United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: September 16-20, 2013

Date of Report: November 11, 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 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 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 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, did a great job, before, during, and after the onsite review. She was available, responsive, and helped ensure that the monitoring team was able to conduct its activities as needed. Her assistant Adrian Marquez was also extremely helpful to the monitoring team.

Second, management, clinical, and direct support professionals continued to be eager to learn and to improve upon what they did each day to support the individuals at EPSSLC.

Third, 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.

<u>Restraint</u>

- There were 33 restraints used for crisis intervention involving six individuals between 3/1/13 and 7/31/13. There were 13 instances of dental/medical restraint from 3/1/13 through 8/8/13 involving 10 individuals. The facility, however, had not made progress in documenting and monitoring medical/dental restraints.
- Two individuals at the facility were wearing mechanical restraints considered protective equipment (e.g., helmets for falls). This was a considerable decrease from the nine individuals wearing helmets as protective restraints at the time of the last monitoring visit. The facility had worked hard to develop less restrictive supports for the seven individuals at the facility who no longer wore helmets. In each instance, the IDT had taken an interdisciplinary approach to developing supports and had been very successful.

- Areas of progress included discontinuing long term use of protective mechanical restraints for seven individuals and implementation of a more thorough review of restraints that included video review of the restraint incident when available.

Abuse, Neglect, and Incident Management

- There were 4 confirmed cases of physical abuse, and 16 confirmed cases of neglect between 3/1/13 and 8/30/13. These were the result of 56 DFPS investigations of 141 allegations. The facility reported that 27 other serious incidents were investigated by the facility.
- There were 508 injuries that included 17 serious injuries resulting in fractures or sutures. This was a significant decrease from the 619 injuries in the previous two quarters.
- Provision items not in compliance were:
    - D.2.a: 67% of the facility investigations were not reported within the timeframes specified in state policy. Medical staff were not reporting serious injuries to be investigated immediately. Medical staff had been retrained on reporting procedures.
    - D.2.c: Not all staff were completing annual retraining within required timeframes.
    - D.3.e: Investigations did not commence within 24 hours for the facility investigations.
    - D.3.f: 28% of the DFPS investigations did not include sufficient evidence to support the investigator's conclusions. The facility is, however, to be commended for thoroughly reviewing investigations and requesting a review by DFPS when findings were not adequately supported by the investigation.
    - D.3.i: The facility was not adequately documenting follow-up to recommendations made at the conclusion of investigations. The Incident Management Coordinator reported that the department had recently implemented a new system for following up on recommendations and ensuring that desired outcomes were met.
    - D.4: The facility was still not adequately identifying trends and developing action plans to address trends on a systemic or individual level. The incident management department had recently begun providing incident and injury trend information to individual IDTs.

Quality Assurance

- The QA program at EPSSLC made a great deal of progress since the last onsite review. The data list inventory improved and many of the lists had additional or different items than at the time of the last review, such as for dental and pharmacy. The QAD and SAC need to ensure that the content of the data inventories are comprehensive, especially ensuring that data are tracked to meet what is specified in the wording of provision E1 in the Settlement Agreement.
- More work needs to be done to tie together the data listing inventory, QA matrix, performance key indicator list, and QA report.

- Data from 16 of the 20 (80%) sections of the Settlement Agreement were summarized and graphed showing trends over time, but few analyzed data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals.
- QAD-SAC meetings with discipline departments occurred for 12-13 (60-65%) of the provisions. In addition, a checklist of 10 items for discussion was created beginning in June 2013.
- The corrective action/CAPs system was better organized than at any previous onsite review. There were 41 active CAPs for 11 of the 20 sections of the Settlement Agreement. Of these 41, all appeared to appropriately address the specific problem for which they were created, however, most failed to ultimately assess whether the problem had gotten any better.

Integrated Protections, Services, Treatment, and Support

- At two ISP meetings and two pre-ISP meetings observed by the monitoring team, progress was seen regarding:
    - Integrating the risk identification process into the ISP process.
    - Engaging in adequate discussions regarding community living options.
    - Assessing each individual's ability to offer informed consent and consideration of the need for guardianship.
    - Offering additional opportunities for individuals to attend day programming in the community.
- All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and available to all team members for review. When new assessments are recommended, IDTs need to meet to review recommendations and incorporate any recommended changes in supports into the ISP.
- IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection.
- Supports need to be monitored for consistent implementation and adequacy.

Integrated Clinical Services

- There were no major integration initiatives and no policy was developed to assist the facility in moving towards substantial compliance with this provision. Even so, the monitoring team observed some very good examples of integration of clinical services. In some cases, however, care was fragmented and lacked integration.
- The interim clinical services director served as the lead for this provision. She had only been in the position for three months prior to the compliance review and had many areas that required attention. Provision G had, therefore, not been the primary area of focus.

Minimum Common Elements of Clinical Care

- There was no progress noted in this area. The interim clinical services director served as the facility lead. She assumed the position only four months prior to the compliance review. In the absence of a facility medical director, there was a need to prioritize the work that needed t be done and addressing provision H was not a priority item.
- The facility lead focused on the medical department for this provision, so it was clear that a great deal of work needed to be done.

At-Risk Individuals

- There was progress in taking a more integrated approach to looking at risk. This was particularly evident at the two ISP meetings observed and at the morning clinical review meetings.
- Important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decision regarding appropriate interventions. Without adequate assessments completed prior to the meeting, it was difficult to make clinical determinations in regards to risks.
- Teams were not using the IHCP to track the completion of assessments and document resulting recommendations. Teams were reviewing supports following a change in status, but failing to document when assessments were completed and recommendations were implemented.

Psychiatric Care and Services

- Psychiatry services made progress towards substantial compliance. There were improvements in the consistency of psychiatric diagnoses across the evaluations of different disciplines and there were improvements with timeliness of quarterly psychiatric medication reviews.
- The monitoring team observed one psychiatric clinic, and one Neuro-Psychiatry clinic. There was discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QIDP, direct care staff, and the individual).
- There were noted improvements in the psychiatric participation in the development of the PBSP.
- In J6, where the facility had previously achieved substantial compliance, there were noted deficiencies. Specifically, two of three individuals admitted to the facility during the current monitoring period did not have comprehensive psychiatric assessments via Appendix B.

Psychological Care and Services

- There were several improvements since the last review, resulting in two additional items rated as in substantial compliance (K4 and K10). Additionally, the facility maintained substantial compliance on the four items (K2, K3, K7, and K11) that were in substantial compliance.
- Improvements included the establishment of a more flexible data system, evidence of data-based treatment decisions, and evidence that in those instances when an individual was not making expecting progress, the progress note

consistently indicated that some activity to address the lack of progress had occurred. There was the initiation of the collection of interobserver agreement (IOA) for every PBSP, and demonstration that minimal frequencies and levels of data collection reliability and IOA were achieved. There was demonstration that all individuals with a PBSP had necessary consents, expansion of the collection of treatment integrity to every PBSP, and demonstration that minimal frequencies and levels of treatment integrity were achieved.

- EPSSLC needs to work on improving the quality of the functional assessments, ensuring that all psychological services other than PBSPs treatment plans contain a plan to generalize skills learned, ensuring that PBSPs are consistently implemented within 14 days of receiving consent, and that every staff assigned to work with an individual, including float/relief staff, has been trained in the implementation of his or her PBSP.

Medical Care

- There was no designated lead physician or medical director who was responsible for the development and oversight of health care services or who fully understood the regulatory requirements of a long term intermediate care facility and the requirements of the Settlement Agreement. This had been lacking at the facility for quite some time.
- While the facility had capable clinical staff, they were not involved in many of the processes of the Settlement Agreement. They did, however, respond to the direction of the interim clinical services director by completing Annual Medical Assessments, Quarterly Medical Assessments, documenting consults, and performing other duties.
- Overall, the primary providers did a good job with basic and preventive care. Annual and quarterly medical assessments were current, however, the compliance for timely completion for annual assessments was quite low. Completion of the quarterly assessments was a notable improvement.
- The facility did not complete the external and internal audits in accordance with state guidelines. Sample sizes were inadequate and none of the internal audits was paired with the external audits to determine inter-rater reliability.
- The facility relied on the internal audits to assess medical quality, but those were not completed as required. There was no progress in the development of a medical quality program and, in the absence of a medical director, no plan had been developed to move forward in this area.

Nursing Care

- Continued progress was seen. The facility continued to meet minimum staffing ratios over the last six months through the use of overtime and one contracted agency nurse. The infection control program continued to sustain and made much progress. The Hospital Liaison nurse continued to make hospital visits and improve upon communication processes between EPSSLC and external health care facilities.
- Although there were reported improvements, there was continued need for improvement in implementing quality nursing assessments and health care plans, and in understanding health risks and risk factors. .

- The CNE, NOO, Nurse Managers, Nurse Educator, and Infection Control Nurse had continued, in the absence of a facility designated RN Case Manager Supervisor position, to provide support, training, and guidance to the RN Case Managers.
- The Nurse Educator had in place several improvement processes related to competency training and tracking systems. The monitoring team did not find that Nursing Policies, Procedures, and Protocols had adequately transferred to nursing practices.
- The care plans continued to lack individualization to meet individual's specific problems, and the plans did not demonstrate integration with other disciplines to meet total needs of the individuals.
- There continued to be serious omissions, for example, following accepted standard of practices when administering medications.

