that end, many employees spoke of how their departments integrated with other clinical services. Individual departments understanding of integration did not translate into significant progress in this area. Moving forward requires that this provision be guided by someone who has the authority to bring clinical areas together to overcome the barriers that prevent integration.
- 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.

Minimum Common Elements of Clinical Care

- Very little progress occurred. The timelines for provision H1 were addressed, but the other components were not. For Provision H2, no additional training occurred related to ICD nomenclature. The medical staff had changed since the January 2012 training. There was no real progress seen for provisions H3 – H7. Much of the provision addressed issues of quality and risk assessment. The development of a comprehensive set of clinical indicators is an essential step in moving forward with this provision. Equally as important is the identification of the systems and data sets that would then be used to monitor health status. EPSSLC had not addressed either issue in a meaningful way.

At-Risk Individuals

- While progress had been made, adequate risk action plans were not yet in place to address risks for individuals at EPSSLC.
- Since the last review, the state office had made revisions to the At-Risk Individuals policy. Revisions to the risk identification process included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually

- Team meetings were very lengthy and the IDTs struggled with how to integrate the risk discussion into the ISP meeting. Teams were spending a lot of time identifying risks, but little time developing measurable outcomes to address risk factors.
- 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. Teams often waited until a critical incident occurred or until the annual IDT meeting before aggressively addressing the risk.

Psychiatric Care and Services

- Psychiatry services at EPSSLC made good progress towards substantial compliance. Half of the individuals received psychopharmacologic intervention (60 of 118, 50%).
- The quarterly psychiatric assessment document had been revised to include the psychiatric treatment plan as well as an enhanced risk/benefit analysis regarding the treatment with psychotropic medications. There were improvements in the consistency of psychiatric diagnoses across the evaluations of different disciplines. 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.
- A review of psychiatric documentation revealed ongoing issues with timeliness of quarterly psychiatric medication reviews.
- There were noted improvements in the psychiatric participation in the development of the PBSP, however, there were questions regarding a new "Individual Mental Health/Behavior Plan" that was being utilized both in lieu of, and in addition to, the BSP in the absence of specific policy and procedure.
- The monitoring team observed two separate psychiatric clinics, and one Neuro-Psychiatry clinic. IDT members were attentive to the individual and to one another and there was participation in the discussion and collaboration between the disciplines.
- 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.

Psychological Care and Services

- There were several improvements since the last review, resulting in three additional items rated as in substantial compliance (K3, K7, and K11). These improvements included a large percentage of psychologists that were either enrolled in or completed BCBA coursework, and moreover, director of psychology became a board certified applied behavior analyst. Peer review now included psychiatry, internal peer review occurred weekly, and external peer review occurred monthly. Data cards were in all treatment sites, and graphing of replacement behaviors occurred for all PBSPs. There were improvements in the data collection and progress note processes. Functional assessments,

annual psychological assessments, and annual updates all improved. The written PBSPs were more comprehensive and treatment integrity was measured more regularly.

- Areas for EPSSLC to work on for the next onsite review include establishing minimal acceptable data collection reliability levels, demonstrating that those levels are achieved, and initiation of the collection of interobserver agreement. There should be increased flexibility of the data collection system. More individuals need to have functional assessments completed, PBSPs with consent, and PBSPs implemented within 14 days. Finally, EPSSLC should provide documentation that all staff assigned to work with an individual (including float staff) have been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter.

Medical Care

- The medical department made some progress since the July 2012 review. The new medical director was provided clinical services, but was not otherwise involved with the Settlement Agreement. The medical clinic nurse was assigned as the lead for provision L, however, she also was not familiar with the Settlement Agreement.
- 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. Many issues related to follow-up were noted, including delays in diagnosis and a lack of follow-up of medical issues. A significant number of individuals had refractory seizure disorder, but none were referred to an epileptologist for management.
- There was improvement in the completion of Annual Medical Summaries, but overall compliance with timelines remained problematic. 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. This was not always consistent with document reviews completed by the monitoring team. This may have been a reflection of a very small sample size.
- Mortality reviews were completed and recommendations generated. The system still lacked an appropriate medical review. Moreover, there was no organized process for following the implementation and status of corrective actions
- The facility made no progress in the development of a medical quality program. No local policies were developed based on the numerous stated issued clinical guidelines.

Nursing Care

- The Nursing Department continued to make progress toward meeting the provisions of section M. Nurses were recruited and hired to fill pivotal positions within the department. A Program Compliance Nurse, was hired in February 2013, and she started conducting monitoring reviews and audits of nurses' implementation of assessment and reporting protocols.

- The Infection Control Nurse continued to build the facility's infection prevention and control program.
- The areas where the Nursing Department continued to need improvement were in its ability to ensure timely and appropriate responses to changes in individuals' health. The Nursing Department also needed to consider how it would ensure that its assessments would meet the standard of practice and the Health Care Guidelines. In addition, the Nursing Department needed to continue to work on improving their performance related to the integrated risk rating and integrated health care planning processes.
- There continued to be problems with nurses properly administering medications in accordance with generally accepted standard of practice. Of the five scheduled medication administration observations that were made on different days and different shifts, only one nurse administered medications in accordance with standards of practice.

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.
- Quarterly Drug Regimen Reviews were competed in a timely manner and were thoroughly completed. Improvement was seen in the documentation of the monitoring of the metabolic risk of the new generation antipsychotic medications, but QDRRs still sometimes had outstanding labs. For the most part, the MOSES and DISCUS evaluations were completed in a timey manner. Drug Utilization Evaluations were completed in a timely manner and the P&T minutes documented the findings, but did not fully document the closure of the corrective actions.
- The ADR monitoring and reporting system continued to be a weak link in the facility's pharmacy safe medication practices system. There was essentially no reporting by the medical staff and 77% of staff identified received the required training. Even more important was that there appeared to be unrecognized ADR patterns that may not have been adequately reviewed.
- The total number of medication variances decreased, but EPSSLC's problems with reconciling non-pill medications remained outstanding.

Physical and Nutritional Management

- Progress was made towards substantial compliance with provision O. The PNMT was fully staffed and attendance at the meetings held was generally very consistent. One re-assessment had been completed, though there had been a number of referrals. During the meeting observed by the monitoring team, the discussion was very good related to follow-up for one individual (Individual #28). The participation by QDDP was excellent.
- There appeared to be a significant delay/absence of referrals of individuals who would benefit from PNMT evaluation. The team was encouraged to establish exit criteria for effective transition from the PNMT. They should also carefully examine their system of documentation in order to streamline the records of their interventions and follow-up.

- The facility must review the existing databases that identify individuals with key health issues in order to effectively track them and to watch for facility-wide trends. Individuals who require PNMT referral may be more effectively identified and in a timely manner.
- The PNMT appeared to be routinely and proactively reviewing individuals with a high risk of key PNM indicators or with incidences of these concerns. They routinely tracked their status though the documentation was cumbersome and evidence of follow-up of individuals for whom they provided assessment/review was difficult.
- Mealtimes and position and alignment were improved, though some issues though positioning continued to be an issue. Staff continued to lack confidence in their knowledge of key risk areas and the rationale for related supports they were responsible for providing.
- PNM monitoring conducted did not address all areas required, such as medication administration, oral care and bathing. A system of effectiveness monitoring was not well established and will be necessary for further progress. Areas such as toothbrushing and oral sensitivity should be addressed through assessment, supports and monitoring.
- There were significant improvements related to the review of weight issues identified in the previous review by the monitoring team. This group was encouraged to not merely focus on weight as the only nutritional indicator for review and intervention. There are many related issues that may contribute to weight loss or gain and all should be explored.

<u>Physical and Occupational Therapy</u>

- The monitoring team noted continued progress and substantial compliance was found for P1. Improvements in the area of positioning were observed though many staff need more training and prompting to check for optimal pelvic alignment, particularly after transfers. There were also some wheelchairs that appeared to need revision (some were scheduled). It was excellent to see that some of the therapists had attended a seating course. These therapists were enthusiastic about what they learned, were applying new strategies, and were seeing improvements in their approach to assessment and product selection.
- OT/PT assessment content improved and was being completed in a timelier manner. The monitoring team observed a wheelchair clinic and an ISP. The participation by the OTs and PTs was exceptional. Establishment of clinical competence of the therapists and review of their continued compliance was accomplished via an audit system that appeared to be very effective
- Approximately 78% of the assessments reviewed (Samples P.1 and P.2) were dated as completed at least 10 days prior to the annual ISP and all assessments were completed prior to the ISP itself.
- The system of documentation of therapy interventions continued to be inconsistent. A routine system of effectiveness monitoring by the licensed clinicians was needed or improvement in the documentation of this process was indicated.

Dental Services

- The dental clinic made progress in providing treatment to individuals who had previously not received treatment due to the inability to cooperate in clinic. The clinic provided services on a daily basis. Overall, it appeared that individuals received appropriate care to the extent that it could be delivered given a limited number of dental hours.
- Individuals received preventive care and emergency care. The percentage of individuals with poor oral hygiene decreased slightly, but remained high. The number of failed appointments remained low.
- Data management in the dental clinic has presented challenges for nearly every compliance review. There were many dental data elements that ended in early November/December 2012. The staff reported problems with the dental database and noted that the "accuracy of database is less than 100% accurate."

Communication

- Progress was made across all elements of section R since the last review. The clinicians were assigned responsibilities for both communication and mealtimes and, as such, the caseload assignments were considered to be moderately high.
- There were some very good communication programs in place and this seemed to be improving with the more recent evaluations. More work related to the application of AAC to adults with developmental disabilities and physical and cognitive challenges was needed.
- The majority of the most current assessments reviewed contained more than 70%, but less than 80%, of the elements considered key by the monitoring team. This was a significant improvement from the previous review.
- A system of effectiveness monitoring was initiated in December 2012 for routine review of all programs and interventions, but implementation was reported to be inconsistent. Further progress in this area was expected over the next six months.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were improvements since the last review, such as an increase in the number of SAPs with a good rationale, establishment of a SAP peer review meeting, and continuous progress in pretreatment sedation reduction. There was improvement in individual engagement across the facility, continued improvement in the community day program, and a plan to measure and improve the implementation of SAPs.
- Areas for EPSSLC to work on for the net onsite review include ensuring that each SAP contains a good rationale, and that each SAP has a plan for maintenance and generalization. EPSSLC needs to operationalize the definition of individual engagement, track engagement across all treatment areas, review trends, and establish acceptable levels of engagement in each treatment area, develop a system to track 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 again continued to make progress across all of section T. The specific numbers of individuals who were placed had increased to an annualized rate of 12% (7 individuals since the last review). Approximately 10% of the individuals at the facility were on the active referral list (12 individuals). The list of individuals not being referred solely due to LAR preference contained 15 names; this appeared to be an accurate list.
- Much progress occurred regarding the educational activities described in T1b2. Family members and LARs received lots of individualized attention and education and as a result a number of individuals were referred. More work was needed for the determinations and opinions of professional members of the IDT regarding most integrated settings to be evident in assessments, meetings, and the ISP document.
- The facility engaged in four new activities: an FST workgroup, new PMM with additional responsibilities, regular meetings of the admissions placement department staff, and a new family relations department.
- Four of the 7 CLDPs (57%) were developed in a timely manner. For the others, there were long lapses (many months) during which there was little or no indication of the reason for the absence of activity.
- Improvements in the quality of the discharge assessments were needed to ensure that the discipline recommendations were designed for the new environments.
- EPSSLC continued to make incremental progress in developing thorough comprehensive ENE support lists. Section T1e details this and focuses on a number of areas for continued improvement.
- A CLDP meeting and a pre-CLDP meeting were observed by the monitoring team. Continued progress was evident and recommendations for continued improvement are provided.
- Of the 8 individuals who were placed by the facility and received post move monitoring, 7 (87%) were maintaining successfully in the community. 22 post move monitorings for 9 individuals were required and all were completed correctly and thoroughly. ISPA meetings following these reviews did not occur, even when there were identified concerns.
- The state and facility submitted an annual obstacles report (T1g). Much good information was included, however, a lot of information and detail was needed to meet the requirement for a comprehensive assessment.

Guardianship and Consent

- The facility had not yet developed an adequate assessment process for determining the need for guardianship. IDTs continued to be in the beginning stages of holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent. IDTs continue to need training to determine each individual's functional capacity to render informed decisions.
- Even so, a priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need.

- The human rights officer worked very closely with individuals and their IDTs to ensure protection of rights at the facility. She was actively involved with every department at the facility and served as an valuable resource to IDTs.

Recordkeeping Practices

- A unified record existed for all individuals, including all new admissions. There was improvement in the IPNs and observation notes. There were fewer items misfiled. Specification of content, availability, and signature legibility still needed improvement.
- Individual notebooks were in use throughout the facility. They were thinner. Some improvements regarding content were still needed. The master records were in good shape and the facility was adequately addressing documents that could not be located. The pink/purple binders needed to be addressed to determine what information in them should be considered to be part of the individual notebook.
- A new document listed all of the state policies and any associated facility-specific policies. It was 11 pages long and included columns stating effective/revision dates, policy numbers, and three columns related to staff training.
- A review of five unified records did not occur each month as required. The tool used by the URC to conduct the audit reviews needed to be updated. The URC had a simple procedure to inform the responsible person of any corrections that were needed and then she followed-up two weeks later. The data, however, showed that only about a third were corrected.
- The MRC and her staff engaged in some activities to try to make progress regarding V4, specifically in trying to come up with a way to determine if the six types of activities that comprise this provision were being addressed.

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 EPPSLC Training Curriculum: Use of Restraint dated April 2012
o EPSSLC Self-Assessment
o EPSSLC Provision Action Information Log
o EPSSLC Section C Presentation Book
o Restraint Trend Analysis Report 7/1/12 – 2/28/13
o Sample of Incident Management Team Minutes
o EPSSLC Quality Assurance Report
o List of all restraint by Individual 7/1/12 through 2/28/13
o List of all chemical restraints 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 List of all restraint related injuries
o EPSSLC “Do Not Restrain” list
o List of all individuals with a Crisis Intervention Plan (2)
o List of individuals with desensitization plans or strategies to reduce the use of restraint
o Desensitization plans for:
• Individual #86, Individual #56, Individual #120, Individual #3, Individual #66, Individual #9, Individual #195, Individual #175, Individual #36, and Individual #108.
o Medical Pretreatment sedation Restraint Documentation and ISPs for:
• Individual #74, Individual #123, Individual #126, Individual #161, Individual #13, Individual #23, Individual #119, Individual #85, Individual #117, and Individual #118.
o Restraint Reduction Committee meeting minutes for past six months
o Training transcripts for 24 EPSSLC employees
o ISPs, PBSPs, Crisis Intervention Plans (when applicable), and ISPAs for:
• Individual #161, Individual #13, Individual #39, and Individual #109.
o A sample of restraint documentation for crisis intervention including:

<table>
<tr><th>Individual</th><th>Date</th><th>Type</th></tr>
<tr><td>#13</td><td>2/27/13</td><td>Physical</td></tr>
<tr><td>#13</td><td>3/1/13</td><td>Physical</td></tr>
<tr><td>#13</td><td>3/6/13</td><td>Physical</td></tr>
</table>
</td></tr>
</table>

#109	3/1/13	Physical
#39	3/13/13	Physical
#161	8/12/12	Chemical

Interviews and Meetings Held:

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

Observations Conducted:

- Observations at residences and day programs
- Unit Morning Meeting 3/19/13 and 3/21/13
- Incident Management Review Team Meeting 3/19/13 and 3/21/13
- Annual ISP meetings for Individual #50 and Individual #89
- Pre-ISP meetings for Individual #88 and Individual #82
- Human Rights Committee Meeting 3/20/13

Facility Self-Assessment:

EPSSLC submitted its self-assessment. It was updated on 3/6/13. 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 reviewed all restraint incidents from 7/22/12 through 1/31/12 (four) to assess compliance with each provision. Additional activities similar to those engaged in by the monitoring team were also used to determine compliance for each provision item. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings.

The facility assigned a rating of substantial compliance to C1, C2, C3, C4, C6, and C8. C5 was rated as noncompliant and C7 was rated as not applicable. While there had been progress made in developing an adequate self-assessment process, findings were not consistent with the findings of the monitoring team. The monitoring team did not find compliance with any of the provisions for section C (except for two parts of C7). This in part might have been due to the sample reviewed. The monitoring team chose a more recent sample of restraint documentation. Further, there had recently been a significant change in leadership within the psychology department. The recent reorganization may have had a temporary negative impact on compliance with restraint requirements.

Additionally, the monitoring team continued to evaluate compliance on a number of factors, not considered

by the facility when determining compliance. For example, the facility looked at training data to determine compliance with C3. The monitoring team verified compliance by reviewing a sample of training transcripts for both completion of training requirements and the timeliness of training.

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 implementing the requirements of the new policy regarding documentation and monitoring of restraints.

Based on information provided by the facility, there were 10 restraints used for crisis intervention between 7/1/12 and 2/28/13. There had been an additional four restraints documented from 3/1/13 through 3/13/13. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C.

Month	Total Restraints	Month	Total Restraints
March 2012	7	September 2012	1
April 2012	2	October 2012	0
May 2012	1	November 2012	0
June 2012	1	December 2012	0
July 2012	3	January 2013	0
August 2012	5	February 2013	1

There were 58 instances of dental/medical restraint including pretreatment sedation from 7/1/12 through 1/25/13 involving 26 individuals. This list included both pretreatment sedation prior to medical appointments and chemical restraints used to promote healing.

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

- Developed a restraint discussion checklist to use when reviewing restraint incidents.
- Revised the function and purpose of the Restraint Reduction Committee.
- Began NEO training on the new restraint policy.
- Director of Behavioral Service trained QDDPs on new restraint policy and IDT discussion following restraint incidents.

Overall, the facility made minimal progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. Staff were not consistently completing required restraint documentation, making it impossible to determine if restraints were implemented and monitored in compliance with state policies. A recent reorganization of the psychology department may have contributed to the temporary lack of progress towards meeting compliance with the provisions of section C. The facility was not in substantial compliance with any of the eight provision items,

	except for two parts of C7. It was very good to see that a very small number of restraints were implemented at EPSSLC. Thus, the monitoring fully expects the facility, under the leadership of facility management, to meet substantial compliance with all of section C when the facility is next reviewed by the monitoring team.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>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.</td><td>The facility provided a list of all restraints used for crisis intervention between 7/1/12 and 3/13/13:

<table>
<tr><th>Type of Restraint</th><th>7/1/12-3/13/13</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>11</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>3</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>14</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>5</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>2</td></tr>
<tr><td>Medical/dental restraints</td><td>58</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>26</td></tr>
</table>

The facility reported that nine individuals at the facility were wearing protective equipment (e.g., helmets). Restraint Plans had not yet been developed for all individuals who were wearing protective mechanical restraints. Plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation.

<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. Posters had been placed in all homes reminding staff that prone restraints are prohibited.

Based on a list provided by the facility of all restraints for the past six months, 0 (0%) showed use of prone restraint. During two restraints in the review period, the individual rolled into a prone position. In both instances, the restraint was terminated because repositioning was not possible.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		behavioral crises. Sample #C.1 was a sample of restraints for four individuals, representing 42% of restraint records over the last nine-month period and 80% of the individuals involved in restraints. The sample included five physical restraints and one chemical restraint. The six most recent restraints were selected for the sample. Individuals in this sample were Individual #161, Individual #13, Individual #39, and Individual #109. <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 six restraints. The following are the results of this review: • In five of the six records (83%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. Documentation was not sufficient to determine whether or not Individual #109 posed an immediate or serious threat to himself or others prior to restraint on 3/1/13. • For six restraint records, a review of the description of the events leading to behavior that resulted in restraint found that five (83%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. The exception was the restraint for Individual #109 dated 3/1/13. The description of behaviors prior to restraint stated "pacing and crying." • In four of the records (67%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Exceptions were: o Individual #13, dated 3/1/13 o Individual #161, dated 8/12/12 • Facility policies identify a list of approved restraints. • Based on the review of six restraints, involving four individuals, six (100%) were approved restraints. In three of six records (50%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Individual #13 (three of the restraints) did not have a behavior support plan in place.	

#	Provision	Assessment of Status	Compliance
		Dental/Medical Restraint There were 58 instances of dental/medical pretreatment sedation from 7/1/12 through 1/31/13 involving 26 individuals. A list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that 114 individuals had been assessed for the need for strategies to address dental/medical restraint and/or desensitization plans. A request for the last 10 desensitization plans developed by the facility was requested for review. All 10 were individualized skill acquisition plans addressing dental desensitization. Good progress had been made towards assessing individuals for the need of desensitization plans and the development of individualized plans. At ISP meetings observed, both IDTs held integrated discussions to develop desensitization strategies for Individual #50 and Individual #89. Based on this review, the facility was not yet in compliance with the requirements of C1.	
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. The restraint records involving the four individuals in Sample #C.1 were reviewed. Of these, two of the individuals (Individual #13 and Individual #161) had Crisis Intervention Plans (CIP) that defined the use of restraint. These plans were not yet in the new format required by the revised state policy. Three physical restraints were reviewed for Individual #13 to determine if there was sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. Two (66%) included sufficient documentation to show that the individual was released according to criteria in his CIP. The restraint for Individual #13 on 3/1/13 did not document his behavior at the time of release. The Sample #C.1 restraint documentation for five physical restraints was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. • Two of five (40%) restraints reviewed indicated that the individual was released immediately when no longer a danger. Documentation was not sufficient to determine if the individual was immediately released when no longer a danger	Noncompliance

#	Provision	Assessment of Status	Compliance
		for: o Individual #13 dated 3/1/13 o Individual #109 dated 3/1/13 o Individual #39 dated 3/13/13 The longest physical restraint in the sample was 15 minutes. This was the maximum duration allowed by the new state policy before an attempt at release was required. The facility was not in substantial compliance with C2. The facility lost substantial compliance in C2. The sample reviewed did not support that staff were adequately documenting release criteria on the restraint checklists. Additionally, the facility had not yet begun implementing the new Crisis Intervention Plan format required by the new restraint policy.	
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 verbal and redirection techniques; • Approved restraint techniques, and • Adequate supervision of any individual in restraint. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • 21 of 24 (88%) had current training in RES0105 Restraint Prevention and Rules. • 13 of the 17 (76%) employees with current training who had been employed over one year completed the RES0105 refresher training within 12 months of the previous training. • 23 of 24 (96%) had completed PMAB training within the past 12 months. The facility investigator had not completed PMAB training. Although it is unlikely that she would be involved in restraints, she could be assigned to investigate allegations resulting from restraint. It is recommended that she complete PMAB training. • 15 of the 20 (75%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. As noted above with regard to Section C.1 of the Settlement Agreement, 67% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Training for a number of staff was not completed within the required timeframes based upon the sample of training records used to assess compliance. The facility should ensure that training is completed annually as required by state policy. The facility remained out of compliance with C3.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of six restraint records (Sample #C.1), documentation in five (83%) indicated that restraint was used as a crisis intervention. In review of three Positive Behavior Support Plans, in three (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. There were 58 instances of medical sedation from 7/1/12 through 1/31/13. This list included both pretreatment sedation prior to medical appointments and chemical sedation used to promote healing. According to a list provided by the facility, strategies to minimize or eliminate the need for restraints had been developed for 101 individuals who required the use of pretreatment sedation. The facility had identified 103 individuals who had historically required the use of pretreatment sedation for medical/dental appointments. Individuals on the list had been assessed for desensitization plans. Two individuals were waiting for plans to be developed. Significant progress had been made in developing desensitization plans, particularly to address dental treatment. At both annual ISP meetings observed, the IDT engaged in good interdisciplinary discussion regarding the development of strategies to reduce anxiety over dental treatment. The facility had created a "Do Not Restrain" list. There were 16 individuals at the facility identified on this list for which physical restraints would be contraindicated due to medical or physical conditions. In five of six restraint records reviewed (83%), there was no evidence that the restraint used was in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
		One individual on the "Do Not Restrain" list had been restrained in contradiction to medical recommendations in the past six months. Individual #161 was appropriately included on the "Do Not Restrain" list. A physical restraint, however, was documented on 1/31/13. Her crisis intervention plan stated that she should not be physically restrained, however, instructions to staff included a list of less restrictive measures to be attempted prior to chemical restraint, including three levels of physical restraint. In reviewing 10 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • Eight (80%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. Examples where this was not the case included: o Individual #13 received pretreatment sedation prior to a bone mass density exam on 11/15/12. His ISP noted that he did not require the use of medical pretreatment sedation for exams and routine tests. His ISP did not include desensitization strategies. o The facility list for desensitization assessment noted that Individual #74 did not require pretreatment sedation for medical procedures. Desensitization strategies were not included in his ISP. On 7/5/12, he was given pretreatment sedation for an ultrasound. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint. The facility 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	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 six crisis intervention restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In six out of six incidents of restraint (100%), there was assessment by a restraint monitor. The new restraint policy requires that the Face-to Face Assessment/Debriefing (FFAD) be used in all instances of restraint used for crisis intervention. • In six instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. • The assessment began as soon as possible, but no later than 15 minutes from the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	start of the restraint in six (100%) out of six instances. Based on a review of five physical and one chemical restraint for crisis intervention that occurred at the facility, there was documentation that a licensed health care professional: • Monitored and documented vital signs in four (67%). Records that did not contain documentation of this were: o Individual #13 dated 3/1/13 o Individual #109 dated 3/1/13 • Monitored and documented mental status in four (67%). Records that did not contain documentation of this were: o Individual #13 dated 3/1/13 o Individual #109 dated 3/1/13 • Conducted monitoring at least every 30 minutes from the initiation of the restraint (for a minimum of two hours with the use of chemical restraint) in two (33%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #13 dated 3/1/13, and 3/6/13 o Individual #109 dated 3/1/13 o Individual #161 8/12/12 Only one (17%), however, met the new state policy requirement that a nursing assessment be completed within 15 minutes of the restraint initiation. Based on documentation provided by the facility, no restraints had occurred off the grounds of the facility in the last six months. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 17% of the individuals for whom medical restraint was used. (See Sample C.3 above) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In 0 out of 10 (0%), the physician specified the schedule of monitoring required • In 0 out of 10 (0%), the physician specified the type of monitoring required. Based on a review of 10 medical pretreatment sedation restraints, there was documentation that a licensed health care professional conducted monitoring at least every 30 minutes for a minimum of two hours in seven (70%) of the instances of restraint. Exceptions were: • Individual #13 dated 11/15/12 • Individual #74 dated 7/5/12 • Individual #126 dated 11/5/12	

#	Provision	Assessment of Status	Compliance
		The facility was not compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy. Physician orders should include the schedule and duration for monitoring medical pretreatment sedation restraint.	
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 Appendix A.	A sample of six Restraint Checklists for individuals in crisis restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In six (100%), continuous one-to-one supervision was indicated as having been provided on the restraint checklist. • In six (100%), the date and time restraint was begun were indicated. • In six (100%), the location of the restraint was indicated. • In five (83%), information about what happened before, including the change in the behavior that led to the use of restraint. The exception was the restraint involving Individual #109 on 3/1/13. • In five (83%), the actions taken by staff prior to the use of restraint to permit adequate review per C8. The exception was the chemical restraint for Individual #161 on 8/12/12. • In six (100%), the specific reasons for the use of the restraint were indicated. • In six (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 three (50%), the observations documented every 15 minutes and at release. Exceptions were: o Individual #161 dated 8/12/12 o Individual #109 dated 3/1/13 o Individual #13 dated 3/1/13 • In three (50%), the specific behaviors of the individual that required continuing restraint; and • In three (50%), the care provided by staff during the restraint, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. 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 six (100%) of five physical restraint incidents, the date and time the individual was released from restraint were indicated. • In three (60%) of five physical restraints, the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries	Noncompliance

#	Provision	Assessment of Status	Compliance
		or other negative health effects were recorded. The exceptions were for Individual #13 dated 3/1/13 and Individual #109 dated 3/1/13. In a sample of six records (Sample C.1), FFADs had been completed for six (100%). These forms were generally complete in checking all the required boxes on the form, supplemented with minimal narrative. Only one post restraint review was completed using the new form developed in conjunction with the new state policy. A sample of 10 individuals subject to pretreatment medical sedation was reviewed, and in three (30%), there was evidence that the monitoring had been completed as required. The facility was not in compliance with documentation requirements for restraint incidents. Restraint incidents should be consistently documented using forms required by the state policy.	
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 is the same as the last report when one individual was placed in restraint more than three times in a rolling 30-day period. This individual (Individual #13) was reviewed (100%) by the monitoring team to determine if the requirements of the Settlement Agreement were met. His PBSP, crisis intervention plan, 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 PBSP or crisis intervention was available for Individual #13. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. Overall, given the small number of restraint occurrences that fall under C7, the facility should be able to achieve substantial compliance with all of C7 by the time of the next onsite review. This item was rated as being in substantial compliance because the ISPA meeting following more than three restraints in a rolling 30-day period reflected a discussion of Individual #13's adaptive skills and biological, medical, and psychosocial factors. The ISPA indicated that the treatment team did not believe that adaptive skills, or	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		biological/medical factors contributed to Individual #13's dangerous behavior that provoked restraint. The ISPA also indicated that the team did hypothesize that psychological factors may affect Individual #13's dangerous behavior, and suggested that he continue to attend psychiatric clinic and be seen psychology.	
	(b) review possibly contributing environmental conditions;	This item was rated as being in noncompliance because the minutes from the ISPA meeting following more than three restraints in a rolling 30-day period did not document a discussion of potential contributing environmental factors. 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 is concerned with a review of potential antecedents to the behavior that provokes restraint. Individual #13's ISPA identified "over prompting" as a potential antecedent to the dangerous behavior that prompted restraint, however, the ISPA indicated that staff were already ware that over prompting of Individual #13 was an antecedent to his aggression. No further discussion or no action to attempt to eliminate or reduce antecedents to dangerous behavior were evident in the ISPA minutes. In order to achieve substantial compliance with this provision item, ISPA minutes need to reflect not only a discussion of the effects of these types of variables on the individual's restraint, and (if they are hypothesized to affect restraints) a discussion of an action plan to eliminate these antecedents or reduce their effects on the dangerous behavior that provokes restraint. This was the case at EPSSLC, that is, that staff were already aware and presumably were following this procedure with the individual. For future reviews of cases of more than three restraints in any 30-day period, the ISPA document should note if no other antecedents were identified, and any actions that will be taken, such as for this case, that staff will be retrained to ensure that there is no over prompting, and/or the facility staff will begin to collect data on prompting.	Substantial Compliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. This item is rated as being in noncompliance because the ISPA following Individual #13 having more than three restraints in a rolling 30-day period did not document a discussion of the variables potentially maintaining the dangerous behavior that provoked his restraint. In order to achieve compliance with this provision item, the ISPA should reflect a	Noncompliance

#	Provision	Assessment of Status	Compliance
		discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that provoked restraint. The ISPA minutes should also reflect an action (e.g., increase staff attention for appropriate behaviors) to address this potential source of motivation for the target behavior that provokes restraint.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	This provision item was rated as being in noncompliance because, at the time of the onsite review, Individual #13 did not have a PBSP or crisis intervention plan to address the behaviors provoking his restraint. In order to achieve compliance with this item a PBSP and crisis intervention plan will need to be presented for each individual having more than three restraints in a rolling 30-day period. Additionally, the PBSP will need to: • Objectively define target behaviors • Contain alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint • Contain, as appropriate, the use of other programs to reduce or eliminate the use of such restraint • Contain interventions to weaken or reduce the behaviors that provoked restraint Finally, to achieve substantial compliance with this item the crisis intervention plan will need to: • Delineate the type of restraint authorized • Specify the maximum duration of restraint authorized • Specify the designated approved restraint situation; and • Specify the criteria for terminating the use of the restraint In the last review and report, this item was rated in substantial compliance. This was because the PBSP and crisis intervention plan was available for the individual who had more than three restraints in a rolling 30-day period. Additionally, that PBSP and crisis intervention plan contained all of the components discussed above. This time, however, there was no PBSP or crisis intervention plan to review, so a rating of noncompliance was given.	Noncompliance
	(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	This item was rated as being in noncompliance because there was no PBSP for Individual #13. In order to achieve compliance with this item, there will need to be evidence that each individual with three or more restraints in a rolling 30 days had a PBSP that was implemented as written (i.e., treatment integrity level of at least 80%).	Noncompliance

#	Provision	Assessment of Status	Compliance
	upon each occurrence of a targeted behavior; and		
	(g) as necessary, assess and revise the PBSP.	This item was rated as being in noncompliance because Individual #13 did not have a PBSP. In order to achieve compliance with this item, the ISPA needs to reflect that the treatment team reviewed the PBSP of individuals with more than three restraints in 30 days, and if the ISPA indicated that a revision was necessary, that there was evidence of this revision. In the last review and report, this item was rated in substantial compliance. This was because the ISPA of the individual with more than three restraints in a rolling 30-day period indicated that the team reviewed his PBSP and a revision was not necessary. This time, however, there was no PBSP to review so a rating of noncompliance was given.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	According to policy, the review of each incident of restraint began with a FFAD completed by a restraint monitor immediately following the restraint. The newly revised FFAD included an area for recommendations regarding the restraint. The facility was not consistently using the new FFAD form. Restraints were reviewed at the daily Unit Meeting and the daily Incident Management Team meeting, within three business days. During the onsite monitoring visit, Unit Meeting and Incident Management Team meetings were observed and, during this timeframe, discussion of restraint was evident on the day after the episode. A summary of the restraint episode was presented at each of the meetings. For the six restraints in sample C1, • Six of six (100%) were reviewed immediately by a restraint monitor. • Five of six (83%) were signed by the unit director indicating review within three business days. The exception was: o Individual #161 dated 8/12/12 (reviewed 8/16/12) • None (0%) were signed by the IMT designee indicating review within three business days. • One of one (100%) chemical restraint was reviewed by the psychologist within three days (this was above the minimum requirement). The new statewide policy now required a review by the psychiatrist and pharmacist, as well. Both had reviewed the restraint. The facility had created a restraint discussion form to be used in the daily Unit meeting when reviewing restraint incidents. A sample of completed discussion forms included in the section C presentation book was reviewed by the monitoring team. It was not evident	Noncompliance

#	Provision	Assessment of Status	Compliance
		that errors found in implementation and documentation of restraints were being adequately addressed. Eight of 11 (73%) review forms noted errors in restraint documentation. As evidenced by the findings in this report, poor documentation continued to be a problem. The Restraint Review Committee (RRC) met regularly and reviewed restraint trends. Although there had been progress made in terms of ensuring that restraint reviews were conducted, the facility was not yet in substantial compliance with this provision item. Review of restraint incidents should be documented on the FFAD, along with recommendations for follow-up or corrective action when appropriate. The facility needs to address the ongoing issue of inadequate documentation of restraints.	

Recommendations:

1. All individuals frequently restrained should have a treatment plan in place to guide staff in addressing behaviors identified by the IDT that might lead to restraint (C1).

2. The long-term use of protective mechanical restraints and medical 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, and/or eliminate the restraint when necessary. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm (C1, C2, C4, C8).

3. Restraint checklist should include evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner (C1).

4. The facility should develop Crisis Intervention Plans that meet the requirements of the state policy for those individuals frequently restrained to guide staff in restraint prevention and implementation (C2).

5. Ensure all staff responsible for applying restraint techniques have successfully completed competency-based training on approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint at least annually (C3).

6. Ensure that IDTs discuss and approve the use of restraints used for routine medical or dental care for an individual. When determined necessary, the ISP for individual should include treatments or strategies to minimize or eliminate the need for restraint (C4).

7. When medical restraints have been ordered, the physician order should specify the schedule and type of monitoring required (C5).

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

9. Ensure all restraints are documented to comply with state policy (C6).

10. 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).

11. Document review of all restraints and any recommendations and follow-up to recommendations (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 #002.4, dated 11/20/12 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021.2 dated 12/4/12 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 Training and background checks for the last three employees hired o Training transcripts for DFPS investigators assigned to complete investigations at EPSSLC o Abuse/Neglect/Exploitation Trend Reports FY13 o Injury Trend Reports FY13 o List of incidents for which the reporter was known to be the individual or their LAR 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 A sample of acknowledgement to self report criminal activity for 24 current employees o ISPs for: • Individual #65, Individual #134, Individual #49, Individual #78, Individual #31, Individual #103, Individual #8, Individual #6, Individual #60, and Individual #3. o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, PBSP, and ISPA related to the last three incidents of peer-to-peer aggression o List of all serious injuries for the past six months o List of all injuries for the past six months o List of all ANE allegations since 7/1/12 including case disposition o List of all investigations completed by the facility since 7/1/12 o List of employees reassigned due to ANE allegations o List of staff who failed to report ANE, or failed to report in a timely manner o Documentation of employee disciplinary action taken 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
#42669468	Neglect	Confirmed	3/1/13 5:21 am	3/1/13 11:52 am	3/7/13
#42663719	Physical Abuse (2)	Confirmed (1) Unconfirmed (1)	2/23/13 1:49 pm	2/24/13 10:50 am	3/5/13
#42662889	Neglect (2)	Unconfirmed (2)	2/22/13 1:27 pm	2/23/13 9:22 am	2/27/13
#42657071	Physical Abuse	Unconfirmed	2/16/13 5:12 pm	2/17/13 11:25 am	2/21/13
#42654290	Neglect (2)	Unconfirmed (2)	2/13/13 8:06 pm	2/14/13 4:00 pm	2/23/13
#42648505	Neglect	Unconfirmed	2/8/13 12:41 am	2/8/13 8:37 pm	2/15/13
#42648497	Neglect	Unconfirmed	2/8/13 12:32 am	2/8/13 11:40 am	2/11/13
#42637468	Emotional Verbal Abuse	Unconfirmed	1/29/13 12:01 pm	1/30/13 10:56 am	2/2/13
#42604864	Physical Abuse	Confirmed	12/31/12 10:00 pm	1/1/13 1:05 pm	1/15/13
#42604602	Neglect (3)	Confirmed (2) Unconfirmed (1)	12/31/12 3:20 pm	1/2/13 12:11 pm	1/10/13
#42601202	Neglect (3)	Inconclusive (2) Confirmed (1)	12/27/12 10:38 am	12/27/12 5:00 pm	1/11/13
#42361154	Neglect	Confirmed	7/2/12 4:29 pm	7/3/12 2:00 am	7/12/12

Sample D.2	Type of Incident	DFPS Disposition	Date of DFPS Referral	DFPS Completed Investigation	Facility Completed Investigation
#42520440	Death	Referred Back	10/20/12	10/24/12	11/2/12

Sample D.3	Type of Incident	Date/Time Incident Occurred	Director Notification		
#13-098	Serious Injury	3/2/13 7:40 am	3/2/13 8:00 am		

#13-096	Serious Injury	2/28/13 6:30 am	2/28/13 6:30 am		
#13-089	Serious Injury	2/8/13 2:30 pm	2/8/13 2:35 pm		
#13-085	Sexual Incident	1/29/13 Unknown	1/29/13 1:30 pm		
#12-112	Serious Injury	7/23/12 9:40 am	7/23/12 9:50 am		

Interviews and Meetings Held:

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

Observations Conducted:

- Observations at residences and day programs
- Unit Morning Meeting 3/19/13 and 3/21/13
- Incident Management Review Team Meeting 3/19/13 and 3/21/13
- Annual ISP meetings for Individual #50 and Individual #89
- Pre-ISP meetings for Individual #88 and Individual #82
- Human Rights Committee Meeting 3/20/13

Facility Self-Assessment:

EPSSLC submitted its self-assessment. 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. For example, for D1, the facility reviewed the facility's Protection From Harm Policy; employee signed acknowledgement to report abuse, neglect, and exploitation; confirmed that disciplinary action was taken following investigations, when appropriate; and reviewed training records.

The facility's review of its own performance found compliance with 21 of 22 provisions of section D. The

	monitoring team found the facility to be in substantial compliance with 19 of the 22 provision items. Both the facility and the monitoring team did not find compliance with the requirements of D4 regarding tracking and trending of incidents. Additionally, the monitoring team was unable to confirm compliance with the requirement that • Staff completed competency based training at least annually (D2c), and • The facility implemented action promptly and thoroughly, and tracked actions and the corresponding outcomes following unusual incidents (D3i). The facility is to be commended for its continued focus on developing an adequate self-assessment process to monitor compliance with section D requirements.
	Summary of Monitor's Assessment: According to a list provided by EPSSLC, DFPS conducted investigations of 41 cases involving 100 allegations at the facility between 8/1/12 and 1/31/13, including 36 allegations of physical abuse, eight allegations of verbal/emotional abuse, two allegations of exploitation, and 54 allegations of neglect. Of the 100 allegations, there was 1 confirmed case of abuse and 13 confirmed cases of neglect. An additional 21 other serious incidents were investigated by the facility, all involving serious injuries. There were a total of 861 injuries reported between 9/1/12 and 2/28/13. These 861 injuries included 8 serious injuries resulting in fractures or sutures. The facility was not adequately addressing injuries and trends of injuries. Some of the serious injuries were preceded by similar incidents, not adequately addressed. The facility needs to address trends that have the potential for serious consequences. The facility made substantial progress in addressing compliance with section D, though minimal progress had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility. The facility will need to make appropriate recommendations with a focus on systemic issues that were identified following investigations, incidents, and injuries. To move forward, the incident management department should take an integral role at the facility in looking at both systemic issues that contribute to incidents and individualized supports and services that place individuals at risk. The department will need to be involved in the emerging risk identification process to ensure that when individuals are at risk, adequate supports are provided.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. 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 Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that	According to DADS Incident Management Policy 002.3, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. With regard to other serious incidents, the state policy addressing Incident Management required that all unusual incidents be reported to the facility director or designee within one hour of witnessing or learning of the incident. This included, but was not limited to: • Allegations of abuse, neglect, or exploitation • Choking incidents • Death or life-threatening illness/injury • Encounter with law enforcement • Serious injury • Sexual incidents • Suicide threats • Theft by staff • Unauthorized departures.	Substantial Compliance

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	official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	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 summary of abuse, neglect, and exploitation investigations provided to the monitoring team, investigations of 51 cases involving 100 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility between 8/1/12 and 1/31/13. From these 100 allegations, there were: • 36 allegations of physical abuse including, o 1 confirmed; o 26 unconfirmed; o 4 inconclusive; o 1 unfounded; o 2 referred back for further investigation; and o 2 pending. • 8 allegations of emotional/verbal abuse; o 7 unconfirmed and o 1 unfounded. • 54 allegations of neglect including; o 13 confirmed; o 30 unconfirmed; o 7 inconclusive; o 1 referred back to the facility for further investigation; and o 3 pending. • 2 allegations of exploitation including, o 1 unconfirmed and o 1 unfounded. According to a list provided by the facility, there were 21 other investigations of serious incidents not involving abuse, neglect, or exploitation between 8/1/12 and 1/31/13. This included: • 13 serious injuries/determined cause • 1 serious injury/resulting from restraint, and • 7 serious injuries/undetermined cause. Note: A sexual incident on 1/29/13 was investigated by the facility, though not included on the list of incidents provided by the facility. The FY13 Facility Trend Report only included two serious injuries during the same reporting period. This raises concerns regarding data collection regarding incidents. The facility will need to ensure that data available to the Incident Management Department are accurate.	

#	Provision	Assessment of Status	Compliance
		From all investigations since 7/1/12 reported by the facility, 18 investigations were selected for review. The 18 comprised three samples of investigations: • Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample (12 cases). • Sample #D.2 included a facility investigation that had been referred to the facility by DFPS for further investigation (1 case). • 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: • 12 of 12 reports in the sample (100%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. DFPS case #42648505 and #42648497 were reported over 24 hours after the incident by unknown callers. There was no evidence that the facility suspected abuse or neglect at the time of the incident. • 11 of 12 (92%) indicated the facility director or designee was notified within one hour by DFPS. The exception was DFPS case #42648505. The UIR did not indicate when the director was notified. • 12 of 12 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • Ten of 12 (83%) documented that the state office was notified as required. Two UIRs did not document notification of the state office (case #42662889 and case #42637468). In reviewing Sample D.3 (serious incidents), documentation indicated: • Five of five (100%) were reported immediately (within one hour) to the facility director/designee when the incident was discovered. • Documentation of state office notification, as required by state policy, was found in five of five (100%) UIRs. • Documentation of DADs Regulatory notification was required for two incidents. Notification was made as required in both cases (100%). 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. • Six of six (100%) investigation files in Sample #D.2 and Sample #D.3.	

#	Provision	Assessment of Status	Compliance
		New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. Twelve new employees hired since 7/1/12 had all signed this form when hired. 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 the requirements of D2a,	
	(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 had 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 7/1/12. The log included the applicable investigation case number, allegation, disciplinary action taken (including retraining), and the date the employee was returned to work. All allegations were discussed in the daily IMRT meeting and protections were reviewed. 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, 12 (100%) UIRs documented additional protections implemented following the incident. This typically consisted of placing the AP in a position of no client contact, an emotional assessment, a head-to-toe assessment by a nurse, and changes in level of supervision when applicable. The facility was in substantial compliance with this provision.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and	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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	exploitation, and maintaining documentation indicating completion of such training.	A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included seven 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. • 18 (90%) of 20 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 23 (96%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 11 (58%) of the 19 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. It was noted during the last review that the facility would need to improve the timeliness of training in order to maintain substantial compliance. The facility was still not ensuring that staff completed training annually as required by the settlement agreement and state policy. The facility was not in substantial compliance with this provision.	
	(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 after completing ABU0100 training. A sample of this form was reviewed for a random sample of 24 employees at the facility. All employees (100%) in the sample had a current signed acknowledgement 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 two cases involving two employees where staff failed to report abuse or neglect as required. All staff involved were required to complete retraining on reporting procedures. The monitoring team assigned a substantial compliance rating to this provision.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(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 8/1/12 was reviewed for compliance with this provision. The sample ISPs were for Individual #65, Individual #134, Individual #49, Individual #78, Individual #31, Individual #103, Individual #8, Individual #6, Individual #60, and Individual #3. • Ten (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The new ISP format included a review of all incidents and allegations along with a summary of that review. This should be useful to teams in identifying trends and developing individual specific strategies to protect individuals from harm. In informal interviews with individuals during the review week, most individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. There was evidence that at least eleven cases investigated by DFPS since 7/1/12 were reported by the individual involved. The facility was in substantial compliance with this item.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	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. The facility investigator reported that regular rounds were made of each residential and day site to ensure ANE information and rights posters were in place in all buildings. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with his name, picture, and contact information.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility remained in substantial compliance with this provision item.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. Based on a review of 12 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and OIG of the allegation in all (100%), as appropriate. OIG investigated four cases in the sample. Criminal activity was not substantiated in any of the four cases. 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 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.	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 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. One name was submitted. The facility had taken disciplinary action against one staff due to involvement in retaliatory action against another employee. 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.	Substantial Compliance
	(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: • Reviewed all reported injuries at the morning unit meetings and again at the daily IMRT meetings.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• Quarterly data reports were compiled to identify trends in injuries. Sample #D3 included investigations completed on a sample of four serious injuries. All four investigations were completed by the facility. The facility investigator investigated all serious injuries. Campus Administrators had been assigned to investigate all discovered injuries within one day of being reported. Findings were reviewed by the Incident Management Coordinator at the unit meetings. The state reported that a new policy had been drafted to offer facilities further direction in developing an adequate injury audit system. The monitoring team will comment further on the new policy during the next round of reviews. Based on observations and the sample of documentation reviewed, the facility's audit system was adequate for ensuring that all discovered and/or suspicious injuries were reviewed to rule out abuse or neglect. The facility was in substantial compliance with this provision item.	
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. Eight DFPS investigators were assigned to complete investigations at EPSSLC. The training records for DFPS investigators were reviewed with the following results: • Eight investigators (100%) had completed the requirements for investigations training. • Eight DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 requested, all investigators had completed training on: • Abuse, Neglect, and Exploitation, • Unusual Incidents, • Root Cause Analysis, and • Comprehensive Investigator Training Facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility remained in substantial compliance with this item.	
	(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 did not cooperate with any outside agency conducting investigations. The facility investigator reported good cooperation between the facility incident management staff and DFPS. The facility identified two who failed to cooperate with investigators in the past six months. Both were required to complete retraining on reporting procedures.	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), OIG investigated four of the incidents. 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		investigations by OIG in the sample reviewed. The facility was found to be in substantial compliance with this provision.	
	(d) Provide for the safeguarding of evidence.	The EPSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.3): • There was no indication that evidence was not safeguarded during any of the investigations. 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.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	<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 with the alleged victim occurred within 24 hours in 11 of 12 (92%) investigations. Contact was the made the following day in the remaining case (#42604602). It did not appear that a delay in contact with the alleged victim impacted the outcome of any of the case. o 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. • Ten of 12 (83%) were completed within 10 calendar days of the incident. DFPS case #42604864 was completed in 15 days. An extension was filed while OIG completed an investigation. DFPS case #42601202 was completed in 15 days. An extension was not filed and it was not clear why completion was delayed. • The facility incident management team continued to work closely with DFPS to facilitate timely completion of investigations. • 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 five of the 13 (38%) DFPS investigations reviewed in Sample #D.1 and #D.2, concerns or recommendations for corrective action were included. One of those cases resulted in a referral back to the facility for further investigation.	Substantial Compliance

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		Concerns were appropriate based on evidence gathered during the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3: • The investigation began within 24 hours in five of five cases (100%). • Five of five (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Three of five included recommendations for the IDT to meet to discuss the incident.. Investigations commenced and were concluded in a timely manner.	
	(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	DADS Incident Management Policy required a UIR to be completed for each serious incident. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were reviewed. The results of these reviews are discussed in detail below; the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • For the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following: o In 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 Facility UIRs included a review of all previous investigations involving the alleged victim. o In 12 (100%), the investigator's findings; and o In 12 (100%), the investigator's reasons for his/her conclusions.	Substantial Compliance

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	alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Facility Investigations The following summarizes the results of the review of four 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. DFPS Investigations The following summarizes the results of the review of a sample of 12 DFPS investigations included in Sample #D.1: • In 12 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. 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, • 12 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 10 of 12 (83%) were reviewed by the facility director and/or the Incident	Substantial Compliance

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		Management Coordinator within five working days of receipt of the completed investigation. Exceptions were: o DFPS case #42662889 o DFPS case #42637468 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. <u>Facility Investigations</u> • In five of five (100%) 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 within five working days of completion. The facility was in substantial compliance with the requirement for review of all investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent.	
	(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 18 out of 18 (100%) unusual incidents in the sample. A 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. Five of 12 investigations in Sample D.1 included confirmed allegations of abuse or neglect with a known perpetrator named. Documentation provided by the facility indicated that disciplinary action had been taken in five of five cases where allegations were confirmed. DFPS noted concerns or made recommendations in five (42%) of the cases in sample #D.1. The facility did not maintain documentation of follow-up action taken to address concerns and recommendations in all cases. • Documentation of follow-up to all DFPS concerns was found in one (20%) of the investigation files in the sample. Cases where evidence was not found that the facility addressed DFPS concerns included: o DFPS #42648505 regarding disagreement among staff over assigned	Noncompliance

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		job duties. o DFPS #42654290 regarding updating Individual #18's BSP to address his self-injurious behaviors. o DFPS #42604864 regarding the late submission of requested documents. o DFPS #42662889 regarding staff documentation of required level of supervision checks. Additionally, the facility made recommendations for follow-up in 12 of the 12 cases in sample #D1. Three (25%) of 12 files adequately documented following up on all issues identified in investigations. • Investigation files that did include evidence of follow-up to all recommendations included: DFPS #42637468, DFPS#42669468, and DFPS #42361154. • Some examples where follow-up was not adequately documented included: o For DFPS #42648505, the investigator recommended that the AP be retrained on rights and values before returning to her position. o DFPS #42654290 included a recommendation to update Individual #18's BSP. o DFPS #42662889 included a recommendation to retrain the AP on requirements of Individual #63's supervision card. o DFPS #42657071 included a recommendation for the IDT to meet to address false allegations. The facility was not sufficiently following up on incidents to ensure that adequate protections were in place and remained in place. Sample #D.2 included one investigation that was referred back to the facility for further review. The facility completed a death review. Recommendations for programmatic actions were made in three of five cases reviewed for facility investigations in Sample #D.3. • UIR #13-089 did not included recommendations for follow-up, even though this was the second serious injury within a three month period for Individual #74. • Investigations included a recommendation for the IDTs to meet to discuss concerns noted during the investigation. Files did not include evidence that recommendations made by the team were completed or followed-up on. For example, the investigator recommended that the IDT meet to discuss possible contributing factors to a serious injury (UIR 13-096) on 2/28/13. The IDT met on 3/1/13 to discuss the injury and further recommended an appointment at the orthopedic clinic, lab work, and a physical therapy assessment. There was	

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		no evidence that the assessments were completed or that if completed, the IDT discussed the results or recommendations. In an attempt to prevent the likelihood of serious incidents from occurring, the Incident Management Department needs to ensure that recommended assessments are completed and that recommendations from those assessments are implemented and monitored for efficacy by the IDT. The facility was not yet following up on all recommendations, documenting follow-up action, and monitoring outcomes of the action for facility investigations. See D4 for additional comments regarding follow-up on trends identified in regards to incidents at the facility. The facility was not in substantial compliance with this item.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.	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. The facility was compiling data on a quarterly basis for allegations of abuse, neglect, mistreatment, and other unusual incidents and injuries. Trends were reviewed in QAQI Council meetings. A list provided to the monitoring team indicated that there were 21 serious injuries at the facility between 8/1/12 and 1/31/13. The FY13 Facility Trend Report only included two serious injuries during the same reporting period. This raised concerns regarding data collection regarding incidents. The facility will need to ensure that data available to the Incident Management Department are accurate. Some of the serious injuries investigated were preceded by similar incidents, not adequately addressed. For example, • UIR #12-112 was the investigation of a serious injury caused by peer-to-peer aggression on 7/23/12. In the month preceding the incident, staff documented	Noncompliance

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		19 incidents of aggression by the individual involved in the incident. A referral was made to psychology on 7/9/12 due to increased aggression. There was no evidence that an assessment was completed or that the team followed up on this referral prior to the incident. Documentation in the investigation file indicated that on 7/30/12 (seven days after the serious incident), assessments recommended by the IDT had still not been completed. • DFPS case #42648497 was the investigation of a neglect allegation following an incident of peer-to-peer aggression. Prior to the incident on 2/2/13, staff documented 16 previous incidents of peer-to-peer aggression in a four month period between the two individuals involved. The aggressor had caused the alleged victim to fall 12 other times during this period. There was no evidence that the IDT had developed adequate protections to ensure that the individual remained safe and injury free. The facility needs to aggressively address trends in injuries and implement protections to reduce these incidents and injuries. The facility made very little progress in addressing incident trends at the facility. 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 incidents and injuries at EPSSLC.	
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	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	Substantial Compliance

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	that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	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. According to information provided to the monitoring team, for FY13, criminal background checks were submitted for 236 applicants. There was 1 applicant who failed the background check in the hiring process and therefore was 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 remained in substantial compliance with this provision item.	

Recommendations:

1. The incident management department should take an integral role at the facility in looking at both systemic issues that contribute to incidents and individualized supports and services that place individuals at risk (D1 and D4).

2. The facility was needs to ensure that staff complete training annually as required by the settlement agreement and state policy (D2c).

3. Whenever 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 (D3i).

4. The facility will need to ensure that data available to the Incident Management Department is accurate (D4).

5. 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, dated 1/26/12 o EPSSLC facility-specific policies: • Quality Assurance Local Policy, 003.1, dated 6/8/12, though it was merely a copy of the state policy • Facility QA Plan, 11/19/12 o One page with 10 signatures regarding training on the Facility QA Plan, undated o EPSSLC organizational chart, undated, but likely February 2013 o EPSSLC policy lists, undated but likely February 2013 o List of typical meetings that occurred at EPSSLC, 2/28/13 o EPSSLC Self-Assessment, 3/6/13 o EPSSLC Action Plans, 2/20/13 o EPSSLC Provision Action Information, most recent entries 2/25/13 o EPSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/18/13 o List of all QA department staff and their responsibilities, undated but likely February 2013 o Workshop training documentation for some QA department staff, August 2012, October 2012 o EPSSLC QA department meeting notes, monthly September 2012 - February 2013 (5 meetings) o EPSSLC data listing/inventory, hard copy (no electronic version), 12/5/12 o EPSSLC QA plan narrative, 11/19/12 o EPSSLC QA plan matrix, undated probably November 2012 o EPSSLC QAQI Council monthly-quarterly-annual key indicator presentation schedule, undated o Set of blank tools used by QA department staff (6) o Sets of completed tools used by QA department staff (none) o Trend analysis report, for all four components, for last two quarters, through 2/28/13 o Data from other EPSSLC databases (3) o FSPI one page description o New section J psychiatry self-monitoring tool o EPSSLC DADS regulatory review reports, July 2012 through December 2012, no annual survey o Quality assurance department QAD-SAC-section leader meeting summaries • Notes: 1/17/13 to 1/31/13 (3 meetings) • Sign in sheets: 9/28/12 to 2/13/13 (7 meetings) o EPSSLC QA Reports, monthly August 2012 to February 2013 (6) o QAQI Council minutes, monthly August 2012 to January 2012 (5 meetings) o PIT, PET, work group reports (none) o Monitoring Committee minutes, July 2012 to February 2013 (5 meetings) o EPSSLC Corrective Action Plan packet, 7/1/12 through 1/31/13, 21 pages

	o DADS SSLC family satisfaction survey online, September 2012 - November 2012, 68 respondents o Community satisfaction survey, October 2012, >20 respondents o List of self-advocacy leadership 2013 o Self-advocacy monthly meeting minutes/notes, monthly July 2012 to March 2012, 7 meetings o Home meetings with individuals (none) o Facility newsletters, Center Stage (3) <u>Interviews and Meetings Held</u>: o Erna Matthews, Interim Director of Quality Assurance o Priscilla Munoz, Settlement Agreement Coordinator o QA department staff: Elaine Lichter, Petra Robledo, Hector Sanchez, Elizabeth Rodriguez o Unit Director: Adrian Hanway o Gloria Loya, Human Rights Officer o Laura Cazabon-Braly, Facility Director <u>Observations Conducted</u>: o QAQI Council meeting, 3/20/13 o Section Leaders meeting, 3/18/13 o Morning medical, morning unit, and IMRT meetings, 3/20/13 o Self-advocacy meeting, 3/21/13
	Facility Self-Assessment The self-assessment, written by the new QA director (during the time she was appointed as interim QA director), was a further improvement from the previous self-assessment. Her activities were more in line with the content of the monitoring team's report and were more focused on activities of the QA program at EPSSLC. Moreover, she included various data on many of these QA activities. The monitoring team commented on similar data in the report below, however, in some instances, the interpretation of the data by the QA director was different than that of the monitoring team. For example, regarding CAPs, the self-assessment seemed to indicate that CAPs were spread across the many departments of the facility whereas the monitoring team believed that the data showed that many departments were not, or only barely, involved in the CAPs process. Similarly, the self-assessment reported that the CAPs form included elements, such as responsible person, due dates, outcomes, and evidence whereas the monitoring team did not see these items completed for most of the CAPs listed on the tracking document. The monitoring team also reviewed the QA director's section E action plan document. Similar to the self-assessment, she laid out a number of action steps and sub-steps that were more in line with the monitoring team's previous reports than ever before. The monitoring team wishes to acknowledge the progress made on the self-assessment and the action

	plans and believes that the QA director will further improve the self-assessment and action plans by reviewing the details in the report that follows below. In addition, a statewide self-monitoring tool for section E will be helpful in future self-assessments for this section. Further, the Monitors and DADS will likely have finalized the expected metrics for each of the five items in this provision in the next few months. This should then result in a revision to the statewide self-monitoring tool, which can then be used by the QA director for future self-assessments. The facility self-rated itself as being in noncompliance with all five provision items of section E. The monitoring team concurred with these self-ratings. During the onsite review, however, the QA director told that monitoring team that she now believed that they had come into substantial compliance with item E3. The monitoring team carefully considered this, but based upon what was presented while onsite and the documents reviewed offsite, the monitoring team rated E3 in noncompliance (see below). During the next onsite review, the monitoring team can review the self-assessment, the monitoring team's report, and any actions plans, in more detail with the QA director.
	Summary of Monitor's Assessment: The QA program at EPSSLC continued to improve since the last onsite review. Progress was slowed, however, with the departure of the previous QA director in December 2012. An interim QA director was appointed a month later. In the weeks following the onsite review, she was appointed permanently to the QA director position. Thus, the facility was without a QA director for more than three months. The interim QA director maintained the work completed through December 2012 and even made some further improvements. With her permanent appointment, along with the appointment of a new facility director in January 2013, the QA program is likely to make good progress over the next six months. The QA plan narrative at the facility was current, complete, and adequate. The QA data list/inventory continued to improve, but the QA department should now ensure that important types of data (i.e., key indicators) are included in the data list/inventory (as well as in the QA matrix) for each of the Settlement Agreement sections. The QA director and the department section leaders should work towards improving their self-monitoring tools, especially regarding content/validity, adequate instructions, implementation, and regular review by the QA department. Data from the QA plan matrix for the self-monitoring tools for 17 of the 19 (89%) sections of the Settlement Agreement (not section E) were summarized and graphed showing trends over time. This was good to see, however, there was a need to review the content of many of these tools. Further, there was a need to identify important data/indicators for each section of the Settlement Agreement and, when appropriate to do so, and to conduct a review that provides analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as is required by this provision. This was occurring for some of what the facility called its monthly and

	quarterly key indicators (e.g., injuries), but not yet for each of the Settlement Agreement sections. Meetings between the QA director, SAC, and department head were beginning to occur. This was also good to see. The schedule content, format, and expectations for these meetings were still in development. A section leader meeting and a monitoring committee were two groups whose activities were also related to the QA program at the facility. The QA report continued to improve. The QA report remained a regular and typical part of the QA program and QAQI Council. This was all good to see. The QAQI Council meeting observed by the monitoring team was improved since the last onsite review. It was only the first or second meeting for the new facility director. A number of work groups, special committees, and special projects were occurring at EPSSLC (e.g., weights, meal improvement, level of supervision). The QA department should keep track of these groups and ensure that their work and data are part of the QA program at EPSSLC. Although additional work was done on the CAPs system, as indicated in E2 through E5 below, more work needed to be done across all aspects of the system, from development, definition, and assignment, through implementation, review, and modification.

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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.	The QA program at EPSSLC continued to make progress towards substantial compliance. An interim QA director, Erna Matthews, was appointed in January 2013 after the departure of the previous QA director in December 2012. The previous QA director had made some improvements in the QA program prior to his departure. After that, progress slowed as the facility moved to select a new permanent QA director. During the weeks following this onsite review, Ms. Matthews was appointed as the permanent QA director. <u>Policies</u> There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy, titled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will	Noncompliance

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		make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. The state policy called for a statewide QAQI Council, and for statewide discipline QAQI committees. Neither was in place at this time. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this. There were EPSSLC facility policies that adequately supported the state policy for quality assurance. There were two facility policies. One remained unchanged since the last onsite review. 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 EPSSLC letterhead on the first page. The second was the QA plan narrative, now designated as a facility policy, as recommended in the previous monitoring report. It was an adequate description of how the QA department operated at EPSSLC. This made sense because the QA plan narrative described much of the facility QA program. More detailed comments regarding the QA plan narrative are provided below. Documentation showed that QA department staff received training on this policy (i.e., the QA plan narrative). <u>QA Department</u> Ms. Matthews, the newly appointed QA director, should work closely with state office regarding the requirements for achieving substantial compliance with all of the provisions of section E. The other QA department staff members were the same as during the last onsite review. This stability will serve the facility well because they had continued to improve upon their skills as monitors and auditors. The QA department staff who worked on section E activities consisted of two program auditors, a QA nurse, a data analyst/database manager, and an administrative assistant. As always, the monitoring team enjoyed meeting with them and appreciated hearing about their QA activities.	