Pharmacy Services and Safe Medication Practices

- Progress continued to be seen. The most significant advancements were seen in the areas of communication between the pharmacists and prescribers. The pharmacy department transitioned documentation to the WORx system and fully implemented in Intelligent Alerts module in June 2013. EPSSLC continued to complete the QDRRs in a timely manner. However, some decline in the clinically applicability and relevance of the QDRR information was noted.
- The MOSES and DISCUS evaluations were completed by nursing staff and reviewed by the psychiatrist.
- The pharmacy did a good job in completion and follow-up of DUEs. Documentation indicated that corrective actions were implemented when appropriate and were followed up to completion.
- The medication variance system appeared to make progress in the areas of medication reconciliation, however, the monitoring team had difficulty in assessing the overall progress because the facility did not provide sufficient data on the extent of each variance.

Physical and Nutritional Management

- Progress was observed. There was a fully constituted PNMT. During the meetings observed, the team demonstrated excellent discussion and problem solving. Assessments and other documentation did not clearly and concisely reflect that.
- Generally, mealtimes were consistent with the last visit. Some of the cottages still required prompts to have the Dining Plans out when individuals were eating. Texture and consistency issues related to bread, particularly for chopped were noted. There were issues related to the preparation of thickened liquids. The Mealtime Improvement Team had been working well together to establish the state-wide initiative for Mealtime Coordinators (MTC).
- For the most part, positioning plans were followed. Transfers were not as consistent with generally accepted practice. Errors were noted with gait belt use for standing transfers.
- The Weight Committee had been established prior to the previous compliance visit and continued to be in place. There were issues with the system of weighing and measuring heights that should have been remedied a year ago as there

continued to be many inaccuracies. There was a need to identify key clinical indicators that would be reviewed by the Committee.

Physical and Occupational Therapy

- Progress continued to be observed. The facility is to be commended for its efforts regarding the process used to examine the need for gait belts and helmets, eliminating many of these. The OTs and PTs clearly played a key role in that process.
- The wheelchair clinic continued to design appropriate wheelchairs using an effective evaluation process to identify properties needed for support and function then product matching to make that happen.
- The quality of assessments had generally been maintained with an ongoing improvement in the focus on skill acquisition and motor skill improvements, along with the continued focus on the clinical aspects of health and safety. Though improvements were evident, the OT/PT supports and services were not consistently integrated into the ISPs.

Dental Services

- Individuals continued to receive dental treatment at EPSSLC. Overall, additional treatment was provided to individuals over the past six months. Most individuals were seen in clinic or their homes for cursory annual exams and were scheduled for comprehensive exams under anesthesia. Even though the exam was cursory, they were not completed in a timely manner. There did not appear to be any effort to provide treatment with any intermediate forms of minimal sedation.
- It appeared that the staff believed the use of anesthesia was safe and a positive aspect of care. Thus, some individuals underwent general anesthesia for cleaning and x-rays.
- EPSSLC did not comply with state policy, which required availability of emergency dental care 24 hours a day.
- The clinic staff continued to be unaware of some of the basic requirements of the Settlement Agreement and the fundamental ICF regulatory guidelines. This impacted clinical care and the ability to assess the progress of the clinic.
- There continued to be problems reporting data. This was reflective of a lack of organization within the clinic.

Communication

- There was continued, but limited and slow, progress. All of the SLPs worked diligently to complete assessments and identify appropriate communication supports for individuals, including AAC.
- Assessments were not consistently completed 10 days prior to the ISP, but were consistently completed prior to the meeting.
- The therapists are commended for the quantity of direct services they provided each week. Integration of communication into the ISP and real time coaching and modeling for staff are also keys to effective functional implementation.

- Maintaining equipment already provided to individuals was an ongoing and costly problem. There was a need to expand the time available for staff training on communication.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were improvements since the last review. These included a reorganization of the writing, monitoring, and training of SAPs; adding a psychologist to the SAP peer review committee, and continued improvement in the community day program.
- The facility needs to ensure that each SAP contains a rationale for its selection, a plan for maintenance and generalization, and operational definitions and training instructions. SAPs and service objectives need to be differentiated and there needs to be an increase in formal training opportunities (i.e., SAPs) in the community program. EPSSLC should 0perationalize the definition of individual engagement, track engagement across all treatment areas, review trends, and establish acceptable levels of engagement in each treatment area.

Most Integrated Setting Practices

- EPSSLC continued to make good progress across most of section T. 4 individuals were placed in the community since the last onsite review. 10 individuals were on the active referral list, plus 2 others were referred during the week of the onsite review. 2 individuals returned to the facility after community placement.
- Lack of availability of openings in the local provider community was identified as a systemic problem. The APC and his staff were in frequent contact with providers so that providers were aware of who was referred for placement, timelines for transition, and possibilities for individuals from the facility to share the same home. As a result, three new homes were scheduled to be ready in the next few months.
- Providing education about community placements continued to be a strength at the facility. Examples included the work done by transition specialists to find new and creative ways to inform staff and families about the quality of some of the providers in El Paso. Individualized plans for education, however, needed some improvement.
- Living options for the individual were thoroughly discussed during the annual ISP and were individualized, including consideration of preferences and support needs. The LA and the transition specialists were very knowledgeable and contributed much information to the discussion.
- The discharge assessments must better address the specific home, day, and employment sites and contexts into which each individual will be moving. The lists of pre-move and post-move supports had not improved from the last review. The lists of supports were surprisingly similar across the 4 CLDPs.
- 12 post move monitorings for 6 individuals were completed. All were completed on time, in the proper format, and were done thoroughly and completely. All six individuals were doing well. A number of problems in support provision were either discovered or fixed by the post move monitoring process.

- EPSSLC provided follow-up and remained involved with all individuals, as needed, even past the 90-day post move monitoring period for some. This was very good to see and demonstrated the facility's commitment to each individual.

Guardianship and Consent

- IDTs were holding a much more in-depth discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent.
- The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued to need training to determine each individual's functional capacity to render informed decisions.
- A priority list of those in need of a guardian had been developed, however, there were some problems with the accuracy of the listing. The facility was moving forward with procuring guardianship for individuals with a prioritized need.

Recordkeeping Practices

- The active records continued to improve. The content of observation notes had improved. The simple tasks of properly and legibly signing and dating entries, however, continued to be a problem. There were numerous examples of missing documents or misfiled documents
- Overall, the individual notebooks were in satisfactory condition. The facility had focused on improving these over the past couple of months and the results were evident.
- A master record existed for every individual and were in a format that was organized and manageable. An adequate system to address missing documents was not in place at this time..
- Quality assurance reviews (audits) were conducted in three of the previous six months (50%). The reviews were done in a consistent manner and were neatly and clearly documented.
- An adequate process was in place to notify staff of errors found during the audit, and the URC had an adequate process for tracking error corrections. Use of data to determine where actions should be taken was not yet in place.
- Provisions V2 and V4 received little/no attention since the last review.

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 EPSSLC Policy: Use of Restraints revised 6/1/12
o Training Curriculum: Restraint Monitor
o EPSSLC Self-Assessment
o EPSSLC Provision Action Information Log
o EPSSLC Section C Presentation Book
o Restraint Trend Analysis Reports for the past two quarters
o Section C QA Reports for the past two quarters
o Sample of IMRT Minutes from the past six months
o Restraint Reduction Committee minutes for the past six months
o List of all restraint monitors and date training was completed
o List of all restraint by Individual in the past six months
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 individual that were restrained off the grounds of the facility (0)
o List of all injuries that occurred during restraint
o EPSSLC “Do Not Restrain” justification
o List of individuals with crisis intervention plans
o List of individuals with desensitization plans
o Sample #C.1:
• 10 records of physical, mechanical, or chemical restraint used in a crisis intervention for five different individuals, drawn from the list provided in response to II.6 of the Document Request. Records drawn for this sample included: restraint checklist form, face-to-face/debriefing form, the individual’s Crisis Intervention Plan (CIP), if applicable, the documentation of any and all reviews of this use of restraint, and any addenda or changes to the ISP or Crisis Intervention Plan that resulted. The restraint incidents in the sample included:
<table>
<tr><th>Individual</th><th>Type of Restraint</th><th>Date</th></tr>
<tr><td>#13</td><td>Physical</td><td>8/20/13</td></tr>
<tr><td>#13</td><td>Physical</td><td>7/23/15</td></tr>
<tr><td>#13</td><td>Physical</td><td>7/21/13</td></tr>
<tr><td>#13</td><td>Physical</td><td>7/18/13</td></tr>
</table>
</td></tr>
</table>

#151	Physical	7/6/13
#151	Physical	4/20/13 @12:55 pm
#39	Physical	6/27/13
#39	Physical	7/22/13
#109	Chemical	6/1/13
#161	Chemical	3/28/13

- Sample #C.2: The following documentation was requested for a selected sample of 24 staff:
  - Their start dates
  - The dates they were assigned to work with individuals
  - Their training transcripts showing date of most recent:
    - PMAB training;
    - Training on use of restraints; and
    - Training on abuse/neglect/exploitation; and
  - The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect.

- Sample #C.3 chosen from the list provided in response to document request II.5.b of 13 restraint reports involving medical/dental restraint for 10 individuals, between 3/1/13 and 8/8/13. The sample of 31% of the 13 restraint episodes or four records was drawn, involving four individuals. Records for this sample included: the restraint checklist. For the following:

Individual	Date
#188	5/1/13
#116	5/22/13
#32	7/10/13
#115	6/25/13

A sample of the last 10 medical/dental restraints was requested by the monitoring team to include: the physicians' orders for the restraint including the monitoring schedule, the medical restraint plan, the restraint checklist, the documentation of the monitoring that occurred, any reviews of this use of restraint, and any applicable desensitization plan.

  - Documentation was only submitted for four instances of medical/dental restraint. Only the restraint checklist was submitted.

- Sample #C.4 (a subsample of #C.1) chosen from II.5a in response to the document request. The total number of chemical restraints for crisis intervention was 2, involving 2 individuals. Sample size was two, involving two individuals, or 100% of the individuals. Records requested included: the restraint checklist, Face-to-face/debriefing form, any reviews of the use of this restraint, and evidence of contact between the psychologist and physician prior to the use of the restraint. For the following:

Individual	Date
#109	6/1/13
#161	3/28/13

- Sample #C.5: There was no restraints off-campus. No sample was drawn.

- Sample #C.6: The following documentation for a selected sample of individuals who were restrained more than three times in a rolling 30-day period:
  - Positive Behavior Support Plans (PBSPs) for:
    - (none)
  - Crisis Intervention Plans for:
    - Individual #13
  - ISPA meeting minutes for:
    - Individual #13

- Sample #C.7 was chosen from the list of individuals for whom protective mechanical restraints were used. This included review of Protective Mechanical Restraint Plans, Individual Support Plan (ISP), ISP Addendums, ISP Action Plan.

Individual	Restraint type
#9	helmet
#59	helmet

Interviews and Meetings Held:
- Informal interviews with various individuals, direct support professionals, program supervisors, and QDIPs in homes and day programs;
- Carmen Molina, Director of Behavioral Services
- Mario Gutierrez, Incident Management Coordinator
- Michael Reed, Facility Investigator
- Gloria Loya, Human Rights Officer

Observations Conducted:
- Observations at residences and day programs
- Incident Management Review Team Meeting 9/18/13
- Morning Unit Meeting 9/18/13
- Morning Clinical Review Team Meeting 9/18/13
- Annual IDT Meeting for Individual #125 and Individual #114
- ISPA regarding restraints for Individual #161
- Pre-ISP Meeting for Individual #65 and Individual #127

	Facility Self-Assessment: EPSSLC submitted its self-assessment. 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 a sample of crisis intervention restraints from 3/1/13 through 7/31/13 to assess compliance with each provision. Additional activities similar to those engaged in by the monitoring team were completed along with the review of restraint documentation. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings. The facility assigned a self-rating of substantial compliance to all provisions in section C. The monitoring team did not find compliance with any of the provisions of section C.
	Summary of Monitor's Assessment: Based on a list of all restraints provided by the facility (document II.6), there were 33 restraints used for crisis intervention involving six individuals between 3/1/13 and 7/31/13. The number of restraint incidents had increased since the last onsite review when it was reported that there had been two restraints during the review period. Four individuals accounted for 27 of the 33 (82%) restraints used for crisis intervention. These were Individual #13, Individual #100, Individual #151, and Individual #39. A log of all dental/medical restraints provided by the facility included 13 instances of dental/medical restraint from 3/1/13 - 8/8/13 for 10 individuals. The facility had not made progress in documenting and monitoring medical/dental restraints in compliance with the Settlement Agreement and state policy. Two individuals at the facility were wearing mechanical restraints considered protective equipment (e.g., helmets for falls). This was a considerable decrease from the nine individuals wearing helmets as protective restraints at the time of the last monitoring visit. The facility had worked hard to develop less restrictive supports for the seven individuals at the facility who no longer wore helmets. In each instance, the IDT had taken an interdisciplinary approach to developing supports and had been very successful. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C. The facility was not in substantial compliance with any of the provisions in section C based on the sample reviewed. Areas of progress included: • Progress had been made in discontinuing long term use of protective mechanical restraints for seven individuals. • The facility had implemented a more thorough review of restraints which included video review of the restraint incident when available.

<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>According to a list of all restraints implemented at the facility (Document II.5),

<table>
<tr><th>Type of Restraint</th><th>Sept 2012-Feb 2013</th><th>March 2013-Aug 2013</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>Not available</td><td>32</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>Not available</td><td>2</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>3</td><td>34</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>2</td><td>6</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>2</td><td>1</td></tr>
<tr><td>Medical/dental restraints</td><td>58</td><td>13</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>26</td><td>10</td></tr>
<tr><td>Protective mechanical restraints</td><td>9</td><td>2</td></tr>
</table>

<u>Prone Restraint</u>
a. Based on facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (list of all restraints between 12/1/12 and 5/31/13) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 3/1/13 and 8/31/13. Sample #C.1 was a sample of 10 restraints for five individuals, representing 29% of restraint records over the last six-month period and 83% of the individuals involved in restraints. The sample included eight physical restraints and two chemical restraints. Sample #C.1 included the three individuals with the greatest number of restraints, as well as two individuals who were subject to some of the most recent application of restraints.

c. Based on a review of the restraint records for individuals in Sample #C.1 involving five individuals, zero (0%) showed use of prone restraint.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		d. Based on questions with five direct support professionals, five (100%) were aware of the prohibition on prone restraint. <u>Other Restraint Requirements</u> e. Based on document review, the <u>facility</u> and <u>state</u> 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; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • f. In 9 of the 10 records (90%), there was documentation showing that the individual posed an immediate and serious threat to self or others. o The section of the restraint checklist to document behaviors leading to restraint was not completed for the restraint for Individual #151 on 7/6/13, thus, the monitoring team was unable to determine if he posed an immediate danger. • g. For the 10 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that nine (90%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. • h. In seven of the records (70%), 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. o The restraint checklist for Individual #13 dated 8/20/13 at 12:33 pm indicated that staff followed steps in the PBSP to avoid restraint. The restraint monitor also documented that he did not have a PBSP. o The restraint checklist for Individual #151 dated 7/6/13 did not include documentation of interventions attempted prior to restraint. o The restraint checklist for Individual #109 indicated that a chemical restraint was administered after changing his environment and prompting replacement behaviors was attempted. There was no documentation that PMAB strategies or a less restrictive restraint was attempted.	

#	Provision	Assessment of Status	Compliance
		• i. Facility policies identified a list of approved restraints. • j. Based on the review of 10 restraints, involving five individuals, 10 (100%) were approved restraints. k. In nine of 10 of these records (90%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. • The restraint checklist for Individual #151 dated 7/6/13 did not include documentation regarding the circumstances of the restraint. l. No restraints were reviewed that were considered to be protective mechanical restraints for SIB by the facility, (Sample C.7). The facility reported that there were no restraints classified as PMR-SIB. Of these, _____ (_____) followed state policy regarding the use, management, and review of PMR. (not applicable) The facility made progress towards compliance with C1 regarding the documentation of restraints used for crisis intervention. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure that documentation includes evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner .	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The eight physical restraint records involving the three individuals in Sample #C.1 were reviewed. One individual in the sample had a Crisis Intervention Plan that defined the use of restraint. a. For the individual involved in physical restraint who had a Crisis Intervention Plan (Individual #13), zero of two (0%) restraint checklists included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. (Two of the four other restraints for Individual #13 in the sample were released because staff could not maintain the correct hold.) b. For two individuals who did not have Crisis Intervention Plans, four of four (100%) included sufficient documentation to show that the individual was released according to facility policy or as soon as the individual was no longer a danger to him/herself. Based on this review, the facility is not compliance with C2.	Noncompliance