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		The QA department began to hold monthly meetings for the staff in September 2012. Agenda items for September 2012 through February 2013 were relevant to their work. The meeting minutes demonstrated that new topics were brought to the QA department staff, such as new areas for monitoring. QA staff attended a variety of trainings, such as on the new ISP process, living options, and resident rights. The monitoring team continues to recommend including a monthly topic related to the overall professional field of quality assurance. <u>Quality Assurance Data List/Inventory</u> The QA data list inventory, an important component of a comprehensive QA program, continued to improve since the last review. Even so, there was not yet a complete and adequate data list/inventory at the facility. The data list inventory was 21 pages long (when printed) and contained 20 topic areas. It appeared that 17 of the 20 provisions of the Settlement Agreement were included (there were no data listed for sections G, H, or I). Some topic areas included more than one Settlement Agreement Provision (e.g., C and K; F and S; O, P, and R). It may be helpful to the facility to have a separate topic area for each Settlement Agreement provision. Further, some topic areas only listed a self-monitoring tool (e.g., section S), that is, no other important data or indicators were included, such as those that would allow for the identification of trends related to program areas, living units, work shifts, protections, supports, and services, and areas of care. Overall, though progress was seen compared to the last onsite review, not all of the data collected at the facility were included in the data listing inventory. In addition to ensuring that all data were included, the data list inventory would be more useful to QAQI Council, the QA department, and the reader if each item was written so that it was evident as to what each item was measuring. For example, item #31 on the nursing data list merely said "Pressure Ulcers." Instead, the item should, for example, read "Pressure Ulcers: number of individuals with unhealed pressure ulcers" (if that was what they were measuring). There were some ways in which the data list inventory had improved since the last onsite review. Some of these improvements were in response to suggestions made in the previous monitoring report: • Columns were added to the data list inventory indicating if the data were reviewed at QAQI Council, in the QA report, reviewed at QAD/SAC meetings, and/or reviewed by the QA department. This was very good to see. • The data list inventory was part of the regular agenda for the QAD/SAC meetings. The minutes, however, did not indicate if the data list inventory was	

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		discussed and/or what actions might have resulted. These meetings are discussed in more detail below. The data listing was noted to have been updated on 12/5/12. Even so, the data list inventory at the facility was not current. That is, for each topic area, the date of the most recent update should be indicated. It is likely that these will occur on different dates. The QA department should have a goal to update these at least every six months. Updating could be spread over a six-month period. Activities could include review at the QAD/SAC meeting, followed by presentation of the data list inventory at the next QAQI Council meeting. If two or three topic areas were presented at each QAQI Council, all topic areas of the data list inventory could be reviewed within a six-month period. <u>Quality Assurance Plan Narrative</u> The QA plan narrative at the facility was current, complete, and adequate. The QA plan narrative was updated in November 2012. It was 12 pages long and provided a very good overview of the components of the QA program at EPSSLC. The QA director correctly noted, in the narrative, that it would be updated at least annually. This made sense because the QA plan narrative contained a lot of very specific information, such as the data collected by the QA staff and a list of many of the committees at EPSSLC. These tended to change regularly. A nice addition to the narrative was a one-page chart (called a schedule) that identified a set of important data/indicators that would be included in the QA report and reviewed at QAQI Council each month, each quarter, or each year. The schedule for review of the 20 provisions of the Settlement Agreement was also on this chart. In addition, as noted above, the QA plan narrative was considered to be a facility-specific policy. This was another good idea. The QA plan narrative could be improved by describing how the most important key indicators for each discipline are determined, a description of how inter rater reliability data are collected for each department and where the results of these reliability checks are to be reported, and where committee data are to be listed, such as in the data inventory for the discipline or in a separate category specifically for committees and work groups. <u>QA Plan Matrix</u> The QA plan matrix was identical to the previous QA plan matrix with the exception of the addition of nine key indicators and a section titled “Data reviewed by QA.” More work will need to be done to make the QA matrix a useable document that helps guide what data are submitted to the QA department, included in the QA report, and presented to QAQI Council.	

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		The QA director should be prepared to demonstrate to the monitoring team that: 1. An adequate set of key indicators are included in the QA matrix for all 20 sections of the Settlement Agreement. 2. These key indicators include both process and outcome indicators for all of the 20 sections of the Settlement Agreement. 3. These indicators provide data that could be used to identify the information specified in E1: 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. The QA matrix should also include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement. The EPSSLC QA matrix listed self-monitoring tools for 17 of the 20 sections (85%), however, the monitoring team was aware of recent changes and revisions to many of the self-monitoring tools, and was also aware that many of the tools were no longer being used (e.g., sections C and S). The QA director needs to update this part of the QA plan matrix. All data that QA staff members collected should be, and were, listed in the matrix. QA staff members collected six different types of data themselves. These were the "100%" record audit, active treatment, promoting rights, mealtime, environmental, and mattresses. The facility had a number other sets of data, such as approximately 10 facility-specific databases (e.g., hospitalizations, weights, community outings), the statewide four-component trend analysis, and the FSPI. Many, but not all, of these appeared in the QA matrix. All should be in the QA data list inventory. Those that are reviewed by the QA department, included in the QA report, and/or presented to QAQI Council should also be in the QA matrix. Satisfaction surveys were included in the QA matrix. • There were satisfaction surveys of families/LARs, and relevant community partners, both now done at least annually. Surveys for individuals and staff were still in development. The community satisfaction survey was recently completed and was overwhelmingly positive. The results of the family survey from earlier in the fall were also extremely positive. There were no significant facility-wide findings for which any follow-up needed to be done, however, the QA director should read the individualized comments written by families/LARs to see if follow-up might be warranted for any of those individual items. • Self-advocacy activities can be one way of obtaining satisfaction information from individuals. The self-advocacy group, under the guidance and facilitation of	

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		Gloria Loya, the HRO, had developed into an organized activity for the dozen or so members. Ms. Loya, with the assistance of Nora Padilla, QDDP, facilitated a regularly occurring monthly meeting. One of the ongoing topics was learning to make decisions. During a meeting observed by the monitoring team, the group made two decisions. One was to choose from four possible t-shirt designs. The other was to decide where to go on their next group outing. For further development of decision-making skills, Ms. Loya and Ms. Padilla might use a typical decision-making problem-solving process. This includes reviewing details about each option, discussing the pros and cons of each option, voting, and making a plan to implement the decision. The QA matrix is really a subset of the larger data list/inventory. Therefore, all items on the data matrix should also be in the data list inventory. That was the case for most, but not all, of the items. <u>QA Plan Implementation</u> Items in the QA plan matrix should be implemented as written, submitted, and reviewed. Therefore, the QA director should indicate which of the items in the QA matrix: 1. Were conducted as per the schedule 2. Submitted/collected/received by the QA department for the last two reporting periods for each item 3. Reviewed or analyzed by the QA department and/or the department section leader A percentage can also be calculated, perhaps monthly, bi-monthly, or quarterly, for each of the three items in the list above. Documentation and observation did not indicate that QA staff assisted each discipline in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. <u>Self-Monitoring Tools</u> The use of self-monitoring tools was an important component of the self-assessment activity at all of the SSLCs and had been so for the past few years. A great deal of importance was placed on these tools and their outcomes. Thus, much attention from the QA department and QAQI Council continued to be directed to self-monitoring tools. Facilities could develop their own tools (or modifications of state-provided tools) for each of the Settlement Agreement sections. At EPSSLC, some of the departments had developed new self-monitoring tools (e.g., psychiatry and nursing) and/or had modified the previous state-provided tools (e.g.,	

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		medical). During the onsite review, the new facility director raised important questions to the department heads and to the QA director regarding whether the self-monitoring tools included the right types of questions and items, that is, those that would capture what they wanted to capture. As the QA director and the department section leaders work towards improving their self-monitoring tools, the monitoring team recommends that she review the comments made in previous monitoring reports regarding these tools. Further, for the next onsite review, she should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at EPSSLC: 1. Content/validity: A description of how the content of the tools were determined to be valid (i.e., measuring what was important) and that each tool received a review sometime within the past six months. 2. Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. 3. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. 4. QA review: A report or summary showing that there was documentation of QA department review of the results, at least once each quarter, for each of the 20 sections of the Settlement Agreement.	
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.	Continued progress was seen at EPSSLC regarding the analysis of data. Data from the QA plan matrix for the self-monitoring tools for 17 of the 19 (89%) sections of the Settlement Agreement (not section E) were summarized and graphed showing trends over time. This was good to see, however, as noted above in E1 regarding the QA plan matrix, there was a need to review the content of many of these tools. Further, there was a need to identify important data/indicators for each section of the Settlement Agreement and, when appropriate to do so, also provide an analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as required by this provision. This was occurring for some of what the facility called its monthly and quarterly key indicators (e.g., injuries), but not yet for each of the Settlement Agreement sections. <u>Monthly QAD-SAC meeting with discipline departments</u> These meetings were initiated since the last review. The QA director and Settlement Agreement Coordinator were still developing this process, thus, it really was in its early stages. For instance, there were some documents that contained signatures, dates of meetings, and a checklist of eight agenda items, many of which were checked. Over the	Noncompliance

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		next few months, the QAD and SAC should determine a monthly (or bi-monthly or quarterly, rather than a weekly) schedule, regular (or rotating) agenda topics, and a simple way to track department participation and performance. These meetings can provide an excellent forum for the review of QA-related activities as well as review of process and outcome data for each section of the Settlement Agreement. Since the last onsite review, a meeting occurred at least twice for 20 of the 20 (100%) sampled sections of the Settlement Agreement. All of the five topics below were documented to have been reviewed during none (0%) of the meetings that occurred. Some of the topics were reviewed, however, in almost all of the meetings. • Review the data listing inventory and matrix, • Discuss data and outcomes, • Review conduct of the self-monitoring tools, • Create corrective action plans, • Review previous corrective action plans. Because the content, structure, and scheduling of these meetings were still being developed, data were available to facilitate department/discipline analysis of data during none (0%) meetings. As a result, data were reviewed and analyzed during none (0%) of the meetings, and action plans (and/or CAPs) were created for systemic problems and for individual problems during none (0%) of the meetings. The QA director should consider a way of keeping these data alongside a short narrative and, in addition, summarizing the activities of these meetings (i.e., the data that indicate the activities that did or did not occur at the meetings). She had some of the foundation for this, therefore, it probably would not be very difficult to improve upon it. <u>Two Other QA-Related Meetings</u> The facility held two other meetings that were related to quality assurance. Both were likely to help the facility meet the requirements of section E of the Settlement Agreement. • Monitoring Committee: This monthly meeting was led by the QA director and focused upon the items on the key indicator list (i.e., the items on the what the facility called the monthly-quarterly-annual schedule). The meeting minutes indicated good discussion of relevant topics regarding four or five indicators. The occurred monthly except there were no meetings in December 2012 and January 2013. • Section Leader: This new weekly meeting was led by the facility director. Each department head gave a brief update of activities he or she was engaged in related to the Settlement Agreement. This appeared to be a good forum and a good supplement to the monthly QAQI Council. The monitoring team	

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		recommends that the facility director ensure that the content of this meeting does not become solely informational updates. <u>QA Report</u> The QA report continued to improve. The QA report remained a regular and typical part of the QA program and QAQI Council. This was all good to see. Since the last onsite review, a facility QA report (for dissemination at the facility and for presentation to the QAQI Council) was created for five of the last six months. The only month missing was December 2012, during the time between the previous QA director's departure and the appointment of Ms. Matthews as interim QA director. Also, the facility reviewed the February 2013 report again in March 2013 thereby postponing (or perhaps cancelling what would have been reviewed in March). How this might impact the pre-determined schedule of section presentations was unknown to the monitoring team. Of the 20 sections of the Settlement Agreement, 12 (60%) appeared in a QA report at least once in each quarter (i.e., twice since the last onsite review). Five others (25%) appeared once in the six months, and three (15%) were not in any QA report. Of the 20 sections of the Settlement Agreement that were presented, none (0%) contained all of the components listed below. Most (93%) contained 12 months or more of data, and most (86%) contained a narrative analysis that was more than merely a description of how the self-monitoring tool was implemented. Most of the section reports, however, only presented self-monitoring data, and no other important data (i.e., key indicators) for the section. • Self-monitoring data o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Other key indicators/important data for the section o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Narrative analysis The QA director, prior to his departure in December 2012, was responsive to many of the recommendations from the monitoring team. In the last report, the monitoring team listed 11 bulleted comments. Specifically, nine of the 11 were addressed by the QA director. Two others remained and are listed below. The new QA director should refer to the previous report for more detail. A third bulleted comment is also added below.	

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		• Inclusion of other 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. • Some CAP information should be in each section of the report. The monitoring team recommends a simple, short, summary piece of data, such as the number of CAPs that are active at this time. • Most, if not all, of the monthly and quarterly key indicators were tied to a specific provision of the Settlement Agreement. For example, injuries were tied to section D. This might be noted alongside each key indicator in the table of contents. <u>QAQI Council</u> This meeting plays an important role in the QA program and, as required by policy, was led by the facility director. The monitoring team attended a meeting during the onsite review and read the minutes of all QAQI Council meetings from 8/22/12 through 1/30/13 (there were five meetings). There was an adequate description of the QAQI Council in the QA plan narrative. Since the last onsite review, the QAQI Council did not meet at least once each month. A meeting did not occur in December 2012. This was due to the transition of the new facility director and was explained in the January 2013 minutes. Minutes from five of the five (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, such as the monthly and quarterly key indicators, and the Settlement Agreement sections scheduled for presentation. An additional topic could be work group updates. These might also be scheduled in the same way the monthly/quarterly indicators and Settlement Agreement sections were scheduled. Minutes from QAQI Council meetings since the last review indicated that many members of the committee were absent from meetings. Therefore, there was not appropriate attendance/representation from all departments. The most recent minutes appeared to only indicate who was present, that is, the minutes did not indicate who was absent. The QA report was presented and reviewed each month during the QAQI Council meeting. Therefore, information from the QA report did not need to be included in the minutes (it wasn't). Thus, in five of the five (100%) QAQI Council meetings since the last review (a) data from QA plan matrix (key indicators, self-monitoring) were presented,	

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		(b) the data presented were trended over time, and (c) comments and interpretation/analysis of data were presented. The minutes did not, but should, reflect discussion that occurred. If there was no discussion or commentary, this should be indicated in the minutes, too. Moreover, the section of the minutes for the monthly/quarterly key indicators was written as one long paragraph, making it difficult to read and follow. Perhaps a new paragraph can be started for each key monthly/quarterly indicator. Similarly, the minutes should reflect if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. During a QAQI Council meeting observed by the monitoring team, there was active participation of participants other than the presenter for none (0%) of the reports/data for Settlement Agreement sections presented during the meeting. Overall, the QAQI Council meeting at EPSSLC had the potential to develop into an active decision-making group. Supplemented by the section leader meeting and the monitoring meeting, the QAQI Council meeting can be a forum for more detailed discussion, questioning among members, and the setting of action plans and CAPs. The monitoring team has the following suggestions for the facility director: • Foster participation by specifically asking for attendees to ask questions about the data chosen for presentation, the data results/outcomes, recommendations for improvement, and the creation of CAPs. • Ensure the minutes reflect discussion and the creation of any CAPs or other actions. Similarly, ensure the minutes reflect if there was no discussion and if there was no need for any action. <u>Work Groups/Performance Improvement Teams</u> A number of work groups, special committees, and special projects were occurring at EPSSLC (e.g., weights, meal improvement, level of supervision). This was good to see and demonstrated that the facility management could target specific important problem areas. Minutes were created for some of the groups and databases were created for some of the groups. The QA department should keep track of these groups and ensure that their work and data are part of the QA data list inventory, QA matrix, QA report, and QAQI Council, as appropriate. <u>Corrective Actions</u> Corrective action plans were tracked by the QA director in a 21-page document that contained 56 CAPS (counting each shaded/un-shaded row as a separate CAP). A new form, called the Corrective Action Reporting Document, was implemented to help guide	

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		those responsible for implementing CAPs. The monitoring team, however, found the tracking sheet to have a number of problems, such as much of it was incomplete, most of the CAPs did not contain an outcome/goal, and the format did not follow the state policy for tracking CAPs. Further, the document indicated that all departments were not yet participating in the CAPs system. Below are seven categories of these CAPs. • Clinical death review (7 CAPs) • FSPI (6) • H&W (5) • Habilitation (2) • Medical audits (34) • Monitoring committee (1) • QAQI Council (1) An adequate written description did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP. The monitoring team could not determine how the facility/department determined if a CAP was to be generated. Some CAPs addressed broader systemic issues, whereas others addressed simple corrections that probably did not require a full CAP to be implemented. The QA director reported that CAPs were generated from committees, departments, and audits. The QAD reported that she followed up on CAPs each month by talking with the staff person responsible for any CAPs that had their status marked as pending. Perhaps the results of these discussions can be included in the status column of the tracking report. Because the goals/outcomes were not accurately worded, the monitoring team could not determine if they addressed the specific problem for which they were created. Based on a review of the tracking document of all 56 CAPs: • All (100%) included the actions to be taken to remedy and/or prevent the reoccurrence (the actions, however, were not accurately worded). • 0 (0%) included the anticipated outcome of each action step • 9 (16%) included the name of the person(s) responsible • 0 (0%) included the time frame in which each action step must occur. Lastly, the monitoring team recommends that the QAD maintain and graph some simple data on CAPS. These data can be part of the section E data list inventory (and possibly the QA matrix, too). For example:	

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		• Total number of active CAPs • Number of CAPs completed and closed out for the month • Number of CAPs that are active (i.e., not completed) past their due date	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the CAPs tracking document of all 56 CAPs: • 0 (0%) included documentation about how the CAP was disseminated • 0 (0%) included documentation of when each CAP was disseminated, and • 9 (16%) included documentation of to whom it was disseminated, including the names of the specific persons responsible. During the onsite review, the QA director spoke about this provision being in substantial compliance (though it was self-rated in noncompliance in the self-assessment). The monitoring team considered this discussion, however, based upon the lack of detail regarding the dissemination of the CAPs (i.e., the above bulleted items), this provision remained in noncompliance. It is very likely, however, that this can be in substantial compliance for the next review.	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. CAPs were discussed and reviewed during the monthly QAD-SAC meetings. Although there was some presentation of CAPs that were implemented (e.g., regarding individuals who stayed back from going to day programs), the monitoring team could not determine how, when, or if the majority of CAPs were or were not implemented. The monitoring team will be looking for: • Indication that CAPs were implemented fully and in a timely manner. • An adequate system for tracking the status of CAPs that indicates the status of the CAP and any action taken if a CAP had not been implemented. • Summary information/data regarding CAPs and their status that was updated within the month prior to the onsite review • Presentation of this information to QAQI Council at least quarterly.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	EPSSLC was not in compliance with this provision item. The QA director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. The monitoring team will be looking for: • Evaluation of the effectiveness of CAPs, including outcomes and timely completion • CAPs are modified when needed • Modifications/results are discussed at QAQI Council.	Noncompliance

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		• Modifications are implemented as written fully and timely.	

Recommendations:

1. Given that the statewide policy was disseminated more than a year ago, edits may already be needed. this (E1).
2. Include a monthly topic related to the overall professional field of quality assurance during QA staff meetings (E1).
3. The data list inventory needs improvement as described in E1 (E1).
4. The QA matrix needs improvement as described in E1 (E1).
5. Report on implementation of the items in the QA matrix (E1).
6. Address the recommendations regarding self-monitoring tools that are in E1 (E1).
7. For each section of the Settlement Agreement and, when appropriate to do so, conduct a review that provides analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as is required by this provision (E2).
8. Develop the QAD-SAC-department meetings as described in E2 (E2).
9. The QA report should include other relevant data for each Settlement Agreement section and, when appropriate, provide information regarding program areas, living units, work shifts, etc., as per the wording of this provision (E2).
10. Prompt and then document discussion and creation of action plans (when necessary) during QAQI Council meetings (E2).
11. Keep track of work groups and special committees and include them in the QA program (E2).
12. Improve the system of CAPs as described in E2, E3, E4, and E5 (E2, E3, E4, 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 #004.1: Individual Support Plan Process o DADS Policy #051: High Risk Determinations o Curriculum used to train staff on the ISP process o EPSSLC Section F Presentation Book o EPSSLC Self-Assessment o The last 10 section F monitoring tools completed by the QDDP Coordinator o List of all QDDPs and assigned caseload o A list of QDDPs deemed competent in meeting facilitation (8) o Data summary report on assessments submitted prior to annual ISP meetings o Data summary report on team member participation at annual meetings. o A list of all individuals at the facility with the most recent ISP meeting date, date of previous ISP meeting, and date ISP was filed. o ISP Draft for Individual #50 and Individual #89 o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, QDDP monthly reviews: • Individual #65, Individual #134, Individual #49, Individual #78, Individual #31, Individual #103, Individual #8, Individual #6, Individual #60, and Individual #3 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Gloria Loya, Human Rights Officer o Mario Gutierrez, Incident Management Coordinator o Michael Reed, Lead Investigator o Carmen Molina, Director of Behavioral Services o Cynthia Martinez, QDDP Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Unit Morning Meeting 3/19/13 and 3/21/13 o Incident Management Review Team Meeting 3/19/13 and 3/21/13 o Annual ISP meetings for Individual #50 and Individual #89 o Pre-ISP meetings for Individual #88 and Individual #82 o Human Rights Committee Meeting 3/20/13

	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 3/6/13 with recent activities and assessment outcomes. The QDDP Coordinator was responsible for the section F self-assessment. The facility added a number of activities to the self-assessment efforts in regards to section F. The self-assessment commented on findings from a monthly sample of Settlement Agreement Monitoring Tools (SAMTs) completed by the QDDP Coordinator, as well as other activities for each provision. The QDDP Coordinator was also observing ISP meetings and monitoring QDDP facilitation skills, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. For example, for F1d in regards to ensuring assessment results were used to develop, implement, and revise the ISP, the QDDP Coordinator used the section F monitoring tool, along with the assessment tracking, to determine compliance. These are the same type of activities that the monitoring team looks at to assess compliance. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts to develop an accurate audit system and believes that the facility was continuing to proceed in the right direction. The QDDPs were recently trained on the new ISP process that was designed to meet the requirements of the Settlement Agreement. The QDDP Coordinator acknowledged that the facility self-assessment process was not yet sufficient for measuring compliance with requirements of section F. She was continuing to make changes in the self-assessment process to address changes in the new ISP process. A larger sample of ISPs completed using the new ISP development process will be necessary before compliance ratings can be considered meaningful. 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 Since the last monitoring visit, the ISP planning and development processes had been revised. EPSSLC QDDPs and other team members had been provided training on the new process by statewide consultants. IDTs began implementing the newly developed process in October 2012. In consultation with the parties, it was agreed that beginning in August 2012, the monitoring teams would only review and comment on the ISP documents that utilized the newest process and format. EPSSLC had recently received training on the new process from state office consultants. The facility submitted 10 ISPs in the new format for review by the monitoring team. The intention of limiting the monitoring team's review to newer plans was to provide the state and facility with more specific information about the revised process. Since a majority of individuals have not had an ISP developed in the new format, the monitoring team concentrated on providing comments regarding areas of improvement and areas that continue to need improvement from the limited sample available rather than offering compliance data in

	most areas. Compliance will be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement Agreement requirements. There had, however, been some positive steps forward with the new ISP process. • The facility had received training and technical assistance on the new ISP process from state office consultants. • The QDDP Coordinator continued to attend ISP meetings and to provide coaching and feedback to QDDPs based on results from the facilitation skills assessment tool. • The facility had begun using the new ISP Preparation Meeting process to identify preferences and needed assessments prior to the ISP meeting. • A process was developed to gather assessment submission data. • The QDDP Coordinator had begun presenting findings from the section F monitoring tools at monthly QDDP meetings. • Home supervisors had begun monitoring the implementation of all plans. The monitoring team observed two annual ISP meetings in the new format. The IDTs were following the format of the new ISP process and team members were holding a more integrated discussion. Team meetings were very lengthy and the IDTs struggled with how to integrate the risk discussion into the ISP meeting. The facility was moving in a positive direction, though additional training was still needed to help team develop meaningful plans through this process. The new process, thus far, was not resulting in adequate supports and measurable outcomes. Though considerable progress was noted, the facility was not yet in compliance with any of the provisions of section F.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings in the new format. The QDDP facilitated both meetings. Both meetings were good examples of facilitation that ensured that team members participated in the meeting and all topics were covered. Progress definitely continued to occur and was evident, with regard to the facilitation of meetings. • A much broader list of personal preferences was developed. • More efforts were made than in the past to elicit information from all team members. • IDTs attempted to integrate strategies from all disciplines when developing	Noncompliance

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		protections, supports, and services. • There was much more careful consideration of how supports could be provided in a less restrictive setting. QDDPs had undergone additional training with a state office consultant on the new ISP format. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QDDP used this template to draft portions of the ISP prior to the meeting. The QDDP came to the meeting prepared with a draft Integrated Risk Rating Form and a draft ISP format. These documents provided team members with some relevant information and assisted the team to remain focused. In both meetings, the risk discussion took a majority of the time. When teams become familiar with this process and more competent at assigning accurate risk ratings, this portion of the meeting should take much less time and more time can be spent on determining if supports in place are adequate and integrated throughout the individual's day. 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. The QDDP Coordinator continued to monitor ISP meetings to evaluate QDDP competency with facilitation skills. The QDDP Coordinator monitored a sample of 16 annual IDT meetings between August 2012 and January 2013. Results of her monitoring were used in the facility self-assessment. 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 ensure that meetings result in comprehensive support plans that focus on the individual's strengths and preferences. The plan should then be monitored and revised as needed. The facility did not have an adequate monthly review process in place to ensure that plans were updated when regression or lack of progress towards outcomes was noted.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and	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 Pre-ISP meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Preferences and Strength Inventory (PSI) was the document that should have identified the individual's preferences, strengths, and needs. This information should assist the IDT	Noncompliance

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	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.	in determining key team members. The QDDP Coordinator had begun to track data on attendance at IDT meetings in July 2012. Data gathered through January 2013 indicated good presence and participation by relevant team members. Review of a sample of ISP attendance sheets confirmed that there was good participation by most disciplines at annual IDT meetings. However, there were key staff missing at annual meetings in the sample. For example, • Nursing staff did not attend the ISP meeting for Individual #134 • Psychiatry staff did not attend the ISP meetings for Individual #134, Individual #60, and Individual #8. The psychiatry department kept its own data on attendance and although this appeared to have improved (also see section J), the psychiatry department's data regarding the psychiatry attendance at meetings were not appropriately tabulated. • The psychologist did not attend the ISP meeting for Individual #78. The state recently developed a new tool to assess personal preference and support needs. The purpose of the Preferences and Strength Inventory (PSI) was to identify preferences and support needs, which should then be beneficial in determining what staff should be present at the annual IDT meeting. In addition, the facility was holding a pre-ISP planning meeting to gather information and identify assessments that needed to be completed prior to the ISP annual meeting. The facility was not yet in compliance with requirements for the IDT ensure input all team members into the ISP process.	
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 to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments from 11/1/12 through 2/28/13 indicated that assessments were not routinely submitted prior to ISP planning meetings. Compliance percentages for the on-time submission of assessments ranged from 0% to 100% with percentages remaining consistently below 80% for occupational therapy, physical therapy, speech and language, psychiatry, psychology, and clinical. Even so, the quality and timeliness of some assessments had improved since the last monitoring visit. 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	Noncompliance

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		the individual's preferences, strengths, and supports needed (see sections H and M regarding medical and nursing assessments, section I regarding risk assessment, section J regarding psychiatric and neurological assessments, section K regarding psychological and behavioral assessments, sections O and P regarding PNM assessments, section R regarding communication assessments, and section T regarding most integrated setting practices). Newer ISPs supported the facility's determination that assessments were not being submitted prior to annual ISP meetings in some cases. IDTs did not always have adequate information needed to develop supports. For example, • Individual #6 did not have a physical exam prior to his annual ISP meeting. • Individual #60's annual physical was not completed prior to her ISP meeting. • For Individual #78, her annual physical and communication assessment were not completed 10 days prior to her ISP date. • For Individual #103, her communication assessment was not completed 10 days prior to the annual ISP meeting. To reiterate, the state recently developed a new tool to assess personal preference and support needs, the Preferences and Strength Inventory (PSI). The PSI was designed to be a rolling document that could be updated throughout the year as new preferences were identified or as preferences changed. Functional assessments were still not adequately addressing individual's preferences related to work, relationships, and community integration. The facility needs to expand opportunities for individual's to experience new activities and record responses to those activities in order to identify a broader range of preferences. Those preferences should then be used to develop new skill acquisition opportunities. 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.	
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 not consistently done in time for IDT members to review each other's assessments prior to the ISP meeting. There had, however, been progress made in integrating assessment recommendations into support plans when available to the team. 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	Noncompliance

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		integrate all supports and services needed by the individual. Recommendations resulting from these assessments need to be addressed in the ISPs either by incorporation, or by evidence that the IDT considered the recommendation and justified not incorporating it.	
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 Support 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. As part of the new ISP process, each discipline was asked to include as part of the pre-ISP assessment process a determination on whether or not needed supports could be provided in a less restrictive setting. Discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with, opinions offered by each discipline. Any barriers to community placement were to be addressed in the ISP. At both the ISP observed for Individual #50 and Individual #89, the team engaged in an interdisciplinary discussion regarding the least restrictive setting. Both teams agreed that the individuals could be supported in a less restrictive environment. Neither team made a referral to the community. In both cases, family members wanted to pursue guardianship before placement was made. The teams agreed to pursue guardianship prior to making a referral. Each team held a brief discussion on supports that would be needed in the community and developed some general goals for further exposure to living options in the community. Both teams stopped short of developing goals that would offer individualized meaningful community integration. The facility had further developed its community day program to allow for more individuals to spend training time in the community. Additional supports were put into place to ensure that time spent in the community was safer and more likely to be successful. This was a very positive step towards providing services in a less restrictive environment, however, the facility continued to struggle with developing ISPs that encouraged training in the community. For the most part, community based outcomes consisted of generic opportunities to visit in the community. When outings are planned specifically for greater exposure to the community, documentation should include a means to capture individual's preferences and interests. Those preferences and interest should be used to develop additional action steps that would encourage greater	Noncompliance

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		independence and integration into the community. Outcomes should be developed to address communication skills, decision making skills, social interaction, work and volunteer opportunities, and increased exposure to life outside of the facility. The facility self-assessment determined that this item was not yet in substantial compliance. The monitoring team agreed with this self-rating. Also see section T of this report.	
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 IDT "will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." 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. As noted in F1, additional opportunities to try new things should lead to the identification of additional preferences. Observation across the EPSSLC campus by the monitoring team did not support that individuals were spending a majority of their day engaged in meaningful activities based on their preferences. Opportunities to explore new interests and develop new skills were limited. The monitoring team observed very little meaningful day programming occurring. Many individuals were working at the facility's sheltered workshop, but it was not evident that doing so would lead to opportunities for supported employment in the community.	Noncompliance

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		Good interaction and engagement was observed in several homes, in other homes, individuals were spending a majority of their evening sitting in chairs with very little staff interaction. Again, there was little opportunity to gain exposure to new activities and learn new skills. At the annual ISP meetings observed for Individual #50 and Individual #89, the IDTs did a much better job of integrating supports into outcomes based on each individual's preferences. For both individuals, the list of preferences included in the ISP was limited by a lack of exposure to new activities and often not specific enough to guide the team in developing meaningful programming. For example, the list of "important personal preferences" for Individual #50 included van rides, outings, eating all meals, keeping to himself, waking up early, going to bed around 8:30, red punch, diet coke, low fat milk, massages, and a relaxed environment. A majority of plans in the sample offered individuals opportunities to visit in the community, but stopped short of offering opportunities for true integration, such as attending church in the community, banking in the community, joining community groups focused on her interests, or exploring volunteer or work opportunities. Individuals were being offered more opportunities for community outings through the community day program, but IDTs were not yet developing formal training programs to be implemented in the community.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report, however, there had been considerable progress made at the ISPs observed in that IDTs considered what supports would be needed to successfully implement action steps developed by the IDT. A sample of skill acquisition plans (SAP) and integrated health care plans (IHCP) were reviewed to determine if IDTs were developing individualized, observable, and/or measurable goals that included strategies and supports to ensure consistent implementation and monitoring for progress. The monitoring team found that there were still many outcomes not written in a way that staff could measure progress towards completion or did not provide enough information to ensure consistent implementation. For example: • Individual #60 had a community awareness outcome that instructed staff to identify a wheelchair accessible vehicle. Teaching methodology referred to choosing her clothing and choosing pictures of places in the community. Another action step developed to provide greater community awareness stated that she would pay for an object of her choice. The only strategy listed was staff will give instructions "get your money." It was not clear what would constitute a successful attempt at this action step.	Noncompliance

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		• Individual #49 had an SAP to brush her teeth daily with physical prompts. The methodology stated, "DSP to provided total oral care." It was not clear what training would occur or how progress would be measured. • The IHCP for Individual #134 included a number of action steps to address his risk for osteoporosis, falls, and fractures. Action steps did not include enough information to guide staff in consistently implementing supports. The action step "continue to assist as needed" was included under falls and fractures. Other action steps that were not clear in what support should be provided included "continue PRN wheelchair" and "continue using assistive devices in cottage." • The IHCP for Individual #60 did not include measurable outcomes with enough information to ensure consistent implementation. Her action steps to address her risk for osteoporosis, falls, and fractures included "continue scheduled BMD testing" with no schedule noted; "continue with physical assistance" with no further instructions. Similarly, her risk for cardiac was addressed with general prompts such as "schedule ECG as ordered and continue scheduled and PRN lab work." Section T elaborates on the facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. Little progress had been made in individualizing action plans to overcome obstacles to community transition, and ensuring that they are measurable. There was not a focus on identifying and addressing barriers to living in the most integrated setting. The facility had made little progress in developing measurable, meaningful training in the community. All individuals were offered opportunities to take trips in the community, but this still was not resulting in opportunities to integrate into the community. Work opportunities were limited to a few options based on contracts that the facility had for work in the onsite sheltered workshop. Little progress had been made in exploring community employment opportunities for individuals.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The outcome of the new ISP process should be a plan that integrates all protections, services and supports, treatment plans, and clinical care plans. The new ISP template included prompts to guide the IDT discussion and ensure that important information would not be omitted during the planning process. It was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed individuals' array of needs for protections, supports, and services, while approaching this in a person-centered manner and incorporating individuals' preferences and strengths. The development of action plans that integrate all services and supports was still an area that the facility was struggling with. State office had established a workgroup to provide	Noncompliance

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		more guidance regarding action plan development. At both ISP meetings observed, the team spent more time trying to identify areas where measurable outcomes were needed, particularly in regards to risks. The teams engaged in more integrated discussion regarding support needs in relation to preferences. This was a much better discussion than was observed during the last monitoring visit. 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. Assessment recommendations need to be available when teams are developing action plans for training and intervention. 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. It is expected that progress will continue to be made in developing comprehensive plans as IDT become more familiar with the new ISP process and more adept at developing measurable outcomes.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	As discussed in F2a2, action steps in the sample of ISPs reviewed did not include clear methodology for implementation. Without clear instructions for staff, it would be difficult to ensure consistent implementation and determine when progress or regression occurred. Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. All SAPS in the sample reviewed included either a completion date of six months after implementation began or ongoing. Completion dates should be assigned with a realistic expectation of when the outcome may be completed based on each individual's rate of learning. ISPs, SAPs, and IHCPs included designation of which staff would be responsible for implementation of the outcome. The facility was not in compliance with the requirement for identifying methods for implementation and time frames for completion.	Noncompliance

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	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 new ISP format provided prompts to assist the IDT in considering a wider range of supports and services when developing the ISP. None of the ISPs in the sample included a full range of strategies and supports to address the individual's needs for services and supports. IDTs will need to accurately identify needed supports and services through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings. The new ISP process should help teams more accurately identify needed supports. Additional training will be needed by IDTs to effectively integrate those supports into a comprehensive, functional ISP. Teams were still struggling with developing action plans to address all needed supports and services, particularly, in developing outcomes to address identified risks.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	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. The new ISP format included columns for person responsible for implementation, frequency of implementation, and person responsible for reviewing progress. Integrated Health Care Plans included similar information. As noted throughout F2a, IDTs were still struggling with developing measurable outcomes with methods that would allow for consistent data collection. IHCPs in the sample did not include enough information to determine what data would be collected and how progress or regression would be measured. For example, • Individual #60's IHCP included an action step "continue with high fiber diet." It was not clear what the outcome of her diet should be or how the team would measure efficacy of this support. She had another action step that stated continue PRN lab work. There was no indication when the lab work would be scheduled or what the desired outcome should be. Also 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.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that	This provision item will 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.	Noncompliance

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	goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted in F1, 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 available to all members of the IDT and integrated throughout the ISP. 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 12 out of 18 (67%) records reviewed. The facility reported that 30 (60%) of 50 ISPs were filed more than 30 days after the annual ISP meeting in the past six months. The facility needs to ensure that plans are distributed and available to staff implementing the plan. More work needs to be done to ensure staff implementing plans are trained on the plan and understand why specific supports are needed. Informal interviews were conducted with staff providing direct support throughout the day programs and residences. Few staff interviewed were comfortable discussing necessary supports without referencing plans in the individual notebooks. In many cases, plans were missing, not updated, or not specific enough to guide staff in providing supports. 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 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	Teams were required to meet to review any incidents, significant injuries, or changes in status immediately when determined necessary. QDDPs completed a monthly review of services, supports, and outcomes for each individual. Each discipline was responsible for reviewing specific services and supports monthly. QDDPs were responsible for reviewing the overall plan. A sample of QDDP monthly reviews was reviewed to see if all supports were reviewed and action was taken when there was a lack of progress, regression, outcomes were not implemented, or outcomes were completed. QDDPs were not commenting on specific progress or regression towards outcomes. It was not evident that action was taken when there was a lack of progress or when outcomes had been met. Monthly reviews did not include a review of outcomes developed to address risks. For example, • The January 2013 and February 2013 monthly review for Individual #60 noted a percentage in the summary section for each outcome. There were no comments regarding specific progress or barriers to progress. Her two community	Noncompliance

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	team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	integration outcomes noted 0% for both months. It was not clear if she had not been offered the opportunity for training or had not been successful at attempts. Other outcomes noted 100% for both months with no indication if the outcome needed to be continued or if she had met criteria for successful completion of the outcome. Supports developed by the team to address risks were not reviewed. The QDDP commented on assessments completed during the month, but did not comment on the outcome of those assessments. For example, it was noted that she was taken to the urologist for a consult. The QDDP did not include the results of that consult. • The QDDP monthly reviews for Individual #6 indicated that he did not participate in a number of activities related to outcomes. There was no explanation for his lack of participation. There were numerous comments noting lack of implementation of outcomes, with no indication that the QDDP had followed up to ensure that implementation would occur. None of the monthly reviews in the sample indicated that a coordinated system for monthly review of supports was in place. 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	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 six employees hired within the past year indicated that six (100%) had completed the new training on ISP process entitled Supporting Visions. All staff were required to attend an initial course on the ISP process. The facility had recently been trained by the state office on developing and implementing the ISP. QDDPs were still learning to use the new statewide ISP format. The facility was documenting staff training on individualized specific plans, but as noted throughout section F, staff instructions for many plans did not offer enough information to ensure consistent implementation. Informal interviews throughout the facility indicated that staff were unable to describe	Noncompliance

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	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	supports and services developed through the ISP process. There was frequent reliance on referring to written plans when DSPs were asked about supports that they provide for individuals, particularly regarding risks and supports to minimize risk factors. All departments will need to be involved in training staff on individual specific plans, such as healthcare plans, behavior support plans, PNMPs, and mealtime plans. An adequate monitoring system should be in place to ensure that all staff are familiar with plans and provide supports competently and consistently.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	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 12 (67%) of 18 individual notebooks in the sample. Individual #7, Individual #96, and Individual #42 did not have a current ISP in the individual notebook. Individual #58, Individual #23, and Individual #40 did not have an IHCP or Risk Action Plan. Informal interviews with staff indicated that not all staff were adequately trained on the requirements of individual ISPs. Familiarity with plans varied widely from home to home. Staff interviewed were generally aware of supports outlined in BSPs and PNMPs, but were not as comfortable discussing healthcare supports. The medical records department was gathering data on the submission of documents for the individual records. A list provided by medical records department reported that 30 of 50 (60%) of ISPs were filed more than 30 days after the annual ISP was held. The facility needs to ensure that plans are distributed and available to staff implementing the plan as soon as possible, but no more than 30 days after development.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility 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 just begun to analyze findings and develop corrective action plans based on self-assessment findings.	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. The facility needs to develop an adequate monthly review system so that plans can be monitored and revised as needed (F1a, F2d).

3. 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, F2a3).

4. The facility needs to expand opportunities for individual's to experience new activities and record responses to those activities in order to identify a broader range of preferences. Those preferences should then be used to develop new skill acquisition opportunities (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. 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, F2f).

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

13. 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).

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

15. Develop a monthly review system adequate for determining the efficacy of all supports and services. 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).

16. 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 scheduled monthly reviews. 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).

17. 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 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 Polypharmacy Committee Meeting o Medication Variance Committee Meeting o Pretreatment Sedation Meeting o ISPs for Individual #50 and Individual #89 o Dental Clinic o Psychiatry Clinics o Daily Medical Provider Meetings 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 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 center's lead to determine a compliance rating.

	In moving forward, the monitoring team recommends that the facility review this report. For each provision item in this report, the facility lead 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. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with both provision items. The monitoring team agreed with the facility's self rating.
	Summary of Monitor's Assessment: The medical clinic nurse served as the lead for this provision. Her primary task was to complete the self-assessment. There were no other particular efforts targeted at improving the integration of clinical services and there was no local policy to guide the work done in this area. Notwithstanding the complete absence of an organized plan, the concept of integration of clinical services had permeated into various clinical departments over time. To that end, many employees spoke of how their departments integrated with other clinical services. Individual departments understanding of integration did not translate into significant progress in this area. Moving forward requires that this provision be guided by someone who has the authority to bring clinical areas together to overcome the barriers that prevent integration. 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. This work must have the proper oversight and guidance.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they	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 Medical Meeting – The daily medical meetings were chaired by the medical director. The meetings lasted 30 minutes or less and reviewed the past 24 hours events and helped ensure that individuals received the clinical services they needed. Consults and ADRs were also reviewed during this meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
	need.	• Weekly Weight Management Meeting - There were weekly Weight Committee meetings, which were chaired by the NOO, and included representatives from medical, PNMT, diet/nutrition, nursing, psychology, pharmacy, etc. This meeting helped to ensure that individuals with nutrition and weight management issues would be identified and that strategies to address their individual needs would be developed and implemented in a timely manner. • The relatively new integrated risk rating and integrated health care planning processes, which were embedded in the ISP process, provided the facility with plenty of opportunity to develop and provided evidence of integrated clinical services. For example, observations of the annual ISP meeting held during the review, which was attended by members of the monitoring team, revealed that the IRRF and the IHCP portions of the meeting included some very good input from the members of the IDT, but not enough. However, it appeared as though this process only stood to get better. • 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. • Medication Error Committee – During previous reviews, the collaborative efforts of nursing, pharmacy, and medical served as an excellent example of integration of clinical services. While these efforts continued, the medical component in this process appeared to diminish. • Psychiatry - 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. Documentation generated via psychiatry clinic was improved with regard to integration of services with these disciplines. In addition, the morning clinical meeting had improved clinical integration. There remained issues with regard to consistent psychiatric attendance at the ISP meetings generally due to resources and schedule. • Neurology and Psychiatry – Integration between neurology and psychiatry continued to improve via the neurology-psychiatry clinic. The monitoring team observed this clinic during the past three reviews and found that it continued to provide value in integration of the two disciplines. • Psychology and Psychiatry - Integration of psychology and psychiatry was improving. A meeting between psychology and psychiatry was implemented to discuss administrative issues. Psychologists and psychiatrists appeared to have meaningful interactions during psychiatric clinic meetings observed.	

#	Provision	Assessment of Status	Compliance
		Several areas offered great opportunities for improvement: • ISP Process – The facility required that the medical providers attend the annual ISP planning. Medical providers had not attended since August 2012. This is a significant obstacle in the planning process because the primary provider has the responsibility to present information to the IDT regarding medical issues (including treatment and medication plans) in a manner relevant to health and well being, goal setting, opportunities, barriers and the case formulation for the individual. True integration of clinical services cannot occur in the absence of this input. • Pretreatment sedation – The facility conducted a meeting for review of upcoming pretreatment sedations. There were no sedation cases reviewed during the meeting attended by the monitoring team. However, the monitoring team noted serious issues about the use of sedation, including adverse events experienced by individuals. The facility must rethink how this meeting is utilized to integrate services and improve outcomes. • MOSES and DISCUS Evaluations – The assessments were completed by nursing and the psychiatrist. Clinically valuable information included in these assessments was never acknowledged in the annual assessments or IPNs by the primary medical providers. Review of this information by the primary providers can only serve to help improve integration of psychiatry, neurology, and medical services.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing 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 40 consults completed after July 2012 (including those from the record sample) were reviewed: • 28 of 40 (70%) consultations were documented in the IPN <u>within five working days</u> The clinic physicians, who were not members of the IDT, reviewed a significant percentage of the consults. Overall, this was done in a timely manner. However, the actual IPN documentation did not always occur within the five working days. Since the last compliance review, the quality of documentation improved. The primary providers were more frequently providing a summary of the recommendations and, in recent months, were indicating agreement or disagreement with the recommendations. The summaries, however, did not indicate when consults required referral to the IDT. While consults were reviewed in the daily medical meetings, there was no formal process to ensure that the IDTs received the necessary information for integration with existing supports and services.	Noncompliance

Recommendations:

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

2. 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).

3. In accordance with the Health Care Guidelines, for each consultation, the IPN entry should include documentation of the recommendations of the consultant, a statement regarding agreement or disagreement, and a decision about referral to the IDT. The primary providers should also indicate the specific consult that is being addressed G2)

4. DADS should develop and implement policy for Provisions G1 and G2 (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 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. In moving forward, the monitoring team recommends that the facility review this report. For each provision item in this report, the facility lead 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. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself noncompliance with all seven provision items. The monitoring team also found noncompliance with all with all seven-provision items.
	Summary of Monitor's Assessment: The facility's medical director had previously served as the lead for this provision. The medical clinic nurse was assigned the responsibly of the provision lead shortly before the compliance review. She explained that she was responsible for completing the self-assessment. She was not familiar with the provision or the activities that occurred in the past related to this provision item. Her duties in the medical clinic were not altered. As a result of this, very little occurred at EPSSLC in this area. The timelines for provision H1 were addressed, but the other components were not. For Provision H2, no additional training occurred related

	to ICD nomenclature. The medical staff had changed since the January 2012 training. There was no real progress seen for provisions H3 – H7. Much of the provision addressed issues of quality and risk assessment. The development of a comprehensive set of clinical indicators is an essential step in moving forward with this provision. Equally as important is the identification of the systems and data sets that would then be used to monitor health status. EPSSLC had not addressed either issue in a meaningful way.

#	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 to 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 actions on the part of the facility were not clear at the time of the compliance review. The medical director was not involved with this provision and the facility's lead was in essence the staff assigned to prepare the self-assessment document. The monitoring team was provided no overarching plan to approach to this provision. The Action Plan listed a series of steps, most of which were "in process" or had not started. Assessments were submitted 10 days prior to the ISP, but there appeared to be no change in the status of tracking tools, auditing tools, and other issues discussed during the July 2012 monitoring team review. The daily medical provider meeting was implemented in early January 20113 and provided one means of following the status of some medical issues. Apart from this, other efforts remained in development. 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, and reviewed assessments and facility data. The results of those activities as well as the facility's reported compliance for the annual ISP are summarized here: • Annual Medical Assessments were found in all of the records in the record sample. The monitoring team found that 59% of AMAs were completed within 365 days of the previous assessment. The facility required that the assessments be submitted two weeks prior to the ISP. This resulted in the facility reporting a compliance rating of 0%. • 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 and overall quality was good. There were no deficiencies identified in the document	Noncompliance

#	Provision	Assessment of Status	Compliance
		submitted to the monitoring team. The facility reported a compliance rating of 58.62% in the self-assessment. • Annual Dental Assessments – Compliance with timely completion for the six-month review period was 92%. The facility reported a compliance rating of 82.6%. • Current annual and/or quarterly nursing assessments were not present in 25% of the 20 records reviewed. The review of sample individuals' records, including one recently admitted individual's admission assessment, and six individuals discharge summaries continued to reveal 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. The facility reported a compliance rating of 53.73%. • Psychiatry clinic was delinquent with regard to completion of quarterly medication reviews. As discussed in section J, while there were improvements in this documentation, there was the need for quality assurance monitoring. There had been two cases reviewed via a peer review process. The facility reported 66.7% compliance with required assessments. • Not everyone had an initial psychological assessment and functional assessments were not completed for all individuals with PBSPs. Annual psychological assessments had, however, been completed for all individuals. The facility's compliance rating for psychology assessment was 26.79%. 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 remained 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	In January 2012, the medical director provided training to the medical staff related to ICD nomenclature. That training was not repeated as new staff arrived. 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 but there appeared to be some slippage in this area. IPN documentation reveled	Noncompliance

#	Provision	Assessment of Status	Compliance
	Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	more frequent use of terms, such as red eyes, rash and increased blood pressure as the diagnoses. Similar findings were seen with drug indications. • Over the course of the visit, the monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Additionally, records reviewed revealed examples of documentation of specific criteria exhibited by an individual indicating a particular diagnosis. • The majority of nursing assessments failed to result in a complete or accurate list of nursing diagnoses, in accordance with NANDA.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	State office, through the development of a rather robust set of clinical protocols, 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. There was no compelling evidence that these protocols were being utilized by the medical staff. The part time physician was not entirely sure that she had received them. Because the medical director was not focusing on activities outside of direct clinical care, no additional work was done in this area. The facility had no systems in place to measure the timeliness and appropriateness of interventions largely due to the lack of clinical indicators.	Noncompliance
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 not addressed this provision item any further. There was no medical director to guide work in this area and EPSSLC did not have a medical compliance nurse. The facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. This is a critical step for this provision as well as the development of a medical quality program. The monitoring team again emphasizes that clinical indicators must be developed for all clinical areas.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	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. The monitoring team was referred to the medical department's administrative assistant for all questions related to information to the database and the reports generated from it. As noted in previous reports, development of a system to monitor health status will require collaboration among many disciplines due to the overlap between risk	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 for the facility to monitor. Each clinical discipline must identify the systems that are in place to monitor health status as well as the data that will be used for monitoring purposes.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	As previously discussed, progress in this area was limited because the facility had not identified the appropriate staff to guide this provision. The facility must identify clinical indicators that will be used to determine when therapeutic outcomes are reached. Many of those will be based on clinical guidelines developed. These indicators will help determine when treatment plans must be altered.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	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 and ICD nomenclature is used (H2).

3. The facility must develop a comprehensive list of clinical indicators across all clinical disciplines. Indicators should 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).

4. 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).

5. 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).

6. The facility must track 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).

7. 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).

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 DADS SSLC Risk Guidelines dated 4/17/12 o List of individuals seen in the ER in the past year o List of individuals hospitalized in the past year 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 constipation o List of individuals with a pica diagnosis 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 with challenging behaviors. 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, Integrated Health Care Plans, and related assessments for: o Individual #65, Individual #134, Individual #49, Individual #78, Individual #31, Individual #103, Individual #8, Individual #6, Individual #60, and Individual #3. <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Mario Gutierrez, Incident Management Coordinator

	o Michael Reed, Lead Investigator o Carmen Molina, Director of Behavioral Services o Cynthia Martinez, QDDP Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Unit Morning Meeting 3/19/13 and 3/21/13 o Incident Management Review Team Meeting 3/19/13 and 3/21/13 o Annual ISP meetings for Individual #50 and Individual #89 o Pre-ISP meetings for Individual #88 and Individual #82 o Human Rights Committee Meeting 3/20/13
	Facility Self-Assessment: EPSSLC submitted its self-assessment. It was updated on 2/20/13. Along with the self-assessment, the facility submitted an action plan that addressed progress towards meeting requirements 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. For each section, the facility reviewed a monthly sample using the section I audit tool and commented on those findings. The facility acknowledged that the section I audit tool needed to be updated to reflect changes in the new risk process. Additionally, the facility reviewed other relevant information including data collected on assessment submission prior to the ISP meeting, ISP attendance data, and Unit Team meeting minutes. The facility recognized that the risk process was a very new process for the IDTs and it would take some time to develop an adequate system for addressing risks. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed. 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 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. Adequate risk action plans were not yet in place to address risks for individuals at EPSSLC.

	Since the last review, the state office had made revisions to the At-Risk Individuals policy. Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically related were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines. Revisions to the risk identification process included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually. Consultants from the state office recently provided training to IDTs at EPSSLC. The monitoring team had a chance to observe two teams hold meetings utilizing the new format. Team meetings were very lengthy and the IDTs struggled with how to integrate the risk discussion into the ISP meeting. Teams were spending a lot of time identifying risks, but little time developing measurable outcomes to address risk factors. IDTs were just beginning to talk about risks in relation to each individual's preferences, strengths, and daily schedule. The facility was moving in a positive direction, though additional training was still needed to help team develop meaningful plans through this process. The facility appointed the QDDP Coordinator as lead for section I. She was using the At Risk Monitoring Tool to evaluate implementation of the at risk process. 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. 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. Teams were often waiting until a critical incident occurred or until the annual IDT meeting before aggressively addressing the risk. Plans should be implemented immediately when individuals are at risk for harm. The facility will need to develop a better system for monitoring outcomes to ensure that assessments are completed, recommendations are incorporated into the integrated health care plans, and that plans are effective in lower risks.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The state policy, At Risk Individuals 006.1, required IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT meeting and the team was required to develop an Integrated Health Care Plan (IHCP) 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. Since the last review, the state office had made revisions to the At-Risk Individuals policy. Changes included regrouping the Risk Guidelines so that the risk factors that were clinically related (regarding outcomes or provision of services and supports) were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Seven groupings of risk categories were identified. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers, and criteria for IDT review. Updates in status were to be noted on the form, making it easier to track status and determine when the team had met to discuss changes in status. The Risk Action Plans for the identified high and medium risk indicators were to be replaced with an IHCP designed to provide a comprehensive plan that will be completed annually and updated as needed. 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. The consultants had recently provided training and technical assistance to IDTs at EPSSLC on the latest revisions in the risk process. The monitoring team was able to observe two IDT meetings using the new style ISP format and new risk rating forms. Progress towards developing an effective process to identify risks was observed in both meetings. Both IDTs followed the newly created IRRF. At the ISP meeting observed for Individual #50, the team spent a considerable amount of time reviewing each risk category, determining an appropriate risk rating, and developing action plans to address his risks. Overall, the team engaged in good discussion and assigned appropriate risk levels for each category. The IDT was more focused on the individual's health history and current diagnosis rather than his potential for risk for each category. For example, the team identified that he was obese, therefore, at risk for weight issues, but did not immediately identify his risk for cardiac issues due	Noncompliance

#	Provision	Assessment of Status	Compliance
		to his obesity since he had not been identified with cardiac issues. There was still quite a bit of uncertainty over the assignment of risk levels and team members were trying to understand how to use assessment criteria to make risk determinations (also see section M5 of this report). At the annual ISP meeting for Individual #89, the team also used the new IRRF to determine risk levels in each category. The risk discussion was lengthy with much deliberation for each risk area. Team members from all disciplines added to the discussion and debated risk levels. Interdisciplinary strategies were developed to address some risks. For example, desensitization strategies to address his risk for dental disease were developed with input from the dental hygienist, psychologist, SLP, nurse, and program developer. The team stopped short of developing measurable goals and designating who would be responsible for monitoring and ensuring that supports were effective. Again, the IDT was not entirely comfortable with the new process and clear on what the outcome should be… but progress was evident. A review of a sample of risk rating forms indicated that, although the risk process had undergone significant improvements, all risks still were not accurately being identified (also see section M5). For example, • Individual #3 was rated as medium risk for falls and fractures. At the time of his annual ISP meeting, he had 17 injuries in the previous year, including at least three falls. He had been the victim of peer-to-peer aggression at least 12 times in the previous year. He had osteopenia and an active seizure history that had contributed to a number of injuries in the past. He should have been considered high risk for falls, fractures, or other injuries. • Individual #31 was rated as low for gastrointestinal problems. Rationalization was "because she does not have GERD." She had multiple food allergies, a history of constipation and took numerous medications that increased her risk of gastrointestinal problems. • Individual #49 was rated as medium risk for falls and fractures though she had at least due falls over the previous year and had been placed on head injury protocol six times due to throwing herself back and hitting her head. Her trend of falls and diagnosis of osteopenia placed her at risk high fractures. 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. As noted in section F, all disciplines were not routinely completing assessments prior to annual ISP meetings or attending ISP meetings. The facility had begun to track submission of assessments by discipline and attendance at IDT meetings. These databases will be useful when the facility begins consistently collecting and analyzing data. As noted in	

#	Provision	Assessment of Status	Compliance
		section F, the submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals. As noted in the last review, for both short and long range planning, teams will need to: • Frequently gather and analyze data regarding health and behavioral indicators (e.g., changes in medication, results from lab work, engagement levels, mobility, peer-to-peer aggression). • 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 are frequently analyzed for indication that supports may not be adequate for safeguarding individuals. The facility had taken many positive steps towards ensuring that an adequate risk assessment process was implemented. A majority of the individuals had not yet had their annual ISP meeting and risk discussion using the new process. The monitoring team looks forward to seeing continued progress in identifying risk and developing strategies for monitoring and minimizing those risks.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the	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. Health risk ratings will need to be 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 resulted in an assessment of current services and support, risk ratings, and/or plan revisions. It appeared that teams were not always meeting immediately following a critical incident to determine if updated assessments were needed. Additionally, it was difficult to determine if assessments were obtained and discussed by the team in a	Noncompliance

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	assessment process as soon as possible but within five working days of the individual being identified as at risk.	reasonable amount of time when recommended. For example, • At the annual ISP meeting for Individual #50, the team reviewed injuries and incidents for the past year. It was noted that he had nine documented falls. The team had met to review his risk for falls and injuries prior to the annual meeting, but did not change his risk ratings or follow-up to ensure that strategies implemented were effective at reducing his risk prior to the annual IDT meeting. • The IDT for Individual #78 recommended an updated swallow study at her annual ISP meeting during the discussion regarding risks on 9/17/12. There was no documentation indicating that the assessment had been completed. • The IHCP for Individual #6 indicated that the nurse case manager would talk with the PCP about medications for address his risk for osteoporosis and provide information to his parents about the side effects of medication "as soon as possible." There was no indication that either had occurred or that the team engaged in further discussion regarding medication for osteoporosis. • The IDT for Individual #3 recommended a new swallowing assessment by the SLP following a choking incident on 2/12/12. On 10/22/12, the IDT realized that the assessment had never been completed. An assessment was again requested and completed a month later. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. The process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance with I2. The facility was not yet in compliance with this provision item.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical	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. As noted in section F, a comprehensive monthly review process was not yet in place to ensure that plans were being implemented and monitored as needed. QDDPs were completing monthly review, but not commenting on specific outcomes related to the monitoring of risks. According to data 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. The facility reported that individuals would be assessed and action plans developed using the IRRF and IHCPs as annual ISP meetings were held. IDTs had begun using the new forms	Noncompliance

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	indicators to be monitored and the frequency of monitoring.	as of October 2012. Risks had not yet been identified and action plans developed to support all risks using the new process for a majority of individuals at the facility. Risk action plans in the sample reviewed did not include specific risk indicators to be monitored for all areas of risk. Risk action plans often referred to an HMP in place or instructions were too general (follow diet plan, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. For example, • Individual #78's ISP and risk action plan referred to a "sensory diet" to address her risk injury due to self-injurious behaviors. Therapy staff were assigned to monitor the plan. Specific staff instructions for implementing the sensory diet were not included in her ISP or PNMP. Her action plan to address her risk for osteoporosis stated, "Continue walking in gait trainer." Her ISP did not include instructions or a schedule for staff to follow when implementing the action step. • Individual #6 was at medium risk for constipation. His IHCP noted that he should be encouraged to drink liquids throughout his day. His plan did not indicate how much liquid he should drink throughout the day, which liquids should be encouraged, how staff would record the amount of liquids that he received daily, or who would monitor his intake of liquids. His risk action plan to address his cardiac risk stated, "Monitor his BP and pulse weekly for two months." The action plan did not include an acceptable range for his blood pressure or pulse or note when nursing staff should notify the physician. It was not evident that consistent monitoring of those risk indicators was occurring. 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. QDDPs were not completing a monthly review of all supports and services. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas. The facility self-assessment indicated that the facility was not in compliance with this provision. The monitoring team agreed 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 Five examples of skills acquisition plans for dental 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 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 #37, Individual #57, Individual #126, Individual #109, Individual #77, Individual 56, Individual #44, Individual #96, Individual #17, and Individual #12 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 3/19/13 regarding Individual #60, Individual #108, and Individual #161. o All data presented, doctor's orders, and physician's documentation for psychiatry clinic 3/19/13 regarding Individual #90. o Documentation regarding the ISP meeting for Individual #50. o Pre sedation committee meeting packet 3/21/13. o Number of dental exams done without pretreatment sedation in the previous six months. o Ten examples of the psychiatry/psychology integration tool. o Pharmacy and Therapeutics meeting packet 3/21/13. o Polypharmacy committee meeting packet 3/21/13 o Documentation regarding the number of ISP meetings dental attended in the previous six months. o Ten examples of polypharmacy justification documentation. o Psychiatry peer review completed regarding Individual #59 and Individual #89. o Any available data regarding Reiss Screens. o Listing of every individual receiving TIVA in the last six months. o All data presented, doctor's orders, and physician's documentation for psychiatry clinic 3/20/13 regarding Individual #59. 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 #56, Individual #57, Individual #7, Individual #74, Individual #83, Individual #123, Individual #120, Individual #50, Individual #52. <u>Interviews and Meetings Held:</u> o Eugenio Chavez-Rice M.D. facility lead psychiatrist with Eustolia Garcia, L.V.N. o Oscar Perez, M.D. o Nohemi Ostos, C.P.T., psychiatry clinic staff o Mary Ann Clark, R.N., Chief Nursing Executive o Don Apodaca, M.D., Medical Director o Amista Salcido, Pharm.D. Pharmacy Director with Giovanna Villegran, Pharm.D. o Carmen Molina, LPC, BCBA, Director of Psychology o Howard Pray, D.D.S., facility dentist with Raquel Rodriguez, RDH o Laura Cazabon-Braly, M.A., LPC, Facility Director <u>Observations Conducted</u>: o Observation of two psychiatry clinics including the following individuals: • Individual #90 and Individual #59. o Observation of ISP meeting for Individual #50. o Observation of Neuro-Psych clinic regarding: • Individual #60, Individual #108, and Individual #161. o Observation of individuals in four facility homes. o Psychiatry/Psychology weekly meeting o Observation of Pharmacy & Therapeutics meeting, Polypharmacy committee meeting and Pretreatment sedation committee meeting o Behavior Therapy Committee and Psychology Peer Review o Morning Medical 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 implemented during this monitoring period. Review of this monitoring tool indicated that facility staff had reviewed the monitoring report and were performing a review similar to that performed by the monitoring team.