#	Provision	Assessment of Status	Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff. b. 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: • 22 of the 24 (92%) had current training in RES0105 Restraint Prevention and Rules. • There was evidence that 0 of the 18 (0%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. o The facility did not provide evidence of prior training in response to document request TT.1 through TT.24 • 24 of the 24 (100%) had completed PMAB training within the past 12 months. • There was evidence that zero of the 18 (0%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training unless documentation indicated that the employee was on leave. o The facility did not provide evidence of prior training in response to document request TT.1 through TT.24. c. Based on responses to questions, five direct support professionals answered the following questions correctly: • Describe two verbal or redirection techniques (100%); • Describe two approved restraint techniques. (100%); and • How would you supervise an individual in restraint? (100%). d. In seven of the 10 records (70%), 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The restraint checklist for Individual #13 dated 8/20/13 at 12:33 pm indicated that staff followed steps in the PBSP to avoid restraint. The restraint monitor, however, also documented that he did not have a PBSP. • The restraint checklist for Individual #151 dated 7/6/13 did not include documentation of interventions attempted prior to restraint. • The restraint checklist for Individual #109 indicated that a chemical restraint was administered after changing his environment and prompting replacement behaviors was attempted. There was no documentation that PMAB strategies or a less restrictive restraint was attempted. Based on this review, the facility was not in substantial compliance with the requirement for annual restraint training. Documentation supporting annual retraining was not submitted to the monitoring team in response to document request TT.1 through TT.24. This requirement will be reviewed during the next onsite visit.	
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.	a. Based on a review of 10 restraint records (Sample #C.1), in nine (90%) there was evidence that documented that restraint was used as a crisis intervention. • Documentation was not sufficient for determining if Individual #151 was an immediate danger to himself or others on 7/6/13. b. Two individuals in the sample had a Positive Behavior Support Plan in place. In review of Positive Behavior Support Plans for Individual #109 and Individual #151, 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) (100%). c. In addition, facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. d. In 10 of 10 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the "Do Not Restrain" list maintained by the facility. e. Restraints from Sample #C.3 were reviewed. In 10 of 10 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the form used by the facility to document restraint considerations/restrictions. f. In 10 of 10 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In reviewing documentation (Sample #C.3) for four individuals for whom restraint had been used for the completion of medical or dental work: • g. 0 (0%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent) (requested documentation was not provided by the facility); • h. One (25%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. A list provided by the facility in response to document request II.5 indicated: o Individual #115 did not require the use of medical pretreatment sedation. o Individual #188 did not have a medical desensitization plan in place. o Individual #32 did not have a medical desensitization plan in place. • i. 0 (0%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. The facility did not provide documentation indicating that strategies had been implemented. Two individuals at the facility were wearing mechanical restraints considered protective equipment (e.g., helmets for falls). ISPs included directions for when the helmets should be used and assigned monitoring to the PNMP. • Individual #59's PNMP included directions for when his helmet should be used. His ISP included a review of the use of his helmet to address his high risk for falls. • Individual #9's IDT met on 7/31/13 to review the use of her helmet to prevent injury. The team revised her PNMP to include instructions for when she should wear her helmet and when it should be removed. Based on this review, the facility was not substantial compliance with C4. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Desensitization or other individualized strategies will need to be considered for all individuals who require the use of pretreatment sedation for routine medical and dental appointments. 2. Ensure that all IDTs are holding adequate discussion regarding the use of 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.	

#	Provision	Assessment of Status	Compliance
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	a. Review of facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. This training was competency-based. Seventy-five staff had been deemed competent to monitor restraints. c. Based on review of document request II.19, 75 staff that performed the duties of a restraint monitor (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. This included the campus supervisors, campus administrators, home supervisors, and psychologists. Based on a review of 10 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In nine out of 10 incidents of restraint (90%) by an adequately trained staff member. The exception was Individual #151 dated 7/6/13. • e. In eight out of 10 instances (80%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. o Restraint documentation for Individual #151 dated 7/6/13 did not include an assessment by a restraint monitor. o The Face-to-Face Assessment and Debriefing Form completed for Individual #13 on 7/23/13 did not document the time of the restraint monitor's assessment. • f. In eight instances (80%), the documentation showed that an assessment was completed of the application of the restraint. • g. In eight instances (80%), the documentation showed that an assessment was completed of the consequences of the restraint. A sample of ___ records for which physicians had ordered alternative monitoring schedules was reviewed. (none submitted) • h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 10 restraint records for restraints that occurred at the facility (Sample #C.1), there was documentation that a licensed health care professional: • j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in six (60%) of the instance of restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
		o Assessments did not begin within 30 minutes for the following restraints: ▪ Individual #43 on 3/5/13 (x2) ▪ Individual #43 on 1/27/13 (x2) o The nurse did not continue to assess Individual #109 for two hours following a chemical restraint as required by state policy. o There was no documentation of monitoring following a chemical restraint for Individual #161. • k. Monitored and documented vital signs in nine (90%). • l. Monitored and documented mental status in nine (90%). Based on documentation provided by the facility, no restraints had occurred off the grounds of the facility in the last six months. • m. Conducted monitoring within 30 minutes of the individual's return to the facility in __ out of ___ (__%). Records that did not contain documentation of this included: (not applicable) • n. Monitored and documented vital signs in ___ (___%). Records that did not contain documentation of this included: (not applicable) • o. Monitored and documented mental status in ___ (___%). Records that did not contain documentation of this include: (not applicable) Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. For these individuals, p. In four out of four (100%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • q. In zero out of zero (N/A), the physician specified the type of monitoring required if it was different than the facility policy. o r. In one out of four of the medical restraints (25%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Three of the restraint checklists in the sample did not indicate that vital signs were taken with the frequency and/or duration required by state policy. These were: ▪ Individual #188 on 5/1/13, ▪ Individual #115 on 6/25/13, ▪ Individual #116 on 5/22/13. Based on this review, the facility was not in substantial compliance with this provision. To gain substantial compliance with the requirements of C5, the facility will need ensure that:	

#	Provision	Assessment of Status	Compliance
		1. Post restraint assessments by nursing staff commence within 30 minutes of the initiation of the restraint and are adequately documented with the frequency recommended by the physician or as required by state policy. 2. A FFAD is completed for each restraint incident within 15 minutes of the start of the 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 (Sample #C.1) of 10 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • a. In nine (90%), continuous one-to-one supervision was provided; o There was not documentation on one-to-one supervision for two hours following a chemical restraint for Individual #109. • b. In 10 (100%), the date and time restraint was begun; • c. In 90 (90%), the location of the restraint; o The restraint checklist for Individual #151 dated 7/6/13 did not indicate where the restraint occurred. • d. In nine (90%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. o The section of the restraint checklist to document behaviors leading to restraint was not completed for the restraint for Individual #151 on 7/6/13. • e. In eight (80%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. o The restraint checklist for Individual #13 dated 8/20/13 at 12:33 pm indicated that staff followed steps in the PBSP to avoid restraint. The restraint monitor documented that he did not have a PBSP. o The restraint checklist for Individual #151 dated 7/6/13 did not include documentation of interventions attempted prior to restraint. • f. In 10 (100%), the specific reasons for the use of the restraint • g. In 10 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • h. In 90 (90%), the names of staff involved in the restraint episode; o The exception was the restraint checklist for Individual #151 dated 7/6/13. • Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In eight (80%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The longest restraint in the sample was 20 minutes.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ The restraint checklist for Individual #13 dated 7/23/13 did not include a release code. ▪ The restraint checklist for Individual #109 did not document observations for two hours following a chemical restraint. o j. In one (100%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; (Individual #151 dated 7/6/13) o k. In ___ (____%), the care provided by staff during restraint lasting more than 30 minutes, 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. (there were none) • l. In 10 (100%), the level of supervision provided during the restraint episode; • m. In eight physical restraints (100%), the date and time the individual was released from restraint; and • n. In 10 (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. o. In a sample of 10 records (Sample #C.1), restraint debriefing forms had been completed for nine (90%). The exception was the restraint of Individual #151 dated 7/6/13. p. A sample of four individuals subject to medical restraint was reviewed (Sample #C.3), and in one (25%), there was evidence that the monitoring had been completed as required by the physician's order or state policy. See comments in C5 regarding restraints that were not monitored in accordance to state policies. Sample #C.4 was a subsample of the two chemical restraints included in Sample #C.1. q. In two (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist or psychiatrist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review, the facility was not in substantial compliance with the requirements of C6 regarding documentation of post restraint monitoring for chemical pretreatment sedation restraints.	

#	Provision	Assessment of Status	Compliance
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to EPSSLC documentation, during the six-month period prior to the onsite review, one individual was placed in restraint more than three times in a rolling 30-day period. This was the same as the last monitoring report when one individual was placed in restraint more than three times in a rolling 30-day period. This individual (Individual #13) was reviewed 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 ISPAs provided to the monitoring team (dated 7/25/13 and 7/30/13) addressed the termination of Individual #13's PBSP and plans to develop a new PBSP. These ISPAs did not address his restraints and, therefore, could not be used to review C7a-C7g. This item was rated as in noncompliance because no ISPA following more than three restraints in a rolling 30-day period was available to review. In the last review, this item was rated in substantial compliance. This was because the ISPA was available for the individual who had more than three restraints in a rolling 30-day period, and it indicated that the treatment team did not believe that adaptive skills, or biological/medical factors contributed to Individual #13's dangerous behavior that provoked restraint.	Noncompliance
	(b) review possibly contributing environmental conditions;	This item was rated as in noncompliance because no ISPA following more than three restraints in a rolling 30-day period was available to review. In order to achieve compliance with this provision item the ISPA should reflect a discussion of possible contributing environmental factors (e.g., noisy environments), and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item was rated as in noncompliance because no ISPA following more than three restraints in a rolling 30-day period was available to review. In the last review, this item was rated in substantial compliance. This was because the	Noncompliance

#	Provision	Assessment of Status	Compliance
		ISPA was available for the individual who had more than three restraints in a rolling 30-day period, and it indicated that over prompting was an antecedent to his aggression, and staff had been trained to avoid over prompting.	
	(d) review or perform functional assessments of the behavior provoking restraints;	This item was rated as in noncompliance because no ISPA following more than three restraints in a rolling 30-day period was available to review. In order to achieve compliance with this provision item, the ISPA should reflect a discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that 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.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	This provision item was rated as being in noncompliance because, at the time of the onsite review, Individual #13 did not have a PBSP to address the behaviors provoking his restraint. In order to achieve compliance with this item a PBSP 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 Individual #13 had a crisis intervention plan. The following was found: • The crisis intervention plan reviewed delineated the type of restraint authorized, • The crisis intervention plan specified the maximum duration of restraint authorized, • The crisis intervention plan specified the designated approved restraint situation, and The crisis intervention plan specified the criteria for terminating the use of the restraint.	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	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	implemented as written (i.e., treatment integrity level of at least 80%).	
	(g) as necessary, assess and revise the 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. This item was rated as being in noncompliance because the available ISPAs indicated that a revision of Individual #13's PBSP was necessary, but that revision was not completed at the time of the onsite review.	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.	A sample of documentation related to 10 incidents of non-medical restraint was reviewed (Sample #C.1), this documentation showed that:
		• a. In eight (80%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. Exceptions were:
		  • Individual #151 dated 7/6/13
		  • Individual #151 dated 4/20/13 at 12:55 pm.
		• b. In eight (80%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. The exceptions were:
		  o Individual #151 dated 7/6/13
		  o Individual #161 dated 3/28/13
		• c. In seven (70%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. Exceptions were:
		  o Individual #151 dated 7/6/13 (no FFAD)
		  o Individual #109 dated 6/1/13 (no signature)
		  o Individual #13 dated 7/23/13 (incomplete form)
		• d. In nine (90%), the review conducted by the restraint monitor and/or psychologist was sufficient to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint.
		• e. The IMRT had begun using the Restraint Discussion Form to document recommendation from their review. This form was included in the documentation for five of 10 restraints in sample #C.1. In four (40%), referrals
			Noncompliance

#	Provision	Assessment of Status	Compliance
		were made to the team,; and • f. Of the four referred to the team, in four (100%) appropriate changes were made to the individuals' ISPs and/or PBSPs. A review of ISPAs for the individuals in the sample indicated that IDTs routinely met following restraint episodes and implemented changes in supports when appropriate. Based on this review, the facility was not in substantial compliance with review requirements. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensuring that a FFAD is completed for each restraint incident and review by the Unit Director and Incident Management Team is documented.	

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 QAQI Data Summary May 2013 o Information used to educate individuals/LARs on identifying and reporting unusual incidents o Incident Management Review Committee meeting minutes for each Monday of the past six months o Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired within the last 2 months (26) o Training and background checks for the last three employees hired o List of DFPS investigators assigned to complete investigations at EPSSLC (21) 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 Data summary regarding employees who were terminated or not hired based upon background checks o A sample of acknowledgement to self report criminal activity for 24 current employees (none submitted) o ISPs for: • Individual #159, Individual #128, Individual #189, Individual #102, Individual #75, Individual #32, Individual #9, Individual #34, Individual #39, and Individual #28. 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 incidents and injuries since 3/1/13 o List of all ANE allegations since 3/1/13 including case disposition o A list of all investigations completed by the facility in the last six months. 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. o Documentation from the following completed investigations, including follow-up:

Sample D.1.	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42831722	Physical Abuse	Unconfirmed	8/10/13 6:02 pm	8/11/13 1:22 pm	8/19/13
#42824696	Physical Abuse (5)	Confirmed (5)	8/3/13 4:13 pm	8/4/13 1:13 pm	8/9/13
#42816063	Physical Abuse	Unconfirmed	7/25/13 5:26 pm	7/26/13 6:56 pm	7/31/13
#42813088	Physical Abuse (2)	Unconfirmed (2)	7/23/13 12:45 pm	7/24/13 12:13 pm	7/31/13
#42810348	Neglect	Unconfirmed	7/19/13 5:27 pm	7/19/13 5:58 pm	7/29/13
#42808585	Physical Abuse	Unconfirmed	7/18/13 10:30 am	7/18/13 12:15 pm	7/22/13
#42801107	Neglect	Confirmed	7/10/13 1:22 pm	7/11/13 12:48 pm	7/18/13
#42798257	Physical Abuse	Confirmed	7/8/13 3:23 am	7/8/13 2:00 pm	7/11/13
#42789653	Physical Abuse	Unconfirmed	6/27/13 8:02 am	6/27/13 12:44 pm	6/28/13
#42785154	Physical Abuse	Unconfirmed	6/21/13 11:28 pm	6/22/13 10:10 am	6/27/13
#42758645	Neglect	Confirmed	5/26/13 9:56 pm	5/27/13 1:25 pm	6/5/13
#42742851	Physical Abuse (4)	Inconclusive (1) Unconfirmed (3)	5/12/13 3:51 am	5/12/13 12:30 pm	5/22/13
#42735634	Neglect (2)	Confirmed (2)	5/6/13 10:15 am	5/7/13 10:03 am	5/22/13 Extension filed
#42734890	Physical Abuse (2)	Unconfirmed (1) Other (1)	5/4/13 5:32 pm	5/7/13 3:48 pm	5/14/13
#42713756	Physical Abuse	Unconfirmed	4/15/13 8:04 pm	4/17/13 5:22 pm	4/25/13
#42710122	Physical Abuse	Confirmed	4/11/13 4:24 pm	4/12/13 4:41 pm	4/21/13
#42817878	Neglect	Referred Back	7/27/13 10:28 pm	n/a	7/29/13
#42703085	Neglect	Referred Back Clinical issue	4/5/13 4:19 am	n/a	4/5/13

Sample D.2	Type of Incident	Date/Time Incident Occurred	Date/Time Incident Reported	Date Completed	
#13-188	Serious Injury	8/16/13 8:40 am	8/22/13 3:00 pm	8/22/13	
#13-180	Serious Injury	8/2/13 3:30 pm	8/8/13 3:32 pm	8/14/13	
#13-170	Sexual Incident	Unknown	7/23/13 4:00 pm	7/24/13	
#13-153	Serious Injury	6/1/13 8:45 am	6/1/13 9:00 pm	6/7/13	
#13-152	Serious Injury	5/31/13 10:00 pm	6/1/13 8:15 pm	6/7/13	
#13-131	Serious Injury	4/29/13 2:55 pm	5/7/13 3:35 pm	5/8/13	
#13-119	Sexual Incident	4/12/13 1:30 pm	4/12/13 1:45 pm	4/19/13	

Interviews and Meetings Held:

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

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 9/18/13
- Morning Unit Meeting 9/18/13
- Morning Clinical Review Team Meeting 9/18/13
- Annual IDT Meeting for Individual #125 and Individual #114
- ISPA regarding restraints for Individual #161
- Pre-ISP Meeting for Individual #65 and Individual #127

	Facility Self-Assessment: EPSSLC submitted its self-assessment. Along with the self-assessment, the facility had two other documents that addressed progress towards meeting the requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement. The second document listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using similar activities implemented by the monitoring team to assess compliance. A sample of completed investigations was reviewed monthly using the statewide section D audit tool. Additionally, the facility looked at other documentation relevant to each provision. The facility's review of its own performance found compliance with 22 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 16 of the 22 provision items. The monitoring team was unable to confirm compliance with the requirements that: • Staff were to immediately report all serious incidents to the appropriate parties (D2a); • The facility ensured that all employees completed training on identifying and reporting abuse, neglect, and exploitation annually (D2c); • Investigations were commenced within 24 hours (D3e); • Investigations provided clear evidence to support the investigator's conclusions (D3f); • The facility will implement action to prevent similar incidents from occurring promptly and thoroughly, and track and document such actions and the corresponding outcomes (D3i); and • Sufficient corrective action was taken to address trends of incidents and injuries (D4). The facility should note findings by the monitoring team for each provision found not to be in substantial compliance and consider further review of those provisions using similar methods used by the monitoring team.
	Summary of Monitor's Assessment: According to a list provided by EPSSLC, DFPS conducted 56 investigations involving 141 allegations at the facility between 3/1/13 and 8/31/13, including 39 allegations of physical abuse, 18 allegations of emotional/verbal abuse, and 84 allegations of neglect. Of the 141 allegations, there were 4 confirmed cases of physical abuse, and 16 confirmed cases of neglect. The facility reported that 27 other serious incidents were investigated by the facility during this same time period. There were a total of 508 injuries reported between 3/1/13 and 8/30/13. These 508 injuries included 17 serious injuries resulting in fractures or sutures. This was a significant decrease from the 619 injuries