	The facility self-rated itself as being in substantial compliance with seven provision items: J1, J4, J6, J8, J12, J14, and J15. The monitoring team agreed with four of these J1, J6, J12, and J15. Additionally, J5 was found in substantial compliance based on the additional psychiatric resources and decreasing population noted in the intervening period since the last monitoring visit. The monitoring team did not agree with the facility self-assessment regarding J4 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 reportedly resulted in serious side effects for at least one individual. Because 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 pretreatment sedation as well as dental. The monitoring team did not agree with the facility self-assessment regarding J8 because there was cause for concern with regard to rapid, multiple 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. The monitoring team did not agree with the facility self-assessment regarding J14 because current facility practice, where the nurse case manager was responsible for obtaining consent, 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.
	Summary of Monitor's Assessment: Psychiatry services at EPSSLC made progress towards substantial compliance. Half of the individuals received psychopharmacologic intervention (60 of 118, 50%). The facility had acquired additional psychiatric resources increasing from 1.0 to 1.2 FTE. The quarterly psychiatric assessment document had been revised to include the psychiatric treatment plan as well as an enhanced risk/benefit analysis regarding the treatment with psychotropic medications. There were improvements in the consistency of psychiatric diagnoses across the evaluations of different disciplines. 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 revealed ongoing issues with timeliness of quarterly psychiatric medication reviews. There were noted improvements in the psychiatric participation in the development of the PBSP. There were issues, as this was not documented via signatures on the plan. In addition, there were lingering questions regarding a new "Individual Mental Health/Behavior Plan" that was being utilized both in lieu of, and in addition to, the BSP in the absence of specific policy and procedure. 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, J5, J6, J12, J15), however, in other areas, while improvements were seen, the facility staff must create a system for the provision of psychiatric services. Approaching section J 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. In November 2012, an additional eight hours of psychiatric services per week were obtained. This additional psychiatrist was board certified in adult psychiatry by the American Board of Psychiatry and Neurology, with added qualifications in Addiction Psychiatry. Based on the qualifications of both physicians, this item was rated as being in substantial compliance. Psychiatry staffing, administrative support, and the determination of required full time equivalents (FTEs) are addressed below in section J5. <u>Experience</u> The lead 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 28 additional months of experience, having started his current job 11/1/10. The part-time psychiatrist was new to the practice of psychiatry in the SSLC environment, however, he reported experience in the treatment of individuals with developmental disabilities. This was not reflected in his curriculum vitae. A wealth of clinical experience	Substantial Compliance

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		was noted, specifically inpatient psychiatric treatment of both adult and adolescent patients. Monitoring Team's Compliance Rating Based on the qualifications of the psychiatrists at EPSSLC, this item was rated as being 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, 60 of the 118 individuals (51%) received psychopharmacologic intervention at the time of this onsite review. In the previous report, it was noted that there had been a focus on the completion of evaluations in the Appendix B format, such that 59 of 60 evaluations had been performed (discussed in J6). Previously, 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. During this visit, it was noted that an additional 0.2 FTE of psychiatric resources had been acquired. Staff voiced concerns that this staffing level would not be maintained because the number of individuals requiring psychiatric treatment had decreased from 74 individuals to 60 individuals in the intervening period since the previous monitoring visit. Regardless, as outlined below, there remained delays with regard to the timeliness of quarterly psychiatric clinical reviews. Evaluation and Diagnosis Procedures Via the monitoring team's observation of two psychiatry clinics and one Neuro-Psychiatry clinic 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 were improved. Concerns with regard to medication regimens remained, including the extensive utilization of antipsychotic medications and rapid medication regimen adjustments. Clinical Justification In order to improve documentation regarding evaluating and diagnosing individuals in a clinically justifiable manner, the psychiatric staff had revised the form utilized for quarterly psychiatric clinic, now titled, "Comprehensive Quarterly Psychiatric Medication Review." There was evidence of the use of these forms in some records, however, this form had only recently been implemented in November 2012.	Noncompliance

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		It was noted in the previous monitoring report that the quarterly psychiatric clinical encounters were occurring on an inconsistent basis. Data provided for this monitoring visit revealed improvements in that, of a total of 60 individuals receiving care via psychiatry clinic, 28 or 46% of individuals were delayed with regard to quarterly psychiatry clinic, that is, they were seen in psychiatry clinic prior to 12/1/12 (i.e., they were overdue for quarterly psychiatric reviews). Further, there were some data that were suspect, as it was apparent that the wrong year had been entered (i.e., 2012 instead of 2013), indicating that the last quarterly clinic was one year ago. These data were eliminated from the analysis. Of the remaining 27 individuals, 24 individuals were last seen by psychiatry clinic in either October 2012 or November 2012. There were three individuals or 5% who had not been seen in psychiatry clinic since August 2012. <u>Tracking Diagnoses and Updates</u> The psychiatry clinic had developed a tracking system to monitor diagnosis changes. Between the dates of 8/29/12 and 1/15/13 they had documented diagnosis changes for nine individuals. This was an overall reduction since the previous monitoring visit, where there were 52 individuals with documented diagnosis changes. It was opined that this reduction was due to the completion of the majority of Appendix B comprehensive psychiatric assessments during the previous monitoring period. A review of 15 individual's records revealed improvements with regard to consistency of diagnoses among disciplines with 13 of 15 records noting consistency, likely due to the ongoing utilization of the Psychiatry/Psychology Integration Tool implemented in March 2012. <u>Monitoring Team's Compliance Rating</u> Based on the early stage of development for the psychiatrists to document delivery of care (i.e., new "Comprehensive Quarterly Psychiatric Medication Review") and the unacceptable gaps of time between quarterly medication reviews, this item was rated as being in noncompliance. The facility also self-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-	<u>Treatment Program/Psychiatric Diagnosis</u> 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. The issue noted in previous monitoring reports, 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 positive behavior support plan (PBSP), had improved during the interim period as discussed in J2. 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	Noncompliance

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	pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	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. In all records reviewed, there was a current (within the past year) BSP included. The content of the PBSPs is reviewed in section K of this report. • It was reported that the BSP for Individual #13 was discontinued. This was concerning because this individual was thus prescribed psychotropic medication meeting criteria for polypharmacy (Latuda, Clozaril, Remeron, Ativan, Trazodone, Lithium, and Clonidine) in the absence of a BSP. Information included in this individual's record revealed that per the ISP addendum dated 1/10/13, "BSP was put on hold 12/13/12…the QDDP is working very closely with [individual's name] to provide informal active treatment." This individual's lack of a BSP must be addressed immediately. The facility had implemented the "Individual Mental Health/Behavior Plan." Per the document located in the record of Individual #56, the purpose of this plan was to identify "indicators (or behaviors) that are present due to their psychiatric diagnoses under Axis I and Axis II. This plan gives instruction on what operational behaviors to look for that indicate symptomatology of their diagnosis. It is also a tool to assist in making data based decisions in regards to psychiatry functions and to assist with data collection of the indicators. This data is collected and compared to psychoactive medications to measure progress/response or lack thereof." This document was located in three of the 15 records reviewed (Individual #56, Individual #13, and Individual #74). This process, parallel to the BSP, was confusing because there were currently no policy and procedure or written guidelines outlining the utilization, implementation, and monitoring of this document. It was notable the BSP documents and the "Individual Mental Health/Behavior Plan" did not include a signature from the treating psychiatrist, yet medication regimen, medication side effects, and medication changes were described in detail in both documents. 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. Interviews and observations performed during the monitoring visit revealed that psychiatry was participating in meetings regarding the development of these plans, yet this was not documented via a signature. Review of quarterly psychiatric medication reviews revealed ongoing improvements in the risk benefit analysis for treatment with specific medications authored by psychiatry as discussed further in J10. There was also evidence of improvements in the collaborative case formulations as noted in the examples reviewed in	

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		J6 and J8 below. Staff interviews and observations performed during this monitoring review revealed that the psychiatrist was participating in the development of both the BSP and the "Individual Mental Health/Behavior Plan" documents during psychiatry clinic and via participation in Behavior Support Committee and peer review where BSPs were reviewed and finalized. Also, psychiatric documentation revealed information regarding the review of the BSP, however, as noted above, there was not evidence of review via a signature. Overall, there was a reduction in the percentage of individuals participating in psychiatry clinic who met criteria for polypharmacy. In the previous monitoring report, 73% of individuals participating in psychiatry clinic met criteria for polypharmacy. During this visit, this had been reduced to 60%. In addition, there were eight individuals in the process of a medication taper in an effort to reduce the medication burden. In an effort to address previously documented concerns with regard to 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), the psychiatric physicians had improved documentation of the justification for these changes. 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. The lack of engagement was also noted with regard to other individuals during visits to their homes. 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 continue to 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.	

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		Emergency Use of Psychotropic Medications The facility self-assessment indicated a review of the documentation associated with the use of emergency psychotropic medications. The facility had implemented a pre-restraint and post chemical restraint clinical review. There were a total of four incidents where emergency psychotropic medications were utilized involving two individuals (Individual #161 and Individual #7). The facility use of emergency psychotropic medication for individuals during periods of SIB/agitation/aggression had remained stable, as there were four instances of emergency psychotropic medication utilization between 7/11/12 and 9/11/12 compared to three incidents in the previous review. Note that the current review covered a span of nine months in contrast to the previous review, which covered six months. The facility self-assessment indicated a review of the documentation associated with the use of emergency psychotropic medications. The facility had implemented a pre-restraint and post chemical restraint clinical review. There were a total of four incidents where emergency psychotropic medications were utilized involving two individuals (Individual #161 and Individual #7). During the onsite monitoring review and per the record review, it appeared that the facility use of emergency psychotropic medication for individuals during periods of SIB/agitation/aggression had remained stable: there were four instances of emergency psychotropic medication utilization between 7/11/12 and 9/11/12 compared to three incidents in the previous review. Note that the current review covered a span of nine months in contrast to the previous review, which covered six months. As was discussed with psychiatric and primary care staff during this and the previous monitoring visits, there was concern on the part of the monitoring team regarding the multiple medications utilized for both chemical restraint episodes and pretreatment sedation. For example, Individual #161 received a total of Phenobarbital 130 mg, Lorazepam 2 mg, and Haldol 10 mg on two occasions, 8/11/12 and 9/11/12. In addition, this individual received Lorazepam on a third occasion 8/12/12. Phenobarbital has no indications for use with regard to psychiatric illness and, therefore, would be utilized in this case simply for sedative properties. Documentation of the review of these restraint episodes was only provided for 8/11/12 and 8/12/12, and for an incident involving Individual #7. In the case of Individual #7, a single agent, Lorazepam, was utilized. It was noted via the post-chemical restraint clinical review performed by the facility lead psychiatrist that Individual #7 experienced a negative reaction to intramuscular Lorazepam. Per the documentation "suffered idiosyncratic reaction with hypertension, unresponsiveness lasting a few minutes but regain [sic] consciousness without complications…individual was managed appropriately during episode EMS called and arrived, but no need for transport to ER or any further complications."	

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		Monitoring Team's Compliance Rating While there were noted improvements with regard to psychiatry participating in the development of the BSP and reviewing this document during psychiatry clinic, issues remained. Due to the paucity of non-pharmacological interventions, confusion with regard to the utilization of the "Individual Mental Health/Behavior Plan," and the lack of a BSP for an individual prescribed psychotropic medication polypharmacy, this provision remains in noncompliance, in agreement with the facility self-assessment.	
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 54 instances of pretreatment sedation for medical clinic attributed to 28 individuals. There was one individual noted who received pretreatment sedation for dental clinic. Of these 28 individuals, 18 (64%) were identified as enrolled in psychiatry clinic. Further review of the provided data revealed that these data were incorrect and a total of 22 individuals (78%) were enrolled in psychiatry clinic. The manner in which the data were presented indicated up to a total of three medications administered 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 1/4/13 in order to undergo an MRA of the brain. She received three medications including Haldol 5 mg, Phenobarbital 129.6 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. Documentation revealed 22 instances of the use of two or more medications. There were 31 instances of the use of three medications, with the most recent on 3/15/13 where Individual #126 received the medications Lorazepam 4 mg and Haldol 10 mg prior to a bone marrow density examination. • There was evidence of one instance of an individual experiencing respiratory suppression requiring emergency medical intervention. Individual #123 received medication including Phenobarbital 97.2 mg, Lorazepam 2 mg, and Haldol 5 mg on 7/10/12 prior to a bone marrow density examination. Documentation was noted in the QDDR dated 9/12/12 that this individual was "sent to UMC for low O2 saturations post pre-sedation." This case is illustrative of respiratory suppression related to combinations of medications. Again, the facility must review its use of multiple medications during pretreatment sedation and chemical restraint episodes, and discontinue this potentially dangerous practice (also see J3).	Noncompliance

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		Regarding TIVA, the document provided to the monitoring team did not provide the information required for tabulating the extent of TIVA. Since 8/15/12, there were 59 instances of TIVA at EPSSLC. Of these, 31 (52%) were for individuals who were currently receiving treatment via psychiatry clinic. An additional number of individuals were reportedly receiving 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 (either on or off campus) 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. 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 115 individuals who had a current dental desensitization plan. There were reportedly no medical desensitization plans. The lack of medical desensitization plans (or other approaches for individuals who have difficulty complying or attending) was concerning, because, as discussed above there were individuals receiving multiple medications in pretreatment sedation for medical procedures. Interviews with psychology staff and examples of desensitization plans provided for review revealed that desensitization was approached from a skill acquisition plan procedure only.	

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		A sample of five dental skills acquisition plans was received. These were apparently individualized, however, no data sheets were provided and there was no indication if there had been any attempts to educate the individual or if there had been any progress toward skill development. Also see discussion in section S below. What was needed was the development of individualized strategies and interventions that could be implemented 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 are 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). 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 had been designated and a flow sheet for the assessment process had been devised. From this, there had been assessments performed to determine the need for intervention with regard to dental desensitization, but no assessments performed with regard to medical desensitization. <u>Monitoring After Pretreatment Sedation</u> A review of provided documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented assessment of the individual and vital signs. <u>Monitoring Team's Compliance Rating</u> This item will remain in noncompliance in contrast to the rating provided via the facility self-assessment 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 reportedly resulted in serious side effects for at least one 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 pretreatment sedation as well as dental.	

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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.	<u>Psychiatry Staffing</u> Approximately 50% of the census (a total of 60 individuals) received psychopharmacologic intervention requiring psychiatric services at EPSSLC as of 3/18/13. At the time of this monitoring review, there was one FTE board certified psychiatrist, designated as the lead psychiatrist, and 0.2 FTE board certified psychiatrist providing services at the facility. This FTE level allowed for a total of 48 hours of clinical resources weekly. In addition, the facility lead psychiatrist was available after hours via telephone consultation. <u>Administrative Support</u> 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. It was noted that more recently, the Rehab Therapy Tech III had been temporarily reassigned to the psychology department, however, the Psychiatric LVN III had done an admirable job of continuing to both organize and document psychiatric activities. 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 evident in the delay in completion of quarterly psychiatry clinical encounters. In order to maintain the clinic structure, temporary staff assistance should be considered. <u>Determination of Required FTEs</u> 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 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 1.2 FTE prescribing psychiatric practitioners at the time of the site visit. Overall, EPSSLC had done an adequate job in assessing the amount of psychiatric FTEs required, however, it was noted that the census at the facility had decreased, as had the number of individuals participating in psychiatry clinic. As noted elsewhere in this report, there were delays in completion of quarterly psychiatric medication reviews. These delays were opined to be due to psychiatric physicians becoming more involved in other treatment processes (e.g., PBSP, ISP) and the need to orient and integrate a new part time psychiatric physician into practice in the SSLC environment. For further information regarding this issue, please see the discussion under J13, J12, and J9.	Substantial Compliance

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		Monitoring Team's Compliance Rating As the facility had acquired additional psychiatric resources, coupled with the decreasing population, this provision was rated in substantial compliance. It should be noted that this rating differs from the rating assigned in the facility self-assessment.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	Appendix B Evaluations Completed EPSSLC psychiatry staff focused on the completion of comprehensive psychiatric evaluations per Appendix B during the previous monitoring period. Documentation revealed that out of a total of 60 individuals receiving treatment via psychiatry clinic, 59 individuals (98%) had psychiatric evaluations performed according to Appendix B. Given the paucity of psychiatric resources available at the facility, this was impressive. It was, however, not without sacrifice. As indicated in the previous monitoring report, the focus on assessments had resulted in delays in completion of quarterly psychiatric clinical assessments. In the intervening period since the previous monitoring report, this had improved, however, delays remained in that data provided for this monitoring visit revealed that of a total of 60 individuals receiving care via psychiatry clinic, 28 or 46% of individuals were delayed with regard to quarterly psychiatry clinic. In the previous monitoring period, it was discussed that in an effort to conserve time and resources, annual and quarterly ISP meetings were utilized as psychiatry clinic encounters. This process had reportedly not continued, and formal psychiatry clinics were occurring. A sample of Appendix B style evaluations were reviewed for the following 10 individuals: Individual #37, Individual #57, Individual #126, Individual #109, Individual #77, Individual #56, Individual #44, Individual #96, Individual #17, and Individual #12. 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. There were ongoing 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 #37: In the initial psychiatric evaluation dated 8/9/12 there was documentation of prematurity and respiratory distress 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 mood disorder due to acquired brain damage and narcissistic/borderline personality disorder. 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	Substantial Compliance

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		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, it was noted that there was a dosage adjustment of the atypical antipsychotic medication Quetiapine on 8/8/12 "for billing purposes." Additional documentation regarding this regimen change was not available. All Appendix B evaluations included information regarding the integrated treatment plan that was taken directly from the ISP document. More recent Appendix B evaluations included a case formulation and integrated treatment planning section where the symptoms resulting in the current diagnosis were reviewed and the treatment plan including psychotropic medications, individualized preferences and interests, and treatment recommendations with regard to non-pharmacological interventions were reviewed. This documentation allowed the psychiatrist to 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. With the recruitment of a part time psychiatric clinician, the development of a peer review process had occurred. There was documentation of review of psychiatric treatment records for Individual #59 and Individual #89. There was documentation of deficiencies as well as acknowledgement and corrective action planned to address the deficiencies in the case of Individual #89. Deficiencies noted in the case of Individual #59 related to the need for psychiatry to review and sign the PBSP, which was discussed in detail in J3 above. <u>Monitoring Team's Compliance Rating</u> 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. While there was room for improvement, and the documents themselves would benefit from ongoing peer review, this provision remained in substantial compliance.	
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,	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 summaries presented to the monitoring team for this provision appeared to be incorrect. <u>Reiss Screen Upon Admission</u> The facility had one new admission for the previous nine months (Individual #149) and was administered a Reiss screen (based on information provided to the monitoring team). Data indicated this individual was referred to and was being followed in psychiatry clinic,	Noncompliance

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	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.	however, data received from psychiatry clinic did not include information regarding this individual. It may be that his admission occurred shortly before the onsite review and psychiatry clinic documents may have been submitted prior to the individual's referral for psychiatric treatment. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> Per a listing of individuals residing at the facility who were not currently receiving treatment via psychiatry clinic, there were 58 individuals who would be appropriate for Reiss screening. Of these, 46 individuals had documented completed screens (79%). There were 26 individuals currently participating in psychiatry clinic who received Reiss screens since 7/11/12. 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 (if any) had occurred that resulted in the screening. Data indicated that individuals who were screened and were psychiatry clinic patients were designated as "currently seen positive" indicating the results of the Reiss Screen. It was noted that there were no individuals screened as a result of a change in status. Interviews with psychology staff revealed that all individuals residing on campus, regardless of their participation in psychiatry clinic had been screened, but the 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> Data did not reveal that any individuals screened were referred to psychiatry clinic as a result of a positive screen other than Individual #149, a new admission. 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 all individuals who were not participating in psychiatry clinic had not undergone baseline screening, this provision remained in noncompliance. This was in agreement with the facility self-assessment.	

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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.	Policy and Procedure 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 11/30/12, 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. Interdisciplinary Collaboration Efforts 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 that graphed, up-to-date data were provided, but psychology must improve the description and analysis of the data and their assessment of what the presented data means, so that all members present have a good understanding. Graphs of data presented to the physician were variable with regard to the inclusion of 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). 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, again, there was a need for improvement in the use of analyzed 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.	Noncompliance

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		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. There was clear documentation of the IDT process in psychiatry clinic as well as the use of information from other disciplines in the formulation of the individual's diagnosis. Improvements in case formulation remained stable during the intervening monitoring period, inclusive of the increased use of DSM-IV and DM-ID criteria in the assessment and diagnostic process. 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. <u>Integration of Treatment Efforts Between Psychology and Psychiatry</u> There were noted attempts by both psychiatry and psychology leadership to improve and integrate treatment efforts. This was noted via the weekly integration meeting attended by the lead psychiatrist, psychiatric clinic staff, and the director of psychology. This meeting was observed during the monitoring review, and the improvement of communication between leadership was apparent compared to prior monitoring visits. Other integration efforts between psychiatry and psychology included the attempts by psychiatry to attend ISP meetings, the psychiatrist attending BTC and psychology peer review, 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..." <u>Coordination of Behavioral and Pharmacological Treatments</u> As noted in J9 and J13 below, there was cause for concern with regard to rapid, multiple 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 previous monitoring visits, the generally accepted professional standard of care is to change medication dosages slowly, one medication at a	

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		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. <u>Monitoring Team's Compliance Rating</u> 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 in conflict with the facility self-assessment. Also see J9 below.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	<u>Psychiatry Participation in BSP and other IDT activities</u> Per interviews with the psychiatry staff, it was reported and then observed that the facility lead psychiatrist had begun, as of October 2012, to routinely attend meetings regarding behavioral support planning for individuals, and he and other psychiatry staff were reviewing said plans with the IDT during psychiatry clinic. During psychiatry clinic, the psychiatrist was observed to ask 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. To meet the requirements of this provision item, there also needs to be documentation 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. In another related issue, discussed in detail in J3, some individuals had an "Individual Mental Health/Behavior Plan" either in lieu of, or in addition to, the BSP. This was confusing due to the absence of policy and procedure governing the use of this plan. It was reported that the psychiatrist attended 33 ISP meetings regarding 22 different individuals between the dates of 7/1/12 and 2/13/13. It was noted that this was 100% of the meetings reported. There was a separate data set provided which included sign in sheets indicating psychiatric attendance at 52 ISP meetings between 8/8/12 and 3/12/13. Of these, 46 were signed by a psychiatry physician, with the remaining six signed by the psych tech. These data regarding the psychiatry attendance at meetings were confusing and not appropriately tabulated. The total number of meetings was not available, so it was	Noncompliance

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		not possible to determine the percentage of meetings attended. <u>Treatment via Behavioral, Pharmacology, or Other Interventions</u> The following example highlighted the continued problems of multiple medication regimen adjustments. Record review noted that the psychiatrists better documented the rationale for multiple and rapid medication adjustments, however, concern with regard to this practice remains. For example, in the record of Individual #14 outlined below, there was notation of multiple rapid and simultaneous medication regimen alterations. Many of these were done in close temporal proximity to each other, which did not allow for the review of data to determine the benefit, or lack thereof, as a result of a specific regimen adjustment: • 7/5/12 it was noted that this individual was "doing well, without any major outbursts, although she has occasional outbursts lasting no more than a minute. It seems that since we increased her Lithium she has improved." At this time, it was decided to increase the Lithium dosage, and check a Lithium level in one to two weeks. Note that this individual was prescribed polypharmacy: Lithium, Latuda, Lamotrigine, Lorazepam, and Imipramine. • 7/18/12 the Lithium dosage was decreased as her Lithium level was 1.2. It was noted, "has stabilized after numerous trials with single medications which she never responded to until we added Latuda and Lithium." • 8/11/12 chemical restraint using three medications: Lorazepam, Phenobarbital, and Haloperidol. • 8/12/12 chemical restraint using one medication: Lorazepam. • 8/13/12 increased agitation, aggression and SIB. Lorazepam tapered to discontinuation over 34 days, while Clonazepam initiated and titrated to 4 mg at bedtime over 17 days. • 8/22/12 seen for an emergency psychiatry clinic where it was noted she was having problems with depression, flashbacks, and throwing herself to floor and "that her BSP is not helping her." Aldactone was started to address edema. The risk of altered Lithium levels associated with the use of diuretics was not documented. A cross taper of the antidepressant Imipramine to Paxil over the course of a month was initiated, as was a cross taper from Lorazepam to Clonazepam. The cross taper of these medications was not considered as an etiology for this individual's symptom exacerbation. • 8/29/12 the taper of Imipramine was ordered. Again, the cross taper from Lorazepam to Clonazepam was not considered as an etiology for this individual's behavioral challenges. • 9/10/12 "three days with severe aggression and agitation…increase Paxil 60 mg in the morning…Increase Clonazepam 1 mg in the morning, 4 mg at bedtime." • 9/11/12 chemical restraint using three medications: Lorazepam, Phenobarbital, and Haloperidol.	

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		• 9/13/12 "for three days, totally out of control, hitting, assaulting...continues with what appears to be some form of delirium…agreed to send to ER." Upon presentation to the ER, it was noted that she had an infection, which may have been the etiology of the behavioral difficulties. • 9/25/12 "discontinue Lithium…Increase Lamictal 200 mg in the morning for seven days, then 250 mg in the morning." <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> The psychiatrist and psychology staff had improved collaboration with regard to the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports. 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 not logged, therefore, it was difficult to determine the intensity of non-pharmacological interventions outside of the BSP. <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 parts of this section J report, 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. In addition, the use of the "Individual Mental Health/Behavior Plan" must be outlined via policy and procedure. Therefore, this provision item was rated as being in noncompliance in agreement with the facility self-assessment.	
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	<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," 11/30/12. There were no procedures for this process delineated. <u>Quality of Risk-Benefit Analysis</u> A current review of the records of 15 individuals who were prescribed various psychotropic medications revealed improvements in the risk/benefit analysis with regard	Noncompliance

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	medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	to treatment with medication as required by this provision item. For example, format of the quarterly psychiatric documentation had been revised via the "Comprehensive Quarterly Psychiatric Medication Review" form. This form had a specific section that outlined the major risks associated with specific psychotropic medications and then outlined the major benefits associated with each medication for the individual. In addition, there was documentation of the "comparison with prior medications and/or alternative strategies." Interviews with psychiatry staff at the facility revealed that this form had been adopted in November 2012, and that all quarterly psychiatry clinics done following this time utilized this format. As noted in various areas of this report, there were individuals who were overdue for quarterly psychiatry updates. In addition, documentation noted that after 11/1/12, 29 quarterly psychiatry reviews were performed. As such, this was the maximum number of individuals who could have had documentation with the revised form, indicating that approximately 50% of individuals had that documentation outstanding. • For example, for Individual #109 the "Comprehensive Quarterly Psychiatric Medication Review" form dated 3/8/13 listed specific risks associated with each prescribed psychotropic medication as well as benefits for each. For example, with regard to Lamictal, risks included "asthenia, somnolence, paresthesia, ataxia, leukopenia, and neutropenia." Benefits included "improve aggression, improve agitation." With regard to the comparison with other interventions, "in the past, the patient used to take Aripiprazole since 2005 until January 2011 when it was switched to Clonidine at a dose of 0.1 mg three times a day. Both medications were discontinued because they were not effective and it was determined that he was mostly showing akathisia rather than agitation or manic depressive disorder or psychosis. Nothing has changed on his active treatment for the past year. BSP was implemented before, but it was switched to mental health plan because it was not felt to be necessary. Medication has not been changed for the last year either." While the above documentation provided good information regarding the risks and benefits of the individual medications, there was cause for confusion due to implementation of the mental health plan in lieu of the BSP. This issue was discussed in detail in J3. 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. 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,	

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		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. 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. This had been resolved in the intervening period since the last monitoring visit, and with increased psychiatric resources and the completion of the Appendix B evaluations, psychiatry staff were able to focus on quarterly clinics. There remained some delays, as discussed in J2, indicating that of a total of 60 individuals receiving care via psychiatry clinic 28 or 46% of individuals were delayed. <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 comprehensive quarterly psychiatry form developed at EPSSLC 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 regarding Individual #9 presented to HRC Committee 1/2/13 demonstrated improved documentation and individualized information, however, deficits remained as discussed below. • Trazodone 100 mg by mouth at bedtime for sleep was presented.	

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		• Objective information including sleep logs and observation notes were utilized to determine the need for additional medication. • Previous adjustments to the medication regimen in order to address this issue were reviewed. • The major side effects of the proposed medication were documented. • The risks of lack of sleep were reviewed. • The plan to monitor this individual's response to the medication was documented • The individual's mother agreed with the plan. The documentation did not, however, note that the addition of this medication would result in meeting criteria for polypharmacy due to three psychotropic medications. <u>Monitoring Team's Compliance Rating</u> There was a need for 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 for all individuals prescribed psychotropic 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. The facility self-assessment rated this provision in noncompliance because, "reasonable alternative treatment strategies to minimize the use of psychotropic medication continue to be lacking in the documentation." This assessment was based on a review of the "Psychiatry, Psychology Integration Tools" where only 40% of the 10 documents reviewed were found to have adequate documentation. The monitoring team agreed with this rating for this reason as well as for the need to complete risk/benefit analysis via the newly developed form for all individuals prescribed psychotropic medications.	
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	<u>Facility-Level Review System</u> The facility had in place a review system for polypharmacy that was centered in the pharmacy department. Since 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 3/21/13 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 36 in February 2013. • The total number of individuals who met criteria for antipsychotic polypharmacy had decreased from six in December 2010 to three individuals in February 2013. • The average number of psychoactive medications prescribed for any individual	Noncompliance

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	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.	who received psychotropic medication had remained about the same from 3.67 in December 2010 to 3.55 in January 2013. A review of the active psychoactive medication list by drug class listing for February 2013 revealed that there were three individuals meeting criteria for intraclass polypharmacy for antipsychotic medications, two individuals with intraclass polypharmacy for antidepressant medications, one individual with intraclass polypharmacy for benzodiazepines, one individual with intraclass polypharmacy for sedative medication (including Trazodone and Melatonin), and one individual with intraclass polypharmacy under miscellaneous (Benztropine, Lithium, Guanfacine, Propranolol, Guanfacine). This was a total of eight individuals. In the previous monitoring report, this number totaled 22 individuals. There were an additional 41 individuals with intraclass polypharmacy for seizure medications (note, not all of these individuals were also participating in psychiatry clinic). 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. As regular psychiatry clinics had resumed, this allowed for a return to regular consultation. Per a review of the active psychoactive medication list by drug class provided by the facility pharmacy, there were a total of 36 individuals who met criteria for psychotropic medication polypharmacy. It was discussed with pharmacy staff that in the intervening period since the last monitoring visit, they had revised the polypharmacy definition utilized at the facility to that approved through out the system. A review of the pharmacy data below revealed marked differences in some areas that were opined to be attributable to the change in definition resulting in changes in data results. It is notable that as there were a total of 60 individuals in psychiatry clinic, 60% 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 36 individuals prescribed antipsychotic medications at the facility (a decrease from 46 individuals during the previous monitoring review). Of these: • Three individuals were prescribed two antipsychotics (decreased from four during the previous monitoring review). • None were prescribed three antipsychotics. There were 50 individuals prescribed anxiolytic medications (a decrease from 56 individuals during the previous monitoring period). • Of these, one was prescribed two anxiolytic medications (a decrease from two during the previous monitoring period).	

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		During previous monitoring reviews, data were provided for other classes of medication including antidepressants, stimulants, and sedatives. These data were not available for this monitoring period. Of the 60 individuals prescribed psychotropic medication of any class in February 2013: • A total of 20 individuals were prescribed two or more psychotropic medications from the same class. The majority of these individuals (12) 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 37 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 somewhat improved in the facility level review process observed by the monitoring team, as well as documented in meeting minutes. It was noted that there was comprehensive review of an individual's case and pharmacological regimen. Review of Polypharmacy Justifications Documentation regarding polypharmacy 2/28/13 for Individual #13 (treated with seven psychotropic medications) stated, "Lithium has been prescribed for mood stabilization. Remeron…for depression and anxiety... Clonidine for impulsiveness. Trazodone…for insomnia. Latuda…for aggression…will start Haldol for aggressiveness and impulsiveness…the second level will be to increase Latuda…later…and if these two do not work, we will have to consider…Clozaril…since his return fro Big Springs there have been no changes…started tapering Clozaril due to abnormal leukocytosis, and the data appears to show that his behaviors have increased…we started Haldol to try to curtail the aggressive behavior and to determine if the Clozaril was, in fact, what was controlling him more…has been on numerous medications in the past…unsuccessfully…seeing that it appears to be the same for Clozaril, which was ineffective in the past…now that we are tapering, appears to give us a contrary response because his behaviors have increased. Therefore, we will have to monitor closely and see if it is the Clozaril which has been helping his aggressive behavior."	

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		• In this example, there were attempts to maintain the medication regimen, however, due to increased behavioral challenges as well as medication side effects, an alteration in the regimen was required. The suspension of this individual's BSP was noted in the comprehensive quarterly psychiatric medication review, but not documented as a potential reason for increased behavioral challenges. Otherwise, this was an acceptable description and justification for polypharmacy. Documentation regarding polypharmacy dated 10/2/12 for Individual #56 (treated with five psychotropic medications) stated "had not been doing well exclusively on Clozapine and when we added Latuda, he improved considerable, as evidence by the data presented…and by confirmation with mother and father, who stated that at this point with polypharmacy, he has been the best he has ever been…polypharmacy is justified in that it has reduced…psychotic symptoms and behaviors considerably…Latuda has improved …psychotic symptomatology, his overall ADL's, decreased his aggression and agitation, and improved his participation in activities…has been on antipsychotics before that have failed to improve his schizophrenia including 1) Risperidone, 2) Haldol #) Zyprexa." • This example noted that there were multiple medication attempts to address this individual's symptoms that had failed. It also noted the rationale for intraclass antipsychotic polypharmacy. <u>Monitoring Team's Compliance Rating</u> The facility had made strides with regard to this provision item. They had corrected the definition of polypharmacy utilized by the facility; improved documentation regarding the rationale for polypharmacy regimens; reduced reliance on polypharmacy overall; and had improved the critical review of polypharmacy justification via the facility level review. Per the facility self-assessment, not all individuals meeting criteria for polypharmacy had justifications for polypharmacy authored. The facility self-assessment rated this provision in noncompliance in agreement with the monitoring team. The facility must maintain current practices and justify polypharmacy for each individual meeting criterion in order to reach substantial compliance.	
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	<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 were evaluated with MOSES and DISCUS scores, the facility provided a spreadsheet containing information including the individual's name, home, exam type (i.e., semi-annual, quarterly, other), MOSES score, MOSES date, DISCUS score, DISCUS date, date signed, conclusion, and action taken. This document was difficult to follow because 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. This must be addressed so staff can quickly glance at the list and determine if a particular	Substantial Compliance

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	on the individual's current status and/or changing needs, but at least quarterly.	individual required an assessment, or to determine if an individual's scores had changed over time. 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 regarding inservice training for nursing case managers revealed that training regarding the MOSES and DISCUS was provided by the facility psychiatrist 12/4/12 to three nursing staff members classified as "newly hired employees." A MOSES/DISCUS refresher was provided by the facility psychiatrist 1/22/13 to nine nursing staff members. Per the facility self-assessment and staff interviews performed during the monitoring visit, following the above noted training opportunities, all facility nursing case managers were current with MOSES and DISCUS training. <u>Quality of Completion of Side Effect Rating Scales</u> 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. In addition, the results of the assessments were documented on the quarterly psychiatric medication review along with comments regarding the interpretation of the results. There was cause for concern because there was no documentation indicating that previous scores were compared to current scores. 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, along with documentation reviewed, indicated that when the individuals were seen in clinic, the examination results were reviewed and utilized. During the previous monitoring visit, psychiatry clinic staff were behind in completion of quarterly reviews. In an effort to save time, 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 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 because 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 this monitoring visit revealed that of a total of 60 individuals receiving	

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		care via psychiatry clinic 28 had been seen in psychiatry clinic prior to 12/1/12, indicating that they were overdue for quarterly psychiatric reviews. There were three individuals who have not been seen by psychiatry clinic since August 2012. Data provided for the previous monitoring period indicated that no individuals had a diagnosis of tardive dyskinesia (TD). Data provided for this monitoring period revealed that there were two individuals with a diagnosis of Orofacial Dyskinesia, and no individuals with a diagnosis of TD. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Medication reduction or the absence of the antipsychotic or metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. To this end, the facility psychiatrist reviewed individual records over a period of 10 years to identify individuals with a history of a TD diagnosis as noted above. <u>Monitoring Team's Compliance Rating</u> There were noted improvements in the tracking of completion of the instruments and in documentation of the review of the instruments. Issues remained with trending of MOSES and DISCUS results and timeliness of quarterly reviews. During the current monitoring period, it was apparent that there was more attention paid to the clinical correlation of information obtained via the MOSES and DISCUS. There were issues with regard to timeliness of clinical correlation due to delays in quarterly reviews, however this had improved compared to the prior review period where quarterly clinics were being conducted simultaneously with IDT meetings. As there had been marked improvements in this area, this provision will return to substantial compliance, also in agreement with the facility self-assessment.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic	<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. The facility specific policy entitled "Psychiatry Services" dated 11/30/12 outlined some procedures for the completion of specific psychiatry related tasks, but it did not 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.).	Noncompliance

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	medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	A new quarterly medication review format entitled, "Comprehensive Quarterly Psychiatric Medication Review" had been devised in the period since 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 treatment plans for psychotropic medication included in the more recent "Comprehensive Quarterly Psychiatric Medication Review" in the section entitled, "Psychiatric Treatment Plan Including Psychotropics." A review of documentation noted 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) also were now included in the "Comprehensive Quarterly Psychiatric Medication Review." <u>Psychiatric Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was psychiatry participation in the ISP process. As one full time and one part time psychiatrist staffed the facility, the schedule did not allow for their consistent attendance or participation in the ISP process. It was not possible to determine the percentage of ISP meetings that the psychiatrist had attended. In an effort to utilize staff resources most effectively, the facility created an IDT meeting during psychiatry clinic, and could consider incorporating IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT into psychiatry clinic may allow for improvements. <u>Psychiatry Clinic</u> During the monitoring review, two psychiatry clinics (for a total of two individuals) were observed. In both 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.	

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		In all instances, the data were up to date; however, timelines for medication dosage changes or stressful life events were not always included in the data graphs. This made data based decision making difficult because 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 for psychology staff to analyze the data and present their interpretation of what the data meant in the context of behavioral health care for the individual. The current information, although relevant, was insufficient if the goal was to implement an evidence-based approach in evaluating medication efficacy. There were noted improvements in collaborative case formulations documented via the comprehensive psychiatric evaluations. Documents revealed 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, 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 improvements resulted from the ongoing utilization of the integration tool utilized in psychiatry clinic. As additional resources were allotted to the psychiatric department at the facility, it is hoped that there will be timely 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 medication. <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	

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		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. A specific example is outlined in J9. <u>Monitoring Team's Compliance Rating</u> A review of a sample of 15 records revealed varying quality in documentation for the psychiatric reviews and delays in completion of quarterly psychotropic medication reviews. Additionally, the data analysis must be improved to allow for data driven decision making with regard to medication. Given the noted deficiencies, the facility remained in noncompliance for this item, in agreement with the facility self-assessment.	
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. Facility specific policy and procedure entitled "Psychiatric Services" was revised 11/20/12 and included a reference to the "Rights Policy" for information regarding informed consent; however, it did not provide detail with regard to requirements or responsibilities for this process. 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 professional practice, 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, which 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	Noncompliance

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		been no progress with regard to this provision. Staff readily noted that they had focused their energies in other areas. Current Practices Informed consent documents in the records available for review revealed that these forms were a signed document that included the medication, dosage, brief listing of side effects, justification, plan, and notation regarding family notification; and a signed checklist to ensure that specific information was addressed via the informed consent process. Ten examples of documentation of consents for psychotropic medication for nine individuals were reviewed (Individual #50 medication Latuda; Individual #38 medication Klonopin; Individual #112 medication Luvox CR, Individual #157 medication Abilify, Individual #9 medication Zyprexa and Trazodone, Individual #12 medication Latuda, Individual #120 medication Haldol, Individual #83 medication Geodon, and Individual #13 medication Latuda). In six of the examples (Individual #9, Individual #38, Individual #12, Individual #120, and Individual #83), the documentation did not include the brief listing of side effects. These forms named the specific medication/dosage and an indication for the medication, however, in the six examples noted above, there was no documentation of the side effects of the medication. In no example was documentation of the risk/benefit analysis for the use of a particular medication included. 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, three were prescribed Latuda, an atypical antipsychotic medication (Individual #50, Individual #12, Individual #13). This was noted in the previous review where five of nine individuals most recently prescribed psychotropic medication were prescribed Latuda. The use of the same medication for multiple non-approved indications was questionable and should be reviewed. In addition, data outlined above revealed that of a total of 10 new medications prescribed, seven were antipsychotic medications, another trend that should be monitored and reviewed by the facility. Monitoring Team's Compliance Rating	

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		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." Facility policy and procedure dated 4/26/11 revised 11/30/12 requires that "the neurologist and psychiatrist must coordinate the use of medications, through the IDT process during Neuropsychiatric Clinic, when the medication is prescribed to treat both seizures and a mental health disorder." The policy also outlines the necessary monitoring for anti-epileptic medications when used as a psychotropic medication 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 41 individuals. At the time of the previous review, there were 48 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, there had been ongoing 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 18 months. Records revealed that of the 41 individuals identified above, 22 were seen in Neuro-Psychiatry clinic in the previous six months. There were 18 individuals seen between January 2012 and September 2012. There was one individual who had not seen neurology in the previous year, as Individual #73 was last seen in Neuro-Psychiatry clinic 11/30/11. 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, three clinical encounters occurred. There was discussion and collaboration between the physicians. In prior observations, there was concern with regard to multiple medication regimen changes. This was not observed during the current observation. In addition, medical records reviewed revealed fewer examples of rapid and/or multi drug titrations. Also worthy of comment was that behavioral data presented during clinic were up to date and graphed appropriately. One issue, staff reporting details regarding witnessed seizure activity, identified in previous reports, remained an issue. For example, Individual #108 had experienced an exacerbation	Substantial Compliance

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		of seizure activity in late 2012. The physicians requested information regarding the character of the seizures observed. Unfortunately, this was not adequately documented by staff who witnessed the incident, thus, limiting the clinical consultation. During this clinic, family members were not present, however, there were attempts to reach the family of one individual via telephone. 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. <u>Adequacy of Current Neurology Resources</u> Given the current monthly Neuro-Psychiatry clinic observed, with three individuals seen in clinic, and a total of 41 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 always seen in clinic annually. As the physicians continue this clinical consultation, they will need to determine if the current contract hours are sufficient. Other data reviewed regarding this issue were confusing. The facility self-assessment indicated that as of 11/1/12 the neurologist's hours were increased to a total of eight hours per month. The schedule of the consulting neurologist provided via the document request indicated that the neurologist is present at the facility weekly on Tuesdays from 9 am until noon. This would total more than eight hours per month. <u>Monitoring Team's Compliance Rating</u> Increased neurology consultation hours allowing for the designated "Neuro-Psychiatry" clinic had been maintained. Document review and clinic observation revealed improvements in collaboration with regard to coordination of medication regimen changes. The facility had included the organization/participation and documentation requirements for Neuro-Psychiatry clinic in facility-specific policy and procedure. As noted above, there were some confusing data regarding available neurology resources. In addition, the need for staff training regard to documentation of possible seizure activity, noted in previous reports remained an issue. This provision will remain in substantial compliance.	

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. Develop policy and procedure regarding the "Individual Mental Health/Behavior Plan" (J3).

3. Continue to integrate psychiatry into the overall treatment program at the facility. This would include involving the psychiatrists in discussions regarding treatment planning, behavioral support planning, and non-pharmacological interventions to reduce the need for restraint and psychotropic medications (J3).

4. Ensure that the current process for monitoring pre and post chemical restraint episodes is documented in policy and procedure (J3).

5. Avoid the utilization of multiple medications during pretreatment sedation and/or chemical restraint (j3, J4).

6. Ensure that all individuals prescribed psychotropic medication have a current and implemented BSP (J13).

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

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

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

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

11. Develop a process for the assessment, creation, and implementation of desensitization plans and/or other treatments or strategies for dental and medical clinic (J4).

12. Monitor the facility census and the number of individuals requiring psychiatric consultation to determine the need for additional psychiatric resources. Resources including telemedicine and collaboration with local medical schools or residency programs could be considered (J5).

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

14. Continue and expand quality assurance or a peer review monitoring process for comprehensive psychiatric evaluations and other psychiatric documentation by reviewing and percentage of the records in each clinician's caseload (J6).

15. 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).

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

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

that medication regimen adjustments are made using data based decision making (J8).

18. 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).

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

20. Ensure psychiatric involvement in the formulation of the BSP. This should include the signature of the psychiatrist on the document (J9).

21. 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).

22. 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).

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

24. 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).

25. 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).

26. Ensure that each individual meeting criteria for psychotropic medication polypharmacy has a justification for same in their record (J11).

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

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

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

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

31. 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).

32. 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 to allow for an analysis of the data (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 (J14).

36. Develop facility-specific policy and procedure regarding informed consent (J14).

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

38. Review prescribing trends, specifically with regard to antipsychotic medications (J14).

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

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

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Annual Psychological updates for: • Individual #12 (1/14/13), Individual #32 (10/5/12), Individual #79 (7/11/12), Individual #57 (9/3/12), Individual #13 (8/8/12), Individual #78 (10/10/12), Individual #67 (9/9/12), Individual #103 (10/11/12), Individual #99 (8/7/12), Individual #74 (10/26/12), Individual #149 (3/1/13) o Positive Behavior Support Plans (PBSPs) for: • Individual #103 (11/16/12), Individual #32 (11/29/13), Individual #49 (1/31/13), Individual #18 (12/20/12), Individual #77 (8/20/12), Individual #51 (10/29/12), Individual #7 (8/24/12), Individual #57 (11/2/12) o Monthly progress notes for: • Individual #103 (1/10/13), Individual #32 (1/16/13), Individual #49 (1/10/13), Individual #18 (12/18/12) and (2/5/13), Individual #77 (11/15/12), (1/8/13), and (2/7/13), Individual #7 (1/16/13) and (2/6/13), Individual #57 (1/15/13) and (2/5/13) o Functional Assessments for: • Individual #73 (8/24/12), Individual #188 (8/24/13) o Full Psychological Assessment for: • Individual #80 o PBSP Peer Review checklist, dated 2/13 o Psychology department meeting agenda, 3/18/13 o Draft of Individual #13's PBSP, undated o EPSSLC Self-Assessment, 3/6/13 o EPSSLC Action Plan, 2/20/13 o EPSSLC provision action information, 2/25/13 o Peer Review minutes from September 2012 to February 2013 o A list of all individuals with date of admission to the facility, 3/20/13 o Data card policy, 2/25/13 o Monitoring sheet for treatment integrity and data collection reliability, undated o Data integrity report, 3/20/13 o Data card contract, 2/25/13 o Section K presentation book, undated o Psychology department meeting minutes from September 2012 to February 2013 o A list of full psychological assessments completed in the last six months o A list of functional assessments completed in the last six months o A list of all individuals and their most recent full psychological assessment, undated o A list of the most recent date of PBSPs, date that PBSP consent was obtained, date of most recent

	functional assessment, and date of most recent annual psychological assessment, undated o Spreadsheet of treatment integrity across individuals, 2/5/13 o A list of all training conducted on PBSPs, undated <u>Interviews and Meetings Held</u>: o Carmon Molina, Director of Psychology o Marisela Franco, Associate Psychologist o Angelin Clarke, Psychology Intern o Mario Rodriquez, Associate Psychologist o Maricela Giner, QDDP o Adriane Hanway, Director of residential services o Ruben Ochoa, acting ADOP <u>Observations Conducted</u>: o Behavior Support Meeting o Peer Review Meeting • Staff present: Carmen Molina, Director of Psychology; Marisela Franco, Associate Psychologist; Martha Davis, Associate Psychologist; Mario Rodriquez, Associate Psychologist; Elsa Mendoza Duante, Associate Psychologist, Dr. Rice, Psychiatrist • Individuals presented: Individual #13 o Pretreatment Sedation/Desensitization Planning Committee Meeting o Neurology/Psychiatry Clinic • Individuals presented: Individual #60, Individual #108 o Psychiatry/Psychology Integration meeting o Psychiatric Clinic • Individual presented: Individual #59 o Observed training of PBSP • Individual's plan: Individual #31 • Staff trained: Kobyastti Dawkins, Gaby Delira, Rosaura Alfaro o Observed treatment integrity session • Individual's plan: Individual #78 o Observations occurred in day programs (both on campus and in the community) and residences at EPSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals
	Facility Self-Assessment: 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 an audit of the completion of data cards, a review of the completion of progress notes, and a review of the presence of interobserver agreement (IOA). These are topics that are included in the monitoring team's review of K4. This self-assessment, however, did not include several additional items (i.e., data collection reliability, graphing of target and replacement behaviors, evidence of action to address the absence of progress, evidence that data are used to make treatment decisions) that are necessary to achieve substantial compliance with K4 and are, therefore, included in the report. The monitoring team suggests that the psychology department review, for each provision item, the activities engaged in by the monitoring team (based on the report), 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 (K8) was in substantial compliance. The monitoring team's review of this provision found K2, K3, K7, and K11 to be in substantial compliance and noncompliance for all other provision items. The reasons for these discrepancies are discussed in detail below. 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: There were several improvements since the last review, resulting in three additional items rated as in substantial compliance (K3, K7, and K11). These improvements included: • Improvement in the percentage of psychologists that were either enrolled in or completed BCBA coursework (K1) • The director of psychology became a board certified applied behavior analyst (K2) • Expansion of peer review to include psychiatry (K3) • Documentation of internal peer review occurring weekly and external peer review occurring monthly (K3) • Expansion of data cards to all treatment sites (K4) • Expansion of the graphing of replacement behaviors to all PBSPs (K4) • Expansion of data collection reliability to all treatment sites (K4)

	• Establishment of minimal frequencies of data collection reliability (K4) • Initiation of monthly progress notes for individuals with PBSPs (K4) • Documentation in the progress note of activity to address lack of progress (K4) • Improvements in the comprehensiveness of functional assessments (K5) • Improvements in the comprehensiveness of annual psychological assessments (K7) • Improvements in the percentage of individuals with a current annual update (K7) • Improvements in the comprehensiveness of PBSPs (K9) • Expansion of treatment integrity to all cottages (K10) • Establishment of minimal frequencies of treatment integrity (K10) • Improvement in DCP's report that they understood PBSPs (K11) The areas that the monitoring team suggests that EPSSLC work on for the next onsite review are: • Establish minimal acceptable data collection reliability levels, and demonstrate that those levels are achieved (K4) • Initiate the collection of interobserver agreement (IOA) (K4, K10) • Increase the flexibility of the data collection system (K4) • Increase the number of individuals with functional assessments (K5) • Ensure that all individual's with PBSPs have consent (K9) • Ensure that PBSPs are implemented within 14 days of receiving consent (K9) • Establish minimal acceptable treatment integrity levels, and demonstrate that those levels are achieved (K10) • Provide documentation that all staff assigned to work with an individual (including float staff) have been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter (K12)

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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	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, four of four psychologists who wrote PBSPs (100%) were either enrolled, or completed coursework, toward attaining a BCBA. This represented stability from the last review when 100% of the psychologists were either enrolled in or completed BCBA coursework. Since the last review the director of psychology became 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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	and loss of skills, and to ensure reasonable safety, security, and 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. EPSSLC recently hired a new director of psychology who had a master's degree, was a BCBA, and had more than five years of experience working with individuals with intellectual disabilities. Additionally, under the new director's leadership, several initiatives had begun toward the attainment of substantial compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	EPSSLC provided documentation that internal peer review meetings consistently occurred weekly, and external peer review meetings consistently occurred monthly. Therefore, this provision was now rated as in substantial compliance. The facility continued to conduct Behavior Therapy Committee (BTC) meetings that contained many of the elements of internal peer review, however, these meetings only reviewed PBSPs that required annual approval. The peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected or were new to the facility. The peer review meetings also allowed more time to discuss cases. The internal peer review meeting observed by the monitoring team reviewed a draft PBSP for Individual #13. This individual presented with target behaviors that had recently resulted in several restraints. The peer review meeting included active participation from all of the department's psychologists, and included representatives from both the rehabilitation department and psychiatry. The meeting appeared to be very productive and resulted in the identification of several new treatment strategies to address Individual #13's target behaviors. Review of minutes from internal and external 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, and that once a month these meetings included a participant from outside the facility, thereby achieving the requirement of monthly external peer review meetings. Additionally, review of Individual #111's PBSP (9/7/12) reflected modifications that were discussed in the last peer review meeting that the monitoring team attended (7/12). Finally, operating procedures for both internal and external peer review	Substantial Compliance

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		committees were established. In order to maintain substantial compliance, EPSSLC needs to ensure that internal peer review consistently occurs weekly, external peer review consistently occurs at least monthly, and evidence of follow-up/implementation of recommendations made in peer review exist.	
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 noted continued improvements in this provision item. In order to achieve substantial compliance, however, the facility needs to initiate the collection of interobserver agreement (IOA), establish acceptable interobserver reliability (IOA) frequencies and levels, establish acceptable data collection levels, and demonstrate that those frequencies and levels are achieved. Additionally, EPSSLC needs to provide monthly progress notes for all individuals with a PBSP, and ensure that the progress note consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred when individuals are not making expected progress. Finally, the facility needs to ensure that all treatment decisions are data based. Since the last review, EPSSLC expanded the use of data cards to collect target and replacement behaviors to all individuals with a PBSP. Direct care professionals (DCPs) were required to record a "yes" if the target and/or replacement behavior occurred during that interval or a "no" if it did not occur during that internal. 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. The monitoring team asked DCPs from several treatment sites how they liked the new data cards, and all indicated a preference for the data cards over the previous data recording system that required going to the individual notebooks hourly to record target and replacement behaviors. The facility indicated that in August 2012, only 71% of data cards were completely filled out and submitted. In February of 2013 a facility wide inservice was conducted, which included a review on how to complete a data card, and a contract signed by each DCP that stated that they understood it was their responsibility to ensure that the data cards were completed and submitted. At the time of the onsite review, the facility reported that 96% of data cards were completed and submitted. Although having complete data cards represents an important improvement, it is also important to ensure that the data cards are filled out as soon as possible after the behavior occurs (rather than waiting until the end of the shift and attempting to remember when the behaviors occurred).	Noncompliance

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		As reported in the last review (July 2012), the facility had begun data collection reliability, and performance feedback, to ensure that that data were recorded in a timely fashion. This data collection reliability consisted of reviewing data cards mid-shift and noting if a "yes" or "no" was recorded up to the previous interval. The psychologist or manager who reviewed the data cards also provided performance feedback to the DCPs to increase the likelihood the cards would be filled out in a timely manner in the future. The facility reported that data collection reliability was 93% in February 2013. The monitoring team did its own data collection reliability by sampling individual data cards across several treatment sites, and noting if data were recorded up to the previous hour. The target and replacement behaviors sampled for 12 of 18 data cards reviewed (67%) were completed within the previous 60 minutes (five cards did not have the previous hours data, and one card did not contain data for the entire shift). This represented an improvement from the last review when 56% of data cards reviewed were completed within 60 minutes of the behavior occurring. It is, however, considerably lower than the data collection reliability reported by the facility. The monitoring team will attempt to collect data collection reliability with members of the psychology department in future reviews in order to better understand the discrepancy between the department's scores and the monitoring team's. Another area of improvement was that that EPSSLC recently began to determine the frequency that data collection reliability, IOA, and treatment integrity (see K10) should be collected. Based on the severity and frequency of each individual's target behavior, data collection reliability, IOA, and treatment integrity were scheduled to be collected weekly, monthly, or every three months. The monitoring team will more closely exam the rationale for determining these levels with selected individuals in future reviews, however, the monitoring team is supportive of this individualized approach to identifying minimal levels of data collection reliability, IOA, and treatment integrity. At this point it is recommended that the facility establish minimum data collection reliability levels (i.e., what are acceptable data collection reliability scores), and ensure that those levels are achieved. As noted above, staff consistently reported that they preferred the new data system to the previous data system. Some psychologists and DCPs, however, also indicated that some individual's target behaviors were difficult to "fit" into the current data system. For example, target behaviors that occurred at very low rates (e.g., once a week or once a month) were still required to be recorded as not occurring every hour. Additionally, the current data system was designed to measure the frequency per interval or duration of target behaviors; both measures that could be important in more accurately representing, and ultimately, understanding target behaviors. It is recommended that	

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		the facility ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors. At the time of the onsite review, EPSSLC was not collecting IOA. As discussed in the last report, while data collection reliability assesses whether data are recorded in a timely fashion, IOA assesses if multiple people agree that a target or replacement behavior occurred. It is recommended that the collection of IOA be initiated. Once IOA is collected, the facility needs to establish specific IOA 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 system in one or two homes. This will allow the facility to work out the logistical challenges to better assess the additional resources that will be necessary to implement it across the all treatment sites. Another area of improvement at EPSSLC was the general use of simplified graphs (i.e., reduced number of data paths and addition of phase lines to mark medication changes and/or other potentially important events). The use of these improved graphs to make data based decisions could, however, be improved. For example in a Neurology-Psychiatry Clinic and a Psychiatry clinic observed by the monitoring team, simplified graphs were presented to assist the team to evaluate the effects of medication changes that occurred approximately 30 days prior to the meeting for Individual #108 (Neurology-Psychiatry clinic) and Individual #59 (Psychiatry clinic). Unfortunately, all of the data points on the graphs represented 30 days of data, so it was impossible to isolate the recent effects of the medication change (i.e., the datum point included both days with and without the new medication). This is also pointed out in section J of this report. In situations where a potentially important change has recently occurred, target behaviors need to be graphed in daily or weekly increments, so that the effects of the potentially important change can be better isolated. In order to increase the utility of graphs in helping the team to make data based decisions, there needs to be flexibility in the graphing of data in increments based on individual needs, rather than all individuals' data graphed in increments of one month. Progress notes were available for seven of the eight individuals (88%) with PBSPs reviewed. They were, however, incomplete (i.e., they contained only one to three monthly notes in a six month period). Nevertheless this represented an improvement over the last review when no individual's with PBSPs had progress notes. All individuals with PBSPs should have monthly progress notes.	

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		In reviewing six months of PBSP data for these eight individuals, four (50%) indicated improvement, or stable and low levels, of severe target behavior, such as aggression or self-injurious behavior (i.e., Individual #51, Individual #7, Individual #57, and Individual #77). This represented another improvement from the last review when only 38% of the PBSP data reviewed indicted decreases or low stable levels of severe target behaviors. Another improvement from the last review was that there was evidence that when progress was not occurring, action to address the lack of progress was occurring (e.g., modification of the PBSP, or retraining of staff). For example: • Individual #32's 1/16/13 progress note indicated that he was having several medical problems that were likely adversely affecting his target behaviors, and the action was to resolve the medical issues prior to changing the behavior support plan. • Individual #18's 2/5/13 progress note indicated that he recently moved to a new cottage and had a medication change, and that the treatment focus should be to help him adjust to his new home and new medication. Since the number of progress notes available was limited (see discussion above), it was not clear that some action (e.g., retraining of staff, modification of PBSP) had occurred in response to every individual not making expected progress (e.g., Individual #51). It is recommended that in those instances when an individual is not making expecting progress, that the progress notes consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred. The monitoring team recognizes the continued progress the facility made on this provision item, and encourages continued focused effort in this important 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 complete initial (full) psychological assessments for each individual, and the absence of complete functional assessments for each individual with a PBSP. <u>Psychological Assessments</u> A list of all individuals and dates of their full psychological assessments indicated that 15 of the 118 individuals at the facility (13%) did not have an initial (i.e., full) psychological assessment. One full psychological assessment (Individual #80) was completed since the last review, and it was reviewed to evaluate its comprehensiveness. It was found to be incomplete because it did not contain a screening or review of psychiatric and behavioral status, review of personal history, or an assessment of medical status.	Noncompliance

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		All individuals at EPSSLC should have an initial (full) psychological assessment. Additionally, these full 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. <u>Functional Assessments</u> A list of functional assessments and PBSPs indicated that nine of 43 individuals with a PBSP (21%) had a current (i.e., revised/reviewed within one year) functional assessment. This represents a slight decrease from the last review when 24% of individuals with a PBSP had a current 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 two were completed. Both of those functional assessments (100%) were reviewed to assess compliance with this provision item. Both of the functional assessments reviewed (100%) included all of the components commonly identified as necessary for an effective functional assessment (e.g., direct and indirect assessment procedures, identification of potential antecedents and consequences of the undesired behavior), and a clear summary statement. This represented an improvement from the last review when 40% of the functional assessments reviewed were evaluated to be complete. Finally, 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. A list of functional assessments indicated that five (Individual #13, Individual #39, Individual #32, Individual #8, and Individual #114) were more than 12 months old. 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).	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The majority of EPSSLC's initial (full) psychological assessments were not current and, therefore, this provision item was rated as being in noncompliance. Only one of the 103 individuals with full psychological assessment (1%) was conducted in the last five years. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance

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K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	All individuals at EPSSLC had a current annual assessment, 100% of the annual assessments reviewed were judged to be complete, and there was evidence that all of the individuals admitted to the facility in the last six months had a psychological update within 30 days of admission. Therefore, this provision item was rated as in substantial compliance. 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 current for 100% of the individuals at EPSSLC. This represented a substantial improvement from the last review when 33% of the annual assessments were either absent or more than 12 months old. The monitoring team reviewed 11 of the 97 annual psychological assessments (11%) that were completed in the last six months, to assess their comprehensiveness. All 11 of the annual assessments reviewed (100%) contained all of the components described in K5. This represented another sharp improvement from the last review when 56% of the annual assessments reviewed for comprehensiveness were judged to be complete. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility in the last six months indicated that this component of this provision item was also in compliance.	Substantial Compliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	EPSSLC's self-assessment indicated that they believed that this provision item was in substantial compliance. Although there were improvements (described below), the monitoring team did not believe this item was in substantial compliance because it was not clear that that psychological services other than PBSPs were provided to all the individuals that needed them, that services reflected evidence-based practices, and no review of progress was available. In order to achieve substantial compliance with this provision, the facility will need demonstrate that all individuals that need services are receiving them, the need for service is documented, progress notes are included, and that the psychological services provided reflect evidence-based practices. As reported in the last review, psychological assessments, functional assessments, ISPs, and PBSPs reviewed, did not document the need for psychological services other than	Noncompliance

#	Provision	Assessment of Status	Compliance
		PBSPs. At the time of this onsite review, two individuals participated in counseling and/or psychotherapy. It was not clear why the number of individuals receiving psychological services other than PBSPs was significantly smaller than the number of individuals reported in the last review (12). Treatment plans for both of these individuals (100%) were reviewed to determine progress with this provision item. No progress notes were available for review. The treatment plans reviewed included the following: • A plan of service • Goals and measurable objectives • 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 • Procedures/plans to generalize skills learned (as recommended in the last review) The materials provided did not include: • Documentation of the need for service • Documentation reflecting evidence-based practices • Review of progress (progress notes were not available) It is recommended that need for psychological services are documented in each individual's annual psychological assessment, ISP, or PBSP. Additionally, each treatment plan should be based on evidence-based practices, and progress should be documented and provided.	
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	EPSSLC continued to make excellent progress on the quality of PBSPs. This item was rated as being in noncompliance, however, because not all PBSPs had consent, and PBSPs were not consistently implemented within 14 days of receiving consent. A list of individuals with PBSPs indicated that 43 individuals at EPSSLC had PBSPs. In the last review the facility had 88 PBSPs. Since the last review, EPSSLC discontinued several PBSPs and replaced them with mental health plans that were managed by a psychiatrist, and focused on individuals who required psychotropic medication for mental health symptoms and did not engage in serious behavior problems (see section J). This provision item will focus exclusively on PBSPs. The monitoring team, however, will continue to review the distinctions between PBSPs and mental health plans, in future reviews. As also noted in section J of this report, there was not yet any policy, procedure, or guidelines regarding mental health plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
	from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	A list of all PBSPs and last date of last revision indicated that all 43 were current (i.e., revised in the last 12 months). This represented an improvement from the last review when 82% of PBSPs were more than 12 months old. Furthermore, a list of PBSPs indicated that two recent PBSPs (Individual #8, and Individual #100) did not have consent for their PBSPs. All PBSPs should have the necessary PBSP consents and approvals. Additionally, the facility's self-assessment and the director of psychology indicated many PBSPs were not implemented within 14 days of receiving necessary approvals and consents. EPSSLC should ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents. Twenty-two PBSPs were completed since the last review, and eight (36%) of these were reviewed to evaluate compliance with this provision item. All eight PBSPs reviewed included descriptions of target behaviors, and all of these were operational (100%). This represented an improvement from the last review when 90% of the PBSPs were rated as operationally defined. All eight of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but one (i.e., Individual #32) of these (12%) identified consequences that appeared to be inconsistent with the stated function of the behavior and, therefore, was not likely to be useful for weakening undesired behavior. This represented a sharp improvement in the effectiveness of antecedent and consequent procedures reported in the last review when 30% were judged to be inconsistent with the stated function. An example of Individual #32's consequent intervention that appeared to be incompatible with the hypothesized function was: • Individual #32's PBSP hypothesized that one function of his physical aggression was positive reinforcement (a way to get things he wanted). Individual #32's PBSP stated that following the aggressive behavior he should be given a snack (an identified reinforcer). If, however, gaining access to desired objects was reinforcing for Individual #32 (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of his physical aggression. Encouraging him (and teaching him if necessary) to request desired objects BEFORE he engaged in the aggression would potentially be an effective antecedent intervention. After the targeted behavior occurred, however, Individual #32 should not be provided the desired object. 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 #77's PBSP hypothesized that one function of her self-injurious	

#	Provision	Assessment of Status	Compliance
		behavior (SIB) was negative reinforcement (i.e., a way to escape or avoid unpleasant activities). Antecedent interventions included pre-training of the task or activity, allowing her time to process the request, presenting tasks in an encouraging manner, and encouraging her use her communication strategies and tell staff what she wanted. Her intervention following SIB included blocking her SIB and maintaining her safety, while prompting every minute until she began to comply. 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 all PBSPs reviewed (100%), replacement behaviors that could be functional were functional. This represented another improvement from the last report, when 90% of replacement behaviors that could be functional were functional. All of the 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. 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). Finally, as reported in the last review, in all PBSPs reviewed (100%), the reinforcement of functional replacement behaviors was included in the PBSP. Overall, seven (Individual #32 was the exception) of the eight PBSPs reviewed (88%) 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 continued improvement over the last three reviews when 70% (July 2012), 33% (January 2012 review), and 50% (July 2011 review) of the PBSPs reviewed were judged to be acceptable.	