	reported the previous two quarters. Injury trends were being generated per individual and made available to IDTs for access on the shared drive. During this review, the monitoring team found the facility to be in substantial compliance with 16 out of 22 provisions of Section D, as opposed to the 19 provisions that were in substantial compliance during the last review. Provision items found not to be in compliance included: • D.2.a: 67% of the facility investigations in sample #D.2 were not reported within the timeframes specified in state policy. The Incident Management Coordinator reported that medical staff were not reporting serious injuries to be investigated immediately. Medical staff had been retrained on reporting procedures to address this problem. • D.2.c: All staff were not completing annual retraining within required timeframes. • D.3.e: Compliance was not met with the requirement to ensure that all investigations commence within 24 hours for the facility investigations included in sample #D.2. • D.3.f: 28% of the DFPS investigations reviewed in sample #D.1 did not include sufficient evidence to support the investigator's conclusions. The facility is, however, to be commended for thoroughly reviewing investigations and requesting a review by DFPS when findings were not adequately supported by the investigation. To gain substantial compliance, DFPS will need to ensure that findings are adequately justified prior to submission of the completed investigation to the facility. • D.3.i: The facility was not adequately documenting follow-up to recommendations made at the conclusion of investigations. The Incident Management Coordinator reported that the department had recently implemented a new system for following up on recommendations and ensuring that desired outcomes were met. The monitoring team looks forward to reviewing implementation of this new process during the next onsite visit. • D.4: The facility was still not adequately identifying trends and developing action plans to address trends on a systemic or individual level. The facility made general recommendations with a focus on systemic issues that were identified in the quarterly trend reports. Recommendations did not include measurable outcomes and follow-up to recommendations was not documented. The incident management department had recently begun providing incident and injury trend information to individual IDTs. The process was in the initial stages and adequate action plans and follow-up to action plans to track outcomes were not yet occurring. IDTs will need additional training on analyzing and addressing trend information.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. 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	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 all abuse, neglect, and exploitation investigations provided in response to document request III.26, 56 investigations involving 141 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last onsite visit (3/1/13 to 8/31/13). From these 141 allegations, there were: • 39 allegations of physical abuse including, o 4 confirmed o 28 unconfirmed o 1 inconclusive o 3 unfounded o 1 referred back to the facility for further investigation o 2 other (unknown outcome).	Noncompliance

#	Provision	Assessment of Status	Compliance
	official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	• 18 allegations of verbal/emotional abuse including: o 0 confirmed o 3 unconfirmed o 1 inconclusive o 1 unfounded o 8 referred back to the facility for further investigation o 4 other (unknown outcome) o 1 pending outcome. • 84 allegations of neglect including, o 16 confirmed o 58 unconfirmed o 4 inconclusive o 2 unfounded o 2 referred back to the facility for further investigation o 1 other (unknown outcome) o 1 pending outcome. According to a list provided by the facility, there were 27 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included: • 14 serious injuries/determined cause, • 4 serious injuries from peer-to-peer aggression, • 2 serious injury/undetermined cause • 4 sexual incidents, • 2 unauthorized departures, and • 1 death. From all investigations since 4/1/13 reported by the facility, 25 investigations were selected for review. The 25 comprised two 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 (18 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (seven cases). Metric 2.a.1: Based on the Monitoring Teams' review of DADS revised policies, including Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.	

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		Metric 2.a.2: According to EPSSLC Protection from Harm Policy, staff were required to report abuse, neglect, and exploitation immediately by calling the DFPS 800 number. This was consistent with the Settlement Agreement requirements. Metric 2.a.3: With regard to unusual/serious incidents, the facility's Incident Management Policy required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to follow reporting requirements detailed on the Exhibit B – Unusual Incidents Reporting Matrix. This policy was consistent with the Settlement Agreement requirements. Metric 2.a.4: Based on responses to questions about reporting, eight of eight (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Metric 2.a.5: Based on responses to questions about reporting, eight of eight (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents. Based on a review of the 18 investigation reports included in Sample #D.1: • Metric 2.a.6: 17 (94%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to DFPS within one hour of the incident or discovery of the incident as required by DADS/Facility policy. o DFPS case #42703085 occurred at 12:05 am on 4/5/13. It was reported to DFPS at 3:19 am on 4/5/13. • Metric 2.a.7: 17 (94%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o 18 of 18 (100%) indicated the facility director or designee was notified of the incident within one hour. o 18 of 18 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. o 17 of 18 (94%) documented that the state office was notified as required. ▪ In DFPS case #42758645, the UIR did not contain documentation of state office notification. • Metric 2.a.8: For the one allegation for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, 0 UIRs (0%) included recommendations for corrective actions.	

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		Based on a review of seven investigation reports included in Sample #D.2: • Metric 2.a.9: Three (43%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. Exceptions were: o UIR #13-180 was the investigation of a serious injury that occurred on 8/2/13. It was not reported as a serious incident for investigation until 8/8/13. o UIR #13-188 was the investigation of a serious injury that occurred on 8/16/13. It was not reported for investigation until 8/22/13. o UIR #13-152 was the investigation of a serious injury due to peer-to-peer aggression on 5/31/13 at 10:00 pm. It was not reported until 8:15 pm the following day. o UIR #13-131 was the investigation of a serious injury due to peer-to-peer aggression that occurred on 4/29/13. It was not reported for investigation until 5/7/13. • Metric 2.a.10: six (86%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. o UIR #13-131 did not document notification of the state office for a serious injury due to peer-to-peer aggression. • Metric 2.a.11: For the four unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, three UIRs/investigation folders (75%) included recommendations for corrective actions. The exception was UIR #13-152. Metric 2.a.12: The facility had a standardized reporting format. 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. Metric 2.a.13 Based on a review of 25 investigation reports included in Samples #D.1 and #D.2, 25 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. Twenty-six of 26 (100%) new employees hired between 6/1/13 and 7/1/13 signed this form when hired. All employees were required to sign an acknowledgement form annually. A random sample of 24 employees at the facility was chosen. Twenty-four of 24 employees (100%) in the sample signed this form annually as required by state policy.	

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		The facility was not in substantial compliance with the requirements of D2a. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. All serious incidents should be reported to the appropriate parties within the time frames indicated by state policy.	
	(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. The monitoring team was provided with a log of employees who had been reassigned between 2/1/13 and 8/10/13. The log included the applicable investigation case number, date of reassignment, any disciplinary actions taken, and the date the employee was returned to work. Based on a review of 18 investigation reports included in Sample D.1, in 15 out of 15 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status immediately. In 14 out of 15 cases (93%), where there was a known alleged perpetrator, 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. • In DFPS case #42758645, the ART recommended a 5 day suspension before returning to work for the AP following a confirmed allegation of neglect. The case was completed on 6/9/13. The employee was notified of a meeting with the unit director on 7/31/13 to discuss disciplinary action.. The employee reassignment log indicated that she returned to work on 6/10/13 prior to disciplinary action being taken. There was no further documentation to confirm that the suspension occurred. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 18 investigation files in Sample D.1, 18 (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. All allegations were discussed in the daily IMRT meeting and protections were reviewed. Based on the facility's actions to remove staff from duty pending the investigation, and documenting additional actions to protect the alleged victims in most cases, the	Substantial Compliance

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		monitoring team found that the facility maintained substantial compliance.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included four employees hired within the past year. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • There was evidence that 14 of the 17 (82%) employees with current training who had been employed over one year had completed the ABU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • There was evidence that 15 of the 17 (88%) employees with current training who had been employed over one year had completed the UNU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. Based on this review, the facility was not in substantial compliance with the requirement for annual training. Documentation supporting annual retraining was not submitted to the monitoring team in response to document request TT.1 through TT.24. This requirement will be reviewed during the next onsite visit.	Noncompliance
	(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	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. 24 (100%) of 24 employees in the sample had a current signed acknowledgement form. Additionally, the facility provided the signed statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS for employees hired June 2013-July 2013. Of 26 new employees, 26 (100%) had signed the acknowledgement form.	Substantial Compliance

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	personnel action in response to any mandatory reporter's failure to report abuse or neglect.	A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that two cases where staff failed to report abuse or neglect as required. Both were retrained on reporting requirements.	
	(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 was reviewed for compliance with this provision. The sample ISPs were for Individual #159, Individual #128, Individual #189, Individual #102, Individual #75, Individual #32, Individual #9, Individual #34 Individual #39, and Individual #28. • Nine (90%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The exception was the ISPs for Individual #9. 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. 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 living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access.	Substantial Compliance

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		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. The HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group.	
	(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 16 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and/or OIG of the allegation in 16 (100%), when appropriate. OIG investigated 10 cases in the sample and criminal activity was substantiated in one of 10 (10%) cases.	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. • "No Tolerance" posters were displayed in all living and day areas throughout the facility. 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. No names were submitted. Based on a review of investigation records (Sample #D.1), there were no concerns related to potential retaliation for reporting.	Substantial Compliance

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The facility policy and/or procedures defined sufficient procedures to audit whether significant injuries are reported for investigation. Metric 2.i.2: The facility conducted audits at least semi-annually, during the preceding 13 months. Metric 2.i.3: The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. The facility had implemented an injury audit process to determine if all injuries that should have been reported for investigation were investigated. This included those injuries defined in DADS policy as "serious injuries" as well as non-serious injuries on parts of the body that might indicate potential abuse or neglect, or patterns of minor injuries both witnessed and discovered Metric 2.i.4: In three of three (100%) cases in sample #D.2, significant injuries identified by the audit that had not previously been investigated were reported to the Facility Director, and/or DFPS, as appropriate and immediately investigated. Injuries were identified by the audit that had not previously been reported or investigated. It was documented in three investigations included in sample #D.2 that staff were retrained on reporting procedures when it was identified that staff failed to appropriately report injuries for investigation.	Substantial Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with	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.	Substantial Compliance