#	Provision	Assessment of Status	Compliance
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	There were improvements in this area, however, it was rated as being in noncompliance because interobserver agreement (IOA) was not collected, and a minimal acceptable treatment integrity level had not been established and attained. IOA was 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 an important component for determining the efficacy of treatment and for achieving substantial compliance of this provision item. Once IOA is collected, it is recommended that the facility establish minimal acceptable levels, and provide documentation that those levels are attained. Target behaviors were consistently graphed, and the graphing of replacement-alternative behaviors was recently expanded to all individuals (see K4). All of the graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path. The quality and usefulness of these graphs continued to improve at EPSSLC. As discussed in K11, all of the DCPs asked about PBSPs indicated that they understood them. They were not, however, able to consistently explain how to implement specific components of the plan. For example: • A DCP indicated that one of Individual #18's replacement behaviors consisted of him engaging in cooperative behavior, however, his PBSP described appropriate escape behavior as the replacement behavior. Confusion with how to implement and record replacement behaviors was found in several cottages among several DCPs. The only way to ensure that PBSPs are implemented with integrity is to regularly collect treatment integrity data. This represented another area where the facility had improved since the last review. The collection of treatment integrity was recently expanded to 74% of the PBSPs on campus. The monitoring team observed a treatment integrity session and found the treatment integrity tool to be an adequate method for assessing treatment integrity. A spreadsheet of integrity data levels across all treatment sites indicated treatment integrity had been variable from 9% (Individual #73, on 9/13/12) to 100% (Individual #81, on 10/12/12). The frequency of treatment integrity was also variable from 41 observations in July 2012 to a total of two treatment integrity measures in November 2012. As discussed in K4, EPSSLC recently developed a plan for establishing the frequency of treatment integrity based on the severity and frequency of each individual's target behavior. It is now recommended that the facility establish minimal acceptable treatment integrity levels, and demonstrate that those frequencies and levels are	Noncompliance

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		achieved.	
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.	All of the PBSPs reviewed appeared simple, clear and allowed for staff understanding. Additionally, all DCPs interviewed, indicated that they understood the PBSPs. Therefore, this provision item was rated as being in substantial compliance. EPSSLC utilized a "working plan" which was written so that DCPs could understand them. As a measure of this, EPSSLC monitored the reading level of each PBSP and determined that all working plans reviewed had a reading level below the 6th grade. The monitoring team also asked several DCPs across all treatment sites if they could understand the PBSPs, and they all indicated that the plans were simple and clear. Finally, review of the plans indicated that they were written in a manner that DCPs were likely to understand. None of the PBSPs reviewed, for example, contained more than three target behaviors, and technical language appeared to be kept at a minimal.	Substantial Compliance
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.	This item was rated as being in noncompliance because, at the time of the onsite review, EPSSLC did not have documentation that every staff assigned to an individual was trained on his or her PBSP. As reported in the previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Psychologists and psychology assistants conducted the trainings prior to PBSP implementation and whenever plans changed. The monitoring team observed the training of DCPs on Individual #31's PBSP. The training included a review of the PBSP by a member of the psychology department, an opportunity for DCPs to ask questions covering varying aspects of the PBSP, and written questions pertinent to Individual #31's PBSP. The monitoring team found the training to be very positive and thorough. There was, however, no system in place to ensure that all staff (including relief staff) implementing PBSPs had been trained. The facility's self-assessment indicated that 69% of staff implementing PBSPs were trained. 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 (including float staff) has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 for every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, EPSSLC had a census of 118 individuals and employed four 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 write Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).
2. The facility should establish minimum data collection reliability levels (i.e., what are acceptable data collection reliability scores), and ensure that those levels are achieved (K4).
3. Ensure that the data system is flexible (K4).
4. Initiate the collection of IOA data (K4, K10).
5. Ensure flexibility in the graphing of data in increments based on individual needs (K4).
6. All individuals PBSPs should have monthly progress notes (K4).
7. In those instances when an individual is not making expecting progress, the progress note should consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).
8. All individuals should have an initial (full) psychological assessment (K5).
9. All initial (full) 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. Functional assessments should be revised when new information is learned concerning the variables affecting an individual's target behaviors, with a maximum of one year between reviews (K5).
12. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).

13. The need for psychological services should be documented in each individual's annual psychological assessment, ISP, or PBSP. Additionally, each treatment plan should be based on evidence-based practices, and progress should be documented and provided (K8).

14. All PBSPs should have the necessary PBSP consents and approvals (K9).

15. Ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents (K9).

16. 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).

17. Establish minimal acceptable treatment integrity levels, and demonstrate that established frequencies and levels are achieved (K10).

18. The facility needs to present documentation that every staff assigned to work with an individual (including float staff) has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter (K12).

19. Revise the self-assessment so that it includes the topics that the monitoring team commented upon in the report (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: 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, October 2012, December 2012, February 2013 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 #24, Individual #161, Individual #60 Individual #104 Individual #191 Individual #117, Individual #28, Individual #31, Individual #76, Individual #52, Individual #149, Individual #123 o Annual Medical Assessments the following individuals: • Individual #23, Individual #109, Individual #125, Individual #79, Individual #1, Individual #144, Individual #8, Individual #40, Individual #56, Individual #112, Individual #103,

	Individual #59, Individual #89, Individual #20 o Neurology Notes for the following individuals: • Individual #12, Individual #15, Individual #109, Individual #77, Individual #23 Individual #28 Individual #125, Individual #70, Individual #4, individual #128 o Consultation Referrals and IPNs and for the following individuals: • Individual #23, Individual #82, Individual #4, Individual #105, Individual #85, Individual #116 o Annual Medical Assessments, Active Problem Lists, and Labs for the following individuals: o Individual #17, Individual #58, Individual #10, Individual #178, Individual #116, Individual #8, Individual #113 <u>Interviews and Meetings Held</u>: o Don Apodaca, MD, Acting Medical Director o Pam Richter, Primary Care Physician o Eugenio Chavez-Rice, MD, Psychiatrist o Linda Delgado, Medical Administrative Assistant o Laura Cazabon-Braly, Facility Director o Veronica Bahner, RN, Medical Clinic Nurse o May Ann Clark, RN, Chief Nurse Executive <u>Observations Conducted</u>: o Daily Medical Provider Meetings o Neurology-Psychiatry Clinic o Medical Clinic o Observations in cottages
	Facility Self-Assessment: The self-assessment was completed by the EPSSLC medical clinic nurse. She was a long-term employee and began working in the medical department in March 2012. Unfortunately, she had never read the Settlement Agreement or previous reports of medical care and was, therefore, not prepared to complete the self-assessment. During interviews, it was obvious that this task was beyond the scope of the duties of the clinic nurse. To her credit, however, she completed the self-assessment using the July 2012 assessment as a template. The monitoring team commented in the July 2012 report that the content and activities of the self-assessment were not particularly linked to the Settlement Agreement. Utilization of the July 2012 assessment as a template yielded similar results. The person responsible for delivery of health care services would be the most appropriate person to complete the self-assessment. However, there was no medical input in the EPSSLC assessment. It will be essential for the self-assessment to align with the topics in the monitoring team's report. The medical director should read this report, take into consideration the findings, and note the recommendations, including those within the body of this report.

	The facility rated itself in noncompliance with all four provisions. The monitoring team concurred with these self-ratings.
	Summary of Monitor's Assessment: The medical department made some progress since the July 2012 review. The current medical director assumed his position in September 2012 following the resignation of the previous medical director. However, his tenure as medical director was limited to the provision of clinical services. He reported that he was not involved with the Settlement Agreement. Therefore, he was not familiar with the content of the Settlement Agreement and had not read any previous reports. He was also not involved in the preparation of the self-assessment, presentation book, or document request. The medical clinic nurse was assigned as the lead for provision L. She admitted that she did not fully understand the Settlement Agreement and had difficulty acting in the role as the center lead. At several junctures during the compliance review, the monitoring team attempted to obtain clarification of processes and data submitted by the facility. In many instances, the medical director reported that the data submitted were not correct or he was unaware of the origin of the information. During discussions with representatives from state office, they reported that the medical director's sole responsibility was the provision of clinical care. 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. Many issues related to follow-up were noted, including delays in diagnosis and a lack of follow-up of medical issues. A significant number of individuals had refractory seizure disorder, but none were referred to an epileptologist for management. There was improvement in the completion of Annual Medical Summaries, but overall compliance with timelines remained problematic. 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. Data provided to the monitoring team did not appear consistent with document reviews completed by the monitoring team. This may have been a reflection of a very small sample size. Mortality reviews were completed and recommendations generated. The system still lacked an appropriate medical review. Moreover, there was no organized process for following the implementation and status of corrective actions The facility made no progress in the development of a medical quality program. Since the last compliance review, one respiratory policy was developed. No local policies were 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 with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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 full time medical director and two part time physicians. The part time physician employee worked eight hours on Mondays and Tuesdays, and four hours on Wednesdays. The contract physician worked eight hours on Thursday and Fridays. The facility continued the contract for weekend on call coverage. The facility maintained nearly the equivalent of two full time primary providers for 118 individuals. This was a sufficient number of FTEs for the census at EPSSLC. The clinic nurse hired in Mach 2012 continued in that position. The document request showed the caseload distributed evenly among three physicians. The medical director reported that he carried a full caseload and completed all annual assessments. 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 physician and/or the part time physician. The part time physician reported that she also did annual assessments. Clinic staff indicated that the medical director did not routinely see individuals in the clinic. He saw individuals on those occasions when one of the other physicians was not available in the clinic. **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 medical meeting. The monitoring team observed a number of these meetings. The content of the meeting was consistent with state issued guidelines. Documentation provided to the monitoring team indicated that the primary medical providers had not attended annual ISPs since August 2012. This finding was affirmed during interviews with the medical director and part time primary care physician. A complete lack of attendance by primary medical providers at annual planning meetings is a serious and fundamental barrier to the integration of clinical services and appropriate delivery of health care services. The primary medical providers should play an integral role in the planning process in terms of determining how the individual's	Noncompliance

#	Provision	Assessment of Status	Compliance
		health will impact goals, barriers, transitioning etc. **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 Center. Labs were also completed at University Medical Center and could be reviewed 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. During the July 2012 review, there was evidence that the weekend on call physician never assessed the individuals. All treatments and referrals were completed by phone. The medical director was encouraged to ensure that weekend on call physicians assessed individuals who were in need of evaluation and provide appropriate record documentation. Record reviews indicated that the pattern of telephone treatment and referral without any medical documentation persisted. Follow-up evaluations appeared problematic at the facility. Individuals who returned from the hospital were often seen once and not again until a new problem arose. The same type of documentation was noted for individuals with acute medical problems. The medical director, however, emphatically reported that individuals were seen all the time. The lack of medical documentation in the records prompted the monitoring team to seek clarification regarding the role of the primary medical provider. During interviews with the medical director and representatives from state office, numerous comments were made with reference to allied health professionals managing problems. To clarify those statements, the medical director explained respiratory and speech and language therapists were very involved in the management of individuals with pneumonia. During the weeks following the onsite review, the facility stated that acute medical problems were not managed by ancillary staff and that ancillary staff helped monitor the individuals. Furthermore, record reviews documented that primary providers frequently wrote orders that indicated actions were occurring "per pharmacy recommendations." Also, physician orders included statements, such as "per PNMT recommendations, please schedule a MBSS to assess oral and pharyngeal swallow functioning." This order for	

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		Individual #90 was written by the SLP. The presence of a co-signature was not clear. The monitoring team was concerned about the absence of medical input in meetings, such as the weight management meeting. While EPSSLC operated within the framework of the interdisciplinary team process, and required the valuable knowledge of all team members, the leadership and content expertise of medical practitioners is vital to the success of the delivery of heath care services. That expertise cannot be substituted by other allied health professionals. Overall, there was evidence that some good care was provided that benefitted the individuals supported by the facility. There were also examples of delayed follow-up and failure to follow-up on the medical care provided. 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 purpose of this review, the AMA was considered timely if it was completed within 365 days of the previous summary. For the Annual Medical Assessments included in the record sample: • 11 of 12 (92%) AMAs were current • 2 of 12 (17%) AMAs included comments on family history • 10 of 12 (80%) AMAs stated "family history not available" • 12 of 12 (100%) AMAs included information about smoking history • 1 of 12 (8%) 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: • 3 of 15 (20%) AMAs were completed in a timely manner • 1 of 15 (7%) AMAs included comments on family history • 14 of 15 (93%) AMAs stated "family history not available" • 15 of 15 (100%) AMAs included information about smoking history	

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		• 1 of 15 (7%) AMAs included information regarding the potential to transition The facility also submitted a list of recent Annual Medical Assessments for the past two years. The list included 116 names: • 68 of 116 (59%) were completed in a timely manner The medical department was in the process of transitioning to a new format for AMAs. Generally, the assessments were improving, but additional work was needed. Many continued to lack important diagnoses, which resulted in a lack of a plan from the medical provider. There was improvement in the timelines for completion of the AMAs. Notwithstanding this improvement, the compliance remained relatively low. The medical director believed that assessments were being completed in a timely manner. However, there had been no review of the data to support this statement and data submitted to the monitoring team as well as the review of records and AMAs indicated that significant improvement was needed. <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 indicated staffing was inadequate to complete this task. <u>Active Problem List</u> For the records contained in the record sample: • 12 of 12 (100%) records included an APL • 6 of 12 (50%) APLs were not signed/dated An overwhelming majority of the documents was not being updated as required. The Health Care Guidelines specify that the APL be updated as problems arise and resolve. That was not being done at the facility. <u>Integrated Progress Notes</u> Physicians documented in the IPN in SOAP format. The notes were usually signed and dated. Vital signs were included in the notes, but this was inconsistently seen. Pre-hospital notes were often not found and there was no documentation when individuals were transferred on the weekend. Post hospital documentation was also very inconsistent. That is, individuals who were hospitalized, sometimes for prolonged periods, had very little medical department documentation of follow-up once they returned to EPSSLC.	

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		Physician Orders Physician orders were overall signed, timed, and dated. Nonetheless, many problems were identified with physician orders. There were missing indications and indications that failed to use ICD nomenclature. This is discussed further is section N1. Consultation Referrals The consults and IPNs for 6 individuals were requested. A total of 40 consults completed after July 2012 (including those from the record sample) were reviewed: • 28 of 40 (70%) consultations were documented in the IPN within five working days Generally, providers summarized the recommendations of the consultants in the IPN. The more recent entries included a statement of agreement or disagreement. It was never clear if the recommendations were being referred to the IDT for integration with current supports and services. Consultation referrals are discussed further in section G2. The monitoring team recommends for each consultation, the IPN entry should include documentation of the recommendations of the consultant, a statement regarding agreement or disagreement, and a decision about referral to the IDT. The primary providers should also indicate the specific consult that is being addressed. **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. Screening for colorectal, breast, and prostate cancer were completed for nearly all individuals who met criteria. Databases maintained information on a number of clinical measures, such as cancer screenings, seizure data, diabetes, and osteoporosis. This was done by the medical department's administrative assistant. These data were not reviewed by the medical director and he was unaware if anyone else reviewed it. It was submitted to the monitoring team for review. 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: • 12 of 12 (100%) records included PCFSs	

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		• 4 of 12 (33%) forms were updated, signed, and dated <u>Immunizations</u> • 12 of 12 (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 PCFSs continued to list "no history" for several immunizations. This was noted in previous reviews and no improvement was observed during this review. The monitoring team was provided a copy of an immunization database, but data were missing. Staff in the medical department believed there was another version of the database. <u>Screenings</u> • 12 of 12 (100%) individuals received appropriate vision screening • 9 of 12 (75%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 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: • 28 of 28 (100%) males had current PSA results documented <u>Breast Cancer Screening</u> • 7 of 7 females met criteria for breast cancer screening • 7 of 7 (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 <u>Cervical Cancer Screening</u>	

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		• 7 of 7 females met criteria for cervical cancer screening • 4 of 7 (57%) females completed cervical cancer screening within past three years A list of females age 18 and older was provided. The list included the names of 52 females, the date of the last pap smear, and explanations for lack of testing: • 39 of 53 (75%) females completed cervical cancer screening • 6 of 53 (25%) females refused <u>Colorectal Cancer Screening</u> • 7 of 12 individuals met criteria for colorectal cancer screening • 7 of 7 (100%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 51 and older was provided. The list contained 51 individuals: • 48 of 51 (94%) individuals had completed colonoscopies • 2 of 51 (4%) individuals did not have colonoscopies due to guardian refusal • 1 of 51 (2%) individuals completed colonoscopies under the age of 50 for diagnosis purposes **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>Diabetes Mellitus</u> The records of 5 individuals were reviewed and data are presented below: • 3 of 5 (60%) individuals had adequate glycemic control (HbA1c <7) • 5 of 5 (100%) individuals had assessment for renal proteinuria • 5 of 5 (100%) individuals had annual eye examinations • 4 of 5 (80%) individuals received ACE/ARB for renal protection • 5 of 5 (100%) individuals received the pneumococcal and influenza vaccinations All of the records included diabetes flow sheets, but not all documents were current. Forty percent of the individuals had an elevated HbA1c indicating poorly controlled	

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		diabetes. The medical director should review the records of all individuals with diabetes to ensure that care is consistent with ADA standards. <u>Pneumonia</u> The monitoring team requested a list of individuals with pneumonia over the pat 12 months as well as AVATAR data. The facility was not using AVATAR to track pneumonia data at the time of the compliance review. For each individual, a brief summary was provided including CXR reports, antibiotics received, and the use of enteral tubes, Several individuals had radiographic findings consistent with pneumonia, but the facility did not include the individuals in the pneumonia listing. This was discussed in detail with the medical director because it appeared that the facility had under-reported the prevalence of pneumonia. For example, Individual #51 had a CXR that showed a RLL consolidation that would be consistent with pneumonia. Individual #57's CXR showed a LLL infiltrate. The document provided to the monitoring team stated for both of these individuals and others that the medical director did not consider this pneumonia. Thus, it was concluded that "no pneumonia" occurred and these individuals did not appear on the facility's pneumonia list. The medical director stated that he was unaware of where the pneumonia information originated and had never seen the documents provided to the monitoring team. Moreover, he reported that the statements attributed to him were incorrect. Based on the information provided, there were approximately 15 episodes of pneumonia reported in 2012 with three individuals having multiple episodes. As previously noted, there were also several other individuals who probably had pneumonia (based on positive radiographic findings). The true prevalence of pneumonia at EPSSLC remained undetermined. When questioned regarding the management of pneumonia, the medical director noted that the respiratory therapist and speech and language pathologist were very involved and managed most of the issues. In reviewing cases of pneumonia during interviews, there was no definitive evidence that the clinical pathways and protocols issued by state office were utilized. Most notably, the facility lacked an algorithmic approach to the management of pneumonia for individuals with recurrent pneumonia based on documentation in the records. The medical director highlighted that care was provided even if not documented. **Case Examples** Individual #161 • This individual was hospitalized in June 2011 with a pulmonary embolism and deep venous thrombosis. Following return to EPSSLC, a DNR order was	

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		implemented. As noted in the January 2012 monitoring report, the individual did not have a terminal diagnosis. Based on treatment recommendations from various consultants, the DNR was rescinded and treatment provided. In February 2012, a hematology consult recommended that this young individual be evaluated for hypercoagulable syndromes. The March 2013 neurology consult noted that results were not available. The AMA dated 5/18/12 listed two values related to this, but there was no discussion of the differential diagnosis of a hypercoagulable syndrome. At the time of the compliance review, this individual had not been appropriately evaluated for the presence of a hypercoagulable syndrome, which could have been the primary factor for the pulmonary embolus and other issues. Additionally, the presence of a hypercoagulable state alters long term medical management for this individual. Individual #52 • This individual had and abnormal mammogram done on 12/19/11. This was documented in the Annual Medical Assessment dated 4/5/12. The follow-up ultrasound was dated 7/17/12 representing a seven-month delay in follow-up. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 81 individuals. The following data regarding AED use were summarized from the list provided: • 10 of 81 (12%) individuals received 0 AEDs • 26 of 81 (32%) individuals received 1 AED • 22 of 81 (27%) individuals received 2 AEDs • 14 of 81 (17) individuals received 3 AEDs • 6 of 81 (7%) individuals received 4 AEDs • 3 of 81 (4%) individuals received 5 AEDs For the 88 individuals diagnosed with seizure disorder: • 0 of 81 (0%) individuals experienced status epilepticus • 8 of 81 (10%) individuals required transport to an acute care facility due to prolonged seizure activity • 8 of 81 (10%) individuals had VNS implantation • 57 of 81 (70%) individuals had refractory/intractable seizure disorder 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	

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Neurology Appointments 2012 -2013	
July	25
Aug	32
Sep	35
Oct	40
Nov	30
Dec	26
Jan	28

The total number of appointments was reasonable given the number of individuals with the diagnosis of seizure disorder who actually received medications. On average, 31 individuals were seen each month compared to 22 for the first six months of 2012.

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
- 10 of 10 (100%) individuals had documentation of current medications for seizures and dosages
- 70 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 consults continued to be handwritten and difficult to read. While the MOSES and DISCUS dates were listed on the consults, there was no other reference made to the side effect data provided. The monitoring team attended the neurology-psychiatry clinic. It continued to be an effective means of integrating neurology and psychiatry services.

During the last compliance review, it was noted that 65% of the individuals were classified as having intractable seizure disorder. This was noted in the report and a recommendation was made to further review these data and take appropriate corrective actions. The prevalence of refractory seizure disorder was discussed with the medical director doing the onsite review. He was not aware of the findings of the July 2012 report and, therefore, this issue was not addressed. He noted that his clinical

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		experience with the individuals appeared to indicate that these data were incorrect. The facility re-submitted the data indicating that 18 individuals (22%) had uncontrolled, refractory seizure disorder. Even so, none of these individuals was followed by an epileptologist or was being considered for more aggressive non-medical therapy. A review of a sample of physician orders showed that a number of individuals were being prescribed oral valium at bedtime for uncontrolled seizure disorder. Additional records were not available, but the medical director must ensure that those individuals have appropriate neurology follow-up. Following the onsite review, the facility reported that only one individual was on this medication, but that it had been discontinued. **Do Not Resuscitate** The facility submitted a list of individuals that had DNR orders in place. The list included one individual with a Level III DNR meaning that no resuscitative measures were to be performed. During the January 2012 review, two individuals had DNRs in place. As noted in the previous reports, 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. Documentation of IDT review of 8/1/12 was provided, but no specific statement form the medical provider was documented. The DNR for Individual#52 was rescinded on 12/21/12. Documentation in the IPN noted that the consulting cardiologist found "no evidence of CHF." The accuracy of the DNR listing must be assessed. For example during July 2012 compliance review, the medical director reported that the DNR was rescinded for Individual #107. This individual was not reported to have a DNR in place at the time of any previous reviews. Documents reviewed indicate that Individual #10 received hospice care from 6/13/12 to 9/25/12. Hospice was discontinued when the individual showed considerable improvement. DNR documentation did not include Individual #10.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of	<u>Medical Reviews</u> Rounds 6 and 7 of the external medical reviews were completed in September 2012 and February 2013, respectively. The state medical services coordinator completed Round 6 while Round 7 was completed by an independent external reviewer. A five percent sample of records (six) was examined for compliance with 30 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. Eight essential elements related to the active	Noncompliance

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	medical care and performance improvement.	problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment were assessed. 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 2013. The results of the reviews completed, based on the data provided, are represented below.	

External and Internal Medical Reviews 2011 -2013			
		Essential	Non-essential
Sep 2011	Round 3	50	41
Nov 2011	Round 4	76	68
Feb 2012	Round 5	91 (93)	96 (94)
Aug 2012	Round 6	93 (91)	77 (85)
Feb 2013	Round 7	92	96

*(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 processes and did not provide any measure of clinical outcomes. Another problem with the process was the small sample size. For Round 7, six records were reviewed. Thus, a compliance rating of 100% for Question 4 might appear to indicate that AMAs were completed as required. This was somewhat misleading given facility data showed that 59% of AMAs were completed in a timely manner. It is important to know if the AMAs were completed, at a minimum, within 365 days of the previous assessment. Similarly, it would appear that there were no issues related to physician orders since 100% compliance was achieved for Question 16, which relates to the requirement to have indications for all medications. Pharmacy intervention data and record reviews provided contradictory findings, which are discussed in section N. Finally, 100% compliance was achieved for Question 30, which evaluated the requirement to have an assessment completed when medical treatment was ordered. Record and document reviews provided numerous examples of medical treatments provided by the weekend on call physician for which no medical assessment or evaluation was documented.

In addition to the general medical audits, external medical management audits were implemented in September 2012. The facility provided results for Round 6 as seen below:

External Medical Management Audits			
	Constipation	Seizure Management	UTI Management
Round 6	60	73	43

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		Round 7 -- -- -- Corrective actions were implemented for the deficiencies identified. The monitoring team is concerned about the low compliance scores. If the scores were reflective of the actual care, the facility should have implemented major performance improvement efforts to assess and address these issues, but that did not appear to be the case. If the scores reflected a process that cannot accurately assess performance due to problems, such as sample size, that should have been addressed as well. <u>Mortality Management at EPSSLC</u> At the time of the review, all death reviews were completed. Since the last onsite review, there was one death. Information for that death is summarized below: • The age of the individual was 37 years • The causes of death was sepsis, bowel obstruction, and renal failure • An autopsy was performed • The individual died in the hospital The facility completed a series of reviews for each death. A medical director from another SSLC participated in the review process for the most recent death, but there was no written report of the findings. Moreover, the reviews did not appear to take into consideration the cause of death and events over the past year. That would require an evaluation of the care surrounding the bowel obstruction that occurred several months prior to death. Reviews focused on the care immediately prior to the death. The monitoring team met with the medical director, chief nurse executive, facility director, and QA director to discuss mortality management at EPSSLC. Corrective actions were generated from the mortality process and several were outstanding at the time of the compliance review. There was no formal process in place to follow-up on the status of the recommendations. The committees met only to review information for newly deceased individuals.	
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;	As previously discussed, there was no progress in this area. The facility did not have a structured medical quality program. A comprehensive set of measures had not been identified and the medical director had not conducted any reviews of data or engaged in any activities that would provide and assessment of the quality of care provided. Because no such activates occurred, discussions with the monitoring, team did not reveal any new information. The medical director was not familiar with the data submitted in the document request. In fact, for much of the data, such as the number of individuals with refractory seizure disorder and the data related to the incidence of pneumonia, the	Noncompliance

#	Provision	Assessment of Status	Compliance
	identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	medical director believed, based on anecdotal experiences, that the data were inaccurate. The facility had not outlined a plan or system to implement a medical quality program. The lack of oversight of the medical care will make it difficult for the facility to move forward. Metrics of good care must be established and the care provided to individuals measured using these metrics. A medical quality program requires that the facility measure what it is doing and take appropriate corrective actions when the measured care falls short of the desired care. For example, because the facility did not measure care provided, the important metric of refractory seizure disorder was not addressed. The result of this was the failure to refer several individuals with uncontrolled seizure disorder to the appropriate specialist for management. In moving forward with this provision, the medical director should review the various indicators discussed in provision L1. 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. These guidelines had not been localized. The part time physician was not definitive regarding the receipt of these guidelines. The medical director indicated that they were provided during orientation. A procedure, Oxygen Therapy Equipment/Supplemental Therapy was developed since the July 2012 compliance review. The facility had not developed any other local policies related to the state issued guidelines since the last review. The medical director must ensure that all clinical medical staff, employees, and contract physicians are appropriately trained on medical policy, procedures, and protocols. The medical director must maintain documentation of such training. A process should also be developed to ensure that all policies and processes are consistent and congruent with state issued guidelines.	Noncompliance

Recommendations:

1. The facility director must address the issue of hiring a full time medical director who will have the responsibility for guiding the delivery of health care services at the facility (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 of the assessments, treatment plans and nee for follow-up (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 medical director should address the immunization database by correcting data (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 facility should implement a multidisciplinary process to review individuals with pneumonia and ensure that pneumonia is accurately categorized and treatment plans are appropriate.

15. 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).

16. 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).

17. 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).

18. 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).

19. 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).

20. 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:** Documents Reviewed: 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 3/6/13) 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, 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 1/1/13-2/28/13 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 Most recently completed medication monitoring tools/audits for 5 nurses o Bowel record/log for Individual #126 for 1/1/13 – 3/22/13 o Admission Nursing Assessment for Individual #149 o Nursing Department's Actual/Working Schedule for 1/1/13 – 3/22/13 o Revised Quarterly Nursing Review/Assessment Form with guidelines/instructions for completion o Examples of Weight Database Reports o Action Plan developed by CNE and Director of Pharmacy to address findings of research project

	o Monthly Infection Control Audits for 12/12 – 2/13 o Compliance rates for PPD tests – individuals and employees for 1/13 – 2/13 o Weight Management Algorithm o Current CPR certification for nurse – AS o State Office Guidelines for QA Nursing Process o Nursing Department's CAP in response to QI Death Review of Individual #191 o QA Walk-Thru Reports for 9/12 – 3/13 o Current schedule of medication pass times, nursing daily assignments, and shift duties for nurses 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 For the last six individuals who transitioned to the community, their completed nursing discharge summary o Records of: • Individual #123, Individual #52, Individual #50, Individual #66, Individual #89, Individual #34, Individual #73, Individual #126, Individual #178, Individual #24, Individual #25, Individual #8, Individual #149, Individual #115, Individual #4, Individual #70, Individual #32, Individual #100, Individual #112, Individual #3, Individual #111, Individual #162, Individual #90, Individual #81, Individual #67, Individual #152, Individual #134, Individual #12, Individual #144, Individual #57, Individual #59, Individual #10, Individual #72, Individual #46, Individual #71 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Mary Ann Clark o Nursing Operations Officer/Hospital Liaison/ Skin Integrity Nurse, Martha Manriquez o Infection Control Nurse, Margaret Amada o QA Nurse, Elaine Lichter o Nurse Educator, Kim Golucke o Nurse Manager, Segrid Maynez o Nurse Manager, Dulce Tullez o Program Compliance Nurse, Belinda Padilla <u>Observations Conducted</u>: o Medication administration observations on selected units o Emergency medical equipment checks on all cottages and Systems Building o 3/18/13 ISP for Individual #50 o 3/19/13 Medication Variance Committee Meeting o 3/21/13 Weight Committee Meeting

	Facility Self-Assessment: EPSSLC submitted its self-assessment, which was updated on 3/6/13. Since the prior review, the Chief Nurse Executive (CNE), Center Lead for section M, again changed the content from what was presented the last time. In that regard, the CNE not only 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, she made certain that the self-assessment included almost everything that the monitoring team looks at by provision item. It was clear that the CNE had taken time to closely read the monitoring team's report and review the extensive notes that were taken during the CNE's meetings with the monitoring team when all topics pertaining to section M were reviewed and discussed at length. Thus, the facility's self-assessment lined up with the topics in the monitoring team's reports. So, for example, in section M1, the CNE reported that he Nursing Department engaged in activities related to staffing and supervision, coordination of care during individuals' hospitalizations and/or transfers to/from hospital emergency room departments, weight oversight and management, infection prevention and control, immunization, and skin integrity. Of note, all of the aforementioned activities were relevant to the facility's review of status toward compliance with this provision item. Although the CNE planned to further align her self-assessment with the monitoring review and report, the monitoring team wanted to again acknowledge the job well done by the CNE to successfully move the self-assessment process forward. The facility rated itself as being in noncompliance with all provisions of section M, except M6. The monitoring team agreed with all of the ratings for M1-M5, but disagreed with the facility's finding of substantial compliance for provision M6, which required that the facility implemented nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care, provided the necessary supervision, and conducted training to minimize medication errors. Section M6 of this report provides additional detailed and specific information related to the monitoring team's finding of noncompliance with this provision item.
	Summary of Monitor's Assessment: The monitoring team was pleased to report that under the leadership of the CNE, the Nursing Department continued to make progress toward meeting the provisions of the Settlement Agreement. In addition, nursing leadership affirmed their expectations for nurses to provide care that met the provisions of the Settlement Agreement, Health Care Guidelines, and accepted standards of practice related to assessing, planning, intervening, evaluating, and ensuring proper care was provided to meet the health needs of the individuals who resided at EPSSLC. Improvements were noted in the facility's self-assessment for Section M, which was very well done. It closely followed the outline of the monitoring report and thoughtfully addressed the recommendations put forward in the report.

	Nurses were recruited and hired to fill pivotal positions within the department. For example, a new Nurse Educator, who was a former nursing instructor in the community and well known by a number of the EPSSLC LVNs, was recently hired. She had already developed a plan to bring the nurses' competency based training and evaluations up to date and implement the state's education initiatives. A Program Compliance Nurse, was hired in February 2013, and she started conducting monitoring reviews and audits of nurses' implementation of assessment and reporting protocols. Under the guidance and direction of the CNE, the Program Compliance Nurse collaborated with the QA Nurse, in accordance with the state's new QA Nursing Policy/Procedure. Together, they were working on implementing these new processes. The Infection Control Nurse continued to build the facility's infection prevention and control program. During the short time that the IC Nurse worked at the facility, she not only reinstituted the Infection Control Committee, conducted environmental surveillance, drafted policies and procedures, and always participated, if not led, the facility's activities to prevent the spread of contagious infections at the facility, she developed immunization and infection databases that provided the facility with easy access to critically important health information. All of the above would not have been possible without nurses in leadership positions in the Nursing Department working together with the direct care nurses to improve the quality of nursing care at the facility. However, one of the problems that plagued the Nursing Department and stood to continue to hinder its progress toward compliance was that nurses were frequently shifted to, and shared with, other departments. If this problem were to continue, it would likely undermine the department's progress toward achieving compliance with the provisions of section M. The areas where the Nursing Department continued to need improvement were in its ability to ensure timely and appropriate responses to changes in individuals' health. The Nursing Department also needed to consider how it would ensure that its assessments would meet the standard of practice and the Health Care Guidelines. In addition, the Nursing Department needed to continue to work on improving their performance related to the integrated risk rating and integrated health care planning processes. Finally, the review continued to reveal problems with nurses properly administering medications in accordance with generally accepted standard of practice. Of the five scheduled medication administration observations that were made on different days and different shifts, only one nurse administered medications in accordance with standards of practice. The problems that were observed included failure to properly check the MARs, failure to properly maintain sanitary conditions and infection control practices, failure to follow the PNMPs, which put individuals at risk of choking and aspiration, and failure to use appropriate clinical judgment.

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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's Nursing Department reported a number of initiatives underway, which would bring the department into substantial compliance with this provision item. First, they reviewed the Nursing Department's staffing needs, recruitment and retention, scheduling, unscheduled absence, use of overtime and agency nurses, RN case manager caseloads, and nurses' daily duties. The presence of capable, competent, qualified nurses was an important first step toward ensuring that individuals' health problems and changes in their health would be readily identified, assessed, reported to the physician, addressed via nursing care interventions, monitored, and appropriately documented in the individuals' records. Second, the Nursing Department continued to conduct reviews of nurses' training records, medical emergency equipment checklists, discharge summaries, issuance of the state's assessment and reporting protocols, and the data analyst's reports from selected monitoring tools, such as infection control, chronic respiratory distress, skin integrity, and documentation. Based upon the Nursing Department's assessment of the aforementioned aspects of the delivery of nursing supports and services, they concluded, "This provision remains as noncompliant due to the continuing nursing documentation short falls. Although nursing documentation remains problematic for the EPSSLC Nursing Department, data results of the documentation audit tools indicate a slow, steady improvement...great strides have been made in the area of developing and maintaining EPSSLC's infections control program..." 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 at least once, daily observations of nursing care were made, 15 nurses were interviewed, 20 individuals' records were reviewed in-depth, and an additional 15 individuals' records were reviewed across specific areas of nursing care, such as performance of assessments, development of plans of care to address infection prevention and control needs, and implementation of infection prevention and control practices. As a result of the review, 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, addressed, and documented.	Noncompliance

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		Staffing, Structure, and Supervision According to the facility's self-assessment, for the first time in a long while, there was "stability of the nursing department." The pride of the Nursing Department was evident in this area of their self-assessment. They received approval to upgrade specific RN positions and fill the position of the Program Compliance Nurse, and as of the monitoring review, they wasted no time upgrading the RN positions, filling almost all RN positions, and hiring a Program Compliance Nurse. In addition, the Nursing Department conducted an analysis of unscheduled absences, and based upon the results, which appeared to be an increasing trend in unscheduled absence over the past six months, addressed "excessive call-ins," in accordance with the facility's positive performance procedures. The Nurse Department reported that, over the past six months, despite the staffing problems that they encountered, they met their minimum staffing requirements through modifying nurses' schedules, redeployment of nurses across the campus, and utilization of mandatory overtime by LVNs and RNs and contract agency nurses. Of note, also for the first time, the Nursing Department presented to the monitoring team the results of their analysis of turnover rates, which revealed that one of the challenges that continued to face the department was how to develop successful and innovative strategies to retain nurses, especially RNs. Also, a review of the monthly Nursing Staffing Reports revealed that use of agency nurses continued to be 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) continued to work evening and weekend shifts to ensure administrative 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 that were noted in the prior review and sustained. During the prior review, the monitoring team challenged the CNE and her leadership team to come up with ways 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. To that end, the CNE and NOO, with input from the nurse managers, developed an outline of daily duties and responsibilities that were expected to occur at a certain time of day and within a specific time frame. Although the nurse managers had adequate flexibility to meet the changing needs of the individuals they served, the outline provided them with a structured set of expectations to follow.	

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		Recordkeeping and Documentation The Nursing Department reported that as a result of the department's sustained efforts to improve nurses' documentation of all facets of the nursing process, "steady improvement was noted in nurses' adherence to the SOAP format of documentation. Notwithstanding this positive finding, the department also reported a decline in the percent of nurses who complied with the expectations and guidelines for documenting nursing care, in accordance with the assessment and reporting protocols. Of course, this begged the question of whether or not nurses were failing to document, failing to implement nursing care, or both. (See Section M4 for more information regarding this problem.) The monitoring review revealed that, although all individuals' records were organized in a unified form/format, and the format of nurses' notes was usually in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format, which was consistent with the state's standardized protocol, there continued to be serious problems with nurses' documentation. The content as well as signature/credentials appearing in a number of nurses' notes were not legible. A number of entries across most of the individuals' records reviewed were out of chronological order. In addition, some nurses' notes failed to have the time of the entry documented on the note. Some nurses' notes included partial dates, such as "10/ /12," referenced no time of the entry, and were not in SOAP format. These problems made it difficult and many times impossible to know when critically important nursing assessments were conducted and when equally important interventions were delivered, and, in some instances, raised question over the authenticity of the entries. Nursing notes continued to be written on the margins of the IPNs rather than new IPNs, and some nurses continued to document references to changes in individuals' health with phrases that were not meaningful or consistent with standards of practice. For example: • Many nurses' assessments of vital signs were limited to, "WNL." • Nurse's assessment of an individual with cellulitis was limited to, "R LE...is the same color as other leg. Both are discolored..." • Nurse's assessment of an individual with abdominal distention was limited to, "...Changes in abdominal girth noted, not measured but can tell it is larger..." • Nurse's assessment of an individual with lower extremity edema was limited to, "...she has L leg more big than the R leg...0 sign of swelling..." • Nurse's assessment of an individual with diabetes suffering from an alteration in skin integrity was limited to, "S: Rash. ABD rash to fold of ABD. Applied [medication]. Bright red." • Nurse's assessment of an individual who suffered a seizure was limited to, "He had a seizure today and appears anxious at this time."	

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		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. (Also see section V of this report, on recordkeeping.) 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 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." Four of the 20 individuals selected for in-depth review were hospitalized one or more times during the period of 10/1/12 – 3/22/13 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 daily 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 continued to benefit from the oversight and advocacy of the NOO/Hospital Liaison. For example, a review of Individual #126's record revealed that throughout her eight-day hospitalization for treatment of abdominal distention and possible small bowel obstruction, the Hospital Liaison regularly collaborated with the tertiary care professionals, family members, and other EPSSLC clinical professionals. In addition, she intervened to assist hospital staff and Individual #126's direct support staff member better manage and address Individual #126's behavior manifestations, which resulted in her release from four-point restraint. EPSSLC's NOO/Hospital Liaison carried out her duties in earnest. Regardless of the day of the week or weekend, the NOO/Hospital Liaison managed the oversight of all hospitalized individuals. It was reported to the monitoring team, that the next step that	

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		the NOO/Hospital Liaison planned to take to further improve the continuity of hospitalized individuals' care was to develop a system where individuals' appointments with non-facility clinicians would be scheduled prior to their discharge from the hospital. The monitoring team agreed that this step was a worthwhile endeavor. Notwithstanding these positive findings, the monitoring team's review of seven individuals' Post Hospital/ER/LTAC Nursing Assessments revealed that they continued to need a lot of improvement. All of the assessments were missing one or more important components of the assessment. For example, there were many occasions when the assessments failed to provide evidence that the individuals' nurses reviewed their hospital discharge summaries, reconciled their medications upon return to EPSSLC, communicated pertinent information to other clinical professionals and/or other IDT members, and developed and implemented appropriate health care plans to address the changes in the individuals' health status and needs. In addition, many of the assessments failed to reveal that the individuals' RN case managers had read and reviewed the assessment upon its completion. <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." EPSSLC reported that the results of their recent monitoring of compliance with the provisions of the Settlement Agreement and Health Care Guidelines that pertained to skin integrity, revealed that they continued to have serious problems, that is 20% to 60% compliance, in ensuring that individuals with alteration in skin integrity would be promptly identified and reported, addressed by the nurse via planned interventions in the individuals' health care plan, and documented daily until resolved. In addition, a review of the documents submitted by the facility revealed that since the prior review, the chairperson of the Skin Integrity Committee resigned, and the responsibilities related to developing a committee that would review data related to skin integrity issues, analyze data for patterns, and formulate recommendations for preventative measures and management were assigned to the NOO/Hospital Liaison. During the monitoring team's interview with the NOO/Hospital Liaison/Skin Integrity Nurse, she reported that she conducted weekly skin assessments on all individuals with alteration in skin integrity, but only documented the results of her assessments and the	

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		plans to address the problems on the "more serious" individuals. Clearly, the NOO/Hospital Liaison/Skin Integrity nurse had good intentions and did the best she could to develop a skin integrity program, however, she frankly reported that she was open to help with conceptualizing it, organizing it, and implementing it at EPSSLC. During the prior review, the facility's former Nurse Practitioner reported that she was assigned the responsibility for developing and implementing the facility's program of addressing and managing individuals' skin integrity problems and planned to work with the Infection Control Nurse to establish a skin integrity database and Skin Integrity Committee. As of the review, there was the very beginnings of a database and a committee that met quarterly, however, there were not yet reviews of data related to skin integrity issues, no analyses of data for patterns, and no formulation of recommendations for preventative measures and management, except for one project that was initiated by the Infection Control Nurse to identify and address the health issues of individuals who suffered from recurrent fungal infections. <u>Infection Control</u> According to EPSSLC's self-assessment, since the prior review, "great strides have been made in the area of developing and maintaining EPSSLC's infection control program owing to the efforts of the Infection Control Nurse." The monitoring team agreed with the facility's self-assessment, and the review revealed a number of improvements. For example, since the prior review the following occurred: 1) an infection control data tracking system and immunization database were developed, 2) a baseline infection control surveillance tool was completed and used by the Infection Control Nurse during her monthly rounds across the campus, 3) facility infection prevention and control policies, such as hand hygiene, blood borne pathogens, MRSA containment, and use of negative pressure isolation room, were revised, and in some cases re-written, 4) education and training was provided to staff at all levels, 5) communication and collaboration between the Infection Control Nurse and the Residential Supervisors was established and "extremely well-received," 6) Infection Prevention and Control Committee meetings were re-established, 7) case studies of individuals who suffered MDROs were conducted, and a root cause analysis of candida infections was completed and reviewed with the facility's physicians and Pharmacy Director. The root cause analysis of the candida infections was very well done, and it resulted in eight recommendations that were relevant and applicable to the individuals who suffered the infections, as well as other individuals who were at risk of developing the infection. For example, the recommendations for ensuring that skin folds were kept clean and dry, removing adult incontinent briefs at night, and developing toileting	

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		programs for specific individuals who would benefit from toileting after meals, were simple, basic strategies that, if implemented, could reduce the likelihood of infection its complications. A review of EPSSLC's Infection Control Committee Meeting minutes revealed a robust agenda that included reviews of old and new business, infection trend and cluster reports, MDROs, pneumonias, compliance with immunization and vaccination schedules, policies/procedures, proposed training agendas, and a round table discussion. The core members attended the meetings, and there was evidence of their discussion of patterns and trends, description of action(s) to address problems, and determination of the status of progress toward completion of the action(s). The facility's compliance rates for PPDs for individuals and employees for January 2013 and February 2013 was 100% compliance. However, in 2012, it was discovered that approximately 20% of the individuals at the facility at some point in time had converted from a "PPD negative" to "PPD positive" status. In September 2012, of those individuals who converted, 12 individuals tested positive on their quantiferon tests, which meant that these 12 individuals were infected with TB, but none were reportedly diagnosed with active tuberculosis. However, despite the variation in the individuals' age, co-morbid conditions, medical histories, risk factors, gender, etc., the El Paso Department of Health physician recommended that no one receive treatment of his or her latent TB infection. In addition, all individuals had the same recommendation; "This patient is cleared medically in regards to TB <u>at this time</u> (emphasis added). This patient is not a candidate for latent TB therapy," and no one had a documented rationale for why he or she was not a candidate for treatment. Upon the monitoring team's request for the individuals' health care plans, all individuals, except Individual #115, had a 3/22/13 Positive PPD HMP filed in their record and/or a reference, albeit brief, to his/her latent TB infection status referenced in his/her IHCP. Subsequent to the onsite review, the facility and state office obtained another opinion from a DSHS physician who concurred with the El Paso Department of Health physician. A rationale for why each individual was not a candidate, however, was not provided. At the time of the review, it was apparent that the facility's prior report of "instability" in their infection prevention and control program was no longer the case. Thus, it was not surprising that the monitoring team's review of the facility's data analysis reports and audits of the infection prevention and control program revealed high scores for many aspects of the facility's program. However, the areas that continued to fail to show positive results were those aspects of the infection prevention and control program that required nurses to implement specific nursing care duties in response to actual infections and/or the increased risk of infection suffered by individuals who reside at the facility. So, for example, the facility's reports revealed low scores for obtaining full sets of	

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		vital signs in response to signs/symptoms of urinary tract infections, conducting complete assessments every shift until symptoms were resolved, assessing and documenting on the last day of antibiotic therapy, identifying what interventions were done to prevent dehydration, and so on. A review of the sample individuals' records revealed problems with nurses' responses to individuals with actual infections and those at risk of developing infections. For example: • The health care plans of five individuals who suffered c.difficile intestinal infections were reviewed. Although the five individuals had very different abilities, behavior challenges, co-morbid conditions, health needs, and health risks, all of them had identical HMPs, including the interventions, which were verbatim across all five individuals. In addition, although four of the five individuals were men, three of them had HMPs that referred to them as women. And, although one of the five individuals was a woman, her HMP referred to her as a man. These errors raised concern over the adequacy and appropriateness of the planned interventions to meet the individuals' needs. And, it raised question regarding the nurses' review of the plan prior to filing it in the individuals' record for staff members to follow. • On 2/16/13, Individual #8 was diagnosed with herpes zoster. There was no evidence that his nurses assessed and monitored his painful, contagious rash at least once a day until it was resolved. • Individual #8, who was a diabetic, also suffered a foot ulcer that tested positive for MRSA. There was no evidence that his nurses assessed and monitored his infection at least once a day until it was resolved. • Over the past six months, Individual #100 was one of several individuals who suffered from conjunctivitis. There was no evidence that his contagious eye infection and his response to his antibiotic was monitored in accordance with the standards of infection control and the assessment and reporting protocols. <u>Emergency Response</u> A review of the state of medical emergency equipment at EPSSLC continued to reveal improvements upon the problems that were noted during the prior reviews. All residential areas were visited during the review of medical emergency equipment. The AEDs were charged and accessible for use in emergencies, the emergency medical equipment for Dorms A, B, and C continued to be stored in one central location, and, across most of the cottages, emergency medical equipment was clean, organized and stored on carts in the record rooms. The only exception was on Cottage 507 where the oxygen tanks were checked as though they were full when they were actually empty. The facility's NOO and respiratory therapist immediately addressed this problem. Notwithstanding these positive findings, there continued to be problems related to	

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		enforcing the facility's expectations for its nurses to make sure equipment was in working order. For example, there were missing checks of emergency medical equipment on Cottages 506, 508, 509, and 511. Also, since the prior review, the facility ensured that they addressed and implemented the recommendations of the Special Task Force to address the "critical and complex issues" of oxygen use and equipment at the facility. During the onsite review, the QA Nurse reported that the comprehensive guidelines, protocols, and procedures related to oxygen use, equipment, and storage that she had drafted had been reviewed and approved. A review of Emergency Drill Checklists for 1/1/13-2/28/13 revealed that approximately 60 drills were conducted during the two-month period. However, as noted during all prior reviews, although nurses continued to participate in over 95% of 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 approximately 80% of these drills. Since the prior review, EPSSLC stepped up its response to staff members, including clinical professionals, who failed to implement the facility's medical emergency policy and procedures during drills and/or actual emergencies. During one of the drills conducted during the two-month period reviewed, a nurse failed to carry out his/her duties. The drill instructor noted that the drill "failed" and notified the Nursing Department. The NOO immediately responded, imposed a Level 1 disciplinary action, and reviewed with the nurse his/her responsibilities during a medical emergency. <u>Significant Changes in Individuals' Health Status</u> According to the Health Care Guidelines, all health care issues must be identified and followed to resolution. In addition, documentation of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate and recovery underway until such time as the problem is resolved. In addition, the 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.	

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		Diet, Nutrition, and Weight During the prior review, the monitoring team identified serous problems with the management of individuals' diets, nutrition, and weight. During the onsite review, the monitoring team met with the facility's newly hired full-time dietician, diet technician, CNE, NOO, and facility director to hear about the many changes that were made to address the diet and nutrition needs of the individuals who reside at the facility. Since the prior review, seven new wheelchair scales were purchased to replace the worn out chair scales in the cottages. A new Weight Committee was established, and it met on a weekly basis. All individuals at the facility were weighed weekly, and if there were three or more pounds difference from the individuals' prior week's weight, they were re-weighed the following morning. Only direct care staff members with advanced training were permitted to weigh the individuals. The RN case managers reviewed the individuals' weight data every week, and they sent out weight notification forms when/if significant changes were noted in individuals' weights. During the daily morning medical meeting, all individuals with diet and nutrition concerns and/or pending dietician consultations were reviewed. The dietician developed a log of service recommendations to help ensure that recommendations were implemented and follow-up to resolution occurred. QDDPs conducted IDT meetings on behalf individuals with diet and nutrition problems and completed ISPAs that addressed their diet and nutrition issues. The QDDP Coordinator regularly reviewed the ISPAs. In addition, the PNMT RN monitored individuals' weights and made referrals to the PNMT as needed. During the onsite review, the monitoring team also attended the facility's newly established Weight Committee meeting. The meeting was very well organized and attended by representatives from all disciplines. Individuals with diet and nutrition issues were reviewed, and action plans were developed to meet their identified needs within an established time frame. The collaboration between the discipline representatives that occurred during the meeting was productive and resulted in plans to address problems at mealtime, obtain individuals' food preferences, and/or offer meal substitutes, other than Ensure, etc., to individuals who frequently refused meals and/or presented challenging situations at mealtime. During the committee meeting, one of the members of the monitoring team recommended that the committee should consider health status indicators, such as pre-albumin levels, in addition to changes in weight during their reviews of individuals' nutrition status. The committee agreed to incorporate these data into their weekly reviews.	

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		Other Significant Changes in Individuals' Health Status 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 his or her 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. Across all records reviewed, there were 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 1/23/13, Individual #66 suffered a spiral fracture of his distal fibula and a displaced fracture of his medial malleolus. He went to the emergency room for an evaluation, and there he received a cast to his right lower leg. Upon his return to EPSSLC, Individual #66 was partially assessed by his nurse, who was unable to complete the assessment due to his "uncooperativeness." It wasn't until almost 12 hours later that Individual #66's nurse noted that he had "possible pain," and an attempt was made to obtain his vital signs. There was no evidence that Individual #66's nurse conducted, or attempted to conduct, an assessment of his pain or an assessment of his health status, including, but not limited to circulatory status of his right leg. • On 3/4/13, Individual #178 was seen in the medical clinic for a change in his health status. He was diagnosed with bilateral conjunctivitis and prescribed antibiotic ophthalmic drops. Over the next several days, there was no evidence of follow-up nursing assessments to monitor Individual #178's responses to his change in health and antibiotic therapy. • On 3/11/13, Individual #149's physician noted that he tested positive for fecal occult blood, which was indicative of bleeding somewhere in the gastrointestinal tract. There was no evidence that his nurses conducted any monitoring or assessment of his health status until 3/20/13 when his nurse simply noted, "Still refuses to cooperate on the collection of sample for hemoccult testing. Only	

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		sample collected and tested was on 3/10/13 at 1930 tested positive for presence of blood in stool." As of the monitoring review, there were no other nurses' notes documented in Individual #149's record.	
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, discharge, quarterly, annually, and as indicated by changes in the individual's health status. Properly completed, the standardized Comprehensive Nursing Assessment, Post-Hospital/ER/LTAC Assessment, and Nursing Discharge Summary 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. The presentation book for section M showed evidence of the Nursing Department's audits of nurses' documentation of their assessments of subjective and objective data and planning to meet individuals' health needs. A review of the results of the audits revealed that nurses' documentation was very likely to be "accurate and truthful," but much less likely to include enough information to meet the requirements of the assessment and reporting protocols and very unlikely to result in changes to the individuals' plans of care. According to the self-assessment, 100% of the RNs hired before March 2013 completed the physical assessment course, and 64% of the RNs and 74% of the LVNs completed the documentation course. Also, since the prior review, EPSSLC distributed all of the state's assessment and reporting protocols to all of its 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, constipation, infection, etc. The review of 20 sample individuals' records, one recently admitted individual's admission assessment, and six individuals discharge summaries continued to reveal that nursing assessments, especially those that occurred as indicated by the individual's	Noncompliance

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		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 monitoring team's rating was consistent with the facility's self-rating, which was also noncompliance because, as reported by the facility, "the Nursing Department does not have an adequate system to evaluate comprehensive nursing assessments for the correct analysis of assessment data thus ensuring complete and accurate nursing diagnoses and subsequent nursing interventions developed addressing identified risk..." The facility's self-assessment further reported that the Nursing Department planned to implement monitoring of the nurses' comprehensive assessments, which would, hopefully, assist them in developing strategies for the RN case managers to better utilize and analyze assessment data. Across the entire sample of individuals reviewed, nursing assessments had many of the deficiencies described below. Of note, these deficient practices were found during all prior reviews: • Three of the 20 sample individuals reviewed failed to have current quarterly nursing assessments filed in their records. • Current active problem lists were incomplete and not up-to-date. • The majority of nursing assessments failed to show meaningful reviews of individuals' response to and effectiveness of all of their medications and treatments. • The "consultation" sections of the assessments were not in any type of order. They were not chronological, alphabetical, grouped by specialty area, or presented in any other type of useful order. Thus, making sense of what happened to individuals, when it happened, why it happened, and how it happened was difficult, and, in some cases, almost impossible. • Dates and results of mealtime monitoring were inconsistently reported across the sample individuals. • Tertiary care reviews were incomplete. • Individuals' significant histories of chronic and acute conditions, including, but not limited to, respiratory illnesses and infections, heart disease, skin breakdown, 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	

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		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 almost always 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 the same 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 continued to fail to provide concise recapitulations of the individual's health status over the review period. • The review of the six Nursing Discharge Summaries revealed the following: o Only one of the six summaries referenced recommendations for supporting the individual's health in the community. o The format of the summaries differed across all individuals. For example, some referenced the individuals' current medications, and others did not. o The "summary" sections of all individuals' discharge summaries completely failed to provide succinct, comprehensive reviews of the individuals' health. So, for example, the summaries failed to reference the level of the individuals' participation in their health care, the degree of their adherence/non-adherence to planned health interventions, their responses to planned health interventions, etc., all of which, if documented, would have been exceedingly relevant and helpful to a community provider. o The discharge summaries more often raised questions than provided answers to community providers' potential questions. For example, one individual's discharge summary noted that on 4/10/12, it was the "plan" for her to stop taking birth control, but there was no information about whether or not she was sexually active, knowledgeable of her sexual health and risks, etc. In addition, the summary section of her report referenced other vague phrases, such as "When she voices a recurrent concern, she usually requires some type of intervention." o The nursing diagnoses were often incomplete and usually failed to reference the individuals' chronic problems, such as constipation, oral hygiene, etc.	

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		The following examples from this sample indicated the seriousness of the problems with comprehensive nursing assessments at EPSSLC. • Individual #24 was a 45-year-old woman who suffered from intractable seizure disorder, severe allergic rhinitis, ataxia constipation, dry skin, problems with oral hygiene, exercise induced hypoxia, and blindness in her right eye. Her comprehensive nursing assessments failed to provide a complete list of her current, active medical problems, and left many important sections, such as toileting, awareness, behavior, infection history, and portions of her physical assessment, were left blank. Thus, as noted in all prior reports, her IHCP and ACPs failed to completely address her health needs and risks. • Individual #66 was a 42-year-old man who was diagnosed with seizure disorder, constipation, excessive drooling, vitamin D deficiency, hypothyroidism, osteopenia, akathisia, and onychomycosis. Individual #66's most current comprehensive nursing assessment was completed one day before he suffered a fall and a spiral fracture of his distal fibula and a displaced fracture of his medial malleolus. Thus, many sections of his comprehensive assessment failed to portray his health status and needs. There was no evidence that a comprehensive assessment to address the significant changes and evaluate their impact on his health status and needs was completed • Individual #70 was a 33-year-old man who was diagnosed with seizure disorder, quadriplegia, contractures, osteoporosis, GERD, constipation, seborrheic dermatitis, dermatitis of left elbow, tinea corporis, excessive salivation, and hyperammonemia. In addition, he was more than 30 pounds below the low end of his DBW range, and his physician noted that he "continues to be very thin in spite of receiving high calorie snacks..." His current comprehensive assessment failed to provide evidence of his nurse's review of his neurology consultation, which was completed two months prior to his assessment. In addition, his nurse's assessment failed to evaluate his response to and effectiveness of his medications and treatments, such as his skin treatments that went on for weeks and months. There were also sections of his comprehensive assessment that were left blank.	
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	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.	Noncompliance

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	conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	In addition, since the prior review, the state's policy and procedures for completing an Integrated Health Care Plan on the basis of interdisciplinary reviews of data, assessment reports, current plans, such as the ISP, PBSP, and PNMP, the PSI, and the IRRF, were in full effect at EPSSLC. Thus, at the time of the monitoring review, 11 of the 20 sample individuals' records included IHCPs and ACPs, two of the 20 sample individuals' records included partially completed IHCPs, HMPs, and ACPs, and one of the 20 sample individuals' records included a draft IHCP and ACPs. During the prior 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 focusing on their main tasks occurred on a weekly, if not daily, basis. Notably, since the prior review, all of the aforementioned obstacles were addressed by facility administration, as well as the Nursing Department. According to the self-assessment, meetings between the RN case managers and the Medical Clinic staff were conducted to help improve their working relationships, RN case managers were granted access to the University Medical Center lab data, the RNs job descriptions were reviewed and revised to help lessen the RN case managers' time spent providing direct care, and the State Nursing Coordinator provided training to all RN case managers on the IHCP and IRRF. According to the facility's self-assessment for section M3, since the prior review, random audits of IHCPs for compliance with the process and content were conducted, random reviews of samples of ACPs to ensure that they were individualized to meet the needs and risks of the individual were done, and the processes for identifying and responding to individuals' pain were completed. According to the self-assessment, the informal results of the aforementioned audits and reviews revealed that that IHCPs were being developed and discussed as an integrated effort by the IDT, and the eight IHCPs reviewed were completed per policy guidelines. However, the facility concluded that the random reviews of samples of ACPs were an "inadequate process for review of individualization and development of interventions related to risk." In addition, the Nursing Department found that they did not have an adequate policy to identify and address individuals' pain. Thus, the Nursing Department reportedly developed and implemented a pain policy.	