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	developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	Fifteen DFPS investigators were assigned to complete investigations at EPSSLC. Fifteen DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. EPSSLC had four employees designated to complete investigations. This included the IMC, Facility Investigator, and Campus Administrators. The training records for those designated to complete investigations were requested. Four (100%) investigators had completed training on: • Abuse, Neglect, and Exploitation, • Unusual Incidents, 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.	
	(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 incident management coordinator reported good cooperation between the facility incident management staff and DFPS.	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 18 investigations completed by DFPS (Sample #D.1), OIG investigated 10 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 investigations by OIG in the sample reviewed.	Substantial Compliance

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	(d) Provide for the safeguarding of evidence.	The EPSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video surveillance was in place throughout EPSSLC, and investigators were regularly using video footage as part of their investigation.	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 included in sample #D.1 (excluding DFPS#42817878 and DFPS #42703085 which were referred back to the facility without investigation) noted the date and time of initial contact with the alleged victim. o Contact with the alleged victim occurred within 24 hours in 14 of 16 (88%) investigations. Exceptions were DFPS case #42734890 and DFPS case #42713756. o 16 (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. • For all investigation in sample #D.1, 17 of 18 (94%) were completed within 10 calendar days of the incident. The investigation not completed within 10 days: o Case #42735634 was submitted on the 17th day (extension filed due to the discovery of new witnesses). • All 18 (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 eight of 18 (38%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. Two of those cases resulted in a referral back to the facility for further investigation. One case (6%) was found that did not include adequate recommendations: o In DFPS case #42831722, one of the witnesses reported that the AV had locked himself in the closet for five minutes after being told that he was to be placed on a higher level of supervision due to an increase in seizures. The investigator did not report this as a concern. The AP also stated that she did not like working with the AV. Another witnesses stated that the AV did not like the AP. This should have been noted as a	Noncompliance

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		concern to ensure that the AP was not reassigned to the AV unless their differences could be worked out. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.2: • The investigation began within 24 hours of being reported in five of seven cases (71%). o UIR #13-153 was a serious injury due to peer-to-peer aggression that was reported on 6/1/13. The UIR documented commencement of the investigation by the facility investigator on 6/3/13. o UIR #13-152 was a serious injury due to peer-to-peer aggression that was reported on 5/31/13. The UIR documented commencement of the investigation by the facility investigator on 6/7/13. • Six of seven (86%) indicated that the investigator completed a report within 10 days of notification of the incident. o The investigator filed an extension for UI #13-152 to gather additional evidence. • Seven of seven (100%) included recommendations for follow-up action to address the incident. The facility was not in substantial compliance with the requirement to commence all investigations within 24 hours.	
	(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	Metric 3.f.1: Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. Metric 3.f.2: The facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations in #D.1 (excluding DFPS#42817878 and DFPS #42703085 which were referred back to the facility without investigation) : • Metric 3.f.3: In 13 out of 18 investigations reviewed (72%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. o The facility requested a review of findings in the following five investigations in the sample due to disagreement over the investigator's conclusion based on evidence reviewed. These were DFPS cases	Noncompliance

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	summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	#42710122, #42810348, #42801107, #42813088, and #42742851
		• The report utilized a standardized format that set forth explicitly and separately:
		o Metric 3.f.4: In 16 (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.5: In 16 (100%), the name(s) of all witnesses;
		o Metric 3.f.6: In 16 (100%), the name(s) of all alleged victims and perpetrators;
		o Metric 3.f.7: In 16 (100%), the names of all persons interviewed during the investigation;
		o Metric 3.f.8: In 16 (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 Metric 3.f.9: In 16 (100%), all documents reviewed during the investigation;
		o Metric 3.f.10: In 16 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;
		o Metric 3.f.11: In 16 (100%), the investigator's findings; and
		o Metric 3.f.12: In 16(100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of facility investigations:
		• Metric 3.f.13: In six out of seven investigations reviewed (86%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		o UIR #13-188 was the investigation of a discovered serious injury. The investigator summarized video surveillance that showed the individual hitting himself with a folder, but no injury was noted. He further noted a staff person discovered the injury in the restroom where there were no cameras. The investigator concluded that the individual was witnessed slapping his face resulting in a laceration to the left eyebrow. While it is likely that the injury was self-caused, it was not witnessed, so the cause of injury was inconclusive/undetermined.
		• The report utilized a standardized format that set forth explicitly and separately:
		o Metric 3.f.14: In seven (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.15: In seven (100%), the name(s) of all witnesses;
		o Metric 3.f.16: In seven (100%), the name(s) of all alleged victims and	

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		perpetrators; o Metric 3.f.17: In seven (100%), the names of all persons interviewed during the investigation; o Metric 3.f.18: In seven (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o Metric 3.f.19: In seven (100%), all documents reviewed during the investigation; o Metric 3.f.20: In seven (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o Metric 3.f.21: In seven (100%), the investigator's findings; and o Metric 3.f.22: In seven (100%), the investigator's reasons for his/her conclusions. DFPS investigations did not include sufficient evidence to provide a clear basis for its conclusion in 28% of the cases in sample #D.1. Although DFPS investigations did not meet the requirements of this provision, as noted in D.3.g, the facility did document concerns in each review and requested a review of each case that did not provide clear evidence to support the DFPS findings. For facility-only investigations, one case did not include documentation to support the investigator's findings. To gain compliance with D.3.f, DFPS investigations will need to show clear evidence that support findings in each case. The facility is to be commended for identifying concerns and following up with recommendations for further review when investigations do not support findings.	
	(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.	Metric 2.g.1: The facility policy and procedures required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. Metric 2.g.2: The facility policy required that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Metric 2.g.3: The DFPS investigations in Sample D.1 did not meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) <u>and</u> D.3.f, however, the facility adequately addressed problems noted with DFPS investigations during the review process.;	Substantial Compliance

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		• Metric 2.g.4: The Facility Incident Review Team (IRT) did not accept 27% percent of the investigations over the six months prior to the onsite review. The facility requested an immediate review of findings in the following five investigations: DFPS #42742851, DFPS #42710122, DFPS #42810348, DFPS #42801107, and DFPS #42813088. • Metric 2.g.5: For five of the DFPS investigation files the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f. Based on a review of the facility's IRT data, for five (100%), the facility IRT correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. • Metric 2.g.6: In five investigation reports the facility returned to DFPS for reconsideration, for five (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. 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, • 17 (94%) DFPS investigations were reviewed by both the facility director and IMC following completion. o In DFPS case #42789653, the director's signature was not found. It appears that a page may be missing from the UIR received by the monitoring team. • 16 (89%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. o DFPS case #42735634 was submitted to the facility by DFPS on 5/22/13. The IMC and facility director signed the completed investigation on 5/31/13. o The facility director did not sign off on DFPS investigation #42789653 Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In seven out of seven investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. • Metric 2.g.8: The supervisor did not identify concerns in any of the cases. For	

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		these investigations, for ___ (n/a), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. • Metric 2.g.9: For the one investigation noted above for which the Monitoring Team identified deficiencies, the supervisory review did not appear to address these deficiencies. 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 25 out of 25 (100%) unusual incidents reviewed. A statement regarding review, recommendations, and follow-up was included on the review form. Metric 3.h.1: The facility-only investigations met the requirements outlined in Section D.3.f.	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.	Metric D.3i.1: The facility policy and procedures required disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. Metric D.3.i.2: In addition, the policy and procedures did specify the facility system for tracking and documenting such actions and the corresponding outcomes. The facility had implemented a tracking log to document completion of all recommendations from investigations. A subsample of investigations was reviewed to confirm that appropriate disciplinary and/or programmatic action was taken following the investigation when warranted. This sample included a total of seven cases: 5 DFPS cases #42798257, #42758645, #42742851, #42735634, #42824696, #41713756, #42817878 and two facility investigations UIR #13-170 and #13-153. Metric D.3.i.3: For four out of five of the DFPS investigations reviewed in which disciplinary action was warranted (80%), prompt and adequate disciplinary action had been taken and documented. • In DFPS case #42758645, the ART recommended a 5 day suspension before returning to work for the AP following a confirmed allegation of neglect. The case was completed on 6/9/13. The employee was notified of a meeting with the unit director on 7/31/13 to discuss disciplinary action.. The employee	Noncompliance

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		reassignment log indicated that she returned to work on 6/10/13 prior to disciplinary action being taken. There was no further documentation to confirm that the suspension occurred. • In DFPS case #42798257, the facility Administrative Review Team (ART) recommended termination of the AP following a confirmed allegation of physical abuse. Termination was still pending for state office approval (i.e., it was no longer under DFPS or facility review). There was no evidence that the employee had returned to work. Based on a review of a subsample of investigations (listed above) for which recommendations for programmatic action were made, the following was found: Metric D.3.i.4: For three out of seven of the investigations reviewed (43%), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator. For the other four: • In DFPS case #42798257, the facility IMC recommended retraining three staff involved in the incident on rights and values. There was no evidence that retraining was completed by the three employees. • In DFPS case #42758645, DFPS noted a concern that staff assignment forms could not be located. The facility UIR included a recommendation to address the DFPS concern. There was no documentation that the facility followed up with the recommendation. • For DFPS case #42742851, both the DFPS investigator and the facility investigator noted that staff failed to follow the AV's PBSP. No action was taken to ensure that staff would follow his plan as written if a similar incident occurred in the future. • For DFPS case ##41713756, DFPS noted a concern that staff assignment sheets and transfer cards were not completed by the two staff involved in the allegation. The facility UIR noted that concern and recommended retraining for one of the staff members (the other resigned). There was no documentation that retraining had occurred prior to the staff person returning to her assigned position. Metric D.3.i.5: For three out of seven investigations (43%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. The facility had recently implemented a new tracking process to track the follow-up and outcome to recommendations made in investigations. The new process included a form	