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		Regrettably, the monitoring team's review of nurses' implementation of the pain policy failed to reveal that they were adhering to the guidelines of the policy. So, for example, there was no evidence that individuals' pain was assessed using either of the pain scales referenced in the policy, there was no documentation that indicated that an assessment of pain was conducted, there was no evidence of consistent follow-up to the administration of pain medication, including an evaluation of the results and/or the individuals' responses to the medications, and no evidence that pain and pain management were adequately reviewed at least quarterly during the individuals' comprehensive assessments. Currently, the monitoring review of the 20 individuals' records revealed that all 20 individuals failed to have IHCPs, HMPs, and/or ACPs that adequately represented the culmination of their IDTs' recommendations for specific, individualized interdisciplinary interventions to address all of their health care needs, including their needs associated with their health risks, in accordance with specific time frames for implementation and completion of the interventions to achieve the individuals' goals, which were specific, measurable, attainable, relevant, and desired health outcomes. As a result, a rating of noncompliance was given to this provision item. However, it should be noted that there were improvements noted in the health care planning process, which occurred as part of the individuals' IDTs annual ISP meeting. (See section M5 for more information). Some general comments regarding the 20 sample individuals' care plans are below. Of note, some 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 for approximately two-thirds of the individuals 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. • As noted in all prior reports, the individuals with HMPs continued to have almost identical HMPs to address health problems they had in common regardless of their co-morbid conditions and/or the precursors, nature, scope, and intensity of the problem. • Many of the sample individuals who had teeth were diagnosed with fair to poor oral hygiene. However, less than one-fourth of these individuals had an HMP to address their oral hygiene needs. • Five individuals' HMPs to address their c.difficile intestinal infections referenced incorrect gender throughout the sections of the plans that were developed specifically to guide their direct care staff members. Of note, these HMPs were supposedly "implemented" and "reviewed" by their nurses, which raised	

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		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. • IHCPs were drafted prior to the individuals' annual ISP meetings and only partially addressed during the conduct of the meetings. So, for example, although interventions were somewhat discussed at the meetings, specifying goals, timeframes for the achievement of goals, and the individuals' responsible for monitoring progress toward goal attainment were left to the RN case manager to figure out after the meeting. This is the typical procedure and the monitoring team hopes that all relevant information will be adequately included in the IHCPs. Examples of problems in the IHCPs, HMPs, and ACPs of specific individuals are presented below: • Individual #25 had chronic health problems, such as seizures, constipation, osteoporosis, diverticulosis, hypothyroidism, and mobility deficits. In addition, over the past several months, she suffered from acute infections, such as facial MRSA cellulitis, candidiasis of her perineum, cellulitis of her upper lip and right eyelid, urinary tract infection, intertrigo of her groin and upper respiratory infection, ingestion of a foreign object, cluster of seizures, and a significantly elevated phenobarbital blood level. Her 12/12 IHCP failed to provide even minimally adequate rationales for her risk levels, goals that were not measurable, implementation dates that indicated that action steps were "already implemented," and completion dates that were either "ongoing" or blank. Strikingly, Individual #25's 12/12 IHCP, which was reviewed by her RN case manager on 3/1/13, was not revised to reference or address any of the untoward health events she suffered since the IHCP was developed. • Individual #89 was a 53-year-old man who was diagnosed with many health problems and risks. In addition, over the past several months, and since his 11/14/12 IHCP was developed, he suffered constipation, prostatitis, a head injury with subgaleal hematoma, a foot contusion, evacuation and drainage of a hematoma of his abdominal wall, and bracycardia. There was not only no evidence that his IHCP was reviewed, in accordance with policy/procedure, there was no evidence that it was reviewed and revised in light of the serious untoward health events he suffered since his IHCP was developed. In addition, Individual #89's IHCP's rationale for his risk levels were vague and failed to provide adequate justification for the risk levels that were assigned. For example, Individual #89's IHCP's rationale for his "medium" risk of falls was that his multiple falls were not all "true falls," and it was only just recently that he was sent to UMC for an "injury." Of note, the "injury" was maxillofacial trauma,	

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		which included facial fractures that required hospitalization for open reduction and internal fixation of his fractures and treatment of lacerations to his eyelid and scalp. • Individual #52 was a 55-year-old woman with many health problems and risks. Over the past several months, Individual #52 suffered two episodes of conjunctivitis, bronchitis, fecal impaction, right lower lobe pneumonia, anorexia, and excessive weight loss. Her six-page, 3/15/13 IHCP completely failed to identify action steps to meet her health needs and risks. For example, the only interventions put forward to address her many health needs and risks related to choking, aspiration, respiratory compromise, dental problems, gastrointestinal problems, constipation, and bowel obstruction were to 1) continue with current diet texture, 2) continue to follow constipation protocol, 3) continue with positioning, and 4) continue with PRN O2 as ordered.	
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 health goals. The facility's self-assessment indicated that, since the prior monitoring review, a new Nurse Educator was recruited and hired, reviews of nursing retention, medication variance, and documentation using the SOAP format in accordance with the assessment and reporting protocols were conducted, and the existing processes for referring nurses to the Nurse Educator, evaluating the nurses' competence, and monitoring the nurses' compliance were reviewed. On the basis of the these activities and the scores on the audits of the nurses' compliance with the assessment and reporting protocols, which ranged from 18% compliance with the assessment and reporting protocol related to diarrhea to 100% compliance with the assessment and reporting protocol related to vomiting, the facility concluded that "provision M4 remains noncompliant because of challenges related to Nurse Educator retention [and] educational opportunities for the EPSSLC Nursing Department are still needed." The monitoring team was in agreement with the self-rating of noncompliance, but based its finding on the 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	Noncompliance

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		and ensure consistent application of the nursing process. Since the prior review, the newly hired Nurse Educator had been on the job less than three months. But, in that time, she read all policies, procedures, protocols, previous Nurse Educators' files, prior monitoring reports, and state surveys, worked with another Nurse Educator at Denton, began discussing with the CT&D Director a pilot training program for new employees during orientation and training on peri-care, oral hygiene, and bathing, began putting data into a 2013 spreadsheet that documented nurses' training across the competence training areas, planned the rest of the year's training with the Mosby manual, and developed a way to get all nurses caught up with their competence-based training by the end of the year. A review of the Nurse Educator's Nurse Competency Data Report revealed that there were a number of nurses that failed to receive training and demonstrate their competence in skills that they were required to do as part of their usual job duties. This was a glaring deficiency in the facility's training and education program, but the Nurse Educator was well aware of the problem and affirmed that this matter was a priority. With already much on her plate, the Nurse Educator reported her ideas to enhance the facility-based education and training program for its LVNs and develop a Preceptor Program and showed the monitoring team her monthly newsletter called, "Nurse's Notes, which was very well done, interesting, and informative. During observations on the units, most of the nurses were observed to have the state's protocols on laminated cards on their person and/or in their workstations. This was a notable improvement from the prior review. However, possession of laminated protocol cards does not, and did not, equate to implementation of the actions and activities specified via the protocols. Thus, as noted in the prior review, 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 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 finding was consistent with some of the facility's preliminary results of audits of nurses' compliance with and implementation of the assessment and reporting 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-	

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		sedation/anesthesia. Thus, there were significant lapses in close monitoring of individuals who were recovering from various medical procedures. • 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. • Individuals who suffered temperature elevations were not assessed and vital signs were not obtained, in accordance with the temperature elevation protocol. As a result, there was no evidence that interventions were implemented to prevent dehydration. • Individuals with seizure activity were not assessment and monitored, in accordance with the seizure activity protocol. • None of the individuals who suffered head injuries were assessed and 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 individual's stool, there was at least one individual for whom the suspected ingestion and 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. Several individuals' situations and risks of harm stood out as especially egregious. Over the three-month period of 10/19/12 to 1/17/13, Individual #100 suffered at least seven different occasions when one or more of the assessment and reporting protocols were not followed. Thus, there was no evidence that he was properly assessed or monitored when he suffered at least two head injuries, two infections, one of which was contagious, receipt of antibiotics, fever, general anesthesia, and pretreatment sedation. Although it was apparent to the monitoring team that adherence to the protocols was still a work in progress, it remained unclear what actions the Nursing Department planned to take, apart from increasing the number of monitoring tools and getting back on track with nurses' competency-based training, to help ensure that their nurses would consistently implement the nursing protocols. Since the prior review, the Quality Assurance Nurse continued to provide extensive consultation to and collaboration with the Nursing Department. During the monitoring	

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		team's interview with the QA Nurse, she candidly reported that she did anything that the CNE asked her to do, from training, to monitoring, to mentoring, to collaborating, to being a knowledgeable colleague and sounding board. The QA Nurse also continued to conduct QA Walk-Thru reviews, which revealed health and safety hazards for the Nursing and other departments to address. However, it was unclear to the monitoring team whether or not facility administration was aware of the repetitive nature of some of the problems and the frequency with which the "status of follow-up" to resident issues, health and safety hazards, etc. remained pending month after month. The QA Nurse continued to conduct monitoring and evaluation of assessment and reporting protocols across areas of nursing care. Recently, the QA Nurse collaborated with the newly hired Program Compliance Nurse on several nursing audits and monitoring tools, and they were working on establishing their inter-rater reliability. The roles and responsibilities for quality oversight and the relationship between QA Nurse and the Nursing Department may become clearer over the next six months as EPSSLC rolls out the state's new "SSLC Nursing Quality Assurance Audit Process." Also see comments in section E of this report. Since the prior review, the QA Nurse also completed one clinical death review of nursing care, which was very comprehensive, complete, thoughtful, appropriately critical, and well documented. The report continued to highlight the persistent pattern of problems in nursing assessments, documentation, reporting, and planning processes. In addition, the report put forward 18 recommendations, but the Nursing Department prepared corrective action plans in response to only three of the important recommendations put forward in the report. A review of these plans revealed that all evidence to show the Nursing Department's implementation of corrective actions were "pending." After the onsite review, the facility reported that two of the three action plans were completed and the third was pending the hiring of the nurse educator. In addition, the corrective actions were limited to conducting an inservice training for all nurses on the acute illness and injury policy, developing competency based training and guidelines on the use of a Baclofen pump, and developing a tracking system to ensure that individuals' changes in their health status is address via the IDT, including unusual incidents. It was unclear to the monitoring team why the Nursing Department failed to accept several of the other recommendations that so clearly pointed out the problems that occur when/if nurses continue to fail to implement the assessment and reporting protocols. These recommendations were especially relevant given the findings of the review.	

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M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	At the time of the monitoring review, EPSSLC had fully implemented the state's integrated risk assessment and integrated rating and planning processes. Once completed, the IRRF (Integrated Risk Rating Form) provided the underpinning for the IHCP (Integrated Health Care Plan). According to the facility's self-assessment, since the prior review, all EPSSLC nurses received training on the IRRF and IHCP processes. In addition, random annual ISP meetings were monitored by nursing leadership to ensure that the IHCPs were discussed and developed in an integrated manner that involved all members of the IDT, random samples of IHCPs and ACPs were reviewed for content and compliance with the processes, and there was a focus on improving the area of infection prevention and control. According to the self-assessment, this provision, "remains rated as noncompliant [because] adequate information and data for evaluation is unavailable at this time." Also, the Nursing Department acknowledged that additional training for direct care nurses on the IHCPs was needed to ensure that they understood and utilized the risk information when they developed nursing interventions and provided nursing care. The monitoring team was in agreement with the facility's finding of noncompliance, however, its finding was based upon observations during an annual ISP meeting and reviews of 20 sample individuals' records that revealed that the facility had not implemented 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 understanding, knowledge, competence, and experience in carrying out their role and responsibilities as the nurse participant in the IDT's health risk assessment, rating, and planning processes. During the conduct of the review, the monitoring team attended the annual ISP meeting, for Individual #50. The QDDP who chaired the meeting was superb, and she worked very well with the RN case manager and vice versa. When it came to the IRRF and the IHCP portions of the meeting, there was some good input from the members of the IDT, but not enough. Also, the IDT proceeded to identify interventions to address the individual's health needs and risks without setting a goal, or goals, to achieve. It was unclear to the monitoring team how, or why, interventions could, or would, be developed in the absence of a specific goal to achieve. In addition, once the IDT finished listing a number of interventions, it appeared as though they viewed their job as done. The IDT seemed completely satisfied with a job	Noncompliance

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		well done once they developed a list of interventions for the RN case manager to organize and incorporate into an IHCP with goals, time frames, and responsible IDT members. It was not until the monitoring team strongly encouraged the IDT to fully complete the process that they began to attempt to set goals and timeframes for the achievement of goals and identify the specific IDT members responsible for the implementation of interventions and monitoring of the effectiveness of the plan. Of note, completing the entire process appeared to be a much more challenging and demanding task than creating a list of interventions. The monitoring team strongly encouraged the IDT to keep this process together within the ISP framework, which was incredibly important, if not absolutely necessary, to the proper development of an IRRF and IHCP, or any other plan for that matter. All 20 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and more than half of the individuals reviewed were referred to as having one or more "high" health risks. However, a review of the 20 sample individuals' records revealed that the majority 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 failed to ensure that the health risks that they identified during their nursing assessments were consistently addressed via health care/risk action plans. Therefore, this provision item was rated as noncompliance. Examples included the following: • Over the past several months, Individual #25 suffered from several acute infections, such as facial MRSA cellulitis, candidiasis of her perineum, cellulitis of her upper lip and right eyelid, urinary tract infection, intertrigo of her groin and upper respiratory infection, ingestion of a foreign object, cluster of seizures, and a significantly elevated Phenobarbital blood level. As of the review, her 12/19/12 IRRF was not reviewed or revised to address her health risks. Thus, her risk of alteration in skin integrity remained "low," her behavioral health risk remained "medium," and the planned interventions to address her already high risk of infection were not revised. • Individual #100's 11/14/12 IRRF indicated that he was at high risk of suffering the side effects of his AEDs, high risk of loss of bone density, and high risk of falls. Nonetheless, despite his history of a broken wrist, clavicle, and thumb, he was rated as "medium" risk of fractures. Thus, as of the review, the only planned interventions in place to reduce his risk of fractures were to document his falls,	

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		notify the nurse of suspected injury, and notify the doctor of serious injury requiring emergent care. It was unclear to the monitoring team how these interventions would reduce Individual #100's risk of fractures. • On 2/19/13, Individual #149 was admitted to EPSSLC from El Paso Psychiatric Center where he was being treated for dangerous behaviors to himself and others. Individual #149 was a 29-year-old man who was diagnosed with mood disorder, intermittent explosive disorder, seizure disorder, hyperlipidemia, and constipation. Over the past month, Individual #149's fecal occult blood test showed positive results, which was indicative of the presence of bleeding somewhere in his gastrointestinal tract. As of the review, Individual #149's 3/14/13 IRRF, which was filed in his record, was blank.	
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 self-assessment indicated that the Nursing Department continued to monitor, record, track and trend, analyze, and report medication variance data. In addition, they monitored and audited the medication administration practices of the EPSSLC nurses using revised audit tools and monitoring procedures. The Nursing Department continued to extensively collaborate with the Pharmacy Department and, over the months since the prior review, appeared to have worked more closely with the Rehabilitation Department to ensure that individuals' PNMPs and MARs accurately referenced the appropriate techniques and adaptations for nurses to use to safely administer medications to the individuals who resided at EPSSLC. In addition, for the first time, the facility's self-assessment indicated that based upon the results of their reviews of medication variances, observations of medication administration, audits of MARs, and sessions of remedial training for nurses with excessive medication variances, this provision item was in substantial compliance with the Settlement Agreement, Health Care Guidelines, and current generally accepted professional standards of care. Regrettably, as indicated in more detail below, although the monitoring team acknowledged that the facility continued to take steps toward improving its procedures for the administration of medications, in accordance with current, generally accepted standards of care, this provision item was rated as noncompliance because there continued to be serious problems in nurses' administration of medications and documentation of medication administration records across 14 of the 20 individuals reviewed. Furthermore, during the review, observations of medication administration were	Noncompliance

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		conducted in the systems building and in the cottages. Only one of the five observations of nurses' administration of medications was administered in accordance with current, accepted standards of practice. This was a decline in performance from the prior review. As noted above, the nurses at EPSSLC were afforded training and re-training on medication administration. They were prompted during oversight reviews, monitored, audited, supervised, and sent to the Nurse Educator for remedial education and training. Nonetheless, observations of nurses' administration continued to reveal problems with nurses properly administering medications in accordance with generally accepted standard of practice. Nurses failed to properly check the MARs, failed to maintain sanitary conditions and infection control practices, failed to follow the PNMPs, which put individuals at risk of choking and aspiration, and failed to use appropriate clinical judgment during the administration of medications. Thus, at least one nurse created a noxious liquid mixture of crushed and liquid medications, chocolate pudding, and V-8 juice, which, of course, the individual refused to accept. When individuals refused their medication(s), at least one nurse set the mixtures of crushed medications, pills, liquid medications, inhaler, etc. on top of the medication cart and on the counters in the medication room with the "plan" to give the unlabeled, unidentifiable medications to the right individual at a later time. This "plan" was not sound or safe, and it certainly was not in accordance with generally accepted standards of practice. The monitoring team reviewed the results of the Nursing Department's Medication Administration Observation reports for the five nurses who were observed by the monitoring team. The one nurse observed by the monitoring team who administered medications in accordance with generally accepted standards of practice achieved a score of 100% on the department's report. The other four nurses observed by the monitoring team who failed to administer medications in accordance with generally accepted standards of practice achieved similarly high scores of 86%, 91%, 93%, and 100% on the department's reports. A closer review of the four nurses' Medication Administration Observation reports revealed that each and every one of them had problems noted during the observation of their administration of medications, including, but not limited to, failure to provide privacy, failure to properly administer medications in accordance with procedures, failure to adhere to standards of infection control, failure to refer to the individual's PNMP, failure to properly store medications, etc. As noted in prior reports, the failure of the Nursing Department's audits to properly identify nurses who performed in accordance with standards of practice from those who failed to do so, and the	

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		discrepancies between the Nursing Department's audit results and the findings of the monitoring team raised question over the reliability of the Nursing Department's audits and observation reports and the validity of their results. The review of 20 sample individuals' 2/1/13 – 3/22/13 MARs revealed that 14 of the 20 individuals had multiple missing entries in their MARs, which indicated numerous potential medication errors in the administration of seizure medications, laxatives, psychotropics, calcium/vitamin D, diabetes medications, anti-hypertensives, eye drops, etc. These problems were fewer, but not significantly 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 3/19/13 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 (see below). <u>Medication Variance by Month (September 2012 – February 2013)</u> <u>2012</u> September 55 October 39 November 31 December 39 <u>2013</u> January 24 February 34 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 associated with the incorrect administration of medications, such as omission of medications, administration of the wrong dosages of medications, and administration of medications to the wrong individual. During the Committee's discussion of these findings, it was reported that the majority of omissions occurred because the nurses failed to follow the	

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		MARs. The Nurse Managers who were present at the meeting reported that follow-up actions, such as remedial education and training, occurred, and corrections to nursing practices were made. The Pharmacy Department's March 2013 Variance Report revealed that the total monthly doses of medications were on the decline. This was the result of an initiative by the Pharmacy and Medical Departments' to discontinue unnecessary medications. In addition, the Pharmacy Department reported that, over the past several months, they reconciled 50 to 60 medications a month that were returned to the pharmacy. A few years ago, they reconciled hundreds of medications a month, many of which were returned to the pharmacy without explanation. Since the prior review, the Pharmacy Department continued to audit and analyze the use/misuse of bulk, stock, and liquid medications. As noted in the 1/12 and 7/12 monitoring reports, the results of the pharmacy's current audits continued to be striking and concerning. And, again, the data collected by the pharmacy suggested that dozens of individuals failed to receive many doses of their medications, in accordance with their physicians' orders. For example, the audit revealed that bulk stock liquids, such as laxatives like Clearlax, and ampules of medications to treat respiratory disease, such as albuterol, ipratropium, and budesonide, lasted days and weeks longer than they should, when/if they were administered as ordered; some individuals potentially missed days of daily doses of laxative medications, and other individuals potentially missed almost as many days of daily doses of respiratory medications. Of note, the Pharmacy Department ensured that their audits and analyses controlled for the days that individuals were away from the facility, which, in effect, ruled that out as an explanation for the potential variance. Although the Pharmacy and Nursing Departments were planning to take corrective actions to address these serious findings, over a year went by since this problem was identified and reported. And, it was already too late to prevent the negative outcomes for individuals that possibly occurred as a result of their continued failure to receive medications in accordance with physician's orders. As was the case in January 2012 and July 2012, the monitoring team again raised significant concern regarding these findings and their potential impact on the variance data reported to the monitoring team.	

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 continue to 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 skin integrity activities are addressed as soon as possible so that the NOO/Hospital Liaison 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. Address the significant potential medication variance identified by the Pharmacy Department and potential failure of individuals to receive their liquid, stock, bulk, and other non-pill form medications, in accordance with their physicians' orders (M6).

6. The Weight Committee should consider health status indicators, such as pre-albumin levels, in addition to changes in weight during their reviews of individuals' nutrition status (M1).

7. Provide additional training to all nurses on the IRRF and IHCP processes, with special mentoring of the RN Case Managers (M5).

8. Consider ways to reward nurses' positive performance (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. Re-establish the Nursing Department's auditing and quality oversight activities to ensure that nursing leadership is kept informed of the status toward compliance with the provisions of the Settlement Agreement, Health Care Guidelines, and generally accepted standards of practice (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:** Documents Reviewed: 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 2/12 o EPSSLC Quarterly Drug Regimen Reviews, 10/11 o Physician Orders, December, January – June 2012 o Pharmacy and Therapeutics Committee Meeting Minutes, 2012 - 2013 o Medication Variance Review Committee Meeting Notes, 2012 - 2013 o Polypharmacy Committee Meeting Minutes, 2012 - 2013 o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations, 2012 -2013 o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #161, Individual #128, Individual #103, Individual #104, Individual #107, Individual #191, Individual #117, Individual #123, Individual #189, Individual #149, Individual #16, Individual #18, Individual #24, Individual #57, Individual #59, Individual #60, Individual #65, Individual #4, Individual #70, Individual #28, Individual #31, Individual #76, Individual #89, Individual #90, Individual #44, Individual #49, Individual #52 o MOSES and/or DISCUS evaluations for the following individuals: • Individual #162, Individual #15, Individual #16, Individual #24, Individual #155, Individual #128, Individual #60, Individual #99, Individual #9, Individual #10, Individual #104, Individual #110, Individual #66, Individual #191, Individual #117, Individual #27, Individual #28, Individual #31, Individual #35, Individual #76, Individual #78, Individual #80, Individual #81, Individual #82, Individual #89, Individual #123, Individual #120, Individual #188, Individual #50, Individual #52, Individual #149 Interviews and Meetings Held: o Amista Salcido, PharmD., Pharmacy Director o Giovanna Villagran, PharmD., Clinical Pharmacist o Don Apodaca, MD, Medical Director

	o P. Richards, MD, Primary Care Physician o Eugenio Chavez-Rice, MD, Psychiatrist o Howard Pray, DDS, Facility Dentist o Raquel Rodriquez, RDH o May Ann Clark, RN, Chief Nurse Executive o Veronica Bahner, RN, Clinic Nurse <u>Observations Conducted</u>: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Medical Provider Meetings o Pharmacy Department
	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. The pharmacy director served as the facility lead and completed the self-assessment. For each provision item, a series of activities were listed that were used to help assess the facility's current compliance rating. In most instances, the activities were similar to those of the monitoring team. However, because several recommendations from the July 2012 report were not addressed, the self-assessment did not include some activities that the monitoring team consistently engages in during the conduct of the compliance reviews. For Provision N1, the self-assessment reported that random orders were reviewed to determine the accuracy of the order entry process. The Pharmacy Intervention Documentation Forms were also reviewed to determine if appropriate notification occurred. The third activity listed was the review of the monthly prospective medication lab monitoring report. The self-assessment included no review of the trends of prescribing patterns or referrals to the medical director. These are issues assessed by the monitoring team. In the case of Provision N4, the self-assessment documented that the QDRRs were completed and signed in a timely manner. The self-assessment should also include information on the justification of rejected recommendations since the monitoring team also assesses this in establishing the compliance rating. Provision N6 reported data on the number of ADRs, training and tracking of remedial actions. These were all essential to the provision. A thoughtful data analysis may have identified trends in prescribing patterns. 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 all eight-provision items. The facility remained in

	substantial compliance with provisions N2, N4, and N7. Provisions N3 and N5 moved into substantial compliance. The monitoring team found provisos N1, N6 and N8 in noncompliance.
	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. Quarterly Drug Regimen Reviews were competed in a timely manner and were thoroughly completed. The monitoring team did identify some issues, mostly related to a lack of consistently identifying monitoring parameters and difficulty in teasing out the recommendations that were made to the medical staff. Improvement was seen in the documentation of the monitoring of the metabolic risk of the new generation antipsychotic medications, but QDRRs still sometimes had outstanding labs. For the most part, the MOSES and DISCUS evaluations were completed in a timey manner, but there was no evidence that the primary providers reviewed or integrated this important information into clinical decision-making. Drug Utilization Evaluations were completed in a timely manner and the P&T minutes documented the findings, but did not fully document the closure of the corrective actions. The ADR monitoring and reporting system continued to be a weak link in the facility's pharmacy safe medication practices system. There was essentially no reporting by the medical staff and 77% of staff identified received the required training. Even more important was that there appeared to be unrecognized ADR patterns that may not have been adequately reviewed. The total number of medication variances decreased, but EPSSLC's problems with reconciling non-pill medications remained outstanding. One year after the disturbing data related to laxatives indicated problems with bulk medication, the facility was still investigating and still presenting preliminary data on the issue of reconciliation of medications.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider	The pharmacy director and clinical pharmacist 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, revised in February 2012, described the process utilized in the pharmacy department: 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	Noncompliance

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.

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.

EPSSLC did not utilize the WORx system to track clinical interventions or prospective lab monitoring. The Pharmacy Intervention Forms were completed for this purpose. The monitoring team requested copies of all pharmacy interventions documented since the last onsite review. Onsite, a copy of the log summarizing the types of interventions was also requested. The pharmacy director reported that the information needed to be updated and it was submitted later during the week of the review. The summary provided is presented in the table below.

Pharmacy Intervention Data 2012 -2013			
	3rd Qtr	4th Qtr	1st Qtr
Contraindication	0	1	2
Indications	13	9	15
DDI	17	20	13
Duplication	6	2	2
Non Formulary Drug	3	1	6
Lab Monitoring	21	24	34
Not Available	20	9	16
Other	28	12	30
Total	108	78	121

There was no consolidated report of the various clinical interventions because these data were not entered into the WORx program. The monitoring team was provided with the Pharmacy Intervention Forms and supporting documents which resulted in a submission of hundreds of pages of documents. Furthermore, problems with the documents resulted in multiple files being submitted, making review even more complicated. As noted in the table above, problems related to indications and lab monitoring were frequently noted. It was not clear from the data if the laboratory monitoring was a reference to prospective lab monitoring or lab monitoring noted in the QDRRs. Regardless, problems with laboratory monitoring represented 26% of all pharmacy interventions and there was no further assessment of this problem. The pharmacy submitted data that indicated 100% of prospective monitoring was completed in November 2012 and December 2012.

The monitoring team also requested the pharmacy's annotated physician orders for the first 10 days of October 2012, December 2012, and February 2013. The pharmacy submitted orders as well as some clinical intervention forms. The monitoring team encountered several problematic orders that did not have Pharmacy Intervention Forms completed. The following are some examples of physician orders that lacked criteria or

		were generally concerning or inappropriate: • Individual #58, 10/8/12: No stop date for medication • Individual #70, 10/9/12: No indication for medication • Individual #45, 10/9/12: Incomplete vaccination order • Individual #28, 10/6/12: Multiple incomplete vaccine orders; repeat vaccine order 10/9/12 • Individual #90, 10/9/12: No diagnosis for medication • Individual #155, 10/5/12: Incomplete vaccination order • Individual #4, 10/6/12: Non ICD nomenclature "red eye" and " scant drainage" eye" Based on a very small sample of orders, it was clear that the number of potential pharmacy interventions was likely higher than reported. In addition to the aforementioned order problems, the physician orders also provided valuable insight into patterns of medical practice. This is discussed in further detail in section L. For example, the following orders reflect problems with the bowel management for this individual; this issue should have been referred to the medical director: • Individual #46, 10/5/12: Fleets enema for no BM x 3 days o 10/5/12: Fleets enema for no BM x 3.5 days o 10/6/12: Soaps suds enema with no indication In the past, the pharmacy director maintained a log summarizing the types of interventions, but this information was not available during the July 2012 review. Although the practice was reinstituted, the data were not complete during the most recent compliance review. It was updated the week of the review and provided to the monitoring team. A request for corrective action was made, but none were available. Given that the data were not maintained, it was not surprising that corrective actions were not implemented to address recurrent issues, such as orders lacking indications, inappropriate diagnosis, and incomplete orders. The facility's approach was to correct each order individually rather than determine what factors resulted in lab monitoring failures or repetitive orders for meds that were not available. Moreover, it was clear that physician prescribing patterns deserved additional attention. The monitoring team was particularly concerned about (1) orders related to vaccinations that failed to address informed consent and the requirement to provide the federally required Vaccine Information Statements, (2) incomplete and unclear vaccination orders, (3) practitioner prescribing patterns, and (4) problems related to bowel management orders. Many of these issues fail to be detected unless data are aggregated and reviewed collectively for trends. EPSSLC clearly did not engage in such activities in an ongoing and	

		timely manner. Finally, this provision item required "upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." The monitoring team received guidelines from state office related to the implementation of the Intelligent Alerts module. The documents provided specific guidelines on implementation, development of a drug list for monitoring, use of the IA module and follow-up by the pharmacy director and medical director. The pharmacy director reported that permission was granted from state office for EPSSLC to opt out of the use of the Intelligent Alerts module. Thus, the facility used the Pharmacy Intervention Forms to record prospective lab monitoring. It was reported that this was done consistently for every new order. Because the WORx program was not used, the facility did not provide a comprehensive report of prospective lab monitoring, such as the report that is generated by the WORx software. The facility also had not really developed a comprehensive list of medications to be monitored above and beyond the core list required by state office and mandatory monitoring, such as clozapine and a few other drugs. Development of the drug monitoring list should be a collaborative effort between medical and pharmacy and should be based of the needs of the facility. The list should be formally adopted and folded into the Prospective Review of New Medication Orders Policy. The monitoring team was provided, in the presentation book, a series of intervention forms that corresponded to a WORx printout of new medication orders. While prospective lab monitoring was reported at 100%, QDRRs sometimes revealed that lab monitoring was outdated or was not completed indicating that greater attention should be placed on the prospective monitoring of labs. This provision remained in noncompliance due to a lack of a systematic approach to problems identified with physician prescribing as well as a failure to demonstrate that the prospective lab monitoring is occurring in accordance with state guidelines.	
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.	Thirty QDRRs and the facility's QDRR schedule were reviewed to determine if the facility remained in substantial compliance with this provision item. The content and timelines were assessed for compliance with state guidelines and facility policy. State office required that a QDRR schedule be generated for the facility that assigned four due dates (every three months) for completion of QDRRs. Per state guidelines, "the QDRR may be conducted up to seven days prior to the end of the review period and will be considered delinquent if completed 14 calendar days from the end date of the review	Substantial Compliance

		period. All subsequent review periods will be set in three month increments from the initial review period…" The facility submitted a schedule, including review dates for the last two quarters of fiscal year 2012 and the first two quarters of fiscal year 2013. Based on state guidelines, no deficiencies in timelines for completion were identified. Reviews of the QDRR sample and QDRRs included in the record sample also indicated timely completion by the pharmacy department as well as timely review by the primary medical providers. The psychiatrist reviewed the QDRRs whenever the individual received psychotropic agents. All documents reviewed were signed and dated by the clinical pharmacist, medical provider and when appropriate, the psychiatrist. The monitoring team made several recommendations in the July 2012 report relative to the content of the actual QDRR report. Specific recommendations included the requirement for the QDRR Report to comment on every medication that is included in the lab matrix and inclusion of the exact values/normal ranges and dates of laboratory values. There was improvement noted in this area, but the clinical pharmacist continued to cite many studies as done within the standard of care in lieu of listing the values. During the initial meeting with the pharmacy director and clinical pharmacist, the monitoring team noted examples where monitoring and /or recommendations offered opportunities for improvement. This was discussed during the compliance review. Similar opportunities were noted in the sample reviewed. The following are a few examples of the clinical issues surfaced through review of the QDRRs: • Individual #60, 1/7/13: The clinical pharmacist noted that TFTs were ordered on 12/28/12. The comments stated that TSH monitoring was appropriate, but no TSH was available in the lab section of the active records. • Individual #89, 1/23/13: The QDRR drug profile noted the use of Fergon for iron deficiency anemia; however, the QDRR provided no assessment of anemia or results of iron studies • Individual #123, 1/25/13: The clinical pharmacist noted no BP in IPN for December 2012 and January 2013. There was no report of the BMD, although the individual received Prolia and no diabetes mellitus monitoring parameters were provided by the clinical pharmacist. Notwithstanding the issues highlighted, given the complexity of the medication regimens, overall the QDRRs were well done. The clinical pharmacist commented on many clinically relevant issues and provided valuable information to medical providers and the entire IDT. The monitoring team continues to recommend that he QDRR Report 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. The use of a systematic format /checklist for each review should help to minimize the oversights noted by the monitoring team.	

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 was documented in the QDRRs. For each use, there was a comment related to the indication and its effectiveness. The use of chemical restraints and emergency medications are discussed further in section J. <u>Polypharmacy</u> The QDRR Report form indicated the presence or absence of polypharmacy. In many instances when polypharmacy was noted, the clinical pharmacist made comments related to justification or reduction of polypharmacy. The facility continued to monitor the use of psychotropic polypharmacy through the Polypharmacy Oversight Committee and the P&T Committee. Additional discussion on EPSSLC's monitoring of psychotropic polypharmacy is found 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. The results of the MOSES and DISCUS evaluations were also provided. Generally, there were no specific recommendations made on how to further minimize the burden, but overall, the issue was brought to the attention of the medical providers allowing or further management. <u>Monitoring Metabolic and Endocrine Risk</u> The facility monitored individuals for the metabolic risk through the QDRRs. The laboratory matrix included several monitoring parameters, including glucoses, HbA1c, weight, lipid panels, waist circumference, and blood pressure. Improvement was noted in this area. Each QDRR, which was completed for an individual receiving new generation antipsychotics, included comments related to metabolic and endocrine risks. Several of the QDRRs in the sample indicated that BPs were not documented in the IPNs as required and this should be addressed since many of the NGA also require monitoring of orthostatic blood pressures.	Substantial Compliance
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not	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 recommendations included in the QDRR were included within the recommendations	Substantial Compliance

	followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	and comments section and were sometimes difficult to identify. The pharmacy staff indicated that each provider received a list of recommendations at the time that the QDRR was provided. The medical director and psychiatrist usually agreed with the recommendations made by the clinical pharmacist. When recommendations were not accepted, comments were provided on the reports to explain the decision. Additionally, the pharmacists were sometimes referred to specific orders that were written to address the recommendations. This provision item remained in substantial compliance. The medical staff should continue to take into consideration the recommendations of the pharmacists. There should be clear evidence of the acceptance or rejection of the recommendations. For prospective reviews, this documentation should be evident in the Pharmacy Intervention Forms. The medical director should be aware of issues related to rejection of recommendations. For the QDRRs, documentation of acceptance or rejection should be consistent with facility policy. For both prospective and respective reviews, the pharmacy director should maintain some data showing that the primary provider and psychiatrist not only accepted, but also implemented, the recommendations of the clinical pharmacist. This information should be reviewed regularly with the medical director and corrective actions taken as warranted.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The facility utilized the Dyskinesia Identification System: Condensed User Scale to monitor for the emergence of motor side effects related to the use of psychotropic medications. The Monitoring of Side Effects Scale was completed to capture general side effects related to psychotropic medications. 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 were reviewed. The findings are summarized below: Thirty-three MOSES evaluations were reviewed for timeliness and completion: • 33 of 33 (100%) evaluations were signed and dated by the prescriber • 30 of 33 (91%) evaluations documented no action necessary • 3 of 33 (9%) evaluations documented actions taken, such as drug changes and monitoring • 7 of 33 (20%) evaluations had a delay of two weeks or more before the physician review was completed Twenty eight DISCUS evaluations were reviewed for timelines and completion: • 28 of 28 (100%) evaluations were signed and dated by the prescriber • 26 of 28 (93%) evaluations indicated no TD was present • 1 of 28 (4%) evaluations indicated the presence of TD	Substantial Compliance

		• 2 of 28 (7%) evaluations had a delay of two weeks or more before the physician review was completed All documents reviewed were completed by the psychiatrists at EPSSLC. Overall, it appeared that the psychiatrists were taking into consideration the findings documented by the reviewer. Moreover, the psychiatrists appeared to make additional comments based on the medical/psychiatric assessments. The timelines for completion improved with 9 of 61 (15%) of evaluations having delays of two weeks or greater between the review dates and completion by the psychiatrist. The psychiatry providers appeared to devote adequate attention to the emergence of motor and other side effects through the use of these valuable evaluation tools. Similar attention, at least with the use of the tools, was lacking on the part of the primary providers and neurology consultants. 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 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. Improvements in the content of the evaluations and timelines for completion resulted in this provision item moving into substantial compliance. Maintenance of substantial compliance will require that evaluations are adequately completed in a timely manner, and are <u>utilized in clinical practice.</u> Providing adequate training to healthcare practitioners on the value, use, and requirements for completion of these tools may be helpful in achieving these goals.	
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. The facility reported that 270 of 349 (77%) clinical/nursing staff and direct support staff received training regarding recognizing and reporting ADRs. This represented progress, but clearly, improvement to a more acceptable level was required. Training continued in New Employee Orientation in addition to annual refresher training. Residential supervisors provided the retraining to direct care professionals. Reporting of ADRs increased for the second half of 2012. Eleven ADRs were reported for the first six months of 2012 while 15 were reported during the second half of the year. The monitoring team is concerned about a lack of overall progress with the facility's ADR reporting and monitoring system. The facility failed to develop a probability scale for determining when an intense analysis would be conducted. The July 2012 report made specific recommendations related to the need to develop and implement an adequate process because the current process of conducting an intense case analysis for severe and	Noncompliance

		fatal reactions following hospitalization was inadequate. The monitoring team's review of the ADR log indicated that there were several ADRs that required greater scrutiny. • In June 2012, Individual #123 experienced low oxygen saturations after receiving three medications for pretreatment sedation. Less than 30 days later, a code blue was called after the individual received the same three medications. An intense case analysis was conducted only for the second episode, but the format for that analysis was unclear. It appeared that that the clinical pharmacist completed the review. Another intense case analysis submitted was neither signed nor dated so there was no indication of the process for completion. • Individual #73 experienced acute renal failure from rhabdomyolysis associated with the use of atorvastatin. The format for the ICA was simply inadequate. The purpose of the review is to critically review the events surrounding the care and to make recommendations specific to the individual or systemic in nature. This should be a collaborative multidisciplinary process. The facility had not outlined a procedure to determine when (threshold) such reviews would be conducted or the process for conducting this important review. • Several individuals experienced moderate to severe reactions to psychotropic medications, AEDs, and other medications. The facility should utilize these ADR data as the starting point to further review the safe use of these medications In addition to these concerns, ADR reporting at EPSSLC continued to be a function primarily of the pharmacy department. More importantly, the medical staff reported no ADRs and this was not in keeping with the current recommendations from major professional organizations, which encourage all health care professionals including physicians to report adverse drug reactions. This provision remained in noncompliance based on the multiple deficiencies highlighted above.	
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 Ergocalciferol, MVIs, Synthroid, primidone, phenobarbital, and calcium/Vitamin D. The DUEs were thoroughly done in accordance with facility policy. Recommendations were made and recorded in the P&T Committee meeting minutes. The P&T minutes did not provide definitive closure related to the recommendations. For example, it was recommended that MVI use be discontinued in all individuals that did not fit the criteria discussed in the DUE. Follow-up minutes should provide documentation that this occurred, however, that documentation was not noted. Record reviews and review of other documents did provide evidence that recommendations were being implemented. The monitoring team continues to recommend that the Pharmacy and Therapeutics	Substantial Compliance

<table>
<tr><td></td><td>standards of care with regard to this provision in a separate monitoring plan.</td><td>Committee meeting minutes document discussion of the DUEs, appropriate plans of correction for deficiencies identified during the conduct of the evaluations, status updates and closure of the corrective action plans.

In order to remain in substantial compliance, EPSSLC will need to address recommendations related to this provision.</td><td></td></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances.</td><td>Some progress was noted with regards to the reporting of medication errors and corrective actions implemented. Many processes had been implemented over a period of years, which contributed to the overall reduction in the number of variances. The overall medication data provided to the monitoring team are summarized in the table below.

<table><tr><td colspan="9">Medication Variances 2012 -2013</td></tr><tr><td>June</td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td></tr><tr><td>60</td><td>64</td><td>52</td><td>55</td><td>39</td><td>31</td><td>39</td><td>24</td><td>34</td></tr></table>
Notwithstanding an overall reduction in the number of medication variances, there were some notable findings related to the management of medication variances:
During the conduct of the Medication Variance Committee meeting, it was necessary for the monitoring team to point out that one variance reported was incorrectly categorized as a Level C variance. The variance was actually a more serious level D variance. The monitoring team was not provided with a reasonable data summary, which would allow for review of all variances in order to determine if variances had been correctly categorized. That is, determination of this by the monitoring team would require a review of hundreds of medication variance forms because the facility could not provide a table that listed each variance, the meds involved, and other data. This was discussed during the Medication Variance Committee meeting. Other SSLCs provide this information to the monitoring team.
The facility completed an assessment of bulk medications with university online pharmacy students. This assessment alluded to problems with non-pill medication reconciliation, but the data were reported as preliminary. The pharmacy director did not believe this was problematic because EPSSLC was performing above and beyond what was required by exploring reconciliation of non-pill medications. The monitoring team strongly disagrees with those comments. During previous compliance reviews, EPSSLC presented evidence of egregious deficiencies related to non-pill medications. For example, during the January 2012 review, the pharmacy director reported that the PEG solution was not being ordered, on average, for nearly 87 days and many individuals were likely not receiving meds as prescribed. Similar findings were seen with regards to respiratory treatments. This information resulted from reconciliation audits of non-pill medications. While many medications had been converted to unit doses, there is a continued need for</td><td>Noncompliance</td></tr>
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		the facility to ensure that medications are accounted for. Thus, reconciliation of medications should not be considered optional. EPSSLC should have progressed pass the stage of preliminary data and have a more definitive idea of the issues related to bulk medications.	

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. 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.
    c. The facility needs to clarify the requirements for use of the Intelligent Alerts module with state office.
    d. The pharmacy director and medical director should collaborate to develop a list of drugs that will require prospective laboratory monitoring. (N1).

2. 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 (N2).

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 primary providers should review the results of the MOSES and DISCUS evaluations and document the findings in the IPN. Consideration should be given to including this in the annual and quarterly evaluations (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 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. An intense case analysis should be conducted as a multidisciplinary review with participation by the CNE, pharmacy director, QA department, medical director as well as an appointee of the facility director.

7. The facility should continue to 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 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. Issues related to medication reconciliation should be resolved (N8).

9. 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 and Curriculum Vitae o Staff PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Section O QA Reports o PNMT Evaluation template o PNMT Referral form o PNMT Meeting documentation submitted o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Effectiveness Monitoring Tool template o Completed Compliance Monitoring sheets submitted o Trend analysis documentation submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Documentation related to choking event for Individual #39 o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with Pain 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 Individuals With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance

	o List of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted o PNMPs and sample picture pages submitted o APEN Evaluations: 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 #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. o PNMP section in Individual Notebooks for the following: • Individual #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. <u>Interviews and Meetings Held</u>: o Susan Acosta, PT, Clinical Coordinator o Amanda Demuth, RN o Eric Herrera, PT o Karin De La Fuente, MS, CCC/SLP o Donna Rice, RD/LD o Nurse case manager and QDDPs who attended PNMT meeting o Various supervisors and direct support staff

	o PNMT meeting o ISP Meeting for Individual #129 o Weight Management meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o OT/PT Treatment Rooms o Toothbrushing for Individual #70
	Facility Self-Assessment: As in previous reviews, the Clinical Coordinator, Susan Acosta, PT, outlined specific activities, many of which were based on 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 taken. 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 activities for self-assessment were numerous. She revised the format at the suggestion of the monitoring team to present the data more in graph or table formats, rather than in the narrative. For example, equipment maintenance was identified as an area that required. There was, however, an effort to better analyze the findings for each provision and this should continue. Further streamlining of the self-assessment process, analysis, presentation of data and reducing the evidence submitted is strongly encouraged. Again, though continued work was needed, the monitoring team acknowledges the facility, Ms. Acosta, and the Habilitation Therapies department for the strides they have made during the last six months. The facility rated itself as in substantial compliance with O1 and O8. While significant progress had been made the monitoring team did not concur at this time. Evidence of the collaboration and consulting with medical staff, beyond merely requesting doctor's orders was needed. While the actions taken continued to be definite steps in the direction of substantial compliance for O2 through O7, the monitoring team concurred with the facility's findings of noncompliance. In O8, 8 of 8 individuals who received enteral nutrition were evaluated annually. Seven of these had an appropriate evaluation to determine the medical necessity of the tube. The rationale for Individual #1 was incomplete and did not clearly support continued medical necessity. Also, the assessment of oral motor status by the SLP and/or OT failed to provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate. There was no clear determination of whether she was a candidate for an oral motor treatment program to improve for intake by mouth (PO) intake and for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be part of assessment findings. None of the APENs reflected an adequate assessment by the dietitian regarding current formula and schedule of feedings with a determination if the feeding schedule was the

	least restrictive or if there were potential modifications needed in preparation of transition to oral intake. Each of these provisions requires extensive cooperation and collaboration across departments in order to meet the expected standards. Excellent progress, however, was made in each of these and the establishment of specific measures of success will ensure continued movement toward substantial compliance. The data reported were generally relevant to each of the provision items. Ms. Acosta used this information routinely. More summarization of trends may be useful to illustrate progress and system change. The action plans developed were extensive. The department was on a very strong footing for continued improvements.
	Summary of Monitor's Assessment: Progress was made towards substantial compliance with provision O. The PNMT was fully staffed, though the only dedicated team member was the nurse. Each of the members, other than the RN, had been participating on the team since the previous review. Back-ups had been identified and attendance at the meetings held was generally very consistent. Only one re-assessment had been completed and, though there had been a number of referrals (self-generated and from the IDTs), no other comprehensive assessments were provided. During the meeting observed by the monitoring team, the discussion was very good related to follow-up for one individual (Individual #28). The nurse case manager, however, presented very little data, most data were provided by the PNMT RN. The participation by QDDP was excellent. There appeared to be a significant delay/absence of referrals of individuals who would benefit from PNMT evaluation by the IDT. The team was encouraged to clearly establish exit criteria for effective transition from the PNMT. They should also carefully examine their system of documentation in order to streamline the records of their interventions and follow-up. The facility must review the existing databases that identify individuals with key health issues in order to effectively track them and to watch for facility-wide trends. Individuals who require PNMT referral may be more effectively identified and in a timely manner. These lists should be developed cooperatively by the facility. They must be accurate and routinely updated. These lists are not for use only by the monitoring team, but should be used by the facility to direct actions needed on an individual basis, but to address systems issues as well. These should be also routinely used by the PNMT during their reviews. There have been some good efforts upon which to build. The PNMT appeared to be routinely and proactively reviewing individuals with a high risk of key PNM indicators or with incidences of these concerns. They routinely tracked their status though the documentation was cumbersome and evidence of follow-up of individuals for whom they provided assessment/review was difficult. The status with regard to outcomes and exit criteria should be clearly established and reviewed and modified as needed to ensure that transition to the IDT occurred consistently. Many individuals were followed by the PNMT for well over a year. Mealtimes and position and alignment were improved, though some issues though positioning continued to be an issue. Staff continued to lack confidence in their knowledge of key risk areas and the rationale for

	related supports they were responsible for providing. Monitoring of staff compliance must be consistent and effective. Monitoring should answer the following questions: • Are staff trained to do what is needed? • Are they routinely expected to do what is in the plan by supervisors? • Are staff doing the right thing even when they think no one is watching? PNM monitoring conducted did not address all areas required, such as medication administration, oral care and bathing. A system of effectiveness monitoring was not well established and will be necessary for further progress with this provision. Areas such as toothbrushing and oral sensitivity should be addressed through assessment, supports and monitoring. There were significant improvements related to the review of weight issues identified in the previous review by the monitoring team. There was good representation the Weight Committee meeting observed with excellent discussion noted. Most of the committee members were well prepared and their participation was significant, with the exception of the physician present who did not participate. This group was encouraged to not merely focus on weight as the only nutritional indicator for review and intervention. There are many inter-related issues that may contribute to weight loss or gain and all should be explored. This group as well as the IDTs and the PNMT would benefit from significant medical provider input and these professionals should actively participate and contribute to the discussion rather than referrals to medical only so as to ensure that the approach to weight management and PNM is comprehensive and effective. While there were notable improvements, there continued to be needs in the provision of supports. The facility as a whole must identify these and address them effectively in order to move forward in this section. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 18 individuals who were chosen from a list provided by the facility of individuals identified as being at a medium or high risk for or experienced an incidence of PNM related issues (i.e., aspiration, choking, falls, fractures, respiratory compromise, weight [over 30 or under 20 BMI], enteral nutrition, GI, osteoporosis), required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, presented with health concerns and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of individuals who were assessed or reviewed by the PNMT over the last six months. Sample O.3 consisted of 10 individuals at SSLC who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included 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	<u>Core PNMT Membership</u>: The PNMT at EPSSLC included the appropriate disciplines as defined in the Settlement Agreement. These were essentially the same staff as during the previous review, (Eric Herrera, PT, Jennifer Ochoa-Evers, OTR, Karin De La Fuente, MS, CCC/SLP, and Donna Rice, RD/LD) with the exception of the RN member. The newly appointed nurse, Amanda Demuth, RN, was excellent, providing appropriate direction and leadership to the team during the meeting observed by the monitoring team and during other meetings attended. Back-up team members were identified for all positions. <u>Consultation with Medical Providers and IDT Members</u> Though the following were listed as consultants to the PNMT, it was not possible to ascertain when and in what capacity they served the group: Dr. Apodaca (medical), Dr. Pray (dental), Omar Sanchez (respiratory therapy), and the pharmacist (no name provided). This could not be verified based on review of the assessments or other documentation because they were too extensive for effective review. <u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members was as follows: 5 of 5 core team members (100%) were currently licensed to practice in the state of Texas. Ms. Demuth's license was scheduled to expire at the end of April 2013. All designated back-up team members held current licenses to practice in their disciplines. 5 of 5 PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. The nurse had been employed at EPSSLC since May 2012, however, she had served as an agency nurse providing coverage at the facility since August 2010. <u>Continuing Education</u> 5 of 5 PNMT core team members (100%) had completed continuing education directly related to physical and nutritional supports and transferrable to the population served during the past 12 months. Courses attended by the team members included the following: • Medication Administration for Nurses for Individuals with Developmental Disabilities 7.0 contact hours • Lower Extremity Ulcers .3 CEUs • Introduction to Vision System .4 CEUs • Sports Nutrition for Therapists .3 CEUs	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Vestibular Rehabilitation in the Military Setting 1.5 CEUs • Wound Management .1 CEUs • Integrated Listening Systems pending CEUs • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities 10 contact hours • Optimizing Nutrition Intervention in Surgery 1.0 CPEU • Effective Neurological Management of Sensory Processing Disorders 12 contact hours • Activities of Daily Living: Assessment and Intervention in the Clinic and at Home 6 CEUs • Anesthesia: The Larynx and the Voice 1.0 CEUs • Addressing Dementia and Alzheimer's Disease in a Community-Based Organization Serving Individuals with Developmental Disabilities with a Focus on Nutrition 1.0 CPEU • Medication Side Effects • ISP Risk Management • Pressure Mapping • Wheelchair Seating Assessment 7.5 contact hours • State Webinar on Positioning • Oral/Enteral Intake • Dental Desensitization • Deaf Blindness • Autism • Wheelchair and Skin Integrity • Selecting the Ideal Wheelchair Seating System • Nutritional Management of the Critically Ill Obese Patient 2.0 CPEUs • Diabulimia in Adolescent Females 1.0 CPEU • Hormone Therapy and the Timing Hypothesis 1.0 CPEU • Soyfood Health and Nutrition • PNMT core team training • ARD Syndrome (presumed to be Acute Respiratory Distress Syndrome) 1.0 CEUs • Helping Latinos through Cancer 1.0 CEUs • Possibilities are Endless: Nursing's Influence on Collaborative Healthcare 1.0 CEUs The extent of continuing education obtained by this group of clinicians was extensive and commendable.	

#	Provision	Assessment of Status	Compliance
		PNMT Meetings Since the last onsite review (6/1/12 to 1/31/13), the team met 63 times. Some of these meetings were identified as "in training" dates. The PNMT generally met at least two times weekly with few exceptions, exceeding the expected standard of weekly meetings. There were minutes submitted for 64 meetings with cancellations recorded for two. Based on review of the minutes, it was noted that from 9/17/12 through 12/6/12, the attendance roster was obscured by a notation on the copies submitted. Accurate attendance could not be determined for these meetings. Attendance percentages were calculated based on the minutes from 6/5/12 to 9/14/12 and from 12/11/2 to 1/31/3 or 44 scheduled meetings with the two cancellations noted above. Attendance by core PNMT members for 42 meetings conducted during this time frame was: • RN: 90% attendance by core member, 7% for back-up member, and 98% overall. • PT: 95% attendance by core member, 5% for back-up member, 100% overall. • OT: 90% attendance by core member, 7% for back-up member, and 98% overall. • SLP: 88% attendance by core member, 12% for back-up member, 100% overall. • RD: 98% attendance by core member, 2% for back-up member, 100% overall. Attendance was very good and the provision for back-up team members ensured representation by all key disciplines at each meeting. Per the training materials related to the PNMT process, the QDDP, nurse case manager and other IDT members critical to PNM risk management were mandated to attend PNMT meetings for individuals they served. Meeting minutes were extensive and there was a plethora of information retained, though it was difficult to assess whether the key elements were present among the volumes of pages including referrals, review of individual health status, PNMT actions, follow-up and outcomes/progress toward established goals and exit criteria for individuals in the sample. These elements were present to some degree as noted during the meeting held and observed by the monitoring team. Information was buried in all of these pages. This amount of documentation was not user friendly, not only for the monitoring team, but likely for others, to navigate. In fact, over time it would likely prove challenging for the core team members to easily locate information needed. The PNMT should consider converting their meeting documentation to a chart format that permitted them to report information more concisely with additional progress notes (IPNs) for individual records. This section of the provision O requires that the PNMP 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. Also, the PNMP is to be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. This aspect of O1 is reviewed in O3 below. The Settlement Agreement	

#	Provision	Assessment of Status	Compliance
		further stated that "as needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant." Because this could not be determined, this section of the provision was not found to be in substantial compliance. All requirements for the PNMT were consistent with the requirements and would be considered to be in substantial compliance. Evidence of collaboration with medical professionals is needed for a finding of substantial compliance.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>Identification of PNM risk</u> All individuals at EPSSLC were provided a PNMP, thereby ensuring that each individual who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who was at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a current PNMP. The identification of other PNM concerns was via the at-risk system implemented at the facility. Improvements were noted in the completion of the risk rating tools, though the IDTs did not always identify family history related to conditions, such as cardiac disease and diabetes. They predominately ruled out the risks as the individual themselves did not present with these. The action plans were also improving as there was more evidence that the IDTs attempted to identify unique strategies to address issues for the individual rather than rotely stating that they would follow existing plans. <u>PNMT Referral Process</u> The PNMT received some referrals from the IDTs, though most individuals followed by the team were self-referrals. From 3/1/12 to 3/14/13, there were 18 individuals referred to the PNMT with 67% of those self-generated. Others were referrals by the IDTs or the PCP in one case (Individual #23). Some individuals were followed by the team for extended periods of time without sufficient outcome measures to identify a continued need for this (Individual #28, Individual #63, and Individual #114). While they may continue to have specific needs for PNMT support, there should be exit criteria for discharge. Twelve individuals were discharged within three days to three months. Eight others were referred and discharged on the same day. The rationale for why they were not evaluated was not evident in the documentation. There were 10 individuals listed as on the current active caseload for the PNMT as of 3/14/13. Four of these (Individual #115, Individual #32, Individual #90, and Individual #93) were not included on the list of referrals in the last 12 months. There was a referral form submitted in the document request materials requesting basic information. The stated criterion for referral on the form was only that an individual classified at high risk who was not stable and for whom the IDT required assistance in the development of a	Noncompliance

#	Provision	Assessment of Status	Compliance
		plan may be referred. The individuals listed were actually referred due to high risk (nine), hospitalization, respiratory distress and weight concerns (1), aspiration pneumonia (2), g-tube (1), non-oral to oral intake (2), weight (3), though most were for multiple concerns also, such as choking history, falls, and fractures. Specific criteria for referrals of individuals who may have benefitted from PNMT assessment or review were in a training provided to the nurse case managers (11/14/12) and the QDDPs (11/15/12) by the PNMT. It listed the following criteria for referral: • Any choking episode • Any aspiration pneumonia • Results for RN post-hospitalization assessment (aspiration pneumonia, GI issues fractures, skin integrity, or seizures) • New or proposed enteral feeding • Unresolved vomiting (>3 episodes in 30 days not related to viral infection) • Unresolved or significant unplanned weight loss or gain (verified) o >5% in one month o >7.5% in three months o >10% of body weight in six months • Decubitus: Any Stage III or IV and any Stage with significantly delayed healing • Fracture of a long bone, spine, hip or skull • Trend of increased incidence of falls (for which supports have not proven effective) • Skin integrity issues that have not resolved, have worsened or for which supports have not been effective • Any other physical and/or nutritional issue for which the IDT needs assistance managing (i.e., transition from G-tube to oral intake) Any of the above listed criteria would warrant a comprehensive assessment by the PNMT, yet the PNMT continued to use the level of support approach to delivery of supports and services as follows: • Level I: Full PNMT Assist (scheduled within five days of referral) • Level II Moderate PNMT Assist (schedule IDT within five days and PNMT within 15 days) • Level III: Minimal PNMT Assist (schedule PNMT within five days) A comprehensive assessment was not provided for other than a Level I assignment. There was no clear delineation between these levels and the scheduling of initial meetings described did not necessarily reflect a sense of urgency for any specific concerns identified by the IDT given that the only referral criterion was for an individual to be at high risk and unstable. There were no specific criteria to justify assignment to any of the other levels. There were statements intended to do so noted in the Level of Involvement	

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		Assessments (e.g., Individual #63, Individual #114, and Individual #23), but these failed to establish a clear rationale. Of the 10 individuals listed as being on the current active caseload, seven of these were identified as Level III with minimal supports by the PNMT, and only three identified as Level I (Individual #93, Individual #90, and Individual #115). • Though Individual #93 had been identified on the Level I caseload, she was initially referred on 10/11/11 and an assessment was not submitted. There was a clearly stated rationale for changing her level of involvement status for I to III on 12/4/12 with continued follow-up on specific action steps. • In the documentation submitted for Individual #162, he was identified as Level I for PNMT follow-up. There was no evidence of discharge and on 12/13/12. On 1/15/13, there was a report that he was being treated for pneumonia. There were two brief subsequent status updates in the documentation, but no action was taken by the PNMT. ON 1/31/13, it was reported that a PNMT referral was in process from the IDT and he was subsequently referred by the IDT back to the PNMT on 2/3/13 due to aspiration pneumonia, g-tube, hospitalization and respiratory distress. It was not clear why the PNMT did not proactively move him to Level I status and conduct an assessment earlier in January 2013. There were extensive action plans and follow-up on action steps, but again documentation was cumbersome and difficult to follow. Action plan formats for follow-up should highlight actions and time frames for ease of analysis by any reader, rather than rolling text. The current methods resulted in voluminous paperwork for the PNMT as well as that contained in the individual record. In either location, it was difficult to get to the core issues related to individual status and needs, actions taken and when, as well, as follow-up to ascertain effectiveness of supports and services. The monitoring team was not able to establish that the PNMT had fulfilled its roles and responsibilities to that end. • In 0 of the 3 individual records reviewed (0%) when an individual experienced a change in status that would warrant a referral to the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. o For Individual #89 (11/15/12), the referral form identified nine falls in one month, then the last fall resulted in a serious injury (fracture to the right eye orbit and maxilla), as well as, a nearly 20% weight loss over a six month period. This was a PNMT self-referral rather than initiated by the IDT and at that was not initiated in timely manner. This was the only current referral form submitted; others were prior to this review period. Individuals, including Individual #15, Individual #114, Individual #92, Individual #23 and Individual #162 (aspiration pneumonia), had been referred in the last six months, but referral forms were not identified by the monitoring team (Individual #114 was referred by the PNMT rather than the IDT). The referral date for Individual #15 was recorded as	

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		10/11/12, though a new gastrostomy tube had been placed on 9/6/12, over one month prior. This was initiated by the PNMT themselves rather than the IDT as expected. Individual #111 was identified with a possible CVA (7/8/12 to 7/11/12), the documentation requested did not include that time period, though there was no other evidence that she had been referred to the PNMT. Individual #104 was identified with a small bowel obstruction (11/2/12 to 11/8/12) with colostomy and a history of weight loss. There was no evidence of IDT referral to the PNMT related to that change in status, though the PNMT met to discuss him on 11/1/12, 11/2/12, 11/6/12, and 11/13/12. o There were 19 falls with serious injury for seven individuals during the last six months. Five of these individuals had experienced more than one serious injury (Individual #23, Individual #59, Individual #61, Individual #147, Individual #84, Individual #89, and Individual #50) and as many as four for Individual #23, Individual #61, and Individual #147. There were 18 individuals listed with three or more falls in a six month period, 10 of whom had five or more falls, and one with as many as 13 during that time (Individual #89). Six individuals with falls were listed with a wheelchair as their primary means of mobility. As stated above, only Individual #89 had been referred to the PNMT, though only after nine falls in one month. o The list submitted related to weight loss of 10% or greater in six months actually reflected weight gain only for 10 individuals. While it was positive that these individuals had gained weight, it was of concern that EPSSLC was not aware of who may have actually lost weight. • 0 of 1 individual who received a feeding tube (not on an emergency basis) since the last review (0%) had been referred to the PNMT prior to the placement of the tube. Individual #15 had a tube placement during a hospitalization, though this did not appear to be an emergency situation. • 1 of 1 individual who received a feeding tube placement (100%) since the last review had been referred to the PNMT after new tube placement, though as stated above, this was initiated by the PNMT and was done over one month later. A PNMT meeting was observed by the monitoring team. Two IDT members were present (Individual #28), though little was reported by the nurse case manager. The QDDP was well-informed and her contribution was significant and meaningful. The meeting was well-organized and there was productive discussion and participation by all PNMT members. There were no specific meeting minutes, but rather extensive documentation that was individual-specific. Clear and meaningful measurable outcomes should be established for each individual with consistent review of the status of these outcomes documented, on at least a monthly basis or other designated interval. As stated above, the	

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		current approach to documentation was extremely thorough, though perhaps excessive, but certainly difficult to navigate for any reader. Consideration for a change in format to streamline for ease of use is suggested. The number of individuals living at EPSSLC with specific PNM-related concerns (and potential needs for supports and services by the PNMT) included, but was not limited to, the following examples: • Difficulty swallowing: (81) • Require positioning assistance: (25) • Chronic dehydration: (7) • Chronic respiratory infections: (8) • ER visit or hospitalization for constipation or bowel obstruction (6) • Decubitus/pressure ulcer (3) • Weight loss of 10% of more over six months: (10), though the facility did not differentiate between planned and unplanned) • BMI equal to or less than 20: (21), 10 of these individuals listed with BMI below 18.5 or underweight status, three were listed with a BMI of 0 (Individual #113, Individual #72, and Individual #99) and one with a BMI of 2.5 (Individual #30) • BMI equal to or greater than 30: (11), one of these had a BMI of 40 or over, or morbid obesity (Individual #178). Obesity was reported in 9% of the census. • Poor oral hygiene (33 in 2012), five to date in 2013. • Aspiration and/or pneumonia incident in the last six months: (1, though six others were listed with bacterial pneumonia and nine others were "ruled out" for pneumonia) • Choking (1) • Received modified diets (90) or liquid consistency (13). • Diet downgrades to diet or liquid consistency (12), two of these were changed to NPO status, or nothing by mouth (Individual #15 and Individual #71). • Enteral nutrition (15), 10 of these received nothing by mouth (NPO status) • Falls with serious injury: (19), for seven individuals. Five of these individuals had experienced more than one (Individual #23, Individual #59, Individual #61, Individual #147, Individual #84, Individual #89, and Individual #50) and as many as four serious injuries (Individual #23, Individual #61, Individual #147). There were 18 individuals listed with three or more falls in a six month period, 10 of whom had five or more falls, and one with as many as 13 during that time (Individual #89). Six individuals with falls were listed with a wheelchair as their primary means of mobility. • Fractures: (5), one individual was considered non-ambulatory (Individual #66), three required assisted ambulation (Individual #20, Individual #58, and Individual #89)	

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		• Non-ambulatory status: (23) • Required wheelchair as primary mobility: (42) • Required transport wheelchairs: (18) • Required ambulation assistive devices: (50) • Required gait belts (53) • Required gait trainers (23) or walkers (3) • Required orthotics and/or braces, orthopedic/custom shoes: (35) • Required mealtime assistance (38), though another list identified only 33, another 52 individuals required some level of prompt. A number of individuals presented with issues in multiple categories of PNM concerns. There was no apparent system to track their status or specific occurrence of events. The facility should consider the development of this type of system. The PNMT should not be solely responsible for maintaining these, but instead there should, in fact, be some type of collaborative facility effort to maintain this or a similar database of key health clinical indicators (see sections E1 and L3). The PNMT should have access to and utilize these routinely. This would be a great effort in the direction needed for appropriate identification of individuals with PNM needs. Specific PNM-related elements should be tracked or reviewed for individuals in weekly PNMT summaries, so that the PNMT could track established thresholds for specific incidents or health events in order to permit individuals to be identified sooner for referral and assessment. These might include, but not limited to, hospitalizations, changes in health status, choking, increased coughing episodes, occurrence of pneumonia, occurrence of skin breakdown, incidents of falls and fractures, weight loss, MBSS results, and others. This information may be gleaned from morning reports attended by the PNMT RN as well as from other sources. This process should also address facility trending of occurrence for specific individuals, occurrence facility wide, over time. Collaboration across systems is indicated to include incident management, risk management, QA, and others. This is another area where specific benchmarks may be tracked in an effort to reduce the occurrence of some of these key indicators. <u>PNMT Assessment and Review</u> Due to the level of involvement system in place at EPSSLC, many individuals did not receive a comprehensive assessment, but rather a review only upon referral (e.g., Individual #23, Individual #63, and Individual #114). In these cases, some limited recommendations were made for implementation by the IDT and review by the PNMT to address these. This metric did not apply because there were no new PNMT assessments completed within the last six months: • ___ of ___ PNMT assessments (%) were initiated at a minimum within five	

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		working days of the referral (or sooner as specified in the PNMT policy). The only assessments (reviewed below) included a re-evaluation secondary to a hospitalization for an individual already on the PNMT caseload (Individual #90) on 1/24/13 and a comprehensive assessment for Individual #162 on 2/18/13. These were the only PNMT comprehensive assessments completed since the previous review. Individual #90's initial referral date was listed as 1/17/12. This re-evaluation was due to a hospitalization from 1/16/13 to 1/23/13 for "bowel obstruction proximal to colostomy site, colostomy stricture," per the hospital reports. This assessment was initiated within 24 hours of his discharge, well within the timeframe established. Individual #162 was referred by his IDT secondary to a diagnosis of aspiration pneumonia on 2/3/13. • 2 of 2 PNMT assessments (100%) were completed in no less than 30 days of the date initiated, or no more than 45 days in extenuating circumstances (critical diagnostics requiring outside appointments, hospitalization, etc. with clearly stated rationale). The assessments completed by the PNMT should be comprehensive, including specific clinical data reflecting an assessment of the individual's current health and physical status with an analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge. Based on review the assessment submitted, the comprehensiveness of the PNMT assessment components was as follows: • 2 of 2 (100%) contained date of referral by the IDT; re-assessment • 1 of 2 (50%) contained date assessment was initiated; • 2 of 2 (100%) contained evidence of review and analysis of the individual's medical history; • 2 of 2 (100%) identified the individual's current risk rating(s), including the current rationale • 1 of 2 (50%) included recommended risk ratings based on the PNMT's assessment and analysis of relevant data; it was not clear if the PNMT recommended any changes to the current risk ratings based on this assessment. • 0 of 1 (0%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition; • 2 of 2 (100%) contained assessment of current physical status; • 2 of 2 (100%) contained assessment of musculoskeletal status; • 2 of 2 (100%) contained evaluation of motor skills; • 2 of 2 (100%) contained evaluation of skin integrity; • 2 of 2 (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; • 2 of 2 (100%) contained evaluation of current adaptive equipment;	

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		• 2 of 2 (100%) contained nutritional assessment, including but not limited to, history of weight and height; intake, nutritional needs, and mealtime/feeding schedule; • 2 of 2 (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; • 0 of 2 (0%) identified residual thresholds, if enterally nourished; • 2 of 2 (100%) contained a tableside oral motor/swallowing assessment, including but not limited to, mealtime observation; • 2 of 2 (100%) contained respiratory status; • 2 of 2 (100%) contained evidence of review/analysis of lab work; • 0 of 2 (0%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; • 2 of 2 (100%) contained discussion as to whether existing supports were effective or appropriate; • 1 of 2 (50%) contained current oral hygiene status; • 0 of 2 (0%) contained evidence of observation of the individual's supports at their home and day/work programs; • 2 of 2 (100%) contained evidence that the PNMT conducted hands-on assessment; • 2 of 2 (100%) identified the potential causes of the individual's physical and nutritional management problems; • 2 of 2 (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations; • 0 of 2 (0%) contained recommendations for measurable skill acquisition programs, as appropriate; • 0 of 2 (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; • 0 of 2 (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; • 2 of 2 (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); and • 0 of 2 (0%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and • 0 of 2 (0%) contained signatures with dates.	

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		Individuals followed by the PNMT, should have clinical indicators included as part of the risk action plans to determine status of the individuals with PNM needs. These were not clearly established for either individual. The IHCPs for individuals with physical or nutritional management difficulties require effectiveness monitoring to assess the individuals' status. The individuals' IHCPs should identify objective clinical data to define health and wellness. Furthermore, the IHCP should identify objective clinical data to indicate when an individual might be experiencing a change in health status. Effectiveness monitoring requires monitoring of this individual-specific objective clinical data to determine the efficacy of the IHCPs interventions. Team review would be necessary to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT should revise these interventions. Plans should be revised within 24 hours, or sooner if is a critical concern, when a change is indicated such as for a change in status or based on effectiveness monitoring findings. Plan development and review should be collaborative between the PNMT and the IDT. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u> Plans resulting from PNMT recommendations included the following components: • For 0 of 2 individuals (0%), all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. See the subsequent metrics below. An IHCP was not submitted for Individual #162. • In 0 of the 2 individuals for whom a HOBE assessment was conducted (0%), as part of the PNMT comprehensive assessment, the HOBE recommendations were integrated into the individual's plans. No evidence of this was noted in the Integrated Health Care Plan associated with the ISP dated 2/20/13, but rather made reference only to continue to follow the PNMP. This should be clearly defined in the IHCP. It was specifically referenced as a support in the IRRF however (Individual #90). • In 0 of the 2 plans reviewed (0%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. Most of the action steps were either reported to be ongoing or pending. Only in the case of training, for example, were specific timeframes established for Individual #162. • In 0 of the 2 plans reviewed (0%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In 0 of the 2 individual's plans reviewed (0%), the plans included the specific clinical indicators of health status to be monitored. • In 0 of the 2 individual's plans reviewed (0%), the plans defined individualized triggers. • In 2 of the 2 individual's plans reviewed (100%), the frequency of monitoring was	

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		included in the plans. PNMT Follow-up and Problem Resolution As described above, it was not possible to effectively track all identified actions recommended by the PNMT through to resolution due to the cumbersome nature of the documentation methods. There was well documented follow-up related to Individual #39 submitted with the evidence related to his choking event on 12/9/12, only days after his discharge from the PNMT. Individuals Discharged from the PNMT There were three individuals discharged from the PNMT during the last six months: • Individual #15 (10/11/12 to 10/18/12) • Individual #92 (11/5/12 to 11/8/12) • Individual #39 (2/23/12 to 12/4/12), not listed, but documented in the minutes For individuals discharged by the PNMT, there should be an ISPA meeting to discuss PNMT discharge to the IDT. A discharge summary should be completed that provides objective clinical data to justify the discharge. All recommendations should be integrated into the IHCP with specific criteria for referral back to the PNMT. All of these elements were not evident in the records reviewed. In any effective PNM program, the referral to the PNMT is indicated in a timely manner, so as to capitalize on the collective expertise of the team members in order to see the problem in a new way and to identify new strategies to address ongoing issues that had not yet been resolved. There is an urgency to complete PNMT assessments that are thorough, current, and accurate, and to implement appropriate and effective interventions to address the identified needs for individuals. This should be completed within 30 days, at most, though some interventions may be implemented immediately based on evaluation findings before the written report is finalized. It is critical that the assessments be completed in a timely manner because these individuals present with significant identified needs for supports and services to address PNM health concerns. The EPSSLC PNMT appeared to understand this responsibility and was certainly moving along the continuum toward compliance with this aspect of O2. Further work was needed, however, with regard to identification of need, timely referral by the IDT, follow-up, and integration into the ISP. The current methods of documentation were likely a barrier to demonstrating these.	

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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>Identification of Individuals Requiring a PNMP</u> In Section O1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. Per current state office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. Attendance by key IDT members for review and approval of the PNMP included the following (16/18 ISPs included signature sheets): • Medical: 13% (2/16), improved from 13% • Psychiatry: 56% (9/16), improved from 13% • Nursing: 100% (16/16) • RD: 19% (3/16), 10 others were attended by the diet technician only • Physical Therapy: 50% (8/16) • Communication: 44% (7/16), one was attended by the SLP assistant only. • Occupational Therapy: 19% (3/16) • Psychology: 69% (11/16) • Dental: 75% (12/16) It is not 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 cannot be reviewed and revised in a comprehensive manner by the IDTs unless each of the team members is present to participate in that process. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O1: • PNMPs for 18 of 18 individuals (100%) were current within the last 12 months. • PNMPs for 18 of 18 individuals (100%) included a list of PNM risk levels. Only PNM risks and triggers were listed. It was not clear if these were high, medium or low risks. The plan for Individual #50, dated 1/8/13, identified both high and medium risk areas. These appeared to be related only to the supports provided in the PNMP, rather than all risk areas. Consideration for whether there is staff understanding that these may not be the only risks will be critical for staff training. No outcomes were identified. There was also no indication on the plan whether the individual had an aspiration trigger data sheet. • It was understood that the state guidelines related to the PNMP format had	Noncompliance

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		changed and that this was consistent with those changes. • In 18 of 18 most current PNMPs (100%), there were large and clear color photographs with instructions. • 18 of 18 PNMPs (100%) listed the adaptive equipment required by the individual with rationale. • In 11 of 11 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions were provided, or it was specified that the individual was independent. • In 18 of 18 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. • In 18 of 18 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 18 of 18 PNMPs (100%), bathing instructions were provided. These were typically general descriptions of level of assistance required, however, often in therapy terms of max-mod-min assist. • In 18 of 18 (100%)PNMPs, toileting-related instructions were provided, including check and change. These were typically general descriptions of level of assistance required, however, often in therapy terms of max-mod-min assist. • In 18 of 18 (%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. • In 18 of 18 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • 18 of 18 individuals (100%) Dining Plans were current within the last 12 months. • 3 of 18 individuals had feeding tubes with no oral intake. 3 of 3 PNMPs/dining plans indicated the individual was to receive nothing by mouth (100%). • In 18 of 18 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. • In 15 of 15 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 15 of 15 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 15 of the 15 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. • In 18 of 18 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid	

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		consistency. • In 18 of 18 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. • 18 of 18 PNMPs (100%) included information related to communication (how individual communicated, how staff should communicate with individual). The PNMPs reviewed were generally very good with very comprehensive content. It was noted that in some cases, however, there was a page break that resulted in a separation of the mealtime equipment from the rest of the dining plan instructions that would make this easy to miss when referring to the PNMP rather than the dining plan. Also the type of assistance required for activities such as bathing and toileting, for example, was in professional jargon (Max-Mod-Min assist), rather than more user-friendly descriptive terms to instruct staff of the specific strategies required.	
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>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u> Dining Plans were readily 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 readily available nearby. General practice guidelines (foundational training) 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 by the therapists and PNMPCs. • 44 of 50+ individuals' (88%+) dining plans were implemented as written. Some examples of concerns included: • Individual #54: No staff were sitting with him for over three minutes. He was identified that he preferred V-8 juice, but none was available during the meal observed. • Individual #129: Staff could not provide hand over hand assistance for eating as instructed while also providing downward pressure on his tongue. • During a medication pass for Individual #89, he was permitted to drink a mixture in his cup at too fast a pace. • Individual #40 was seated too far from the table during her meal for independent eating. • Staff was observed offering a beverage during a snack for Individual #72. He was encouraged to sit forward in the recliner for a sip, but permitted to lay back against the back for the swallow. His trunk and head were not in a safe position for swallowing and his plan stated that he should be in an upright position for all eating activities. • Staff stood to provide hand over hand assistance for Individual #195. • In home 508, at dinner, individuals were seated in the dining room prior to 4:20	Noncompliance

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		pm though dinner was reported to be served at 4:30 pm. Four individuals were finally served at 4:55 pm and at least one still had no food at that time. Each had been offered something to drink, but these had been completed well before they were served. • In home 507, at least five individuals were seated at the dining tables at 5:20 pm with beverages only, no food and no activities for more than 15 minutes. Based on additional observations: • 0 of 1 (0%) individuals' oral hygiene plans were implemented as written (Individual #70). Staff stood above eye level when providing oral hygiene assistance. • 42 of 50+ individuals' positioning plans were implemented as written (84%). • 2 of 3 individuals' transfer plans were implemented as written (67%). • In 3 of 4 observations of medication administration (75%), the nurse followed procedures in the PNMP. One other individual refused to take the medication at the time of the observation. No bathing was observed so the following metric did not apply: • ___ of ___ individuals' bathing plans were implemented as written. <u>Choking/Aspiration Events</u> There were 8 individuals identified at high risk for choking and 86 others considered to be at medium risk. There was one choking incident for an individual reported by the facility during the last six months (Individual #39). One other had occurred during the previous review period for Individual #57 on 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. Individual #39 had a significant history of multiple choking episodes (8/17/10, 5/31/11, 7/30/11, 1/6/12). The PNMT did not conduct a PNMT evaluation until 2/23/12. As of that time there had been no SLP assessment. The outcome established by the PNMT was "no choking episode in three months." As of 5/15/12, PNMT documentation indicated that he had not experienced a subsequent choking event and he was moved from Level I to Level III involvement by the PNMT at that time. Re-assessment was to occur if he experienced a near choking or choking event within six months (8/31/12). Frequency of PNMT and IDT review was established at one month intervals. Individual #39 met the	

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		established criteria, but due to some additional acute weight loss issues the PNMT continued follow-up. With resolution of identified concerns, the PNMT recommended discharge as of 12/4/12. On 12/9/12, another choking event occurred, due to staff noncompliance with his diet order (he was given a peanut butter sandwich). A meeting between the PNMT and the IDT was not scheduled until 12/20/12. The IDT reportedly met on 12/10/12 and developed plans for staff training and staff monitoring to begin on 12/27/12 and end on 1/25/13. It was not clear why the there was such a significant lag in monitoring of staff compliance in this case. It was also reported that he had been sleeping during meals, and was hungry so staff needed to provide alternative foods within his prescribed diet texture to offer. The key to the refrigerator was not readily available to staff. He was also permitted to eat in his room by report, determined to be unsafe per the PNMT. It was of concern that these situations had not been previously reported and resolved rather than after another life threatening choking event for Individual #39. Many staff continued to require prompts to answer questions related to risks. Most immediately indicated that they needed to look at the plan in order to answer questions. They continued to need to refer to a written plan to know what they were to look for in an individual for whom they were providing supports. Review of the plans and risks should be done when the staff were initially assigned for the day, but even so, staff should have an active knowledge of the individuals to whom they were assigned on any given day. This should not be routinely acceptable for the following reasons: • The staff were clearly assigned as responsible for the individual. • The staff should have already reviewed the plan prior to taking on that responsibility. • The staff should be trained to competency to work with that individual. • Staff should know many, if not most, of the risks and rationale for the supports they provide. It is critical that they know what to look related to potential triggers or clinical indicators so that any necessary action may be taken promptly. It was noted on the monitoring sheets that in some cases, staff were given a "yes" response if they looked at the plan and could describe the individual's risk at that time.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed	<u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundation PNM-related skills. Class time was approximately only six hours, however, to address dysphagia management, communication/deaf awareness and AAC. Other PNM/OT/PT topics were conducted across several days, though much of this appeared to be repeated, perhaps to ensure a smaller class size. It was not known if there was adequate opportunity for demonstration, participant practice, and check-offs requiring return demonstration. It was reported that there was a presentation of foundational skills, with	Noncompliance

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	competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	modeling by the trainers to new employees. Practice time was provided with coaching by the trainers and then new employees were checked off on each skill using the checklist. This was described as validation. If the new employee failed to demonstrate competency, the check-off was discontinued with re-training and coaching provided. New employees were given three attempts to successfully pass each skill-based competency. Written examinations were passed with 80% accuracy, while with skills based foundation skills, new employees were required to pass every step for every skill without coaching. An entire day was scheduled for orientation and mobility that was taught by Habilitation Therapy staff. It may be beneficial to review this curriculum to ensure that it covers information that is key to staff performance for the individuals at EPSSLC to determine if additional time may be re-allocated to other critical PNM content areas. The PNM-related core competencies (i.e., foundational skills), in addition to communication and AAC addressed in Section R, included in the NEO training was comprehensive. It was an extensive curriculum containing the following minimum elements: • Lifting and Transfers; • Positioning (Alternate, wheelchair, and bathing/showering); • Adaptive Equipment; • PNMP orientation and implementation; • Safe Mealtime strategies; and • Basics of Dysphagia. There were associated skills-based competency check-offs for most of this content. Revisions had occurred over the last six months resulting in improvements in content. After NEO classroom training there was an established shadowing period when the new employee was released to the supervisor for home assignment. An assigned validator then completed home-based training during a seven day period in which they were not assigned a caseload, but were allowed to assist other already competent DSPs on that home. Validation was completed for all foundational skills and any identified non-foundational skills (individual-specific, NFS) for individuals on that home. In some cases, common non-foundational skills were added to the curriculum, but others that were more specific required additional staff training and check-off to ensure competent implementation. After successful completion of all competency-based training (foundational and non-foundational) and check-offs, the new DSP was assigned to work without restrictions on that home. Validators may be PNMPCs or residential supervisors that were trained and checked-off by a professional staff. Re-validation occurred every quarter thereafter by a COTA, PTA, or SLPA. The facility reported that this could also be	

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		done by other trained personnel, such as CTD staff, RN, PNMC, or home supervisor. A tracking system was in place to ensure that new employee validation was conducted as well as revalidation of PNMPCs and residential supervisors. PNM Core Competencies for Current Staff Refresher courses for all existing staff were required annually with essentially the same or nearly equivalent curriculum as that for NEO. Skills-based competencies were also required in most cases. It could not be determined from the Presentation Book how many staff who required it had participated in refresher training during the last six months. All DSPs, technicians, PNMPCs, and professional staff (OT, PT, SLP, and respiratory therapists) were required to take the foundational skills PNM training in NEO. Locally this was also required of RNs and LVNs. It was not clear who was required to take annual refresher training in each of the PNM-related content areas. Other theme-based training occurred throughout the year based on identified need from the findings of PNM and mealtime monitoring, though this had focused predominately on communication during the last six months. The format of this training was to continue during the town hall meetings held and participation was expected to improve by report. Mealtime Coordinator training had been conducted with modeling to reinforce implementation of the strategies There continued to be identified issues related to staff training and performance. The systems in place were new and continued to be revised. As such, this element was not considered to be in substantial compliance at this time.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	Facility's System for Monitoring of Staff Competency with PNMPs The monitoring tools generally included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. Instructions for use of these forms were not submitted. EPSSLC continued to use separate PNMP monitoring and mealtime monitoring forms rather than the Universal Monitoring Form used in other facilities. The forms used at EPSSLC included more discrete measures and issues could be more readily flushed out for system change. For example, there were separate elements related to implementation positioning, techniques, adaptive equipment, bite size, and pace, where on the universal form these were clustered together and it was not readily apparent which staff errors had occurred. The staff conducting monitoring were also generally competent in the areas they were monitoring based on the existing system of validation and re-validation on a routine basis.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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Monitoring was typically conducted monthly or quarterly depending on the individual's risk levels. While the department had the ability to track staff names, these were not used to ensure that all staff were routinely monitored for the implementation of all aspects of the PNM for individuals to whom they were assigned. The frequency of monitoring (PNM and mealtime) appeared to be occurring at the prescribed frequency and, in the case that one was missed, it was typically made up within the next month.

While this level of frequency was adequate to establish staff competency, it was not sufficient for those individuals at highest risk for PNM concerns. It was also of concern that it was likely that some staff were not monitored routinely for continued compliance with implementation of plans for which they were deemed to be competent.

The monitoring team requested monitoring forms completed in the last month. There were 48 Individual PNMP Monitoring forms and 46 Individual Mealtime Monitoring forms submitted. None of these was marked as a reliability check.

PNMP monitoring was completed as follows:

There was no monitoring conducted on third shift.
26 forms (23%) were marked as completed after 2:00 pm (second shift) and approximately 15 of these were completed after 5:00 pm.
3 forms were completed between 12 noon and before 2:00 pm.
19 forms were completed between 7:00 am and before 12 noon.
3 forms were initiated prior to 8:00 am.

Compliance scores:
<table>
<tr><th>100%</th><th>90%</th><th>80%</th><th>70%</th><th>60%</th><th>No score</th></tr>
<tr><td>7</td><td>19</td><td>16</td><td>6</td><td>0</td><td>0</td></tr>
</table>
Compliance scores were high, with at least 84% of scores were above 80%.

The PNMP monitoring process did not consistently cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, including bathing, medication administration, and oral care. Also, because monitoring occurred only one time (though often over a period of 30 minutes or more), all aspects of alternate positioning were not typically observed. In most cases, the monitor identified the position the individual was in at the time of the observation.
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		Mealtime monitoring was completed on a monthly, quarterly, or every six months as follows: • There was no monitoring conducted on third shift, because breakfast times were scheduled on first shift only. • 23 forms (23%) were marked as completed for the dinner meal. • 11 forms were completed for lunch. • 10 forms were completed for breakfast. • 1 form was completed for an individual who was enterally nourished. It was of concern that only 1 individual had been reviewed because a number of the individuals who received enteral nutrition were at high risk in some area of PNM and should have been monitored at least monthly, if not more frequently. • Home mealtime monitoring and mealtime engagement monitoring supplemented the monitoring conducted by the PNMPCs. This was general monitoring for a home and was not individual-specific. Frequency was as often as three times a week in homes 506, 507, and 508; other homes were conducted less often secondary to improved compliance scores Compliance scores: 100% | 90% | 80% | 70% | 60% | No score 19 | 15 | 8 | 3 | 1 | 0 Compliance scores were high, with at least 91% of scores were above 80%. A number of issues were identified on the forms, but it was not clearly indicated on most that there had been timely resolution. Skill drill questions were rotated every quarter to monitor staff knowledge in various content areas. There was a tracking system that examined each of the elements on the forms to identify trends and needs for additional training or monitoring. Though it was reported that corrective actions were taken, review of the CAPS actual steps taken to impact the findings was not evident, but rather the reports continued to document data and did not link back to determine if any actions taken resulted in an improvement. In the case that it did not, corrective actions did not appear to be modified. <u>Individual-Specific Monitoring</u> The current monitoring system for implementation compliance and staff competency was based on individual risk levels. While this type of monitoring focused on staff performance, it was tracked per individual rather than per staff, though staff names were a data point. It was not possible, however, to ensure that all staff were monitored for continued and consistent compliance. This is different than monitoring that focuses on	

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		the individual's health status and the impact of supports and services on health, function, and risk levels, as well as effectiveness. This should be a key element in an effective PNM system and is reviewed in O7 below.	
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.	<u>Effectiveness Monitoring</u> A system of routine effectiveness monitoring of the PNMPs and dining plans by the professional staff was to be conducted at least quarterly, or more often as indicated. There was no specific process for this established at EPSSLC. There was frequent documentation by therapists related to direct interventions or contacts for equipment or other troubleshooting, but none routinely done to review all interventions for effectiveness related to the occurrence of PNM/health concerns for which they were designed to address. These reviews should also report on compliance with implementation of plans by staff. Effectiveness monitoring should include programs across all environments and not only in the home.	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Individuals Who Received Enteral Nutrition</u> There was list of individuals who received non-oral intake that identified 13 individuals who received enteral nutrition (11%). Individual #15 was listed as having received a new tube placement since the previous review. Nine individuals were listed as no oral intake (NPO) and four received some type of oral intake. <u>Evaluation of Individuals who Received Enteral Nutrition</u> Though 10 APENs were requested, only eight had been completed during the previous six months. Six of these had occurred related to the annual ISP, one due to a new aspiration pneumonia diagnosis (Individual #162) and a new tube placement for Individual #15. • 8 of 8 individuals who received enteral nutrition were evaluated at a minimum annually. • 7 of 8 individuals evaluated had an appropriate evaluation to determine the medical necessity of the tube. The rationale for Individual #1 was incomplete and did not clearly support continued medical necessity. Assessment of Oral Motor status by SLP and/or OT failed to provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate. No one admitted to EPSSLC since the previous review received non-oral intake so the following metric did not apply: • ____ of the ____ individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days.	Noncompliance

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		<u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • 7 of 8 individuals who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. The APEN for Individual #1 did not clearly reflect assessment by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake, but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as a part of assessment findings. • None of the APENs reflected an adequate assessment by the dietitian regarding current formula and schedule of feedings with a determination if the feeding schedule was the least restrictive or there were potential modifications needed in preparation of transition to oral intake. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be: • Integrated into the IHCP, ISP, and/or an ISPA. • Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and Dining Plan that included the same elements as described above.	

Recommendations:

1. Continue to provide training and support to the IDTs for consistency and timeliness of appropriate referrals to the PNMT (O1, O2).

2. Ensure that evidence of participation by medical providers is clearly documented (O1).

3. Consistently document completion of actions and recommendations to close the loop on identified needs. Streamline system of documentation to ensure ease of use of this valuable information (O2).

4. Consider the establishment of episode tracking in a clear and concise manner to establish thresholds for individuals that would generate referral to the PNMT or other key interventions (O2).

5. Review specific measurable exit criteria established in the assessment and include these routinely in PNMT documentation. These should pertain to the reason for referral, but also other issues identified as a function of the comprehensive assessment (O2).

6. The IDTs should utilize referral criteria and other measurable outcomes developed by the PNMT for improved consistency of referral of individuals in a timely manner (O2, O3).

7. Centralize database of key health clinical indicators to ensure it is current and accurate. This should be a facility-side project that includes key staff. This information should be updated routinely. These may be used by the PNMT to track individuals who meet certain thresholds for health issues that would indicate a need for referral (O2).

8. Improve integration of PNMT recommendations into the IHCP and other plans developed by the IDTs (O2).

9. Ensure that ISPAs are held to initiate PNMT assessment/review and termination or any changes in the plan based on individual status or findings of monitoring conducted. Discharge summaries should include clinical health indicators, monitoring with specific intervals, and criteria for re-referral to the PNMT.

10. Consider including the following in the PNMT evaluation: timeframe of medical history (such as last 12 months, for example), doses, schedule and start dates of medications (O2).

11. PNMPs require better integration into the ISP via descriptions of PNM strategies and clear evidence of review of these and their effectiveness relative to risk levels (O3).

12. Address toothbrushing via actual observations in the PNMT evaluations and OT/PT evaluations (O2, O3, and O4)

13. Establish a system of effectiveness monitoring (O7).

14. Clarify the purpose and process for completion of the APENs. Perhaps this should be a function of the ISP process. Integration into that document may be more meaningful and useful (O8).

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o EPSSLC client list o Admissions list o Staff list and Curriculum Vitae o Continuing Education documentation o Section P Presentation Book and Self-Assessment o Section O and P QA Reports o OT/PT Tracking o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Effectiveness Monitoring Tool template o Completed Compliance Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months (10/17/12) o Individuals with Pain 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 Individuals With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation

	o Individuals with Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted (Dining Plans) o PNMPs and sample picture pages submitted o PNM Maintenance Log o Wheelchair evaluations submitted o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment log o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to EPSSLC: Individual #149 o OT/PT Assessments and ISPs for the following individuals: o Individual #42, Individual #134, Individual #112, Individual #127, Individual #25, Individual #117, Individual #49, Individual #103, Individual #60. o OT/PT Assessments, ISPs, ISPAs, and other related documentation for the following individuals: • Individual #63, Individual #78, Individual #90, Individual #84, Individual #104, and Individual #111 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 #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31 o PNMP section in Individual Notebooks for the following: • Individual #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31 o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31

	Interviews and Meetings Held: o Susan Acosta, PT, Clinical Coordinator o Jessica Cordova, MPT o Rocio Alvarenga OTR o Silnettra Barhill, OTR o Eric Herrera, PT o Fred Diaz DeLeon, COTA o Sandra Moreno o Various supervisors and direct support staff o PNMT meeting o ISP Meeting for Individual #129 Observations Conducted: o Living areas o Dining rooms o OT/PT Treatment Rooms o Toothbrushing for Individual #70 o Wheelchair assessment
	Facility Self-Assessment: As in previous reviews, the Clinical Coordinator, Susan Acosta, PT, outlined specific activities, many of which were based on 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 taken. 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 activities for self-assessment were numerous. She revised the format at the suggestion of the monitoring team to present the data more in graph or table formats, rather than in the narrative. For example, equipment maintenance was identified as an area that required. There was, however, an effort to better analyze the findings for each provision and this should continue. Further streamlining of the self-assessment process, analysis, presentation of data and reducing the evidence submitted is strongly encouraged. Though continued work is needed, the monitoring team acknowledges the strides that Ms. Acosta and the habilitation therapies department made during the last six months. The facility rated itself as in substantial compliance with P1. This provision was also found to be in substantial compliance by the monitoring team. The clinicians currently providing services appeared to be exceptional and the work environment positive, as evidenced by the retention of long-term employees and contract staff. While the actions taken continued to be definite steps in the direction of substantial compliance for P2 through P4, the monitoring team concurred with the facility's findings of noncompliance. P3 and P4 also require extensive cooperation and collaboration across departments in order to meet the expected

	standards. Excellent progress, however, was made in each of these and the establishment of specific measures of success will ensure continued movement toward substantial compliance. The data reported was generally relevant to each of the provision items, but at times, the extensive data were difficult to navigate. Creating smaller incremental outcome statements may assist in recognizing what actually remained to be done. That said, the department was on a very strong footing for continued improvements.
	Summary of Monitor's Assessment: The monitoring team noted continued progress. Improvements in the area of positioning were observed, though some individuals were not properly positioned and staff required prompts to correct this. Staff need more training and prompting to check for optimal pelvic alignment, particularly after transfers. There were also some wheelchairs that appeared to need revision (some were scheduled). It was excellent to see that some of the therapists had attended a seating course. These therapists were enthusiastic about what they learned, were applying new strategies, and were seeing improvements in their approach to assessment and product selection. OT/PT assessment content improved and was being completed in a timelier manner. The monitoring team observed a wheelchair clinic and an ISP. The participation by the OTs and PTs was exceptional. Provision P1 was found to be in substantial compliance. All of the assessments for individuals newly admitted (one) were completed prior to the ISP. Establishment of clinical competence of the therapists and review of their continued compliance was accomplished via an audit system that appeared to be very effective Approximately 78% of the assessments reviewed (Samples P.1 and P.2) were dated as completed at least 10 days prior to the annual ISP, though in some cases, the dated signature occurred after the ISP due date. All assessments were completed prior to the ISP itself. Based on the tracking log submitted, 100% of the assessments were performed prior to the designated due date. The facility is strongly encouraged to clarify this practice, but the monitoring team did not see this as impacting substantial compliance. The system of documentation of therapy interventions continued to be inconsistent. A routine system of effectiveness monitoring by the licensed clinicians was needed or improvement in the documentation of this process was indicated.

#	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>Timeliness of Assessments</u> There was only one individual admitted to EPSSLC since the previous review (Individual #149): • 1 of 1 admitted individuals since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Only assessments and updates were completed rather than OT/PT screenings, so the following metric did not apply: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening (%), received a comprehensive OT/PT assessment within 30 days of identification. Based on review of the tracking log for referrals, response to these was consistently well within 30 days of the referral date, with assessments or other actions as indicated. For the individuals included in Sample P.1 and P.2: • 21 of 27 individuals' OT/PT assessments (78%) were dated as completed at least 10 days prior to the annual ISP. In some cases, the assessment date in the heading was prior to the ISP due date, but the signatures were later and, as such, would generally be considered late. In some cases, there were signatures and no dates, but in each of these cases, the assessments appeared to be completed on time. Additionally, there were 83 assessments listed in the tracking log submitted, for ISPs dated June 2012 through January 2013. Based on this log, 100% of the assessments were performed prior to the designated due date. The assessment date used was that contained in the heading of the written report, rather than the date the assessment was signed and dated. Reconciliation of this should be considered. If the assessment is electronically logged as submitted on the assessment date recorded in the heading, this would be acceptable. Otherwise, the date of the therapists' signature would be the actual completion date. This was a decrease from the previous review, however, the monitoring team had used 10 calendar days as the standard rather than the established due dates of 10 working days prior to the ISP. • 27 of 27 assessments (100%) were current within 12 months for individuals who were provided PNM supports and services. <u>OT/PT Assessment</u> Based on review of the sample of most current assessments in Sample P.2, the analysis for comprehensiveness of the OT/PT assessments was as follows: • 10 of 11 individuals' OT/PT assessments (91%) were signed and dated by the clinician upon completion of the written report (Individual #79). Same as previous review.	Substantial Compliance

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		• 11 of 11 assessments (100%) included diagnoses and relevance to functional status. Same as previous review. • 11 of 11assessments (100%) included a section that reported health risk levels that were associated with PNM supports. • 11 of 11 assessments (100%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • 11 of 11 individuals' OT/PT assessments (100%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. Same as the previous review. • 0 of 11 assessments (0%) included medical history and relevance to functional status. While the medical history portion of the evaluation was very extensive, it did not refer to the manner in which these impacted functional status. There were numerous medical issues reported that were not specifically or even indirectly related to the provision of OT and PT supports and services. Omitting these may be considered. • 11 of 11 assessments (100%) addressed health status over the last year. Same as the previous review. • 11 of 11 assessments (100%) listed medications and potential side effects relevant to functional status. Improved from the previous review. • 11 of 11 assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills. Same as the previous review. • Description of the current seating system for those requiring a wheelchair (11 individuals) with a rationale for each component and need for changes to the system outlined as indicated also with sufficient rationale (100%). o This represented a significant improvement from the previous review. The monitoring team commends the facility for carefully analyzing the report findings and recommendations in order to make changes in the assessment process and other systems to enhance services and move toward substantial compliance. • 11 of 11 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). Improved from the previous review. • 11 of 11 assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. Improved from the previous review. • 11 of 11 assessments (100%) included discussion of the expansion of the individual's current abilities. Improved from the previous review. • 11 of 11 assessments (100%) included discussion of the individual's potential to	

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		develop new functional skills. Improved from the previous review. • 11 of 11 individuals' OT/PT assessments (100%) included individual preferences, strengths, and needs. Same as the previous review. • 11 of 11 assessments (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. Same as the previous review. • 11 of 11 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. Same as the previous review. • 11 of 11 assessments (100%) included a monitoring schedule. Same as the previous review. • 11 of 11 assessments (100%) included a re-assessment schedule. Same as the previous review. • 11 of 11 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. • 11 of 11assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. Same as the previous review. • 11 of 11 assessments (100%) include recommendations for services and supports in the community. Same as the previous review. • 11 of 11 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. Same as the previous review. Further findings were as follows: • 100% of the assessments contained at least 22 of 24 (92%) of the elements. • Only one assessment (Individual #79) did not have signatures and dates for all three disciplines. • The only element rated as below 90% was related to medical history. While an extensive medical history was provided in each assessment, the relevance to functional status was not identified. The facility could consider reducing the content of this section to include only issues that could potentially impact OT/PT services and add statements as to how functional status was or was not affected. This was not considered to be a significant concern by the monitoring team due to the overall excellence of the assessments reviewed, otherwise. None of the assessments submitted were updates so the following metrics did not apply: • ____ of ____ updates (%) were completed consistent with the established schedule, or the individuals' need.	

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		• For ___ of ___ individuals for whom updates were completed, the updates provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data. As each individual received a comprehensive assessment, the facility should begin to consider the completion of updates to reflect current functional status, supports and services provided over the course of the previous year, review of health status, progress with functional outcomes and effectiveness of direct and indirect supports and services, as described in the previous metric. This assessment should not have to be as lengthy as the existing comprehensive assessments so as to permit further delivery of services. A comprehensive re-assessment may be completed every three to five years or as needed due to a change in status. The update should be provided for those who were provided OT/PT supports and services. This provision was found to be in substantial compliance. The facility also self-rated this provision in substantial compliance in its self-assessment. All of the assessments for individuals newly admitted (one) were completed prior to the ISP. Establishment of clinical competence of the therapists and review of their continued compliance was accomplished via an audit system that appeared to be very effective, as the assessments reviewed (10 most current, Sample P.2) met the required elements at above 90% compliance. Approximately 78% of the assessments reviewed (Samples P.1 and P.2) were dated as having been completed at least 10 days prior to the annual ISP, though in some cases the dated signature occurred after the ISP due date. All assessments were completed prior to the ISP itself. Based on the tracking log submitted, 100% of the assessments were performed prior to the designated due date per the assessment date used contained in the heading of the written report. The facility is strongly encouraged to clarify this practice, but the monitoring team did not see this as impacting the finding of substantial compliance.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health	<u>Direct OT/PT Interventions:</u> The records of individuals in Sample P.3 were reviewed resulting in the following findings: • 6 of 6 individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • For 4 of 6 individuals' records (67%) reviewed, the current OT/PT assessment identified the need for direct intervention with rationale. There was no annual or interim assessment to provide justification for the initiation of direct OT/PT services for Individual #63 or Individual #78. • For 0 of 6 individuals' records (0%) reviewed, there were measurable objectives	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	related to functional individual outcomes included in the ISP or ISPA. • For 1 of 6 individuals' records (17%) whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner (Individual #90 only). There was no clear review of the discontinuation of therapy services by the IDT noted in an ISPA for any of the individuals reviewed. The system for documentation was inconsistent. In some cases, there was an evaluation to initiate direct interventions (Individual #90**,** Individual #84**,** Individual #104**,** and Individual #111), and a discharge summary to discontinue the service (Individual #90). In most cases, there was a SAP associated with the service and daily progress notes, though some were in the IPNs and others were filed in the Habilitation Therapies tab only. The ISP identified continued PT for Individual #84 and the initiation of therapy for Individual #104, but there was no ISP to initiate therapy for the other four individuals. In the case of Individual #63, the ISPA identified that therapy was being provided, but there was no evidence that there had been an ISPA to initiate therapy. Some cases included monthly summaries in addition to the daily notes and others did not (Individual #84). Documentation was inconsistent and did not effectively close the loop on direct services provided. There were unexplained gaps in service without explanation, inconsistency in the provision of services, and lack of rationale for discontinuing services. Review of progress notes should be considered with the following elements: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. • A comprehensive progress note was completed on at least a monthly basis that offered a comparative analysis to progress made the previous month or across a quarter. • Termination of the intervention was well justified and clearly documented in a timely manner. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O3 above regarding PNMP format and content. Implementation of PNMPs is addressed in section O5. • For individuals included in the Sample P.1, 18 of 18 PNMPs (100%) were	

#	Provision	Assessment of Status	Compliance
		developed within 30 days of the date of the ISP, and/or assessment/update, or sooner as indicated by need. • For 9 of 13 individuals (69%), the ISPs addressed each of the recommendations for indirect supports outlined in the current OT/PT assessment beyond the PNMP. <u>Integration of OT/PT Supports and Services in the ISP</u> Review of the ISPs submitted was as follows: • 100% (18 of 18) of the ISPs submitted were current within the last 12 months. 17 of 18 current ISPs had attached signature sheets (none for Individual #99). • 12% (2 of 17) of the current ISPs with signature pages submitted were attended by both the PNMT OT and PT. • 35% (6 of 17) were attended by PT only. • 6% (1 of 17) was attended by OT only. • 47% (8 of 17) of the current ISPs had no representation by an OT or PT. Five had an SLP serving as the Habilitation Therapies representative and two others had a Habilitation Representative, but the discipline was not clearly designated. It was not likely that the SLP could adequately represent the OT or PT at the ISP meeting. In four cases, the OT or PT served as the representative for the other discipline, which would likely be more effective representation. The new system of pre-ISPs will designate which disciplines will be required to attend the ISP. The monitoring team looks forward to review of this system during the next review. This level of attendance was not acceptable. As the clinicians worked very closely together, attendance by either OT or PT based on the identified needs as adequate representation would be provided by either in most cases. There is no expectation/requirement that the PNMT OT and PT attend any ISP meeting. In those cases where the PNMT OT and/or PT attend the ISP meeting, however, the individual's assigned OT and/or PT should make sure he or she attends that meeting, too. (In some cases, the PNMT OT/PT is the same person who is the assigned OT/PT.) This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	

#	Provision	Assessment of Status	Compliance
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	Competency-Based Training Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs were addressed in detail in section O.5 above. Substantial compliance with O.5 is the standard for compliance with this element. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	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 for staff compliance with the implementation of physical supports and the condition and availability of adaptive equipment was implemented at EPSSLC. This was addressed in section O.6 and O.7 above. There was a system of routine effectiveness monitoring conducted by the clinicians. Recommended frequency of PNMP monitoring was included in the OT/PT assessments in a specific section to permit ease of reference for the IDT. Routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Per the maintenance log, these were conducted for 13 of 13 individuals included in Sample P.1 who required them (100%). Most of these were conducted at least quarterly, though some were more frequent, as indicated. In addition, a fabrication technician conducted random audits of cleanliness. PNMP monitoring conducted by PNMPCs checked all equipment for working order, and cleanliness had been added as an element reviewed. In general, based on the data presented by the facility, maintenance continued to be an issue with corrective actions taken and reviewed to promote improvements. 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 monthly meetings held with the fabricators to ensure that maintenance and fabrication of new systems and modifications were completed in a timely manner. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	Noncompliance

Recommendations:

1. 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 (P1 and P2).

2. Reduce medical history documentation and relate directly to function (P1).

3. Consider implementing annual updates for individuals with a strong comprehensive assessment (P1).

4. Establish documentation guidelines to ensure that all necessary elements are present and that there is a consistent system used across therapists (P2).

5. Rationale for therapist attendance in the pre-ISP process needs to be sound and clearly supported (P2).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o EPSSLC: Facility Operational Dental Services Policy, 11/19/12 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 Documentation of strategies for dental refusals the following individuals: • Individual #84, Individual #172, Individual #71, Individual #152 o Complete Dental Records for the following individuals: • Individual #100, Individual #147, Individual #146, Individual #5, Individual #4 Individual #102 Individual #15, Individual #16, Individual #17, Individual #24, Individual #59, Individual #63 Interviews and Meetings Held: o Howard Pray, DDS, Facility Dentist o Raquel Rodriquez, RDH o Jennifer Pacheco, RDH Observations Conducted: o Dental Clinic o Informal observation of oral hygiene regimens in residences o Pretreatment Sedation Meeting

	Facility Self-Assessment: The facility submitted its self-assessment, which was similar to that submitted for the July 2012 review. The dental self-assessment followed a template issued by the state dental services coordinator. For each provision item, a series of activities engaged in to conduct the self-assessment was listed. For each activity, a result or data point 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 appeared to have concerns about its data integrity, noting in the self-assessment that accuracy was less than 100%. The facility will need to invest time in exploring data accuracy. To take this process forward, the monitoring team recommends that the center lead continue this type of self-assessment and add additional metrics specific to dental clinical outcomes. 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 providing treatment to individuals who had previously not received treatment due to the inability to cooperate in clinic. The clinic provided services on a daily basis. The facility dentist provided services nine days a month. 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. Individuals received preventive care and emergency care. The percentage of individuals with poor oral hygiene decreased slightly, but remained high. Many individuals continued to require multiple extractions of 10 or more teeth. The facility dentist explained that this was largely a result of individuals receiving little care over many years. The expectation was that with proper home care, oral health would improve and more individuals could move into the phase of having restorative work completed. The number of failed appointments remained low. EPSSLC did not have any "no shows" because the hygienists continued to go to the home to pick up individuals. The facility also reported very few refusals. Data management in the dental clinic has presented challenges for nearly every compliance review. For this review, additional data were required. In many instances, that data were not found for the dental department and a request was made to update during the compliance review. This was discussed with the clinic staff and the Settlement Agreement Coordinator, but was not fully resolved. Thus, EPSSLC had many dental data elements that ended in early November/December 2012. The staff reported problems with the dental database and added to the self-assessment "accuracy of database is less than 100% accurate."

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q1</td><td>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.</td><td>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. For some areas, the monitoring team did not have adequate information because the documents were not updated past November 2012.

<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 dentist worked less than three days a week for a total of approximately nine days each month. Of these, two to three 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. The facility continued to operate without an onsite dental director.

<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 below.

<table>
<tr><td colspan="7">Dental Clinic Appointments 2012</td></tr>
<tr><td></td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td></tr>
<tr><td>Preventive Care</td><td>42</td><td>56</td><td>42</td><td>53</td><td>42</td><td>3</td></tr>
<tr><td>Restorative</td><td>0</td><td>2</td><td>2</td><td>5</td><td>2</td><td>0</td></tr>
<tr><td>Emergency Care</td><td>1</td><td>2</td><td>4</td><td>1</td><td>2</td><td>0</td></tr>
<tr><td>Extractions</td><td>1</td><td>2</td><td>3</td><td>7</td><td>2</td><td>1</td></tr>
<tr><td>Total Clinic Appointments</td><td>43</td><td>58</td><td>46</td><td>54</td><td>44</td><td>3</td></tr>
<tr><td>EPSSLC Dental Appointments</td><td>40</td><td>54</td><td>39</td><td>49</td><td>42</td><td>2</td></tr>
</table>

The data submitted by the facility represented total dental appointments. This was inclusive of home visits, EPSSLC clinic visits, and off campus visits. Additional data were obtained by reviewing the tracking log. As noted in the table above, there were three appointments in December 2012. One appointment was off campus and the other two appointments were completed in the homes. This information appeared to be from an early document request and was not updated. A cross check of other documents showed that the dentist provided 62 hours of service in December 2012 and individuals were seen in clinic.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Emergency Care During previous visits, it was reported that 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. State issued policy required that all individuals have access to emergency dental treatment by a licensed dentist 24 hours a day. The self-assessment highlighted that the dentist was available nine days a month and emergencies were handled through the medical department until the dentist returned. The professional services contract did not include any requirements for on call availability. Oral Surgery There were no referrals to the oral surgeon. Referrals were made to a general dentist who provided care under general anesthesia in a hospital setting. Oral Hygiene The facility submitted the following data for oral hygiene ratings Oral Hygiene Ratings (%) 2011 2012 Good 14 18 Fair 44 54 Poor 31 27 The data reflected an improvement in overall oral hygiene for the facility. Record reviews and consultation notes documented many individuals with poor hygiene and marked decay with non-restorable teeth. There was also evidence that individuals had SAPs related to oral hygiene implemented. Staff and individuals were trained on proper oral hygiene. Fourteen individuals were reported to receive treatment with suction toothbrushing and Biotene. Chlorhexidine was no longer used at the facility. The facility targeted individuals who received enteral nutrition and were NPO. The treatment was provided by the nursing staff. The facility developed a suction toothbrushing procedure, which was included in the revised dental services policy. At the time of the compliance review, staff training had not occurred. Staff Training All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td>Policies and Procedures
The facility revised its operational dental services policy to include a section on suction toothbrushing. Training remained outstanding.

Annual Assessments
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>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td></tr>
<tr><td>No. Exams</td><td>6</td><td>9</td><td>14</td><td>6</td><td>18</td><td>2</td></tr>
<tr><td>Compliant Exams</td><td>5</td><td>9</td><td>13</td><td>6</td><td>18</td><td>1</td></tr>
<tr><td>% Compliance</td><td>83</td><td>100</td><td>93</td><td>100</td><td>83</td><td>50</td></tr>
</table>

The overall compliance data (excluding December 2012) was 92%. This was an improvement from previous reviews.

Initial Exams
Individual #149 was admitted since the last review. His dental exam was completed within the required timeframe.

Dental Records
Dental records consisted of initial/annual exams, annual dental summary, dental progress treatment records, dental progress notes, and documentation in the integrated progress notes. Providers documented in the integrated progress notes. An entry was also made in the dental progress notes and dental treatment record. IPN entries were written in SOAP format and were generally dated, timed, and signed.

Copies of the complete dental records, for individuals listed under documents reviewed, were requested. The request specifically required submission of all documentation including progress notes, all treatment forms, consult reports, x-ray reports, etc. That information was not provided as requested. The Annual Dental Summary was provided, but there was no Dental Record Initial/Annual Examination or Dental Progress Notes for any of the individuals reviewed. The data submitted are summarized below:
• 0 of 12 (0%) records included current annual examinations
• 0 of 12 (0%) records included periodontal charts
• 12 of 12 (100%) records included Annual Dental Summaries
• 12 of 12 (100%) records included treatment plan records</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The lack of information resulted in the inability to adequately review the care provided to several individuals. The following entry was made in the IPN on 2/8/13 for Individual #195: S – Brought to dental clinic for annual exam O – cooperation fair, OH – fair A – annual exam P – GA recall here 3/13 The dental progress/treatment records listed: • 2/16/12 – Annual exam • 5/17/12 – General anesthesia • 5/22/12 – POT – normal healing • 10/4/12 – OH instructions with DSP • 2/8/13 – Annual exam There was no other information on the annual exam provided. This type of documentation was seen for all of the individuals reviewed. This may be attributed to the document submission because Dental Progress Notes containing detailed information were reviewed onsite. <u>Failed Appointments</u> The facility reported data on refusals and missed appointments only. Those data are summarized in the table below:	

Failed Appointments 2012 -2013								
	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Missed	0	1	0	1	0	1	3	3
Refused	2	1	0	0	1	0	1	0
Total Failed	2	2	0	1	1	1	--	--

The facility reported very few refusals. The hygienist continued to pick up individuals for clinic appointments.

The monitoring team was provided a list that included a brief statement for four individuals who missed or refused appointments.:
- Individual #84 had documentation in the ISP (1/12/12) that an electric toothbrush would be provided to help improve oral hygiene.
- Individual #172 had difficulty cooperating in clinic. The ISP (3/7/12) stated that psychology would talk to the individual about cooperating.

#	Provision	Assessment of Status	Compliance
		• Individual #71 had consent for pretreatment sedation to have x-rays done in with the community dentist. The clinic-tracking log indicated the appointment was cancelled. • Individual #152 had a statement submitted that information could be found in the IPN of the active records The first two responses were dated in 2012 and no follow-up was provided. The third document was simply a consent related to sedation and no other information was provided. There was no information provided for the fourth individual. In the weeks following the onsite review, however, the facility provided the monitoring team with an update on these four individuals that indicated that all four received treatment to completion by the end of April 2013. <u>Dental Restraints</u> The self-assessment noted that pretreatment sedation was utilized once for dental clinic. All other documents noted that the facility used no chemical restraints for the EPSSLC dental clinic. The number of individuals receiving pretreatment sedation and general anesthesia is summarized below.	

Restraint/Anesthesia 2012 -2013							
	July	Aug	Sep	Oct	Nov	Dec	Jan
Oral Sedation	0	0	0	0	0	0	0
General Anesthesia	0	8	0	9	6	9	8
General Anesthesia (community)	1	0	4	1	1	1	4

The facility began providing routine care under general anesthesia in August 2011. This service was provided two to three days each month. In 2011, 70 appointments were completed with general anesthesia. There were 58 general anesthesia cases in 2012. In 2011, 42 appointments involved the use of pretreatment sedation. There was no sedation used in 2012. The facility dentist believed that general anesthesia was the safest approach.

Clinic staff reported that exams were completed without sedation. A review of the sample of documents submitted as the complete dental records showed that individuals did go to clinic and have annual exams, but for nearly all exams, the findings were similar. Documentation noted that the individuals were uncooperative and were referred for general anesthesia or would have a general anesthesia recall. Twelve records were reviewed. One individual was edentulous. For the individuals reviewed, 11 of 11 (100%) had documentation in the IPN in the form of a very brief SOAP note indicating the individual was uncooperative and required general anesthesia.

#	Provision	Assessment of Status	Compliance
		Strategies to Overcome Barriers to Dental Treatment The dental hygienist reported that there were 31 desensitization places in place. Many of these were skills acquisitions plans developed to improve cooperation with oral hygiene and cooperation in dental clinic. They appeared appropriate. Details on the effectiveness of the plans, some of which were implemented in early 2012, were not provided. It appeared that in many ways, the facility adopted a good approach by utilizing a number of techniques to overcome barriers. Now that all individuals had received their first round of treatment, it will be important that individuals who experienced an improvement in oral health have proper hygiene to maintain that status. Moreover, continued hygiene and treatment will allow for further improvement in oral health. The plans that are developed must be fully implemented and monitored for effectiveness. When the plans are not successful, additional measures must be taken.	

Recommendations:

1. The facility needs administrative leadership in the form of a dental director or other designated lead (Q1).
2. The facility must complete the training for suction toothbrushing (Q1).
3. The facility must continue to address the problem of oral hygiene in the homes (Q1).
4. The facility director must ensure that the emergency dental care is available in accordance with state policy (Q1).
5. 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).
6. The facility must address the issue of data integrity (Q1, 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:** **Documents Reviewed:** o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Current SLPs (including contract staff), caseloads and ratios o Current SLP vacancies o Copies of SLPs of current license o Continuing education and training completed by the SLPs since the last review o Draft Communication policy o Facility list of new admissions since the last review o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment template o SLP/Communication assessment template o List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior o List of individuals with PBSPs and replacement behaviors related to communication o PBSP minutes and attendance rosters for the past six months o List of individuals with Alternative and Augmentative communication (AAC) devices o AAC-related database reports/spreadsheets o List of general common area AAC devices o List of individuals receiving direct communication-related intervention plans o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o Communication Assessment for individuals recently admitted to EPSSLC: Individual #149 o Communication Assessments and ISPs for the following individuals: • Individual #42, Individual #134, Individual #112, Individual #127, Individual #25, Individual #117, Individual #49, Individual #103, Individual #60. o Communication Assessments, ISPs, ISPAs, SAPs and other related documentation for the following individuals: Individual #90, Individual #17, Individual #18, Individual #92, and Individual #117. 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 #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. o PNMP section in Individual Notebooks for the following: • Individual #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. <u>Interviews and Meetings Held</u>: o Susan Acosta, PT, Clinical Coordinator o Valerie Villegas, MS, CCC-SLP o Jacqueline Lopez, MS, CCC-SLP o Rebecca Roberts, SLPA o Various supervisors and direct support staff o PNMT meeting o ISP Meeting for Individual #129 o Clinical meeting for SLPs <u>Observations Conducted</u>: o Living areas o Dining rooms
	Facility Self-Assessment: As in previous reviews, the Clinical Coordinator, Susan Acosta, PT, outlined specific activities, many of which were based on 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 taken. 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 activities for self-assessment were numerous. She revised the format at the suggestion of the monitoring team to present the data more in graph or table formats, rather than in the narrative. There was information, however, that was unrelated to the provision items that could be eliminated (e.g., education and training for technician level staff in R.1.).

	While the data presented was generally useful, it would likely be even more useful to the facility to set some benchmarks (in measurable terms) rather than merely stating the activities conducted. These benchmarks could then be used to assess progress and when inadequate progress was made, the analysis could reflect what steps were taken to resolve problems. For example: • IPNs were identified as an area that required improvement due to inconsistency and limited sample size per the data submitted, but there were no strategies identified for implementation to address this need and effect change over the next six months. • In section R3 of the self-assessment, results of an audit related to integration into the ISP were presented. Percentages were documented in a chart form for nine elements, but these were not identified. The summary included an analysis of which areas were deficient, but no steps and strategies to address this were offered other than the implementation of the new ISP format. • In section R4, data related to monitoring for communication and AAC conducted over the last six months were presented. The analysis, however, did not identify the concern noted by the monitor relating to the fact that an AAC device could be missing entirely and a finding for compliance (80% or better) was possible. There was, however, an effort to better analyze the findings per element included on the monitoring form and this should continue. Though continued work is needed, the monitoring team acknowledges the strides that Ms. Acosta and the speech department made during the last six months. The facility rated itself as not in compliance with all four items of section R (R1 through R4). While the actions taken continue to be definite steps in the direction of substantial compliance, the monitoring team concurred these findings.
	Summary of Monitor's Assessment: Progress was made across all elements of section R since the last review. • The clinicians were assigned responsibilities for both communication and mealtimes and, as such, the caseload assignments were considered to be moderately high. This may impact the ability of the speech clinicians to appropriately provide adequate supports and services in each area as noted below. The facility also identified this as a concern per the Presentation Book, but no plan to address this issue was evident. • The speech clinicians initiated a routine review of evidence-based studies in journal articles. An article was selected, read by the clinicians, and then discussed for relevance and application to the population of individuals at EPSSLC. These clinicians are commended for this effort and they appeared highly motivated to learn and to provide effective communication supports and services. • There were some very good communication programs in place and this seemed to be improving with the more recent evaluations. • More work related to the application of AAC to adults with developmental disabilities and physical and cognitive challenges was needed. The clinicians appeared to rule out this as an option based on cognition, limited used of the upper extremities, and initial lack of interest shown by the individual during the assessment, rather than recognizing the role of relevance, alternate access

	sites, environmental context and meaningful contextual training opportunities as effective methods in the development of AAC use in this population. • The majority of the most current assessments reviewed contained more than 70%, but less than 80%, of the elements considered key by the monitoring team. This was a significant improvement from the previous review. • A system of effectiveness monitoring was initiated in December 2012 for routine review of all programs and interventions, but implementation was reported to be inconsistent. Further progress in this area was expected over the next six months. • Though there continued to be identified needs for improvement across all the elements included in this provision, the direction they were taking and the accomplishments since the previous review reflected the greatest strides made since the baseline review. <u>The following samples were used by the monitoring team:</u> • Sample R.1: Individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals with assessments submitted by EPSSLC as most current. • Sample R.3: Individuals admitted since the last compliance review. • Sample R.4: Individuals from R.1 above with AAC systems. • Sample R.5: Individuals receiving direct speech services • Sample R.6: Individuals from R.1 above with indirect communication supports (i.e., skill acquisition plans not directly provided by the SLP/Speech Assistant and Communication Dictionaries).

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	<u>Staffing</u> Jacqueline Lopez and Valerie Villegas were identified as SLPs and Rebecca Roberts was identified as a SLPA; each provided services in the area of communication. There were three positions budgeted. Each was filled with no vacant positions listed. There was one part-time contractor. The facility used the full time SLPA as equally providing communication services with the two full time SLPs. While this position was critical to adequate service provision at the facility, it should be noted that the SLPA was not licensed to conduct assessments and should not be included in the ratios for service provision. She was assigned to assist the two SLPs and provided services as required for individuals under their supervision. Responsibilities of the fulltime SLPs included, but were not limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to communication. The same duties were required for the provision of mealtime supports for these individuals as well. The Presentation Book for this section identified that these clinicians were also required to attend ISP and ISPA meetings and served as mentors for the risk process. The two SLPs were assigned caseloads as follows: • Valerie Villegas: Cottages (506, 507, 508, 509, 510, 511, and 512) = 76	Noncompliance

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		individuals • Jacqueline Lopez: Systems (A, B, and C Dorm) = 41 individuals Per the list submitted, there were at least 36 of 41 individuals in the Systems dorms (88%) who were identified with severe language deficits. Additionally, there were at least 52 of 76 individuals (68%) in the cottage areas (homes 506, 507, 508, 509, 510, 511 and 512) also identified with severe language deficits. This represented approximately 75% of the total census as having severe language deficits who would benefit from communication supports and services to improve and enhance their expressive and receptive communication skills. The clinicians were assigned responsibilities for both communication and mealtimes for these individuals and, as such, the caseload assignments were moderately high. This may impact the ability of the speech clinicians to appropriately provide adequate supports and services in each area as noted below. The facility also identified this as a concern per the Presentation Book, but no plan to address this issue was evident. Compliance with provision R1 is dependent on compliance with the other provisions R2 through R4. <u>Qualifications:</u> • 1 of 2 SLPs (50%) and 1 of 1 SLPAs (100%) were licensed to practice in Texas as verified online. The license for Valerie Villegas could not be verified per the license number provided and was later reported to be a wrong number. <u>Continuing Education:</u> Based on a review of continuing education completed in the last 12 months: • 2 of 2 SLPs staff (100%) and 1 of 1 SLPAs (100%) had completed continuing education. The dates of these were listed, but actual course names and length of courses were not provided, so adequacy of continuing education could not be determined. Continuing education topics that appeared to be relevant to communication included: • AAC • Deaf/Blindness • Autism • Communication and Behavior • AAC/PECS Course names and article reviews were listed in the Presentation Book for this section, but were not consistent with the evidence submitted. Again, course hours were not provided:	

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		• Practical Interventions for Autism Spectrum Disorders • AAC Assessment (Independent Consultant) • AAC PECS Training • Positioning Webinar • Supporting Augmentative and Alternative Communication Use by Beginning Communicators with Severe Disabilities (article review) The speech clinicians initiated a routine review of evidence-based studies in journal articles. An article was selected, read by the clinicians, and then discussed for relevance and application to the population at EPSSLC. These clinicians are commended for this effort and they appeared highly motivated to learn and to provide effective communication supports and services. There were some very good programs in place. More knowledge and experience was needed, however, in enhancing their understanding of AAC use with adults with developmental disabilities and physical and cognitive challenges. They appeared to rule out this as an option based on cognition, limited used of the upper extremities, and initial lack of interest shown by the individual during the assessment, rather than recognizing the role of relevance, alternate access sites, environmental context and meaningful contextual training opportunities as effective methods in the development of AAC use in this population. <u>Facility Policy:</u> The facility used the state policy, Communication Services (016). A localized policy was in draft form at this time. The local policy should provide clear operationalized guidelines for the delivery of communication supports and services, including the following components: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Outlines assessment/update schedule including frequency and timelines for completion of new admission assessments (within 30 days of admission or readmission), timelines for completion of comprehensive assessments (within 30 days of identification via screening, if implemented), and timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within 5 days of identification as indicated by the IDT). • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment. • Addressed a process for effectiveness monitoring by the SLP. • Methods of tracking progress and documentation standards related to intervention plans. • Monitoring of staff compliance with implementation of communication	

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		plans/programs including frequency, data and trend analysis, as well as, problem resolution.	
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> The facility did not have a Master Plan used to prioritize communication assessments. Each individual was provided a comprehensive assessment or an annual update at the time of his or her annual ISP and, as such, a separate Master Plan was not indicated at this time. A tracking log of assessment due dates and performed dates was submitted. The due dates were reflective of the facility policy of 10 working days prior to the ISP. An assessment referral database was also submitted and SLP consults/assessments were reported in the Presentation Book for this section. There was no key for the source of identified need listed and it did not appear that all the assessments were turned in. Further, the consult tracking numbers reported in the Presentation Book were not consistent with the referral database, so the monitoring team was not able to interpret these. <u>Assessments Provided</u> Communication assessments were submitted as requested for the following: • Sample R.1 = 18 individuals (two were duplicated in Sample R.2 below and included Individual #79 and Individual #31) • Sample R.2 = 10 individuals • Based on review of these, it was noted that 26 of 26 individuals in Sample R.1 and R.2 (100%) were provided a communication assessment. Each was current within the last 12 months and 25 were identified as comprehensive. The assessment for Individual #50 was identified as a Speech Language Communication Update (2/28/13). There was no previous associated comprehensive assessment in his individual record, though the update referenced a previous annual comprehensive assessment on 3/26/12. The reassessment schedule indicated that the SLP would complete a comprehensive assessment or update yearly. It was not clear why he was provided an update versus a comprehensive because the update appeared to be of the same format and content as the other comprehensive assessments. The other assessments were completed from 4/5/12 through 3/1/13. Twenty-four of these had been completed in 2012. The intended schedule for completion of communication assessments was reported to be comprehensive assessments every three years with interim updates for individuals who received supports and services. Only one individual had been newly admitted to EPSSLC in the last six months included in Sample R.3 (Individual #149).	Noncompliance

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		• 1 of 1 individual admitted since the last review (100%) received a communication assessment within 30 days of admission. The following metric was not applicable because assessments, rather than screenings, were completed for individuals at EPSSLC: • If screenings were completed, ___ of ___ individuals identified with therapy needs through a screening (%), received a comprehensive communication assessment within 30 days of identification Per the tracking log (June 2012 to January 2013), for 78 of 83 individuals (94%), comprehensive assessments were dated as having been performed at least 10 working days prior to the annual ISP. Three were dated as performed after the due date (Individual #70, Individual #147, and Individual #12). Based on the 10 assessments submitted as most current for each SLP, the date of the assessment was the same as the date performed in the tracking log. In each case, however, the date of the assessment was not the actual completion date (date signed by the clinician). For two individuals, the date of completion (date signed) was after the due date listed in the tracking log and, as such, would be considered late (Individual #127 and Individual #31). • 5 of 5 individuals (100%) in the sample of individuals who were provided direct communication supports and services were provided an assessment current within the last 12 months. Each was identified as a comprehensive assessment. <u>Communication Assessment:</u> Based on review of the sample of assessments submitted as most current (Sample R.2), the comprehensiveness of the communication assessments were as follows: • 10 of 10 individuals' communication assessments (100%) were signed and dated by the clinician upon completion of the written report. • 8 of 10 individuals' communication assessments (80%) were dated as completed at least 10 working days prior to the annual ISP. • 9 of 10 individuals' communication assessments (90%) included diagnoses and relevance of impact on communication. • 10 of 10 individuals' communication assessments (100%) included individual preferences, strengths. • 0 of 10 individuals' communication assessments (0%) included medical history and relevance to communication. The medical history provided was extensive, but did not typically describe how medical conditions would impact the provision of communication supports and services. • 10 of 10 individuals' communication assessments (100%) listed medications and discussed side effects relevant to communication. • 0 of 10 individuals' communication assessments (0%) provided documentation	

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		of how the individual's communication abilities impacted his/her risk levels. • 10 of 10 individuals' communication assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. • 6 of 10 individuals' communication assessments (60%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). • 10 of 10 individuals' communication assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally. • 9 of 10 individuals' communication assessments (90%) included discussion of the expansion of the individuals' current abilities. • 5 of 10 individuals' communication assessments (50%) provided a discussion of the individuals' potential to develop new communication skills. • 10 of 10 individuals' communication assessments (100%) included the effectiveness of current supports, including monitoring findings. • 8 of the 10 individuals' communication assessments (80%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC. • 0 of 10 individuals' communication assessments (0%) offered a comparative analysis of health and functional status from the previous year.10 of 10 individuals' communication assessments (100%) gave a comparative analysis of current communication function with previous assessments. 0 of 10 individuals' communication assessments (0%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. • 10 of 10 individuals' communication assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. • 10 of 10 individuals' communication assessments (100%) had a reassessment schedule. • 10 of the 10 individuals' communication assessments) (100%) supplied a monitoring schedule. • 6 of 10 individuals' communication assessments (60%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. • 10 of 10 individuals' communication assessments (100%) made a recommendation about the appropriateness for community transition.10 of the 10 individuals' communication assessments (100%) defined the manner in	

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		which strategies, interventions, and programs should be utilized throughout the day. Additional findings related to the communication assessments were as follows: • 2 of 10 assessments contained more than 80% of the elements listed above. • 7 of 10 assessments contained more than 70%, but less than 80% of the elements listed above. • 1 of 10 assessments contained 65% of the elements listed above. • 0 of 1 update (0%) had an associated comprehensive assessment that was consistent with the established format and content guidelines. There was no associated comprehensive assessment for the update contained in the individual record for Individual #50. • 52% of the elements listed above were noted for 100% of the assessments reviewed. There was a system of assessment audits implemented by the department for the establishment of competency of the speech clinicians and to ensure continued compliance with the assessment guidelines. <u>SLP and Psychology Collaboration:</u> There were 43 individuals listed with PBSPs and at least 15 of these were included in the samples identified above. • 6 of 10 communication assessments reviewed for individuals in Sample R.2 (60%) contained evidence of the individual's behavior challenges and any communicative intent of these behaviors. While all of the assessments described the PBSPs when indicated, as well as, target and replacement behaviors in a section titled "Behavioral Considerations," the communicative intent of the behaviors identified was not consistently addressed (Individual #127, Individual #60, Individual #79 and Individual #31). In some cases, there was also reference to this in the analysis section, but was inconsistent. For individuals in Sample R.1 for whom PBSPs, ISPs, and communication assessments were requested and received, the following was noted: • For 2 of 11 individuals (18%) communication strategies identified in the assessment were included in the PBSP (Individual #31 and Individual #50). • For 7 of 11 individuals (64%) communication strategies identified in the assessment were included in the ISP. Based on review of the psychology department BST meeting minutes from 7/24/12 to 1/7/13, participation by the SLPA was noted in 15 of the 22 meetings (68%). There was	

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		no evidence that a SLP attended any of these meetings. Due to the fact that the speech assistant was not qualified to provide assessments or to design communication plans, it was not clear what role the SLPA played during these meetings. This was an opportunity to promote collaboration between psychology and the SLPs for assessment and program development so SLP participation in these meetings should be considered.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP:</u> Based on review of the ISPs for 18 individuals in Sample R.1 (each was current within the last 12 months) the following was noted: • In 9 of 17 ISPs reviewed with sign-in sheets submitted (53%) for individuals with communication needs, an SLP attended the annual meeting. A PT representative was present for five others and an OT representative was present for one. For individuals who present with communication needs, it is important that an SLP be present during the meeting. For the 10 individuals for whom a Pre-ISP had been held for an upcoming ISP meeting, a communication assessment was required for each individual, but attendance by an SLP was required for only five. One indicated that an SLP had to be available by phone, and one required only a Habilitation Therapy representative. Three others did not require SLP attendance. Some concerns related to those cases for which an SLP was not required: o Individual #123: The Pre-ISP justified that that the SLP did not have to be present due to there being no eating concerns and that the supports in place were working. Other documentation, however, indicated that the supports were not working. For instance, her communication assessment, 4/11/12, reported that she will bite her wrist and refuse to eat by throwing her plate. The speech clinician stated that her communication was not effective and that DSPs had to anticipate her needs and wants. Assessment of AAC was limited. It is critical that assessment occur in the natural environment in settings determined to be motivating and meaningful for communicative intent to determine if a particular system may be effective or that there may be potential for training. Individual #123 was not interested in pushing buttons and AAC was ruled out by the clinician, rather than exploring other potential AAC systems that may have been more effective and meaningful. The supports provided to warranted speech participation in her ISP. o Individual #104: He was described as nonverbal and his assessment stated that his communication was ineffective. The Pre-ISP indicated that he did not receive any communication services, yet had been provided communication strategies and a communication dictionary. He was also provided a trial with a Put 'Em Around device and also reported to not show interest in pushing the button or looking at a	Noncompliance

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		picture. This also did not suffice as an adequate assessment to determine potential for AAC use. Certainly, he provided warranted speech participation in his ISP. • In 9 of 18 ISPs reviewed (50%) the type of AAC and/or communication supports (may include, but not limited to, the Communication Dictionary and strategies for staff use) were clearly identified. This was limited to the communication strategies for staff use and in a few cases a type of device available for use by the individual. In four cases, the communication supports were referenced, but specifics as to communication strategies, for example, were not outlined. There was no evidence that the details of the Communication Dictionary were reviewed for effectiveness or accuracy in any case. • Communication Dictionaries provided to 0 of 18 individuals (0%) were reviewed at least annually by the IDT, as evidenced in the ISP. • 18 of 18 ISPs reviewed (100%) included a description of how the individual communicated. Most of these did not address AAC use by the individual, however, but rather only the communication dictionaries and strategies for staff use. • 3 of 18 ISPs reviewed (17%) contained skill acquisition programs to promote functional communication. Only one of these involved participation related to program development by the SLP (Individual #111). • In 0 of 18 ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. <u>Individual-Specific AAC Systems:</u> There were approximately 117 individuals who were provided a communication card that reflected the communication strategies identified in the communication assessment. These served as cues for staff as to how they may most effectively communicate with the each individual. Additionally, there were 30 individuals with picture communication sheets. This was another no-tech device, but could serve as a means for the individual to communicate a want or need by pointing to a picture on the sheet. Likewise staff could point to pictures to reinforce their spoke words to more effectively add meaning and understanding for the individual receptively. Two others had a sign language book or picture choice board. Low-tech devices were limited to talking photo albums, or Put 'Em Around devices for 16 individuals. Three others had a sound amplifier, an AbleNet Sound Generating Device or call switch. These required a power source yet were easy to program. Six individuals had environmental control switches not necessarily related to communication, but rather access to their environment. There were no individuals who were provided mid- or high-tech devices to	

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		enhance or augment their communication skills. While this reflected an overall very slight increase in the provision of AAC for individuals living at EPSSLC, there continued to be a limited number of systems provided to individuals. The variety of the systems was also limited. The assessments for the individuals in Sample R.1 did not provide an adequate assessment of the individuals' potential for AAC use through direct intervention and trials occurring in the natural environment in situations that were most meaningful to the individual. There was very limited evidence of the use of training/teaching models to expose and promote interest and use of AAC across settings. It appeared that the clinicians only considered the use of a specific AAC system if the individual spontaneously showed ability or interest in the system presented (the variety of which was extremely limited, i.e., Put 'Em Arounds in most cases). It was not clear that attempts were made for use in a setting over time that would spark interest such as to request a favorite item, food, beverage, music, vibration or massage, for example. Though this seemed to be improving based on review of the most current assessments and the speech clinicians appeared to be very knowledgeable and interested, they continued to need to use a more creative approach to assessment and design of AAC systems and supports, particularly with those individuals with greater cognitive deficits. That said, the direction they were taking since the previous review reflected the greatest strides made in this area since the baseline review and they are congratulated on that note. Observations were conducted in four homes and also in the dining areas for each of these for individuals in Sample R.4 with AAC. Findings included the following: • AC systems for 0 of 16 individuals in Sample R. 4 (0%) were present and in use during observations in A, B, and C Dorms, and in home 507. Thus, these would not be considered to be portable, functional and meaningful. <u>General Use AAC Devices:</u> There were a number of general use devices as follows: • Put 'Em Arounds: These were located in at least seven homes, the workshop, groups and activity room. None were observed in use. • Wallboards: Located in at least eight homes and the activity room. Most were related to grooming, dining, and other general use activities. None of these were observed in use. There was a plan developed by the speech clinicians to revise these to ensure that they were more meaningful.	

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		Direct Communication Interventions: There were at least 13 individuals listed as participating in direct communication-related interventions (provided by the SLP or SLPA). Records related to the provision of direct intervention plans for individuals included in the Sample R.5 were reviewed. This included assessments, ISPs, ISPAs, SAPs and progress notes as submitted. Findings were as follows: • Individual #92: A SAP was outlined as per the communication assessment in her ISP dated 1/4/13. The ISP indicated that speech staff would interview her quarterly to identify specific signs that she wanted staff to learn in order to better communicate with her. There was no evidence of this as implemented in the documentation submitted. There was also a learning objective for her to combine two to three abstract symbols on a low/high tech communication device with minimal gestural cues for 80% of trials across three speech therapy sessions by March 2013. Progress notes were completed for each session as well as a monthly summary. The goal and interventions appeared consistent with her needs and interests and reflected a creative approach to service delivery. Documentation was consistent. • Individual #18: A SAP was written, as per the communication assessment, to use socially appropriate communication to gain attention to mitigate maladaptive behaviors in his environment with 70% accuracy with verbal and visual prompts. There was no SAP strategy sheet or documentation, however, related to the implementation of this. On 11/20/12, an emergency Psychiatry Clinic was held to address an increase in SIB and aggression. One of the actions was that the SLP, psychologist, and program developer were to develop effective communication strategies within one month. The SAP and first progress note were dated 12/14/12 and reflected direct intervention by the SLP for a PECS Phase 1 program. The SLP was working with him, but there was no evidence of collaboration between speech, psychology, and the program developer and no training objective was documented at that time. An alternate SAP Strategy Plan Sheet was submitted with a begin date of 2/25/13 and a training objective to independently complete a request sequence in 90% of trials when the communication partner was 10 feet away and with five to 10 reinforcers, two or more communication partners and two or more environments. There was no assessment documented to establish the need and rationale for this goal. Neither of the SAPs submitted appeared to be integrated into the ISP. • Individual #90: The communication assessment dated 2/6/13 recommended two measurable objectives for SAPs to point to one symbol on low/high tech AAC system to request or label preferential objects and to point to abstract symbols to represent feelings. Neither of these goals was clearly stated in the ISP dated 2/20/13, nor were there ISPAs documenting integration into the ISP.	

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		There were no SAP strategy sheets or SLP documentation related to these submitted with the document request. • Individual #17: The ISP dated 8/15/12 did not reflect direct speech services or a SAP related to improving his communication skills as per his assessment. There was no evidence of an ISPA held to add a SAP to his ISP. There were a number of SAP Strategy Plan Sheets related to a PECS program submitted with documentation of direct therapy, but the recommendation had been related to using Put 'Em Around devices to make requests. • Individual #117: The ISP dated 12/7/12 identified that a communication SAP to request Cheetos, as recommended in the communication assessment. It was reported that the program was not implemented in December 2012 due to resource constraints. This should not be an acceptable rationale for not providing required services to address an identified need. Generally accepted practice standards for comprehensive progress notes related to communication interventions include: • Contained information regarding whether the individual showed progress with the stated goal. • Described the benefit of device and/or goal to the individual. • Reported the consistency of implementation. • Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. Documentation of SLP review for 4 of 5 individuals (80%) was generally comprehensive as per the indicators above. The progress notes for Individual #117 did not consistently address the elements above. The clinician identified the measurable goal in the objective part of the progress notes (SOAP) and then identified the objective findings in the assessment aspect of the note, rather than analyze the findings. <u>Indirect Communication Supports:</u> Programs for individuals who received indirect communication supports (Sample R.6) generally included the communication dictionary and the communication strategies provided to the individuals in the samples reviewed. These were inconsistently described in the ISPs. There was no evidence of consistent quarterly documentation for the individuals in Sample R.1, each of whom was provided indirect communication supports, related to the benefit and effectiveness of the supports, consistency of implementation, or recommendations related to necessary changes. The presence of these supports were primarily reviewed as an aspect of the monitoring system, but review of effectiveness was not yet consistently conducted by the speech clinicians.	

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		Competency-Based Training and Performance Check-offs: New employees participated in NEO classroom training prior to their assignment in the homes and completed competency check-offs for foundational skills related to communication. Per the schedule, the combined classes for deaf awareness and AAC were only two hours. This seemed inadequate to sufficiently cover the necessary material for new employees. These employees were then shadowed in their assigned home for approximately seven days after being validated as competent on home specific skills. These validator/trainers had previously been validated by trainers in the Habilitation department to ensure their competence in this role. Non-foundational training was identified as training that required individualized techniques or strategies that varied from the basic foundation skills taught in NEO and, as such, required further training and check-offs. Trainers were trained to competency and to train and check-off others to ensure that all home staff knew how to implement this aspect of individual plans. Based on review of the NEO training curriculum, direct support professionals, PNMPCs, and therapy aides were provided with competency-based training related to communication as evidenced by the following content areas: • Methods to enhance communication • Implementation of programs • Benefits and use of AAC • Identification of nonverbal means of communication. • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • Adequacy of skill performance check-offs The content material appeared to be thorough, but would have to be presented quickly to permit sufficient time for staff to practice and complete return demonstration of related foundational skills. There were written tests for both general communication and AAC, with competency check-offs completed for adaptive switches, communication cards, picture communication boards and sheets, talking photo albums, Put 'Em Around devices, and general communication strategies. As stated above, however, only two hours were allotted for classroom training, practice, and check-offs, which was likely inadequate to cover this material effectively. Refresher training was also completed in the area of communication, but the timeframes and content were not known to the monitoring team. In addition, various theme-based trainings had been conducted related to communication moments and equipment repair. The effectiveness of this training was evaluated by the Habilitation Therapies Director based on pre- and post-test scores. This training was more recently transitioned to the	

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		Town Hall Meeting format as of February 2013. The monitoring team looks forward to see the progress with this new approach.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	<u>Monitoring System:</u> A system of monitoring was well established at EPSSLC to include the following: • Monitoring of communication plans using the validity tier system per the frequency determined by the ISP. • Random audits of monitoring forms were conducted to determine if identified issues were resolved through re-training or other means. • A system to monitor general use AAC devices in common areas to ensure that the devices were present, in good working condition, and readily available, in use and effective. • Tracking of the effectiveness monitoring of AAC systems that was conducted by the speech therapists or the IDT with documentation in the IPN or ISP. Individual monitoring was conducted related to implementation of the communication supports and services provided including the communication dictionary and communication strategies designed for staff reference and AAC systems used by the individuals. The Individual Communication Monitoring Form (revised 11/1/12) was used. The draft speech policy indicated that monitoring would be conducted quarterly for condition, functionality and effectiveness, use of device, and relevance. It was noted that the assessments for the individuals included in the Sample R.1 outlined individualized monitoring schedules at monthly (4), quarterly (6), or semi-annual intervals (7). The frequency of monitoring was not designated in the assessment for Individual #58. There was also a system in place to conduct biweekly preventative maintenance checks for all electronic communication systems (individual and general use devices) to ensure that they remained in working order. Documentation was submitted to demonstrate that this was completed routinely. The local speech services policy (in draft) related to monitoring of communication supports defined the following: • Monitoring for the presence of communication adaptive equipment or other AAC supports/materials. • Monitoring for the working condition of communication adaptive equipment. • The frequency of monitoring. This policy, however, did not include the following key elements: • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work). • The process for identification, training, and validation for monitors. • The process of inter-rater reliability. • A process for data trend analysis and utilization of findings to drive training and	Noncompliance

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		problem resolution (individual and systemic). Based on a review of the facility's monitoring data in the last six months, 9 of 15 individuals with AAC systems included in the Sample R.4 (60%) who were observed by the monitoring team were monitored in the last month. The facility monitoring data reported on compliance indicators, including, but not limited to the following: • AAC was present • AAC was in working order The facility monitoring data did not report on the following key compliance indicators: • Frequency of monitoring per recommendations (Required frequency was not indicated on the form). • AAC used in various environments (it appeared that monitoring occurred only in the home environment). • In the case a problem was identified, there was evidence of resolution (in the case that a problem was identified, there were notations that the facility monitor reported the issue or returned to find a missing item, for example, but actual resolution was not clearly documented on the form). In the case of Individual #92, it was reported that her communication book was torn on 1/9/13, but there was no evidence that the book was ever repaired or replaced. Also, in the case of Individual #113, his photo album was reported missing on 1/16/13. The monitor reported follow-up on 1/22/13, but that the album was still missing. There was no evidence that the photo album was ever found or replaced. There were six individuals in the sample who were monitored during the last month with a compliance score of 100%. Each of the AAC systems was found to be present, but there was no indication if they were in use. It appeared that the monitor asked where the device was (or located it himself or herself), then asked specific questions of staff related to the use of the device. Item number six on the monitoring form indicated that staff were following the communication instructions, or could demonstrate its use when asked, or could describe the features and use of the system for a "yes" response. Each of these is a significantly different aspect of compliance (i.e., not equivalent). The monitoring team did not find that any of these devices were in use at times when observed and none were visible in the areas noted. It was of concern that finding the device when requested was considered to be compliance rather than the observation of the device in use according to the communication plan. Further, based on the form and the system for scoring, an AAC device could be missing (Individual #113) or torn (Individual #92), yet compliance could still be found to be	

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		acceptable (as in a score greater than 80%). Also, in the case of Individual #113, where the photo album was missing, whether it was in good working order, appropriate and individualized were each scored as "not applicable" rather than a "no." Further staff reported to not know what his devices were, but were able to explain them "after" the monitor told the staff what each device was (Put 'Em Arounds and wallboards). They were given a "yes" response for those items despite this significant coaching. Monitoring forms for at least 39 other individuals were submitted. Approximately 26 of these were scored to be 100% in compliance. Seventeen of these reported that staff only described AAC use correctly, but were not observed using each of the systems nor were they required to demonstrate proper use of the AAC. In cases where staff were not able to locate a system (Individual #4, Individual #77), communication sheets were missing (Individual #162), staff were not able to demonstrate proper use of AAC (Individual #5, Individual #36), staff did not know what a communication dictionary was (Individual #63), and switch was not available (Individual #169) were still scored at greater than 80% (i.e., in compliance) despite these significant infractions. This was of concern to the monitoring team. Review of the completed monitoring forms identified the following: • The facility self-assessment identified that since June 2012, 100% of the scheduled monitorings were conducted. • 9 of 9 individuals (100%) included in the sample were monitored consistently at the recommended frequency. This was difficult to assess over time, however, because only one month of monitoring forms was submitted. The average compliance rating per the Presentation Book was 75% in June 2012, improving to 97.92 as of January 2013. This was misleading, however, because the individual could have a missing device with a compliance rating as high as 90%. • 9 of 9 (100%) individuals included in the sample were monitored for the working order of their communication system. Again, the device could be broken and the compliance rating potentially could be as high as 90%. • 0 of 9 (0%) individuals included in the sample were monitored for use in a variety of environments. • For 1 of 6 (17%) individuals included in the sample for whom an issue was identified on the monitoring form, there was evidence of problem resolution. Based on the existing tracking and review system of monitoring results, the facility continued to self-identify issues that required attention. Re-training of monitors was ongoing and reflected a determination on the part of the facility to effect changes and improvement in this area. With consideration of automatic scoring of noncompliance if certain elements resulted in a "no" answer, this system may be further improved.	

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		A system of effectiveness monitoring was initiated in December 2012 for routine review of all programs and interventions, but implementation was reported to be inconsistent per the findings presented in the Presentation Book and record review by the monitoring team.	

Recommendations:

1. Continue to pursue speech therapists for the provision of supports and services related to mealtime and communication (R1).
2. Address identified concerns via the existing assessment audit system (R2).
3. Consider SLP attendance at the BTC Committee meeting rather than the SLPA (R2).
4. Improve SLP attendance at ISP meetings (R2).
5. Integrate all communication interventions into the ISP (R3).
6. Improve consistency of documentation, provide guidelines (R3).
7. Examine individual monitoring elements (missing or non-working equipment) and impact on compliance scores (R4).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plan (ISPs) for: • Individual #60, Individual #78, Individual #103, Individual #49, Individual #3, Individual #8, Individual #31, Individual #65, Individual #134, Individual #69, Individual #35 o Skill Acquisition Plans (SAPs) for: • Individual #134, Individual #65, Individual #8, Individual #78, Individual #103, Individual #3, Individual #31, Individual #60, Individual #6, Individual #49 o SAP data for: • Individual #134, Individual #65, Individual #8, Individual #78, Individual #103, Individual #3, Individual #31, Individual #60, Individual #6, Individual #49 o Functional Skills Assessments (FSA) for: • Individual #78, Individual #60, Individual #49, Individual #6, Individual #103 o Personal Focus Assessments (PFA) for: • Individual #78, Individual #60, Individual #49, Individual #6, Individual #103 o Vocational assessments for: • Individual #78, Individual #60, Individual #49, Individual #6, Individual #103 o Monthly reviews of SAP progress for: • Individual #81, Individual #20, Individual #72, Individual #114, Individual #25, Individual #78, Individual #73, Individual #57, Individual #13, Individual #7 o Dental desensitization plans for: • Individual #175, Individual #3, Individual #36, Individual #120, Individual #195, Individual #56, Individual #66, Individual #9, Individual #108 o SAP validation monitoring form, 4/1/13 o EPSSLC action plans, 2/20/13 o EPSSLC self-assessment, 3/6/13 o EPSSLC provision action information, 2/25/13 o SAP peer review tool, undated o Multi-purpose Center schedule of activities for March 2013 o Section S Presentation Book, undated o Group activity schedule, undated o Pretreatment sedation/desensitization planning committee minutes, 3/20/13 o Monitoring Committee Active Treatment level of compliance, 11/1/12-1/31/13 o Engagement, Dignity and Respect, and Group Management Observation form, 4/26/12

	o A list of all instances of skill training provided in community settings, undated o A summary of community outings per residence/home, undated o Listing of on-campus and off-campus day and work program sites, undated o A list of individuals who are employed on and off-campus, undated o List of individuals who attended public school (two individuals, but one transitioned to the community) o ISPs, ARD/IEPs, and EPISD progress notes for: • Individual #35 <u>Interviews and Meetings Held</u>: o Jonana Alferez, Director of Community Relations o Cynthia Martinez, QDDP Coordinator o Guadalupe Azzam, Active Treatment and Day Programs Coordinator o Maricela Giner, QDDP o Ana Ottega, DCP II active treatment staff o Adriane Hanway, Director of residential services o Ruben Ochoa, acting ADOP o Alex Euzaragga, QDDP, EPISD Liaison <u>Observations Conducted</u>: o Pretreatment sedation and desensitization planning committee o SAP peer review meeting o Active treatment meeting o Multi-purpose 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: Overall, EPSSLC's self-assessment included some relevant activities in the "activities engaged in" sections that were the same as those found in the monitoring team's report. The monitoring team believes, however, to most useful, the self-assessment should include activities that are identical to those the monitoring team assesses as indicated in this report. For example, S1 of the self-assessment included a review of the necessary elements of SAPs and engagement, which are topics that are included in the monitoring team's review of S1. Not all activities described in the self-assessment, however, were consistent with what the monitoring team reviewed. For example, S2 of the monitoring team's report addresses the need for a demonstration that assessments were consistently used to identify individual SAPs, which were not addressed in the facility's self-assessment. 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 to 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 team's 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 facility's 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 suggests 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: • Increase in the number of SAPs with a rationale that was specific enough for the reader to determine if the SAP was practical and functional for that individual (S1) • Establishment of a SAP peer review meeting to ensure that SAPs contain all the necessary components identified in S1 • Continuous progress in pretreatment sedation reduction (S1) • Improvement in individual engagement across the facility (S1) • Continued improvement in the community day program (S1) • A plan to measure and improve the implementation of SAPs (S3) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that each SAP contains a rationale for its selection that is specific enough for the reader to determine that it was practical and functional for that individual (S1). • Ensure that each SAP has a plan for maintenance and generalization that is consistent with the definitions below (S1) • Operationalize the definition of individual engagement, track engagement across all treatment areas, review trends, and establish acceptable levels of engagement in each treatment area (S1) • Document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2 • Develop a system to track 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.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at EPSSLC. As detailed below, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at EPSSLC had multiple skill acquisition plans (SAPs). As indicated in past reviews, SAPs were written and monitored by four program developers. At the time of the onsite review, program developers were supervised by QDDPs, and SAPs were implemented by direct care professionals (DCPs). The facility planned, however, to reorganize the writing, training and monitoring of SAPs. SAPs will be written by the QDDPs, and DCPs will be trained in SAP implementation and monitored by two program developers. 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. Forty-four SAPs across 10 individuals were reviewed to determine if they appeared to be functional and practical. In 26 of the 44 SAPs reviewed (59%), the rationale appeared to be based on a clear need and/or preference. This represented an improvement from the last report when 44% of the SAPs reviewed were judged to be practical and functional. Examples of rationales that were specific enough for the reader to determine if the SAP was practical and functional for that individual were: • The rationale for Individual #8's SAP of flossing his teeth stated, that he had been picking on his teeth with foreign objects, therefore, he will be taught to use floss picks, so he can floss his teeth after meals. • The rationale for Individual #3's SAP for identifying the Star of David was Individual #3's religious preference is Jewish, this plan will assist him in identifying the Star of David. In 18 of the 44 SAPs reviewed (41%), however, the rationale was not specific enough for	Noncompliance

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		the reader to determine if it was practical and functional for the individual. For example: • The rationale for Individual #60's SAP of purchasing a soda from a vending machine was that she will benefit from a program that teaches her to identify US bills. 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/or needs impacted the selection of a particular SAP. 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 majority of SAP training sheets reviewed contained all of the above components, however, a dental compliance SAP for Individual #78 did not contain a rationale, and all seven of Individual #8's SAPs were missing generalization and maintenance components. All skill acquisition plans should include all of the above components. 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. None of the SAPs reviewed (0%) contained a plan for generalization consistent with the definition above. This represented a decrease from the last review when 69% of	

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		generalization plans reviewed were consistent with the above definition. Many of the plans for generalization sounded more like rationales than plans for generalization. The following plan for generalization was typical: • The plan for generalization in Individual #49's SAP of putting on her sweater stated, "It is important that [she] stays warm daily, this plan will assist her in putting her sweater on." An example of a plan for generalization for Individual #49 that would be consistent with the above definition could be: • In order to generalize Individual #49's dressing skills, she will be asked to put on her sweater (when appropriate) on weekends and when going on home visits. None of the SAPs reviewed (0%) contained maintenance plans were consistent with the above definition. This represented another decrease from the last review when 57% of the SAPs reviewed contained acceptable plans for maintenance. Many of the maintenance plans sounded more like generalization plans. For example: • The plan for maintenance in Individual #31's SAP of learning to place her dirty dishes in a designated bin stated, "Make sure to continue offering (Individual #31) the opportunity to pick up her dirty dishes not only after meals but as needed throughout the day..." An example of a plan for maintenance for Individual #31 that is consistent with the above definition could be: • After mastering placing her dirty dishes in the designated bin and the termination of the SAP, she will continue to be requested to independently place dirty dishes in the appropriate area in order to maintain this skill. It is recommended that all SAPs contain individualized generalization and maintenance plans that are consistent with the above definitions. At the time of the onsite review, the facility used 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). A positive development was the recent establishment of monthly SAP peer review meetings. The purpose of these meetings as to review SAPs and ensure that they contained all the necessary components of an effective plan discussed above. The monitoring team observed a SAP peer review and was impressed with the quality of the reviews, and believes these meetings will result in a dramatic improvement in the SAPs	

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		in future reviews. Compliance and Dental Desensitization plans EPSSLC continued to make progress in this area. Compliance and desensitization plans designed to teach individuals to tolerate dental procedures were developed by the program developers, and an interdisciplinary team reviewed progress. Nine of these plans were reviewed. As recommended in the last report, compliance and dental desensitization plans were incorporated into the new SAP format. As such they share similar strengths and weakness to the SAPs discussed above. The monitoring team was pleased that the use of sedating medications for routine dental assessments/procedures continues to be low (see section Q). Replacement/Alternative behaviors from PBSPs as skill acquisition plans 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 44 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 EPSSLC was measured by the monitoring team in all treatment sites, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals	

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		and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each cottage and day program is listed in the table below. As reported in past reviews, the monitoring team was encouraged by the general positive interaction of staff and individuals at EPSSLC. Additionally, the community day program continued to develop. As recommended in the last review, this program expanded to include all individuals residing at the facility, and utilized staff that were trained on each individual's program. During the onsite review, the monitoring team observed many examples of meaningful individual engagement in this community program. Many of these activities represented opportunities to learn/practice new skills in the community. At this point the facility is encouraged to increase the formal training opportunities (i.e., conduct SAPs) in the community program. There were also dramatic improvements in the level and quality of engagement in the day programing area on campus (i.e., 515 building). During the July 2012 review the average engagement in this area was 49%, while the average engagement observed during this onsite review was 74%. Additionally, it was obvious that both the individuals and the staff were enjoying the activities in this treatment site. The overall observation of engagement in the cottages, however, was mixed. In some homes visited (e.g., 509 and 512), 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 staff did not appear to be attempting to engage them. The table below documents engagement observed in various settings throughout the facility. The average engagement level across the facility was 60%, an improvement from that observed during the last three reviews (i.e., 49%, 50%, and 51%). Although engagement is improving, 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 facility conducted regular monitoring of individual engagement. The monitoring tool consisted of 18 observations that were marked yes or no by the observers. The observations covered several aspects of engagement including the presence of appropriate materials, staff consistently encouraging individual's to participate, etc. The active treatment monitors also conducted regular active treatment meetings to review	

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		the results of these observations with DCPs and supervisors from each treatment site. Additionally, the active treatment monitors collected individual engagement data during 15-30 minute observations. The active treatment and day programs coordinator indicated, however, that the definition of "engaged" was not consistent across all monitors. It is likely that this monitoring process and review with DCPs and their supervisors contributed to the overall improvement in engagement discussed above. It is recommended, however, that the facility operationalize the definition of individual engagement (e.g., how long does an individual need to be engaged during a 30 minute observation to be rated as engaged?), and add the discussion of these engagement data to the active treatment meeting and review. Additionally, it is recommended that engagement targets for each home and day program be established, and sites with low engagement be provided plans for improvement. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
C Dorm	2/6	3:6
B Dorm	3/9	1:9
B Dorm	3/10	2:10
A Dorm	2/6	3:6
Workshop	4/15	3:15
515 day program	6/6	3:6
515 day program	4/5	1:5
Cottage 506	4/6	3:6
Cottage 506	2/4	3:4
Cottage 512	3/4	3:4
Cottage 512	3/3	3:3
Cottage 507	4/8	3:8
Cottage 511	1/4	1:4
Community day program	4/4	1:4

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Community day program	5/5	2:5
Cottage 509	3/3	1:3
Cottage 509	2/2	1:2
Cottage 510	8/9	3:9
Cottage 510	5/8	2:8
Cottage 511	3/6	3:6
Cottage 511	5/7	3:7
515 day program	6/8	4:8
515 day program	5/10	4:10
515 day program	2 /3	2:3
Workshop	7/13	5:13
A Dorm	1/8	2:8
C Dorm	1/11	3:11
C Dorm	2/10	3:10
Cottage 509	3/3	1:3
Cottage 509	3/4	1:4
Cottage 508	2/5	2:5

<u>Educational Services</u>
EPSSLC continued to maintain an excellent relationship with the El Paso Independent School District (EPISD). Alex Euzaragga, QDDP, continued to support and foster this relationship in his role as liaison to EPISD.

There was only one individual at EPSSLC who was under age 22 and attended public school (Individual #35). During the onsite review, he was on spring break, but was being appropriately engaged by facility staff during school hours whenever the monitoring team observed him.

His public school program was thoroughly and appropriately referenced in his ISP. His EPSSLC activities were appropriately reference in his ARD/IEP.

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		EPSSLC, however, had stopped reviewing EPISD progress reports and report cards. This should occur and be done and documented by the QDDP. That was not the case for this review period. A special ISPA meeting is only required if there is a problem that needs to be addressed.	
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. This item was rated as being in noncompliance because, at the time of the onsite review, it was not clear that assessments were consistently used to develop SAPs. EPSSLC completed the transition from the use of the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). The EPSSLC also used a vocational assessment, and the personal strength inventory (PSI) to assess preferences. To assess compliance with this item, the monitoring team reviewed ISPs, FSAs, PSI, and vocational assessments for five individuals. The 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. No assessment tool, however, is going to consistently capture all the important underlying conditions that can affect skill deficits and, therefore, the development of an effective SAP. Therefore, to guide the selection of meaningful skills to be trained, assessment tools often need to be individualized. The FSA 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 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 are considerable data that demonstrate that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. There was no documentation of the use of individualization of assessment tools to identify SAPs in any of the FSAs reviewed. There were examples of how assessments and preferences were used to develop some SAPs in the ISPs. For example:	Noncompliance

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		• Individual #103's ISP indicated she was dependent for bathing (which was consistent with the FSA results), but enjoyed the interaction with staff (consistent with PFA results), so a bathing SAP was developed for her. • Individual #6's ISP indicated that his SAP of activating a music cube helped with learning the concept of cause and effect (consistent with the FSA results) and was based on his preference for music (documented in his PFA). This represented an improvement over the last review when none of the ISPs reviewed documented how assessments impacted the development of Individual SAPs. Review of ISPs and assessments did not, however, consistently document how assessments impacted the development of SAPs. The following were typical: • Individual #60 had a SAP to purchase a soda and identify the change from $1.00. Her FSA, however, indicated that she did not have the prerequisite skills of identifying coins. Therefore, it was not clear why she would be taught to make change when she could not identify coins (other than a quarter). • Individual #78 had a SAP to identify a stop sign. There was nothing in her ISP, FSA, or PSI that indicated a preference and/or need for this SAP. • Individual #49 had a SAP to put on her sweater, but no mention in her ISP of any assessment results (e.g., FSA or PSA) that suggested that this was a practical SAP for her. The facility should ensure that assessments are consistently used and documented to select individual skill acquisition plans.	
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	EPSSLC needs to demonstrate that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAPs are consistently implemented with integrity, before this item is rated as being in substantial compliance. Since the last review, EPSSLC transitioned from Quarterly SAP reviews to monthly SAP reviews. Ten monthly reviews of SAP data were reviewed to determine compliance with	Noncompliance

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	most integrated setting consistent with the individual's needs, and	this provision item. As reported in the last review, monthly SAP data were graphed. There were two monthly reviews of SAPs (e.g., Individual #72 and Individual #25) that represented examples of SAPS being modified or discontinued as a result of the absence of progress. The other eight monthly reviews, however, provided no evidence of decisions concerning the continuation, discontinuation, or modification of SAPs being based on outcome data. It is recommended that the facility ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data. Finally, 12 of the 22 SAPs reviewed with at least three months of data (55%) showed progress or the achievement of sustained high levels (i.e., above 90%). This represented an improvement in SAP progress from the last report when 45% of SAPs showed progress. As during the last review, the implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. The results were mixed: • Individual #6's SAP of manipulating music cubes appeared to be conducted as written, and staff were able to explain how to implement the plan. • Individual #38's SAP of engaging in leisure activities appeared to be conducted as written, however, the DCP was confused as to how to record the data, and indicated that she needed to check with her supervisor The only way to ensure that SAPs are implemented and documented as written is to conduct integrity checks. The QDDP coordinator acknowledged the challenges associated with ensuring that SAPs are consistently implemented as written, and indicated that EPSSLC had a plan to begin training DCPs in the implementation of SAPs, and for the collection of integrity data.	
	(b) Include to the degree practicable training opportunities in community settings.	As noted in the last two reviews, 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 facility provided data indicating that community outings occurred each month. There was, however, considerable variability among the number of individuals from each home that participated (i.e., 0-52). Additionally, the facility provided the monitoring team with several examples of SAPs that were implemented in the community. As discussed in the last review there was, however, there was no way to evaluate how often	Noncompliance

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		SAP training occurred in the community, or how many individuals at EPSSLC had skill training in the community. It is recommended that skill training activities in the community be recorded so that trends could be tracked. Additionally, acceptable levels of both activities should be established. The newly developed community day program (see S1) appeared to represent a wonderful opportunity to provide a model for training skills in the community. The monitoring team look forward to seeing how this new, exciting program is utilized by the facility to achieve both meaningful individual engagement (S1) and community training (S3b). At the time of the review, no individuals at EPSSLC worked in the community.	

Recommendations:

1. Ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual (S1).
2. All skill acquisition plans should include all of the necessary components described in S1.
3. All SAPs should contain individualized generalization and maintenance plans that are consistent with the above definitions (S1).
4. Expand the number of communication SAPs for individuals with communication needs (S1).
5. Increase the number of SAPs conducted in the community day program (S1).
6. The facility should operationalize the definition of individual engagement (S1).
7. Engagement targets should be established for each home and day program, and sites with low engagement provided plans for improvement (S1).
8. Review EPISD progress notes and report cards. The QDDP should document this review (S1).
9. Ensure that assessments are consistently used and documented to select individual skill acquisition plans (S2).
10. Ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are consistently based on outcome data (S3).
11. Ensure that SAPs are implemented with integrity (S3).

12. Develop a system to track training in the community (S3).

13. The facility should 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).

14. 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 policies regarding most integrated setting practices • Most Integrated Setting Practices, 11/21/12, signed 1/18/13 (same as state policy, 018.1) • Transferring EPSSLC Individuals to/from State Hospitals/Private Psychiatric Hospitals, 1/18/13 o EPSSLC organizational chart, undated, but likely February 2013 o EPSSLC policy lists, undated but likely February 2013 o List of typical meetings that occurred at EPSSLC, 2/28/13 o EPSSLC Self-Assessment, 3/6/13 o EPSSLC Action Plans, 2/20/13 o EPSSLC Provision Action Information, most recent entries 2/25/13 o EPSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/18/13 o Community Placement Report, last six+ months, 9/1/12 through 3/21/13 o List of individuals who were placed since last onsite review (7 individuals) o List of individuals who were referred for placement since the last review (10 individuals) o List of individuals who were referred and placed since the last review (2 individuals) o The APC's four-colored spreadsheet indicating IDT, individual, and LAR preferences and status of referral, 3/21/13 o List of total active referrals (12 individuals), as of 3/21/13 o List of individuals who requested placement, but weren't referred (3 individuals) • Documentation of activities taken for those who did not have an LAR (2 individuals) • Those who requested placement, but not referred due to LAR preference (1 individuals) o List of individuals who were not referred solely due to LAR preference (15) o List of rescinded referrals (3 individuals) • ISPA notes regarding each rescinding (3 of the 3) • Special Review ISPA Team minutes for each rescinding (3 of the 3) o List of individuals returned to facility after community placement (none) • Related ISPA documentation (n/a) • Root cause analysis report form (n/a) 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 (2 of 9 individuals who moved since 3/1/12, i.e., 1 year since placement) o List of individuals who died after moving from the facility to the community since 7/1/09 (none, 0 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (none) o Graphs of most integrated setting related data, five pie charts, undated probably February 2013 o APC weekly reports • Statewide weekly enrollment report (1/18/13-2/8/13) • Detailed referral and placement report for senior management (included in the report in the above bullet) o APC Department meeting minutes, weekly, 1/10/13-3/7/13 o APC's placement status/progress spreadsheet, every 2-3 weeks, 1/8/13-3/18/13 o Emails demonstrating APC distribution of the APC's placement status/progress reports, 3/18/13 o FST workgroup description, agenda, handouts, and minutes, first/only meeting, 3/12/13 o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, (2) September 2012, March 2013 ▪ Announcements, attendance sheets, evaluation information, and summaries • Community tours, 7/11/12 through 2/27/13 (13 for 52 individuals, many individuals went more than once) ▪ One page report form per individual completed for almost all • Meetings/trainings with local LA (2), 8/30/12, 10/9/12, 10/25/12, 12/21/12 • Email correspondence/meetings with local providers regarding roll-in showers, 12/18/12, and transition specialists, undated • Facility-wide staff trainings ▪ New employee orientation, July 2012 through February 2012 (145 staff) ▪ APC living options trainings with residential staff, house by house and with various disciplines (204 staff), January 2013 to February 2013 ▪ Community transition, for QDDPs and IDT members, 12/21/12 • Emailed updates and information ▪ Descriptions of providers and their homes, 1/16/13 ▪ Reminder about most integrated setting practices policy, semi-annual, 1/18/13 ▪ Obstacle reporting form, 1/25/13 • Training for admissions placement department staff ▪ DADS promoting independence advisory committee emails ▪ Living options: 2/6/13 ▪ Policies: most integrated setting practices, transfers, 1/18/13 • Self-advocacy meeting (2), presentation by PMM 2/22/13, former resident 8/31/12 • Family association meetings (none) • Posters about community living, throughout the facility • Facility newsletter, information on admission and placement (1)

	• CLOIP and Permanency Plan tracking sheets, July 2012 through January 2013 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), obstacles were not included o List of individuals who had a CLDP completed since last review, 8/10/12-12/28/12 (7 individuals) o Detail on activities engaged in during gaps of time in CLDP for 3 individuals, 4/23/13 o Blank checklist used by APC regarding submission of assessments for CLDP, and completed checklists (none) o DADS central office written feedback on CLDPs (1) o For the three statewide monitoring tools for section T: (none submitted) o Data and presentation information from the QA report, section T, February 2013 o State obstacles report and SSLC addendum, FY12 data, 2/26/13 o Facility obstacles list, 1 page, 117 individuals, 2/6/13 o Blank, new, competency exams for community provider staff, 3/21/13 o Various documents regarding collaboration with provider regarding Individual #37's behavioral challenges after his move the community, 1/3/13 through 3/11/13 o PMM tracking sheet, 3/21/13 o Transition T4 materials for: • (none) o ISPAs regarding living options discussions for: • (none) o Pre-ISP documents: • Individual #50, Individual #9, Individual #129 o ISPs in the new style for: • Individual #103, Individual #49, Individual #3, Individual #6, Individual #8, Individual #78, Individual #60, Individual #31, Individual #65, Individual #134 o Draft ISP used during the ISP meeting: • Individual #50 o CLDPs for: • Individual #76, Individual #37, Individual #61, Individual #133, Individual #47, Individual #69, Individual #95 o Draft CLDP for: • Individual #3 o In-process CLDPs for: • Individual #100, Individual #78, Individual #105 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 #110: 45, 90 • Individual #76: P, 7, 45, 90 • Individual #37: P, 7, 45, 90, post 90 days

	• Individual #133: P, 7, 45, 90 • Individual #61: P, 7, 45, 90 • Individual #47: P, 7, 45 • Individual #69: P, 7, 45 • ----------: 7, 45 (from Mexia SSLC) • Individual #95: P, 7, 45 <u>Interviews and Meetings Held</u>: o Antonio Ochoa, Admissions and Placement Coordinator o Luz Delgado, Post Move Monitor o Gloria Loya, Human Rights Officer o Adrian Hanway, Unit Director o Olga Arciniega, Family Relations Director o Martalena and Yvonne, staff at Community Options, residential provider <u>Observations Conducted</u>: o CLDP Meeting for: • Individual #3 (pre CLDP meeting) o CLDP assessment review meeting for: (none) o ISP Meeting for: • Individual #50 o ISP preparation meeting for: • Individual #9, Individual #88 o Community group home visit for: • Individual #95 o Self-advocacy meeting, 3/21/13 o Parent advisory council, 3/21/13
	Facility Self-Assessment The APC's self-assessment continued to improve. The APC self-rated T1c, T1c1, T1c2, T1c3, T1d, T1e, T1f, T1h, and T2a in substantial compliance. The monitoring team agreed with some of these (T1c, T1c2, T1c3, T1d, T1h, T2a) and also rated T2b in substantial compliance. The differences in ratings were primarily, if not solely, due to the APC's reliance upon the statewide self-monitoring tools. These tools did not capture all of what the monitoring team looks at when conducting the six-month monitoring reviews.

	Summary of Monitor's Assessment EPSSLC again continued to make progress across all of section T. This was due, in large part to the work of the APC, Tony Ochoa. In addition to engaging in many activities himself, he supervised and coordinated the work of the new post move monitor, Luz Delgado, and the two transition specialists, Fernando Fraga and Helen Alvarez. Further, Mr. Ochoa and Ms. Delgado enthusiastically responded to the comments, suggestions, and recommendations in the previous monitoring report. The specific numbers of individuals who were placed had increased to an annualized rate of 12% (7 individuals since the last review). Approximately 10% of the individuals at the facility were on the active referral list (12 individuals), about the same percentage as during the last review, however, given that more individuals were placed, this indicated that more individuals were being referred. The list of individuals not being referred solely due to LAR preference contained 15 names; this appeared to be an accurate list. Much progress occurred regarding the educational activities described in T1b2. Family members and LARs received lots of individualized attention and education and as a result a number of individuals were referred. More work was needed for the determinations and opinions of professional members of the IDT regarding most integrated settings to be evident in assessments, meetings, and the ISP document. Of the 8 individuals who were placed by the facility and received post move monitoring, 7 (87%) were maintaining successfully or fairly successfully in the community. The facility engaged in four new activities that, although not specifically required by the Settlement Agreement, were in support of helping the facility achieve substantial compliance with various aspects of section T. These were an FST workgroup, new PMM with additional responsibilities, regular meetings of the admissions placement department staff, and a new family relations department. Four of the 7 CLDPs (57%) were developed in a timely manner. That is, activities related to transition and placement occurred at a good pace for about half of the CLDPs. For the others, there were long lapses (many months) during which there was little or no indication of the reason for the absence of activity. IDT members continued to be very involved in the placement activities of the individuals. Team members thoughtfully evaluated the homes and day programs being explored by the individual. Changes to improve the quality of the discharge assessments were not done as recommended in the previous report. Primarily, the APC and transition specialists were not ensuring that the discipline recommendations were designed for the new environments. EPSSLC continued to make incremental progress in developing thorough comprehensive ENE support lists. Section T1e details this and focuses on a number of areas for continued improvement.

	A CLDP meeting and a pre-CLDP meeting were observed by the monitoring team. Continued progress was evident and recommendations for continued improvement are provided. Since the last review, 22 post move monitorings for 9 individuals were completed. The post move monitoring report forms were completed correctly and thoroughly. Good information was included. ISPA meetings following these reviews did not occur when there were identified concerns. The state and facility submitted an annual obstacles report (T1g). Much good information was included, however, a lot of information and detail was needed to meet the requirement for a comprehensive assessment.

#	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 again continued to make progress across all of section T. This was due, in large part to the work of the APC, Tony Ochoa. In addition to engaging in many activities himself, he supervised and coordinated the work of the new post move monitor, Luz Delgado, and the two transition specialists, Fernando Fraga and Helen Alvarez. Further, Mr. Ochoa and Ms. Delgado enthusiastically responded to the comments, suggestions, and recommendations in the previous monitoring report. The specific numbers of individuals who were placed had increased to an annualized rate of 12%. Approximately 10% of the individuals at the facility were on the active referral list, about the same percentage as during the last review, however, given that more individuals were placed, this indicated that more individuals were being referred. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 7 individuals were placed in the community since the last onsite review. This compared with 3, 4, 1, 1, 3, and 1 individuals who had been placed during the periods preceding the previous reviews. o The number of community transitions showed an increasing trend. o This was the highest number of placements during any period since monitoring began. • 10 individuals were referred for placement since the last onsite review. o This compared with 9 and 6 who were newly referred at the time of the previous reviews. o 2 of these 10 individuals was both referred and placed since the last onsite review. o This indicated that IDTs were continuing to make referrals. • 12 individuals were on the active referral list. This compared with 12, 8, 9, 10, 4,	Noncompliance

		and 7 individuals at the time of the previous reviews. o The number of community referrals showed a stable/increasing trend. o 2 of the 12 individuals were referred for more than 180 days. ▪ This compared with 3, 1, and 6 individuals who were referred for more than 180 days during previous monitoring reviews. ▪ 1 of the 2, however, was scheduled for placement within the next month or two. ▪ 1 of the 2 was referred more than one year ago. Her placement was delayed due to the need for a provider who could meet her adaptive equipment needs. • 3 individuals were described as having requested placement, but were not referred. This compared with 4, 3, 2 individuals at the time of the previous reviews, respectively. o Of the 3 individuals who requested placement, but were not referred, 1 individual had an LAR who made this decision. o Of the remaining 2 individuals, an appropriate review and/or appeal was conducted for 2 (100%). They were both not referred due to legal reasons. These were the same individuals described in previous reports. Additional documentation was not necessary, however, the facility indicated that IDT activities were continuing to address the issues. • The list of individuals not being referred solely due to LAR preference contained 15 names (compared to 10 individuals at the time of the previous reviews). o The APC did a nice job of creating a list that was more accurate than ever before. o Now that an accurate list was available, the APC will be able to determine if the number of individuals who would be referred by the IDT but were not referred solely due to LAR preference shows a stable or decreasing trend over time. • The referrals of 3 individuals were rescinded since the last review. This compared to 2, 2, and 2 at the time of the previous reviews. o Documentation was provided for 3 of the 3 individuals regarding the reasons for the rescinding, including ISPA notes. o Two were due to increased unstable medical problems. The rescinding of these referrals appeared to be reasonable to the monitoring team. o The third was due to LAR preference. A new LAR was appointed since his original referral and the LAR rescinded the referral. The PMM, however, reported that she was having a number of positive discussions with the LAR. o An adequate review to determine if changes in the referral and transition planning processes at the facility was not conducted for the rescinded referrals. If done and if actions were recommended, the	

		monitoring team would look for indication of implementation of actions. o The monitoring team again recommends that the APC conduct some sort of review (e.g., RCA) for all rescinded referrals. Depending upon the details of the rescinding, it might be sufficient to conduct the review solely within the admissions and placement department. • 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, had ER visits or unexpected hospitalizations, transferred to other group homes or to a different provider, who had run away from their community placements, and/or had other untoward incidents continued to be tracked and recorded (but not yet graphed). This was good to see. These data were now being obtained for at least a one-year period after moving. o Of the 9 individuals who moved in the past 12 months, 2 were reported to have one or more untoward events (22%). One had a relatively minor issue (Individual #76). The other had repeated and ongoing problems (Individual #37). The facility, however, continued to be engaged with the provider for Individual #37. This was very good to see. ▪ The monitoring team, however, found that other individuals also had untoward events that were not included in the APC's data and, therefore, would not be reviewed by the APC (e.g., Individual #69, Individual #61). o The APC should do some sort of analysis or review of each of these situations to, once again, learn what might be improved in the CLDP and transition planning process. This should not be a complicated or overly time consuming activity. The benefits may be very helpful to the APC, PMM, and transition specialists. o Of these, an adequate review was not conducted either of the cases to determine if changes in the referral and transition planning processes at the facility should be made. If this were done and if any actions were recommended, the monitoring team would look for indication of implementation of these actions. o The spreadsheet tracking sheet used by the APC should be organized by individual by date of placement so that it is easy to look at those individuals placed within the past 12 months. This is minor and easy to fix. • 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 be graphed separately. The APC had taken some initial steps by creating five pie charts, all related to	

		some reasons individuals were not referred. These were very interesting and gave a good snapshot of these sets of data. In particular, the monitoring team found the "IDT Preference" and the "Population Breakdown" charts to be very informative (even though the color assignments in the legend key were incorrect). Pie charts are most useful for showing the current status. A line graph showing month to month data can be useful for looking at trends. The APC reported that he will be working on creating a more comprehensive set of data graphs and will include them in his part of the facility's QA program (see sections E above and T1f below). The monitoring team suggests that APC add to his set of graphs so that he has a full set of relevant graphs. A list of suggestions is provided below. The printouts can have more than one small graph on each page (e.g., three or four) to make the set of graphs easier to manage for the APC and for the reader. • Number of individuals placed each month • Number of new referrals each month or six-month period • Number of individuals on the active referral list as of the last day of each month • Number of individuals on the active referral list for more than 180 days, as of the last day of each month • Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers) • Number of individuals who have requested placement, but have not been referred, as of the last day of each month • Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month • Number of individuals not referred solely due to LAR preference as of the last day of each month • Number of individuals who had any untoward event happen after community placement each month o Cumulative number of each type of untoward event for all placements • Number of rescinded referrals each month or each six-month period • Number of returns from the community in each six-month period • Number of deaths in each six-month period • Number of alternative discharges (T4) • From T1b1 below: number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles • From T1b2 below: number of individuals who went on a community provider tour each month	

		Other activities Since the last review, the APC and the facility engaged in four new activities that, although not specifically required by the Settlement Agreement, were in support of helping the facility achieve substantial compliance with various aspects of section T. Furthermore, these activities were another indication of the facility's commitment to supporting individuals moving to the most integrated setting, as per this provision. One activity was the formation of what the APC called the FST Workgroup. This was an outstanding idea, one that shows the facility understood the relationships between various Settlement Agreement provisions and that multiple section leaders would need to collaborate in order to achieve substantial compliance in all of their sections. The group had met once and had set some appropriate and reasonable goals. Moreover, the APC created an example of a sample ISP that he felt would contain wording that would meet the requirements of sections T, F, and possibly S. He also highlighted various aspects of the last monitoring report in these three sections where he felt comments really applied to all three sections. This was very good to see. If possible, the monitoring team would like to attend this meeting during the next onsite review. • The monitoring suggests that this group ensure that the four open bullets in T1b2, item #1 in T1b2 are explicitly identified. Second, the new post move monitor, Ms. Delgado, had taken an extremely active role in working with the APC and the two transition specialists. This included talking with and working with family members and LARs regarding community options, learning more about available options, listening to their concerns, and bringing this information back to the department and the IDT. The monitoring team was very impressed with the energy that Ms. Delgado brought to this position. Third, the APC held a weekly, or biweekly, meeting with the PMM and transition specialists. They covered very relevant topics, including a discussion of the status of each individual on the referral list. This was also a great idea and helped this group to focus their efforts for the upcoming week, keep each other informed about what they were doing, and set the occasion for learning from one another. A detailed document, called Placement Progress, had the latest information on each referral. As far as the monitoring team could tell, this activity resulted in LARs and family members who were initially opposed to referral recently supporting referral and placement (e.g., Individual #49, Individual #37, Individual #47). If possible, the monitoring team would also like to attend this meeting during the next onsite review. Fourth, the facility created a family relations department headed by the former APC. She was well known to the families throughout the facility and although she was not part of the admissions and placement department, she provided another resource for family members, LARs, the APC, PMM, and the transition specialists.	

		<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 requirement belongs to the QDDPs and the professionals. Thus, the monitoring team looks for indications in each professional's assessment, in the written ISP that is completed after the annual ISP meeting, and during the conduct of the annual ISP meeting. In assessments: Of the 10 ISPs reviewed, all of the assessments for 0 individuals (0%) included an applicable statement/recommendation. On the other hand, some of the assessments for all (100%) of the individuals included an applicable statement recommendation. In general, the status of professional determinations in the written assessments remained largely the same as during the last review. That is, all assessments done by nursing, habilitation, speech and language, recreation, psychiatry, and psychology included a statement. The habilitation and speech/language assessments even included a special one page signed explicit statement by the clinicians. Some of the assessments by pharmacy, dietary, and vocational; and none of the assessments by medical contained a statement. It seemed that if there was a paragraph header in the assessment template, the professional responded. Thus, this may be relatively easy to address. In the written ISPs: Of the 10 ISPs reviewed, 10 (100%) included an independent recommendation from the professionals on the team to the individual and LAR. Of these 10, each professional's opinion was given and described in 2 (Individual #65, Individual #134); some but not all professional's opinion in 3 (Individual #103, Individual #49, Individual #78); and a general statement saying that all professionals were in agreement or consensus for the other 5. Observation of ISP meetings: Of the 2 ISPs observed, 0 (0%) included an independent recommendation from each of the professionals on the team. Individuals referred: In reviewing the 7 CLDPs and ISPs for 5 individuals who were on the referral list, 12 (100%) individuals and/or LARs did not oppose transition to the community.	

		Referrals and Transitions
		There were two systemic issues delaying referrals (at the facility/local level) identified during this onsite review. There were actions being taken to resolve them.
		• One issue was that there were no openings in any of local providers for any new community placements.
		  o In response, local providers were identifying new properties and planning to open new homes.
		• A second issue was that the provider community was not prepared, or preparing, to serve individuals who had multiple and complicated accessibility and adaptive home needs. That is, more individuals would have been placed if proper lifts, roll-in showers, and so forth were available.
		  o To address this, the APC communicated directly with providers about the types of individuals who were being referred (see his email and attachments to providers), involved EPSSLC habilitation department in planning for referrals and visiting providers, and continued to work on each individual's referral, such as ensuring that the provider understood exactly what was needed in the new setting.
		
		Funding availability was not cited as a barrier to individuals moving to the community.
		
		Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list via a weekly emailed report from the APC. The report included a detailed paragraph about each of the individuals on the referral list. This was excellent.
		• The monitoring team again recommends that this also be presented orally to senior management, perhaps during the now-weekly section leaders meeting. It can be done briefly, without repeating the same information every week. Also, including occasional updates on the successes (and challenges) experienced by some of the individuals who had moved would likely also be of great interest to senior management.
		
		Transitions were occurring at a reasonable pace. The state's expectation was that once a referral was made, the transition to the community should occur within 180 days. The IDT was required to meet monthly to review and address the obstacle to transition after the 180-day window. The ISPA was then to be sent to state office.
		• Of the 7 individuals placed since the time of the last onsite review, 3 (43%) were placed within 180 days of their referral. 2 of the other 7 were placed within a month or two past the 180 days, and the other two were placed approximately one year after referral.
		• At the time of the review, 12 individuals had been referred for community transition. 2 of these 12 individuals had exceeded the 180-day timeframe.
		  o Of these, 1 individual had exceeded one year.	

		o The other was scheduled to move in April 2013. • The number of 180-day/1-year referrals, however, was decreasing. • Reasonable activity and actions related to the transition and placement for 2 of the 2 (100%) individuals. • Gaps of time (e.g., multiple months) during which little or no activity occurred for 0 of the 2 (100%) individuals. • Adequate justification was provided for the lengthier transition process for 2 of the 2 (100%) individuals. • All of the above indicated that the APC, his staff, and the facility were taking seriously all referrals, acting on them, and moving them forward as possible.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The 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. Thus, there was not a state policy that adequately addressed all of the items in section T of the Settlement Agreement. The facility-specific policy was merely a copy of the state policy with the EPSSLC letterhead on the first page. When the new state policy is finalized, the APC should consider developing a facility-specific policy (or policies) regarding specifics of implementation of the state policy at EPSSLC. Thus, at this time, there were not facility policies that adequately supported the state policy for most integrated setting practices. The APC regularly disseminated (emailed) the policy to management and clinical staff. He also met with staff of each facility department, the individuals' homes, and day sites to review and train the policies on most integrated setting practices (see T1b2 below). The rating for T1b is based solely on the development of adequate state and facility policies. Sections T1b1 through T1b3 are stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major	EPSSLC had received state training and consultation on the newest iteration of the ISP process (also see section F). Further training was expected, especially given that the state was focusing upon two other facilities to further refine this new ISP process. The APC's FST workgroup should try to stay abreast of developments in the ISP process across the state. <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.	Noncompliance

	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.	DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted above in section F of this report, substantial compliance was not found for F1d, F2a1, and F2a3. Of the 4 individuals who were referred for placement and reviewed by the monitoring team and of the 7 CLDPs reviewed by the monitoring team, documentation indicated that the IDTs for 0 individuals (0%) included SAPs, and other supports, that were chosen with the individual's upcoming transition in mind. • Most ISPs at EPSSLC included two actions plans under the headings Community Awareness and Community Integration. This was great to see, however, once referred, consideration should be given to SAPs or other supports directly related to the upcoming transition. • The monitoring team recommends that, upon referral, the APC, PMM, and/or transition specialist seek out the IDT, and the active treatment coordinator to talk about what SAPs might be considered now that the individual was referred for placement. <u>Obstacles to Movement</u> The APC further developed a very good spreadsheet that listed each individual; the preferences of the LAR, IDT, and individual; whether or not referred; and the reason for not being referred. He color-coded each line to indicate those who were not referred solely due to the LAR's preference, those whom the IDT and LAR agreed upon not referring, those who's funding or legal status prevented referral, and those who were referred. This spreadsheet, called the Living Options Database Log, will be very helpful to the APC as he tracks data over the subsequent months, quarters, and years. The APC also noted that he planned to revise the QDDP's obstacle form. The data system, however, was undergoing changes, such as allowing for more than one obstacle to be reported and to separate obstacles to referral from obstacles to placement. He should be sure to take all of this into consideration. Even though more work was needed, as indicated below and by the APC during the onsite review, the work being done at the facility (e.g., what is described in the above two paragraphs, the FST workgroup) should result in progress by the time of the next review. Of the 10 ISPs reviewed, 6 should have had obstacles defined (the other 4 individuals were referred for transition to the community). Of these 6 ISPs, 6 (100%) included an adequate list of obstacles to referral and obstacles to transition. • In addition, the APC had a one page listing of obstacles for 117 individuals, taken from the statewide list of possible obstacles. This further supported the findings of the monitoring team's sample.	

		Of the 2 annual ISP meetings observed, an adequate list of obstacles to referral or obstacles to transition was identified for 2 (100%). Of the 6 ISPs, 6 (100%) included an action plan to address/overcome obstacles identified. Of these 6, 6 (100%) were individualized, but were not measurable or with expected timelines. Of the 2 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 2 (100%). Of these, 2 (100%) were adequate. <u>Preferences of individuals and LARs</u> Of the 10 ISPs, 10 (100%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). Most of these individuals could not adequately express a preference. The ISP indicated this and what the IDT had done to try to make this determination. Of the 2 annual ISP meetings observed, the individual's preference for where to live was adequately described in 2 (100%), and this preference appeared to have been determined in an adequate manner for 2 (100%), that is, that they were unable to give a clear indication of preference. Of the 10 ISPs, 10 (100%) included an adequate description of the LAR's preference and how that preference was determined by the IDT, or indicated that there was no LAR. Of the 2 annual ISP meetings observed, there was not an appointed LAR for either. Family member preference, however, was discussed in both meetings.	
	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.	Below are the nine activity areas upon which the Monitors, DADS, and DOJ agreed would comprise the criteria required to meet this provision item. The solid and open bullets below provide detail as to what is required. EPSSLC was addressing almost all of these activities. Excellent progress was demonstrated. <u>1. Individualized plan</u> • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Individualized and specifies what will be done over the upcoming year 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>: In reviewing 10 recently completed ISPs, 4 individual(s) had been	Noncompliance

		referred for placement, and were engaged in the CLDP process. For the remaining 6, 6 (100%) had a plan that addressed education about community options. Of these, 0 (0%) were adequate, primarily because they were not written in measurable terms (e.g., many only referred to visiting community homes) and it was not clear that they addressed the specific educational needs of the individual (e.g., many said take on tours without specificity of what type of tours, no specificity of the educational activities addressing behavioral or medical needs). o The APC reported that one of the focuses of the FST workgroup was to address this particular item. 2. Provider fair • 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 EPSSLC status: The facility did hold a provider fair within the past 12 months. The facility did conduct the above bulleted activities. o The APC organized and oversaw implementation of provider fairs in March 2013 and September 2012. He was also responsive to comments from previous reports regarding collecting data, assessing satisfaction, and making changes and improvements. He created a nice one-page summary of comments from the past three provider fairs. Improvements included holding the fair on a Saturday, including the LA, and consideration of moving the provider fair types of activities to the providers (the providers were supportive of this idea, too). The monitoring team was impressed with the way the facility was handling this part of this provision. 3. Local MRA/LA • Regular SSLC meeting with local MRA/LA • Apparent good communication and working relationship with LA • Quarterly meetings between APC/facility and LA • Agenda topics are relevant EPSSLC status: The facility maintained good communication and a good working relationship with the LA, participated in quarterly meetings with the LA, and ensured relevant topics were on the agenda for the LA meetings. 4. Education about community options • 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. 5. 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. • Tours are for individuals or no more than 4 people • Individual's response to the tour is assessed (need methodology and indicators) EPSSLC status: A lot of effort continued to occur at the facility for individuals to go on tours of community providers. The APC and his staff worked with the LA staff to make this happen. Two tours continued to be available each month, a one-page report for each individual was completed by the staff, and the information was sent along to the IDT. By the monitoring team's count, it seemed that there were 13 tours and 52 individuals went on these tours. Many individuals went on more than one tour, so the number of different individuals who went on tours was less than 52. The APC should have a way of ensuring that everyone who should go on a tour does indeed have the opportunity to do so. Thus, even though lots of work went into these tours (and should continue), some simple data collection will be needed, as indicated below. o The facility did not have an adequate system to track and manage tours of community provider, that is, identified all individuals for whom a tour was appropriate, what type of tour was appropriate, and whether or not each went on a tour that was appropriate to his or her needs. o Because all of the individuals at the facility for whom a tour was appropriate still needed to be determined at EPSSLC, the percentage who went on a tour appropriate to their needs within the past year could not yet be determined. 6. Visit friends who live in the community EPSSLC status: Since the last onsite review, there were not visits by individuals to friends who had moved to the community. Of the 10 ISPs reviewed, visits to friends appeared to be appropriate for 0. Even so, these types of visits were not offered to any individuals. This should be a relatively simple activity to add into the activities of those individuals for whom this would be appropriate. 7. Education may be provided at • Self-advocacy meetings	

		• House meetings for the individuals • Family association meetings or • Other locations as determined appropriate EPSSLC status: Since the last onsite review, other educational activities for individuals did occur during self-advocacy meetings, did not occur during house meetings for individuals (house meetings for individuals did not occur at EPSSLC), did occur during family association meetings, and did occur during other situations. o The APC and his staff maintained good performance in this area. This included a presentation to self-advocacy group, presentation by a former resident to the self-advocacy group, frequent discussions with family members and the family association, mailings to families, and posting one-page flyers about community living around campus. 8. A plan for staff to learn more about community options EPSSLC status: Since the last onsite review, educational activities for DSPs did occur at least once. Since the last onsite review, educational activities for clinicians did occur at least once. Since the last onsite review, educational activities for managers and administrators did occur at least once. o This continued to be a strength of the APC and his staff. A large number of trainings, meetings, and emails occurred for DSPs (e.g., most every house had documentation of training of staff), clinical departments, and management. Presentations occurred at new employee orientation (145 new employees), information was presented in the facility staff newsletter, a resource guide describing every local provider was created and made available the shared drive, and information about statewide initiatives and activities were shared with various staff. o Trainings and information about community was an ongoing, constant, and pervasive activity at EPSSLC. 9. Individuals and families who are reluctant have opportunities to learn about success stories EPSSLC status: Since the last onsite review, information about successful community placements was shared with (a) individuals who were reluctant to consider community placement and (b) LARs who reluctant to consider community placement. o This was one of the improvements since last review, especially due to the work of the new PMM and the two transition specialists, combined with the positive histories that many families had with the APC and with the family relations director. o The monitoring team requests more specific documentation (e.g., notes, list, narrative) for next review.	

	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. 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. To meet substantial compliance with this provision item, the facility will need address the following four items to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual written 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 occurring regularly and consistently. • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o Living options were thoroughly discussed during every ISP. • Documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the individual, as well as the decision regarding referral of the entire team, including the individual and LAR. o The set of ISPs reviewed by the monitoring team included very good statements about the decision made by the entire team for 9 of the 10 reviewed (i.e., all except for Individual #8).	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The APC submitted 7 CLDPs completed since the last review. This was 100% of the CLDPs completed since then. The monitoring team reviewed all of these (100%). A set of in-process CLDPs was also reviewed. <u>Initiation</u>: 7 of the 7 (100%) CLDPs, and 3 of the 3 (100%) in-process CLDPs, seemed to be initiated right after the referral. The monitoring team looks for this to occur within 10 calendar days of referral. It would be helpful if the initial date of creation of the CLDP document could be added to the front of the CLDP. <u>Timeliness</u>: 4 of the 7 (57%) CLDPs included documentation to show that they were updated throughout the transition planning process. That is, activities related to transition and placement occurred at a good pace for about half of the CLDPs. For the others, there were long lapses (many months) during which there was little or no activity and no indication of the reason for the absence of activity. That was not the case for	Substantial Compliance

		Individual #61, who's CLDP indicated the delay was due to the need for dental work. During the weeks following the onsite review, the monitoring team requested additional information regarding the 3 CLDPs. The APC provided a detailed description of the activities that occurred. The monitoring team considered this to be an adequate indication that there were no gaps in activity, however, these activities need to be documented in the CLDP going forward. 3 of the 3 (100%) in-process CLDPs indicated ongoing activity. IDT member participation: 7 of the 7 (100%) CLDPs included documentation to show that IDT members actively participated in the transition planning process (i.e., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). IDT members continued to be very involved in the placement activities of the individuals. Team members thoughtfully evaluated the homes and day programs being explored by the individual. To accomplish this, there were visits to providers, overnight trials, and IDT meetings to review and discuss. At least one IDT member visited the proposed home and day sites. In some cases, multiple providers were not explored because the individual or LAR chose a specific provider, or because there were limited spaces available and the IDT (correctly) determined that the available space was a good placement for the individual. Coordination with LA: 7 of the 7 (100%) CLDPs included documentation to show that the facility worked collaboratively with the LA.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The 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. 0 of the 7 CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that all six of the activities listed in the below six bullets occurred adequately and thoroughly. • Training of community provider staff, including staff to be trained and level of training required. All 7 of the CLDPs indicated a great deal of training that was to occur. This was fabulous to see. The training should also indicate who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), the method of training (e.g., didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP), and a competency demonstration component, when appropriate. o The APC shared some new competency exam (6) that he planned to use	Noncompliance

		with all future placements. They contained five or six very relevant questions for provider staff in six different important topic areas. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). This was not indicated in any of the CLDPs. • Assessment of settings by SSLC clinicians (e.g., OTPT). This was not indicated in any of the CLDPs, however, the APC reported that habilitation staff were now taking a more active role in visiting the new home and day sites. This should also occur for psychology and possibly education and recreation, too. • Collaboration between provider day and residential staff is ensured. This was alluded to in some of the CLDPs, but should be more explicitly addressed. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not indicated. The IDT needs to consider this. • Collaboration between Post-Move Monitor and Local Authority staff. This was likely occurring, but not indicated in the CLDP. <u>Day of move activities</u>: 7 of the 7 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, 5 indicated the responsible staff member, and 0 indicated documentation that the activities did indeed occur. <u>CLDP meeting prior to moving</u>: During the CLDP meeting observed during the onsite review (via audio only), an adequate and complete CLDP meeting was conducted for Individual #3. The monitoring team looked for the following components. Comments are below each: • Attendance by all relevant IDT members, community providers, and LA o This was observed. • Individual preparation occurred prior to the CLDP meeting, if appropriate o This appeared to have occurred, as appropriate. • DSP preparation occurred prior to the CLDP meeting, if appropriate to do so o DSP attended and participated. • Individual participation occurred, or was facilitated, if needed o This was done as appropriate. • There was active participation by team members o This was observed. • All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved o All supports were mentioned and most were discussed, however, as noted in T1e, not all supports were thoroughly addressed in the list presented at the meeting. The APC should provide the leadership and facilitation of this in future CLDP meetings. • The post move monitor actively participated to ensure that supports were	

		adequately defined and required evidence specified. o This occurred, however, when the list of supports improves (T1e), the PMM will need to ensure that the evidence required for all of those supports are also adequately described. During the onsite review, a pre-CLDP meeting was held for Individual #3. This was a meeting to prepare for the CLDP by reviewing assessments and the status of each assessment as well as a preliminary list of pre- and post-move supports. It was a good meeting and helped set the occasion for the full CLDP meeting described immediately above. During the meeting, the monitoring team made raised some of the points noted in T1e below regarding supports for the important components of PBSP, PNMP, etc., and the inclusion of SAPs.	
	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 pre- and post-move supports and other pre- and post-move activities. In 7 (100%) of the CLDPs, the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and/or title for each support. In 7 (100%) of the CLDPs, the facility identified specific timeframes/specific dates for completion and/or implementation for each support. In 7 (100%) of the CLDPs, signatures of facility director/APC, provider, and LA were included. In 7 (100%) of the CLDPs, other activities, names, and timelines/dates for other community living monitoring activities were included.	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. Family members who were not appointed as LARs were also highly involved. 7 of the CLDPs (100%), included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by • Signatures on CLDP • Narratives in the CLDP • Observation at CLDP and other transition-related meetings	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall	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. These assessments were then fully inserted into the CLDP document and they were attached to	Substantial Compliance

	have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	the CLDP. For 7 of the 7 CLDPs reviewed (100%), all necessary assessments were completed. For 7 of the 7 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. For 7 of the 7 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. Even so, the content of the assessments needed more improvement, as also indicated in the last report. The APC needs to ensure each assessment contains the following: • A summary of relevant facts of the individual's stays at the facility. o This was done sufficiently in the assessments. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o This was done sufficiently in the assessments. • Assessments specifically address/focus on the new community home and day/work settings; there are recommendations for the community residential and day/work providers. o Although there was a section in some, but not all, of the assessments with a header, such as Recommendations for the Community, the content for most did not specifically address the new setting. One good exception was the medical comment for Individual #61 and the educational/recreational comments. Most problematic were the recommendations from psychology (not near enough detail regarding the prevention-type techniques found effective at EPSSLC) or nursing (see section M). • Assessments identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. o Similar to the above bullet, many supports provided at EPSSLC will need to be continued in the community, but will need to provided in a different or modified manner. This was not addressed. EPSSLC received substantial compliance at the time of the last review. The monitoring team has kept this rating, but the above improvements must be made if substantial compliance is to be maintained. Each section of the CLDP contained the APC's summary of the discussion and deliberations. The APC did an excellent job of describing these deliberations in a way that seemed to capture the content and intent of the participants. This was very helpful	

		to the monitoring team and likely to any reader of the CLDP.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The monitoring team was very impressed by the progress that continued to be made by the APC and the IDT members in creating better sets of pre- and post-move required supports. Clearly, under the leadership of the APC, a wider variety of topics were included. This is one of the most important aspects of the CLDP and transition process. The APC reported that he and his staff work towards ensuring that all appropriate supports are included in the CLDP by reviewing every assessment, talking with DSP staff, talking with the RNCM, and with others. These were very good activities. They did not use any type of checklist or guide to help ensure all supports were included. The monitoring team recommends that they do so. A checklist of items for this type of activity was suggested in the previous monitoring report. The same list is provided in the bulleted items below, too. More work continued to be needed in order for substantial compliance to be obtained in this provision item. The list of pre- and post-move supports should meet the following standards. These are listed below along with comments regarding EPSSLC's status. These comments should be read with the understanding that good progress was observed by the monitoring team. • The list should be comprehensive and inclusive, demonstrated by: o Sufficient attention paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ The list of supports did not adequately take into account the many assessments that pointed to concerns over behavioral and psychiatric history, including some behavioral exhibitions and psychiatric symptoms that had not occurred that long ago (Individual #37). This individual exhibited serious behavioral and psychiatric problems within a short time after his move, resulting in at least three psychiatric hospitalizations. ▪ The first few pages of the CLDPs for those with histories of behavioral problems thoroughly described many prevention, interaction style, and communication aspects of supporting the individual in a way that reduced the likelihood of behavior problems and increased learning and perhaps even satisfaction. This specific important information did not make it on to the list of supports (Individual #133, Individual #37, Individual #69). This information should be on the list as one or perhaps even a number of separate supports. ▪ It was not clear what aspects of a mental health plan were important to implement (Individual #69, Individual #47, Individual #133). This was further noted by the PMM when she	Noncompliance

		wrote about a community provider's residential staff and case manager who said that the mental health plan was too general and did not provide insight into the individual's behavior problems (Individual #69). o All safety, medical, healthcare, risk, and supervision needs addressed. ▪ This appeared to be addressed, however, consider that improvements to the nursing and psychology discharge assessments were needed (see T1d). o What was important to the individual was captured in the list. ▪ This appeared to be adequately in 6 of the 7 CLDPs. The CLDP for Individual #47 include some preferred items, but did not include supports to ensure receipt of her favorites, such as shiny items, gum, and spicy foods. ▪ Many of these preferred items and activities were put into a single support. It would be more helpful to the provider and to the PMM if these were separated, perhaps by category of preference (Individual #61, Individual #37) o The list thoroughly addressed the individual's need/desire for employment. ▪ This was done very well in all of the CLDPs. Employment was not a relevant or realistic activity for some of the individuals. For those for whom it was, the CLDP (and the IDT) thoroughly discussed it and relevant supports were included (Individual #61, Individual #133). o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included. ▪ This was not addressed at all in any of the CLDPs, but needs to be, especially for whom the facility had success in supporting positive behavior change. o There were ENE supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. ▪ So many of the individuals had long lists of varied and interesting SAPs while at EPSSLC. Unfortunately, few were carried over to the provider. Usually only one or two. Although there may not be a requirement for HCS community providers to implement more than one or two SAPs, the monitoring team has found providers to be more than willing, and often eager, to implement SAPs when there is good rationale to do so and when it is something that will benefit the individual. ▪ One good, related example was a support for Individual #37 to enroll in a community college cooking class.	

		o 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. ▪ PBSPs often contain lots of procedures that reduce the likelihood of the behavior problem occurring, such as reward systems, successful styles of interaction, ways to de-escalate agitated behavior, structured activity schedules, and so forth. There should be ENE supports that call for implementation of these aspects of PBSPs and there should be documentation to evidence that they were provided. ▪ Similarly, it is not sufficient to have a support that says implement the mental health plan. This gives the provider and the PMM insufficient detail on what to do and what to look for. The important aspects of the mental health plan need to be specified. ▪ Supports should call for implementation of important components to address GERD, dining safety, ground food, and constipation; not merely to say follow the dining plan, follow GERD procedures, or implement as written. o Topics included in training had a corresponding ENE support for implementation. • The wording of every ENE support is in appropriate, measurable, and observable terms. o Most of the supports were not written in a way that was measurable so that the provider and PMM know how much, how long, how many, etc. In other words, there was more need for observable reportable outcomes and a criterion for each support. • 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 as to why it was not included. o This appeared to be addressed adequately by the APC and IDT, based upon the well-written deliberations sections. • Every ENE support included a description of what the PMM should look for when doing post move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. o Progress was observed, however, there were many references to ADL sheets, progress notes, and MARs. The monitoring team could not determine what an ADL sheet or a progress note was. o During the last review, the PMM and one of the providers developed a simple checklist for provider staff to record implementation of many of the supports. That did not seem to have continued to occur (unless that	

		was what an ADL sheet and/or a progress note were). o The CLDP support should indicate what it is that will be documented, whether it be a checklist, a special ADL sheet, or progress note. o Daily narrative paragraphs in a progress note can be interesting for the PMM to review, however, unless they are designed properly (e.g., include a checklist), the PMM may not be able to determine the implementation of a support. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. A pre-move site review was conducted for all individuals. Each review indicated that each essential support was in place. These reviews were conducted by the PMM, Ms. Delgado. They were exceptionally detailed and descriptive and, thus, very helpful to the reader. • Each of the nonessential supports needs to have an implementation date. Each nonessential support in the CLDP did have an implementation date.	
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 continued to engage in some activities related to this provision, however, a more organized system of quality assurance is required in order to obtain substantial compliance. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. Data/information were being collected, however, only for the living options discussion, not for all of the portions of the CLDP process. The APC reported that the living options discussion tool was relevant and valid. In fact, he had conceptualized this tool as addressing four domains of the living options discussion and he also used this tool when training and re-training staff. The tool for the CLDPs was not being used and there were questions about the relevance of its contents. Data were reviewed, summarized, and analyzed for the living options tool. These data were included in the facility's QA program. The monitoring team suggests that a quality assurance process be more than just the living options tool and a soon-to-be-developed CLDP tool and include: • These two tools • Graphs of the outcomes of these tools • Graphs of the other outcomes noted throughout this report, especially in T1a • Section T QAD-SAC meeting summaries and monthly data submissions • The provision T section of the QA report	Noncompliance

		• Presentations to QAQI Council • Corrective actions and/or corrective action plans	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • <u>Definitions</u>: Section T.1.b.1 of the Settlement Agreement required that the facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The state's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." • <u>Referrals</u>: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • <u>Transitions</u>: Surprisingly, adequate methodologies were not in place to collect	Noncompliance

		data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In addition, the plans included in the facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives, however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).	
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	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 9/1/12 through 3/21/13. 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	Substantial Compliance

	Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	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. At EPSSLC, this would be a list of 15 individuals.	
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	EPSSLC maintained substantial compliance with this provision item. Since the last review, 22 post move monitorings for 9 individuals were completed (one of the individuals was placed from Mexia SSLC). This compared to 10 post move monitorings for 5 individuals at the time of the last review (an increase of 100%). The monitoring team reviewed completed documentation for all 22 (100%) post move monitorings. Of the 22 post move monitorings, 19 were complete by the new post move monitor Luz Delgado, 2 were completed by the transition specialist Helen Alvarez, and 1 was completed by the APC Mr. Ochoa.	Substantial Compliance

	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.	Timeliness of Visits: For the 9 individuals, 22 reviews should have been completed since the previous review. Of the 22 required visits, 22 (100%) were conducted and 21 (95%) were completed on time. The one that was late was because the individual was hospitalized due to a behavioral incident. It was eventually, and shortly thereafter, completed. Locations visited: For the 22 post move monitorings conducted, 20 (91%) of the sites at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited. The two post move monitorings for Individual #69 did not include his public school. Content of Review Tool: 22 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. 22 (100%) of the post move monitoring report forms were completed correctly and thoroughly, as evidenced by: • The checklist was completed in a cumulative format across successive visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination. • There was adequate justification for findings for each support. • Detail/comment was included in the evidence boxes at the end of each of the supports sections. Every support received some narrative comments. They were numbered to correspond with each support in 21 of the 22 reports. o The monitoring team wishes to acknowledge the detail that the post move monitor provided in these descriptions. She did not hesitate to include a lot of detail regarding what she observed and what she found. This was excellent and helped the reader to understand her many activities and, most importantly, the status of the individual and what the facility and provider were doing to support him or her. • LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11) were explicitly stated in the comments section in 20 of the 22 reviews (in all but Individual #110's). • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements could easily be determined from the narrative comments provided by the PMM. The monitoring team recommends that the PMM include a list of the staff who were interviewed on the first page of the report to help the reader understand which staff were interviewed during the post move monitoring.	

		General status of individuals Based upon the monitoring team's review, of the 9 individuals who received post move monitoring, 8 (88%) ultimately transitioned very well and appeared to be having great lives. For example, Individual #47 was described as being very interactive and social, improved weight, and absence of SIB and other problem behaviors. Individual #76 and Individual #95 were also doing extremely well. Three individuals had some problems during transition that eventually settled. One other (Individual #37) was still having serious post-placement problems. As discussed with the APC, a review needs to be done of any individuals whose placements failed or who had the kinds of problems noted in T1a. Use of Facility's best efforts when there are problems that can't be solved: In 8 of the 22 (36%) post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 5 of the 9 individuals. Of these 8, the post move monitor took assertive action in 7 (87%). The 1 case was when the PMM should have insisted on an EPSSLC team meeting, but didn't (Individual #76 45-day). For all of the others, the PMM, Ms. Delgado was extremely assertive and tenacious in following up on concerns, such as: • A missing medication. The PMM refused to leave the home until there was an assurance that the medication would be delivered later that same day. • Putting EPSSLC clinicians in contact with provider and community clinicians. • Attending to clothing and room cleanliness. • Making sure staff followed a toileting routine correctly and regularly. • Continuing to monitor past the 90 days if any issue was not totally and fully resolved. ISPA meetings after each post move monitoring visit: An ISPA meeting should occur after every post move monitoring during which a problem or concern is noted by the PMM. An ISPA meeting was held and there were minutes/documentation of the meeting following 6 of the 20 (30%) post move monitorings. (EPSSLC was not responsible for an ISPA meeting for the individual placed from Mexia SSLC.) During and following this review, the facility was very explicit in their intention to hold an ISPA meeting following every post move monitoring going forward, however, the requirement is that these meetings are held if problems or concerns are noted by the PMM. The importance of holding these meetings was evident when one looks at some of the problems that were occurring for at least five of the individuals. The IDT would likely have had some suggestions, comments, or interventions for the provider, including phone conferences, document sharing, and onsite visits to the provider.	

		In order to maintain substantial compliance, the facility needs to hold an ISPA review after each post move monitoring visit in which a problem or concern was noted by the PMM.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team observed one post move monitoring. The PMM, Luz Delgado, did a thorough and complete job post move monitoring. This was based on observation of the PMM's: • Examination and verification of every ENE support • Review of documents • Direct observation of the individual and staff • Staff interview • Individual Interview (as much as possible) • Gathering of information by directly observing/examining, not only by provider staff report • Professional interaction style • No use of leading questions • Assertive and tenacious in obtaining information The home of Individual #95 was visited for the 45-day review. The provider was Community Options. Two staff were present, both of whom were relatively new hires (three months), however, they were extremely professional, interacted very pleasantly with Individual #95, and were very knowledgeable about his needs (e.g., asthma, GERD, diet, oxygen, follow-up to hospital visit, toileting, bowel movements, sleep, medications, adaptive equipment), skills and independence (e.g., toothbrushing, hand over hand assistance), and preferences (e.g., rattle, dancing, backyard). Individual #95 lived in a beautiful, spacious, and clean home. His bedroom was well furnished, had colorful paintings on the bedroom walls, and was also clean and neat. Individual #95 appeared to be comfortable and stable during the hours of the observation. Overall, this seemed to be a good and successful placement.	Substantial Compliance
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	This item does not receive a rating.	

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

Recommendations:

1. The APC and his department should do a review (e.g., root cause analysis) of each rescinded referral, each failed placement/re-admission to the facility, 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. Ensure that the data spreadsheet includes all individuals who had untoward events occur (T1a, T2a).

2. Create a set of graphs of referral and placement activities, and include them in the facility's QA program (T1a, T1f).

3. The FST work group should address items in T1b2, especially item #1 (T1a, T1b2).

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 APC should make an occasional oral presentation to senior management regarding the status of all referrals (T1a).

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

7. Upon referral, the APC (or one of his staff) should seek out the IDT and others as noted in T1b1 to talk about what SAPs might be considered now that the individual was referred for placement (T1b1).

8. Action plans to address/overcome each individual's obstacles need to be measurable and with expected timelines (T1b1).

9. The plan for education about community options need to be in measurable terms and address the specific educational needs of the individual (T1b2).

10. Track and manage tours of community providers: identify all individuals for whom a tour was appropriate, what type of tour was appropriate, and whether or not each went on a tour that was appropriate to his or her needs (T1b2).

11. Visiting friends who live in the community should be an activity available to those individuals for whom it would be appropriate (T1b2).

12. Ensure gaps in time are thoroughly explained in the CLDP and in the in-process CLDPs, or in some other document in the individual's record (T1c).

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

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

15. Document the completion of the day of move activities (T1c1).

16. Ensure the individual and his or her DSPs are prepared for the CLDP meeting (T1c1).

17. Assessments for discharge need to specifically address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting (T1d).

18. Ensure a list a list of pre- and post-move supports is comprehensive and inclusive (much detail in provided in the report) (T1e).

19. The APC should consider a self-assessment prior to finalization of the list of the CLDP supports. A suggested list of items for a self-assessment of supports is discussed T1e (T1e).

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

21. Regarding the facility and statewide reports and assessments of obstacles (T1g)
    a. The format the state provides facilities for their facility-specific obstacle reports should include data for the list of obstacles to referral for all individuals at the facility, as well as the subgroup of individuals who have expressed an interest in transition, but their guardians are reluctant to consider it.
    b. The state should define the process facilities use to collect data on obstacles to transition.
    c. The facility should expand the analysis of the data included in its facility-specific report, include specific action plans to address the findings from the analysis, and whenever issues identified are outside of the scope of the facility to correct, the facility should include recommendations for DADS' intervention.
    d. The state should conduct and include in the report an analysis, on a systemic level, of the data the facilities provide, and provide a description of the specific steps, if any, the state had or planned to take "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities…"
    e. In the obstacles report, the state should include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).

22. Include visits to public school programs when doing post move monitoring (T2a).

23. Conduct an ISPA meeting after each post move monitoring if there were any problems or concerns noted by the PMM (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o EPSSLC Self-Assessment and Provision Action Information for section U o EPSSLC Referral for Personal Advocate/Guardian form o ISPs and Rights Assessments for : Individual #65, Individual #134, Individual #49, Individual #78, Individual #31, Individual #103, Individual #8, Individual #6, Individual #60, and Individual #3. o EPSSLC Section U Presentation Book o A Sample of HRC Minutes o EPSSLC Prioritized Guardianship/Advocate List o A list of individuals for whom guardianship had been obtained in the past six months. o Documentation of activities the facility had taken to obtain LARs or advocates for individuals Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Gloria Loya, Human Rights Officer o Mario Gutierrez, Incident Management Coordinator o Michael Reed, Lead Investigator o Carmen Molina, Director of Behavioral Services o Cynthia Martinez, QDDP Coordinator Observations Conducted: o Observations at residences and day programs o Unit Morning Meeting 3/19/13 and 3/21/13 o Incident Management Review Team Meeting 3/19/13 and 3/21/13 o Annual ISP meetings for Individual #50 and Individual #89 o Pre-ISP meetings for Individual #88 and Individual #82 o Human Rights Committee Meeting 3/20/13 o Guardianship Committee Meeting 3/18/13
	Facility Self-Assessment: EPSSLC submitted its self-assessment. The self-assessment was updated on 3/6/13. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment, the results of these self-assessment activities, and a self-rating for each item. 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

	a review of the facility guardianship policy, review of a sample of 28 ISPs for documentation of discussion regarding the need for guardianship, review of the priority list for guardianship, and review of 31 Rights Assessments updated in the past year. Findings from the facility self-assessment were similar to findings of the monitoring team for the two provisions of section U. The facility self-rated U1 and U2 as not in compliance. The monitoring team agreed with the facility's compliance ratings for U1 and U2.
	Summary of Monitor's Assessment: The facility had not yet developed an adequate assessment process for determining the need for guardianship. IDTs continued to be in the beginning stages of holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent. This assessment process will need to be fully implemented for compliance with U1. Then U2 will be the next step which is procuring guardians for individuals assessed as high priority. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had developed a priority list of individuals needing an LAR, though this list was not based on an adequate assessment process. IDTs continue to need training to determine each individual's functional capacity to render informed decisions. • 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. A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need. The human rights officer worked very closely with individuals and their IDTs to ensure protection of rights at the facility. She was actively involved with every department at the facility and served as an valuable resource to IDTs.

#	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	A prioritized list of individuals lacking both functional capacity to render a decision and a LAR to render such a decision was still in place, though the facility still lacked a formalized assessment process that included adequate IDT discussion. The facility maintained a prioritized list of individuals in need of an LAR. The current list identified 35 individuals as Priority I or high need for an LAR, 6 individuals as Priority II, and 0 individuals as Priority III. This list was based on the need for restrictive practices, the individual's ability to advocate for himself/herself, the presence of an active advocate, and the individual's risk level.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Steps taken to address compliance with the requirements of section U included: • The facility had a guardianship committee to review all referrals for guardianship and track progress towards obtaining a guardian for those individuals referred for guardianship. • The Human Rights Officer provided additional training to QDDPs regarding the IDT discussion for determining guardianship and/or advocacy needs. • A tool was developed to monitor and score ISP discussion regarding the need for guardianship. • A database was developed to track ISP guardianship discussion monitoring results. A sample of ISPs and relevant assessments was reviewed to determine the adequacy of IDT discussion regarding individuals' ability to express their own wishes or make determinations regarding their health or welfare. Most ISPs in the sample documented a brief discussion on guardianship. None included an adequate discussion of the individual's ability to express his or her own wishes or make determinations regarding his or her own health or welfare. For example, • The ISP for Individual #78 noted that she had recently obtained an advocate that advocated on her behalf, then later noted that her advocate had been less active this past year, so she now was a priority I (high need) for guardianship. The IDT had determined that she was "least able to express their own wishes or make determinations regarding their own health or welfare." There was no clear documentation of discussion regarding the need for guardianship. Specific information on how she communicated her choices or what decisions she made throughout her day was not discussed in the ISP. • The ISP for Individual #134 did not include documentation of a discussion regarding his need for guardianship. It was noted that had difficulty expressing his preferences due to "not being able to communicate with others." It was further noted that his mother advocated on his behalf. His rights assessment noted that he was a priority III (low need) for guardianship because he did not require frequent need for decisions requiring consent. It further noted that he would benefit most from having an advocate. The IDT for Individual #50 agreed that he could not give informed consent in a number of important areas. His sister had also recently expressed interest in pursuing guardianship. The team agreed that he would benefit from his sister acquiring guardianship. To that end, the HRO was assisting her to gain guardianship. Again, the discussion regarding his ability to make informed decisions and possible training opportunities to improve decision making skills was not adequate.	

#	Provision	Assessment of Status	Compliance
		IDTs were not holding thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship was not based on an adequate assessment process. 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 aggressive efforts to obtain LARs for individuals through the guardianship process including contact with family members and local guardianship providers. Fourteen new guardians were obtained for individuals between 7/1/12 and 1/31/13. Twenty-three guardianship process packets had been provided to families since 12/1/12. From the 23 packets distributed, eight families had requested additional guidance through the guardianship process. The human rights officer was actively assisting families complete the guardianship process. There was a guardianship committee in place to review all requests for guardianship and track progress towards obtaining guardianship. This was all very good to see. The facility had some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human rights officer employed by the facility. The facility continued to offer self-advocacy opportunities for individuals at the facility, including a self-advocacy group. 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 an HRC meeting, however, did not support that adequate discussion was occurring prior to approving all restrictive practices, particularly the approval of psychotropic medications. Committee members approved the use of psychotropic medications without adequate discussion of risk factors, such as other medications that the individual was taking or medical risks associated with the medications. The facility continued to make progress in this area, however, compliance with U2 will be contingent on the development of an adequate assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	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 such as developing training outcomes to develop and/or improve communication and decision making skills (U2).

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o EPSSLC facility-specific policies: • Recordkeeping Practices," dated 4/28/12 (though it was merely a copy of the state policy) o EPSSLC organizational chart, undated, but likely February 2013 o EPSSLC policy lists, undated but likely February 2013 o List of typical meetings that occurred at EPSSLC, 2/28/13 o EPSSLC Self-Assessment, 3/6/13 o EPSSLC Action Plans, 2/20/13 o EPSSLC Provision Action Information, most recent entries 2/25/13 o EPSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/18/13 o Note stating that there were no changes in the six recordkeeping processes since the last review o List of all staff responsible for management of unified records o Training documentation for two new staff for all six recordkeeping processes, October 2012 o Documentation of new employee orientation, August 2012 to January 2013 o Documentation of current employee refresher training, July 2012 to January 2013 o Unified records committee: quarterly meeting minutes (two meetings, October 2012, March 2013) o "100% record audit" blank tool, description, and results for September 2012, December 2012, March 2012 [2 times]) o List of other binders or books used by staff to record data (six) o Description of the EPSSLC shared drive, undated o List of medical consultations used by the URC, January 2013 o Tables of contents for the active records, updated 3/11/3, and the master records and individual notebooks, both last updated 2/24/11 o Blank tools used by the URC (checklist forms and statewide form), not updated recently o List of 14 policies updated in the last six months o An 11-page spreadsheet that listed state and facility-specific policies and also showed various information regarding training (e.g., who, how, data/numbers), undated, probably February 2013 o List of individuals whose unified record should have been audited by the URC, and those that were audited by the URC, August 2012 to February 2013 o Completed unified record audit tools for 18 individuals, from August 2012 through February 2013 (0 to five per month): • Statewide self-monitoring tool • Active record and individual notebook • Master record • Various notes and lists, such as of ISP SAPs and consents

	o Emails from URC requesting corrections be made, August 2012 through January 2013 o Errors spreadsheet that summarized the errors that were found, August 2012 through January 2013 • One spreadsheet was for items that could be corrected (e.g., missing document) • One spreadsheet was for items that could not be corrected (e.g., illegible signature) o Graphic presentations for each month (none) o Correction follow-up spreadsheet for each month o Description and table regarding how EPSSLC addressed section V4, through January 2013 o Completed V4 interview forms (5) o Active records and/or individual notebooks of: • Individual #88, Individual #8, Individual #50, Individual #96, Individual #169, Individual #108, Individual #45, Individual #46, Individual #178, Individual #72, Individual #5, Individual #114 o Master records of: • Individual #6, Individual #149, Individual #175 <u>Interviews and Meetings Held</u>: o Priscilla Guevara, Medical Records Coordinator (MRC) o Melissa Hall, URC <u>Observations Conducted</u>: o Records storage areas in residences o Overflow and master records storage area o Unified Records Committee meeting, 3/18/13
	Facility Self-Assessment There was some progress in the self-assessment in that a few additional items were added and a few items were deleted or edited. Overall, however, the self-assessment was almost identical to the one submitted during the previous monitoring team review. The monitoring team, therefore, again recommends that the self-assessment contents line up directly with the contents of the monitoring team report. That is, there should be a self-assessment of each aspect of each of the four provisions of section V that the monitoring team comments upon (e.g., active record, individual notebook, master record, purple/pink binders, existence of policies, training on policies, components of the V3, implementation of the audit, presentation of results, follow-up, each V4 component). To do the V3 audits, the URC used a table of contents checklist for the components of the unified record, and she also completed the statewide tool. It appeared that only the statewide tool was used for reporting to the QA department (and in the QA report and to QAQI Council) and only the statewide tool was subject to interobserver agreement with the assigned QA staff member, Petra Robledo.

	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: Overall, the recordkeeping staff worked hard, engaged in numerous activities, and continued to strive for improvements in recordkeeping practices at EPSSLC. Progress, however, was somewhat slowed by changes in department staffing. The monitoring team is very optimistic that much progress can be obtained by the time of the next onsite review. A number of activities contributed to the progress found by the monitoring team, such as training of the new URC, new employee orientation, annual refresher training for all staff, a Unified Records committee, review of ISP documents in every active record, and receipt of all ISP assessments. A unified record existed for all individuals, including all new admissions. The active records continued to improve. There was improvement in the IPNs and observation notes. There were fewer items misfiled in the wrong individual's active record. More actions were taken to thin the active record. Specification of content, availability, and signature legibility still needed improvement. Individual notebooks were in use throughout the facility. They were thinner and were now a typical, standard part of the EPSSLC service and support system. Some improvements regarding content were still needed. The master records were in good shape and the facility was adequately addressing documents that could not be located. The pink/purple binders needed to be addressed to determine what information in them should be considered to be part of the individual notebook. A new document listed all of the state policies and any associated facility-specific policies. It was 11 pages long and included columns stating effective/revision dates, policy numbers, and three columns related to staff training. The monthly quality assurance audits were neat, the contents were easy to read, and dates of documents were included making it easy for the reader to understand the contents. A review of five unified records, however, did not occur each month as required. The tool used by the URC to conduct the audit reviews needed to be updated. It was old and did not reflect many of the changes and modifications that had occurred to all of the components of the unified record over the past year or so. After conducting the audit, the URC had a simple procedure to inform the responsible person of any corrections that were needed and then she followed-up two weeks later. Her own data, however, showed that only about a third were corrected. It may be that more time was needed, or perhaps a different way of getting corrections completed was needed. Data from the audits were now on a graph. This was good to see. Recommendations for improvements to the graphic presentations are below. The MRC and her staff engaged in some activities to try to make progress regarding V4, specifically in

	trying to come up with a way to determine if the six types of activities that comprise this provision were being addressed in a way that met substantial compliance. It appeared, however, that only two activities occurred: continuation of the interviews of staff (this was worthwhile) and attendance at a portion of the annual ISP meeting (this was not the best use of recordkeeping staff time, as also noted in the previous report).

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The EPSSLC recordkeeping department experienced changes in staffing since the last review. The previous URC was now the director of the recordkeeping department, a new URC was hired, the two record clerk positions were reduced to one, and there was a new administrative assistant. Thus, the recordkeeping department was in transition. Even so, the recordkeeping staff worked hard, engaged in numerous activities, and continued to strive for improvements in recordkeeping practices at EPSSLC. The procedures and processes observed during the last review remained in place. It was good to see that performance had not declined. Moreover, the monitoring team expects there to be much more progress by the time of the next onsite review. State policy and facility-specific policies, including the facility's six recordkeeping processes, remained the same since the last onsite review and, therefore, no new comments are provided here. As was the case during previous reviews, the recordkeeping department engaged in a number of activities that were contributing to their facility's performance in this provision. These were: • Specific, organized, and documented training and orientation of the new URC and administrative assistant. • New employee orientation sessions specifically about recordkeeping practices. • Annual refresher training for all staff (database maintained by CTD) • A Unified Records committee that met quarterly. Minutes indicated that relevant topics were discussed. • A quarterly (or more) review of whether a set of specific ISP-related documents was present in the active records. This was called the "100%" record audit" because 100% of the records at EPSSLC was examined for the presence of this set of documents. ISP documentation is also addressed in section F above. o The efforts of staff across the facility to conduct these audits is acknowledged by the monitoring team. These efforts resulted in improvements in the active records and individual notebooks, as detailed below. • All ISP assessments were now submitted to the recordkeeping department for	Noncompliance

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		tracking and filing. The information was maintained in a database and the data were shared with senior management. • A plan to participate in the facility director's periodic town hall meetings for staff. • A plan to do training (or retraining) sessions for staff, homes, departments, etc. when repeated recordkeeping problems are identified. This was occurring at the time of the last review, but had been discontinued due to the staffing changes in the department. <u>Active records</u> The active records continued to improve. The monitoring team reviewed active records in many of the dorm and cottage residences. Aspects in which improvement was noted. • The 100% audits appeared to result in the ISP portions of the active record (and the individual notebook) continuing to improve in content, appearance, and organization. • There was improvement in the IPNs and observation notes. This was a recommendation in the previous report. The facility responded to this. It appeared that improvements occurred as a direct result of facility activity. o Entries were more clearly written. o Physician and dentist IPN entries were generally written in SOAP format and most were legible. o During the last review, there were many documents in the IPNs that should not have been in the IPNs. This had improved greatly. It appeared that actions were taken in September 2012 because many of the active records reviewed by the monitoring team seemed to have improved after that month. • There were fewer items misfiled in the wrong individual's active record. Only one item was found misfiled by the monitoring team (Individual #114's QDRR was in Individual #169's active record). • There was a better indication of what SAPs were to be in the active record. The facility's program developers made a one-page list that was placed at the front of the SAP section of the active record. The URC, however, will need to check the accuracy of this list when doing the V3 audit. • More actions were taken to thin the active record. For instance, 30 days after every ISP, the administrative assistance was responsible for doing thinning of the active record. Aspects that needed attention/improvement:	

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		• Even though legibility of entries in the IPNs and observation notes had improved, legible and appropriate signatures still needed additional improvement. o The UR Committee discussed this topic and was planning to address it. • The availability of the active record throughout the day for nurses, clinicians, and others who needed access was reported to continue to be a problem. This was also observed by the monitoring team (see V4 below) and was discussed during the UR Committee. • There was inconsistency in what was in a number of sections of the active record. The facility should determine what the minimum components are for these sections, so that the recordkeeping department staff know what should be included when they file documents and so that the URC knows what to look for when doing the V3 audits. The minimum components of these sections could be added to the Active Records Guidelines Table of Contents (and V3 audit tool). Three sections of the active record that need more specificity regarding content are listed below. o Consents: For example, Individual #88's active record only contained consents for medical treatments. o Rights: For example, only Individual #169's active record had a document "Explanation of Rights." o Functional assessments: the content varied across the active records. For example, some contained only the FSA whereas other records contained additional assessments. • Numerous problems in nursing entries in the active record were noted in section M1 of this report. The 35 records reviewed for sections M and I were well organized, but there continued to be problems with legibility of content and signatures, writing on the margins of the IPNs versus starting another page, and many nurses' notes were not in chronological order. This raised question regarding the actual occurrence of timely notification of physicians of significant changes in individuals' health, implementation of interventions and follow-up of changes in health to resolution. This problem was a notable negative change from the prior review. <u>Individual notebooks</u> The individual notebooks were in use throughout the facility. They were now a typical, standard part of the EPSSLC service and support system. The MRC and the URC reported that they had heard no reports of problems in the use of the individual notebooks. The said that everyone was OK with them. The monitoring team did not hear anything contrary to this except for one comment during the monitoring committee regarding ensuring that individual notebooks were always available to direct care staff (see V4).	

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		Similarly, the monitoring team found the individual notebooks to be improved since the last onsite review. One of the problems found during the last review had been corrected. That is, the individual notebooks were thinner, documents were moved from the individual notebooks to the active records more regularly (it was now the monthly responsibility of the MRC and the URC), and information that did not need to be in the individual notebook was removed. The monitoring team found a few items that needed to be corrected. These were having the correct table of contents guidelines (Individual #8, Individual #50), ensuring that gaps in SAP data were corrected (Individual #8), and removing duplicates of the same document (Individual #72). These few number of needed corrections also demonstrated progress to the monitoring team. The issue of the other binders (called the pink or purple binders), however, had not yet been resolved (see below). <u>Other binders/logs</u>: The existence of the pink/purple binders had not been addressed. The monitoring team recommends that the MRC and URC meet with the unit director about how best to address this. To repeat from the last report: • The monitoring team believes that the information in the pink/purple 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 did 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. Please know that the monitoring team understands that having some documents in this type of accessible binder may be a very practical way to increase accurate data collection. Thus, the monitoring team's point here is not for the facility to discontinue the pink/purple binders, but to assess if what is in them is indeed what should be in them and, if so, to ensure that the documentation in these binders is incorporated into the facility's procedures about individual notebooks (i.e., training, processes, audits, etc.). <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 master records were in very good shape and all were in the new format. The recordkeeping staff addressed a problem identified in previous reports. That is, they	

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		now had a process to deal with items that were missing from the master record. This was for the URC to (a) go to the overflow files to look for the document, (b) request it from, and work with, the local authority, and (c) request it from another source, if one was identified. The missing component of this process was documenting that this was done, so that it was evident to the reviewer of the master record, and so that any future recordkeeping staff would not unnecessarily repeat the search process. This would be especially important for those items that could not be obtained, even after going through this process. <u>Shared drive</u> The shared drive was described to the monitoring team. The recordkeeping department reported that all information in the shared drive also appeared in hard copy in the active record and/or individual notebook. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	EPSSLC submitted four documents to the monitoring team. Three were identical to what was submitted during the last onsite review and, therefore, comments are not repeated here. It may be that these were submitted in error because (a) the self-assessments lists 17 other new or updated policies, and (b) the fourth document was new and listed all of the state policies (by provision letter order as in the Settlement Agreement) and any associated facility-specific policies (listed under the state policy and Settlement Agreement provision) . This new document showed that EPSSLC was making some progress towards this provision. The document was 11 pages long and included columns stating effective/revision dates, policy numbers, and three columns specifically related to this provision V2: • Person responsible for training • Staff required to receive training • How often training occurs The next step is for the facility to indicate the following, perhaps in additional columns: • The number of staff who are supposed to have received training • The number of staff who did receive training o It would be helpful to include an “as of” date on this spreadsheet so that the reader knows that the training data were valid/correct as of a certain date. Because many trainings need to be re-done periodically, the “as of” date will be important to the reader. • For each policy, either in a new column, or within the “Person responsible for	Noncompliance

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		training column," include o what type/method of training is needed (e.g., classroom training, review of materials, competency demonstration), o type of documentation necessary to confirm that training occurred and where this documentation is stored and summarized. In addition, not all state policies were in place yet, though continued progress was evident.	
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.	The change in recordkeeping staffing also impacted the department's progress on this provision. The new URC, however, appeared to be thorough and detailed in her work and as she becomes more experienced with the quality assurance review audit process for V3, it is likely that she will make further improvements to the process. Overall, her audits were neat, the contents were easy to read, and she included dates of documents making it easy for the reader to understand the contents. A review of five unified records did not occur each month as required. From August 2012 through February 2012 (seven months) a total of 18 reviews were completed, ranging from zero to five per month. Five reviews were conducted in only one of the seven months (August 2012). Further, although not a requirement for substantial compliance, the monitoring team suggested in the last report that the URC not re-audit a unified record if she had audited it within the previous 12 months. In this way, it is very likely that every unified record at EPSSLC can be audited within a two year period. Further, re-auditing a unified record that was recently audited (and in which corrections were made) does not make the best use of the URC's limited time to conduct audits. The tool used by the URC to conduct the audit reviews needed to be updated. It was old and did not reflect many of the changes and modifications that had occurred to all of the components of the unified record over the past year or so. The updated tool might incorporate both the table of contents tool and the statewide tool, it should address the pink/purple binders (see V1 above), and might even include items for rating whether the active record and individual notebook were accessible, locked when appropriate to do so, and properly thinned and stored. Similarly, the URC must know what documents should be in the sections of the unified record, especially in the active record. As noted in V1 above, the recordkeeping department should work with the appropriate facility department so that they know what documents should be in sections, such as rights, consents, and functional	Noncompliance

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		assessments. This detail should probably be added to the audit tool (as well as to the table of contents guidelines as noted in V1). During each audit, the URC made a list of what documents were in these sections. This was helpful to the reader, but begged the question of whether any documents were missing that should have been there. After completing the audit, the URC implemented a very simple and straightforward process. It consisted of putting all of the errors into the department databases. There were two "error" databases: (a) errors regarding documents that could be corrected (e.g., missing, out of date, unsigned, incorrect) and (b) legibility errors (i.e., those that could not be corrected). The facility called the first type of errors "Documented Errors" and the second type of errors "Undocumented Errors." The URC then sent an email to the responsible person regarding those errors that needed to be corrected (the monitoring team reviewed all of these). She then followed up on whether the errors were corrected two weeks later. Sometimes the responsible person emailed back and forth with the URC, sometimes she checked on whether it was corrected without having any further interaction with the responsible person. She then entered whether the correction was made into a third database, one that indicated whether the error was corrected and the date of correction. Data from the recordkeeping department's activities were summarized in a number of ways. First, the results of the statewide audit tool (not the table of contents tool) were summarized, graphed, and presented as part of the QA report each quarter. As indicated in previous reports, data on the table of contents reviews is also very important and these data should be presented, too. Second, the two types of errors were put into a table and graphed using two separate lines on a single graph with data points each month creating month to month line graphs. Having month to month data was a good improvement. The graph, however, had a high number of undocumented errors in August 2012 (616) and the ordinate set at 700. This had the result of making changes in the documented errors line hard to see. The monitoring team recommends that there be two separate graphs so that the changes in the trend lines can be more discernable to the reader. The staff reported that they were going to start grouping errors such as legibility of signatures rather than counting every single one. This seemed to make sense to the monitoring team. Further, the number of errors should be presented as an average number of errors per audit. If a different number of audits was done each month (as did occur over the past seven months), it is incorrect to present only the total number. For example, if two audits were done and there were a total of 40 errors, that would not really be comparable to a month in which five audits were done and there were also a total of 40	

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		errors. Further, there was no graphing of the percentage of errors from the documented errors list that were corrected within the two week period. This should be done, perhaps on a third graph. The data seemed to be available for graphing because they were listed in the self-assessment under V3 item #4. Overall, the data in the self-assessment showed that about one-third of the errors that could be corrected were corrected after two weeks. This seemed like a low percentage. The recordkeeping department should consider whether the period of time for follow-up should be extended or perhaps a different approach needs to be taken in order for these corrections to be completed. Also, now that data were being collected, the MRC and URC (along with the QA department) should review these data to identify unresolved issues, analyze the data in more depth to identify specific issues or departments requiring more attention, and develop corrective actions, as appropriate, to address them. This would then be incorporated into the monitoring committee, QA report, and QAQI Council presentations.	
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.	In previous monitoring reports and during previous onsite reviews, the monitoring team detailed the six types of activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. To that end, the MRC and her staff engaged in some activities to try to make progress regarding this provision, specifically in trying to come up with a way to determine if the six types of activities that comprise this provision were being addressed in a way that met substantial compliance. The monitoring team understands that this is a complicated provision and appreciated the efforts of the recordkeeping staff. It appeared, however, that only two activities occurred: continuation of the interviews of staff (this was worthwhile) and attendance at a portion of the annual ISP meeting (this was not the best use of recordkeeping staff time, as also noted in the previous report). The five V4 interview tools given to the monitoring team only indicated the URC's comments about how the active records and/or individual notebooks were used during the ISP meetings during the time that she observed. The spaces to indicate IDT member responses to the handful of questions, however, were blank on each of these V4 tools. In the self-assessment, each of the six components of this provision were given a score, apparently based upon the five completed V4 interview tools. The scores ranged from 25% to 100% for the six components. The monitoring team could not determine how	Noncompliance

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		these scores were determined. Perhaps the completed interview tools were not given to the monitoring team and/or perhaps the URC used her findings from her V3 audit to help her make a rating of these V4 components. If so, this was also not made clear to the monitoring team. Even so, although much work was still needed to make this a valid system, it was good to see that the recordkeeping staff were working towards a systematic, eventually objective, method of determining whether the requirements of V4 were being met. Once a valid data system is created, these data should also be part of the recordkeeping department's QA activity (e.g., in the QA data list inventory, reported in QA report, presented to QAQI Council). Below, the six areas of this provision item are again presented, with some comments regarding EPSSLC's status on each. <u>1. Records are accessible to staff, clinicians, and others</u> The monitoring team observed that: • Records were readily available to medical staff. • Records were accessible to the psychiatrist during clinic. • Individual notebooks were usually available. • Direct support staff reported that the individual notebooks were easy to use and readily accessible. • During the UR committee, attendees reported two problems with record accessibility. One was that the active record (or one or two volumes) were in the medical department for the entire day, thus, making those volumes unavailable to others who needed them, especially for nursing. The second was a comment that the individual notebooks needed to stay with the individual because they contained very important information, such as PNMPs, dining plans, and risk descriptions. It was not clear, however, whether this was a facility-wide problem or based on one or two examples. • Unavailable active records were reported as a barrier to nurses being able to complete their duties. • Records were difficult for habilitation clinicians to access. In part, as a result, they typically typed up progress notes and filed these in the Habilitation Therapy section rather than in the IPNs. • A sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Both a current ISP and IHCP were available in 12 (67%) of 18 individual notebooks in the sample. <u>2. 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	

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		information from these reviews, however, should be used to satisfy this requirement, too. The monitoring team observed that: • The recordkeeping department had begun gathering data on the submission of documents for the individual records. A list provided by recordkeeping department reported that 30 of 50 (60%) of ISPs were filed more than 30 days after the annual ISP was held. • Medical data were filed timely and accurately. • Psychiatry data were located when needed. • Habilitation therapy documentation was generally completed in a timely manner, though often documented on a separate sheet and filed in the Habilitation Therapy tab. Other progress notes, such as related wheelchairs, etc. were completed in the IPNs. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> The monitoring team observed that: • Data were up to date when presented to psychiatry, however, graphs were, at times, confusing and of limited utility. They did not always indicate other events (medication changes, specific life stressors) that may have influenced the individual's behavior. • Data collection reliability improved. • QDDP monthly reviews indicated that data on progress towards ISP outcomes was often unavailable at the time of review. • Aspiration trigger sheets were not consistently completed fully by DSPs or reviewed by the RNs. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> The monitoring team observed that: • This was the case for the psychiatry department. • IPN entries made by Habilitation Therapies described actions taken by clinicians, findings from issue specific assessments, post-hospitalization assessments, and documentation related to direct therapy. • Habilitation therapy IPN entries were incomplete in that they presented a description of the interventions, but little analysis and justification to continue, modify, or terminate. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> Interviews were conducted, but as noted above, at the beginning of the V4 section of this report, the monitoring team could not determine staff responses to these interviews because the documents submitted were mostly blank. During previous monitoring team	

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		reviews, the URC presented the details of each response and also wrote a short paragraph or two describing her interpretations of the interview content. The monitoring team observed that: • When IPNs were illegible (e.g., some neurology notes), the entries were difficult to use. • Psychiatry clinic staff also used other information with regard to making treatment decisions (e.g., psychology evaluations, data graphs, MOSES, DISCUS, nursing information, and other clinical data). • Habilitation therapists conducted record reviews of health/medical history consults and risk ratings in preparation for their assessments. This information was routinely reported in the assessments, though not consistently applied in their analysis of the individual's habilitation status and needs. <u>6. 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 reported data in the self-assessment regarding whether or not each discipline used the records during seven ISP meetings observed. She reported that 18% of the attendees used the record. The intent of this item, however, is for the record to be present and available, and that it is used when, and if, needed, such as if there is a question about data, diagnoses, incidents, etc. Many times, there is no need to open the record because IDT members do not need to access additional information. In other words, it is possible to satisfactorily meet this component if the record is present, not used, and no examples of it failing to be used when it should have been used. Further, the recordkeeping department might take advantage of asking others who are already observing the ISP meetings for other purposes (e.g., for sections T or F) to collect some simple data for the recordkeeping staff so that they do not have to also attend a meeting. Also see comments in the previous monitoring report regarding this. The monitoring team found the following: • The QDDP provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #50 and Individual #89. Data from assessments were entered into these two forms, so that team members could reference current assessments when developing necessary supports. • Pre ISP meetings were observed for Individual #88 and Individual #82. The QDDP used information in the unified record to update IDT members to determine which assessments were needed prior to the annual meeting and to review progress towards outcomes. • The active record and individual notebook was present and available at the ISP	

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		and pre-ISP meetings observed by the monitoring team for Individual #50, Individual #9, and Individual #88. • During the PNMT meeting individual records were available and used throughout the meeting. • Records were available and used/reviewed during neurology-psychiatry clinic.	

Recommendations:

1. Legible and appropriate signatures need additional improvement (V1).

2. The availability of the active record throughout the day for nurses, clinicians, and others who needed access was reported to continue to be a problem and should be addressed (V1).

3. The facility should determine what the minimum components are for a number of sections of the active record, so that the recordkeeping department staff know what should be included when they file documents and so that the URC knows what to look for when doing the V3 audits. This includes consents, rights, and functional assessments (V1).

4. There remained a need to incorporate the contents of the pink/purple binders into the facility's procedures about individual notebooks (i.e., training, processes, audits, etc.) (V1).

5. The master records should include documentation whenever the recordkeeping department has been unable to obtain a document after conducting a document search as per their own procedures (V1).

6. Add additional information to the spreadsheet of state and facility policies to indicate what type/method of training is needed (e.g., classroom training, review of materials, competency demonstration), what type of documentation is necessary to confirm that training occurred and where this documentation is stored and summarized, the number of staff who are supposed to have received training, and the number of staff who did receive training (with an "as of" date) (V2).

7. Complete state and facility policies for all provisions of the Settlement Agreement (V2).

8. Conduct five quality assurance audits each month (V3).

9. Update the tool (or tools) used by the URC to conduct the audits (V3).

10. When choosing the five unified records for the monthly audit, do not choose a unified record if it was audited within the previous 12 months (V3).

11. Check the accuracy of the program developer's SAP list by comparing it to the ISP when doing the V3 audit (V3).

12. Improve the graphic presentations of audit data, such as fixing the ordinate and/or making separate graphs (V3).
13. Present the average number of errors per audit (V3).
14. Consider whether two weeks is a sufficient amount of time to allow for corrections to be made (V3).
15. Incorporate all recordkeeping data into the facility's overall QA program (V1-V4).
16. Engage in valid activities to determine whether the requirements of V4 were being met (V4).
17. The facility needs to ensure that ISPs and IHCPs are filed and accessible to staff implementing the plan within 30 days of development (V4).
18. Work with other departments and/or ISP meeting observers so that the recordkeeping staff do not use their valuable and limited time observing ISP meetings (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
BC	Board Certified
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
CM	Case Manager
CMA	Certified Medication Aide
CMax	Concentration Maximum
CME	Continuing Medical Education
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
DBW	Desirable Body Weight
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
DNP	Doctor of Nursing Practice
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
ERC	Employee Reassignment Center
FAAA	Fellow, American Academy of Audiology
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FFAD	Face to Face Assessment Debriefing
FLACC	Face, Legs, Activity, Cry, Console-ability
FLP	Fasting Lipid Profile
FMLA	Family Medical Leave Act
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)
IA	Intelligent Alert
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
IHCP	Integrated Health Care 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
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KPI	Key Performance Indicators
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
LLL	Left Lower Lobe
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
MCER	Minimum Common Elements Report
MCG	Microgram
MCP	Medical Care Plan
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MDRO	Multi-Drug Resistant Organism
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
NFS	Non Foundational Skills
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
OH	Oral Hygiene
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
PA	Physician Assistant
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
PDR	Physicians Desk Reference
PECS	Picture Exchange Communication System
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
PM	Physical Management
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PMRP	Protective Mechanical Restraint Plan
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
POT	Post Operative Treatment
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	Personal Skills Assessment
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSI	Preferences and Strength Inventory
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
RLL	Right Lower Lobe
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
SIS	Second Injury Syndrome
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOB	Shortness of Breath
SOP	Standard Operating Procedure
SOTP	Sex Offender Treatment Program
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPD	Sensory Processing Disorder
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
ST	Speech Therapy
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
TCA	Texas Code Annotated
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
TED	Thrombo Embolic Deterrent
TFT	Thyroid Function Tests
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSHA	Texas Speech and Hearing Association
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
UR	Unified Record
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
UT	University of Texas
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VOD	Voice Output Device
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