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		to be completed at 30 days, 60 days, and 90 days. This should be beneficial in determining whether recommendations resulted in the desired outcome. Based on identified issues with the documentation and tracking of recommendations and desired outcomes, the facility remained out of compliance with this provision.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a 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.	Metric D.4.1: For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending by: • Type of incident; • Staff alleged to have caused the incident; • Individuals directly involved; • Location of incident; • Date and time of incident; • Cause(s) of incident; and • Outcome of investigation. Over the past two quarters, the facility's trend analyses: • Metric D.4.2: Were conducted at least quarterly; • Metric D.4.3: Did address the minimum data elements; • Metric D.4.4: Did use appropriate trend analysis procedures; • Metric D.4.5: Did provide a narrative description/explanation of the results and conclusions; and • Metric D.4.6: Did contain recommendations for corrective actions. Metric D.4.7: Based on a review of trend reports, IMRT minutes, and QAQI Council minutes, when a negative pattern or trend was identified, corrective action plans were not always developed. Metric D.4.8: As appropriate, corrective action plans were not developed both for specific individuals and at a systemic level. It was not evident that the facility was monitoring data specific to individuals (i.e., injuries, falls). Metric D.4.9: The trend reports and minutes did not show that corrective action plans	Noncompliance

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		were implemented and tracked to completion. When trends were identified, the incident management department made general recommendations to investigate the trend. A status update was not included the following quarter in the trend analysis. The facility developed unrelated new outcomes to address the current quarterly trends without following up on previous recommendations. Metric D.4.10: The report/minutes did not review, as appropriate, the effectiveness of previous corrective actions. Based on a review of resulting action plans included in quarterly trend reports and documentation related to implementation: • Metric D.4.11: Zero out of two action plans included in the quarterly trend report (0%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. • Metric D.4.12: For 0 out of 2 of the action plans reviewed (0%), the plan had been timely and thoroughly implemented. Implementation was not documented • Metric D.4.13: For 0 out of 2 action plans (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. To move forward, the facility will need to ensure that as trends are identified, • Measurable outcomes and action steps are developed; • Specific staff are assigned to monitor and document implementation; and • A date is set to review efficacy of the plan and make revisions when needed.	
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	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks.	Substantial Compliance

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	whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	In concert with the DADS state office, the facility had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. Background checks were conducted on new employees prior to orientation and completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. According to information provided to the monitoring team, for FY13, criminal background checks were submitted for 445 applicants. Seven applicants failed the background check in the hiring process and therefore were not hired. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. A sample was requested for 24 employee's acknowledgement to self report criminal activity forms. • Signed acknowledgement forms were submitted for 0 of 24 employees (0%). The facility remained in substantial compliance with provision D.5.	

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, updated 5/22/13 with new DADS administrative staff names o EPSSLC facility-specific policies: • Quality Assurance Local Policy, 003.1, dated 6/8/12 (a copy of the state policy) • Facility QA Plan, 11/19/12 o EPSSLC organizational chart, August 2013 o EPSSLC policy lists, undated but likely August 2013 o List of typical meetings that occurred at EPSSLC, undated but likely August 2013 o EPSSLC Self-Assessment, 8/29/13 o EPSSLC Action Plans, 8/29/13 o EPSSLC Provision Action Information, most recent entries 8/28/13 o EPSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/16/13 o EPSSLC DADS regulatory review reports, April 2013-August 2013 o List of all QA department staff and their responsibilities, August 2013 o Town Hall agendas and handouts, 7/29/13 and 8/26/13, QA presentation on 8/26/13 o EPSSLC QA department meeting notes, April 2013 to June 2013 (3 meetings) o EPSSLC data listing/inventory, hard copy, 9/19/13 o EPSSLC QA plan narrative, 11/19/12 o EPSSLC QA plan matrix, 8/31/13 o EPSSLC Performance Key Indicators, 8/31/13 o QAQI Council (and QA report) presentation schedule of monthly-quarterly-yearly performance key indicators, Settlement Agreement provision sections, and satisfaction surveys, August 2013 o Set of blank tools used by QA department staff (5) o Sets of completed tools used by QA department staff (none) o Trend analysis report, for all four components, last two quarters o Completed FSPI repots, 9/5/13 o EPSSLC list of 27 databases, September 2013 (28 if include ISP packet audit) • Descriptions/examples of six o Self-monitoring tool for section C, updated with new guidelines/instructions, May 2013 o Monthly QAD-SAC-1:1 meetings, various summaries, at least once per month, May 2013-July 2013 o EPSSLC QA Reports, monthly, April 2013 through September 2013 (6) o QAQI Council minutes, monthly April 2013 to August 2013 (5 meetings) o PIT, PET, work group reports (none) o EPSSLC Corrective Action Plan documents • Revised CAP form, 6/3/13

	• Definition/description of CAP, one page, undated • Graphs of completed/pending CAPs, through September 2013 • CAPs database, 20 pages, 9/17/13 • CAPs action reporting documents, 41, 1-2 pages each o DADS SSLC family satisfaction survey (none) o Self-advocacy monthly meeting minutes/notes, April 2013 to July 2013 o Home meetings (for individuals) agenda and notes (none) o Facility newsletters (none) <u>Interviews and Meetings Held</u>: o Erna Matthews, Quality Assurance Director o Priscilla Munoz, Settlement Agreement Coordinator o Hector Sanchez QA department data analyst o Gloria Loya, Human Rights Officer, Nora Padilla, QIDP, self-advocacy facilitator o Laura Cazabon-Braly, Facility Director <u>Observations Conducted</u>: o QAQI Council meeting, 9/18/13 o Section/department leaders meeting, 9/16/13 o Morning medical, morning unit, and IMRT meetings, 9/18/13 o Change of status database meeting/discussion, 9/18/13 o Self-advocacy meeting, 9/19/13 o Parents advisory council, 9/19/13
	Facility Self-Assessment The QA director again improved her self-assessment of section E. The self-assessment was more lined up with what the monitoring team looks at and, therefore, her findings were more similar to the monitoring team's than ever before, including similar data for some of the metrics in E2, and agreement on a determination of substantial compliance for E3 and noncompliance for the other three provisions. The QA director might also find it useful to employ the same metrics to her self-assessment that the monitoring team uses and has included in this report. One of the items that the self-assessment did not look at was whether the data being collected and assessed adequately met the requirements specified in the wording of E1 regarding tracking and trending of data across program areas, etc.
	Summary of Monitor's Assessment: The QA program at EPSSLC made a great deal of progress since the last onsite review. Facility staff were trained in the QA policies via the town hall meeting system.

	There was not yet a complete and adequate data list inventory at the facility though progress was made. It was good to see that many of the lists had additional or different items than at the time of the last review, such as for dental and pharmacy. The QAD and SAC need to ensure that the content of the data inventories are comprehensive and do not omit any important indicators, especially ensuring that data are tracked to meet what is specified in the wording of provision E1 in the Settlement Agreement. More work needs to be done to tie together the data listing inventory, QA matrix, performance key indicator list, and QA report. Self-monitoring tools had recently been updated for sections F, M, N, and U. Section J was updated about a year ago. Sections O, P, and R were in the final stages of review. The goal of the facility director and QA director was to get rid of tools that were of no use. Data from 16 of the 20 (80%) sections of the Settlement Agreement were summarized and graphed showing trends over time, but few analyzed data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals. QAD-SAC meetings with discipline departments occurred for 12-13 (60-65%) of the provisions. In addition, a checklist of 10 items for discussion was created beginning in June 2013. In the last six months, a facility QA report was created for six of the last six months (100%). Of the 20 sections of the Settlement Agreement, 17 (95%) appeared in a QA report at least once each quarter in the last six months. Of these 17 sections, none (0%) contained all of the components listed in E2 below, however, data were presented for self-monitoring data for 14 of the 17 (82%), and some narrative analysis of the data was present for 12 of the 17 (71%). Since the last onsite review, the QAQI Council met at least once each month. The corrective action/CAPs system was better organized than at any previous onsite review. There were 41 active CAPs for 11 of the 20 sections of the Settlement Agreement. Of these 41, all appeared to appropriately address the specific problem for which they were created, however, most failed to ultimately assess whether the problem had gotten any better.

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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 made a great deal of progress since the last onsite review. Since then, Erna Matthews was appointed the QA director position. The facility director was highly involved in the QA program and in supporting the QA director. Some of the progress seen by the monitoring team was the facility putting infrastructure into place for the QA program to improve, such as the QAD-SAC 1:1 meetings, databases, the data listing inventory, and the CAPs report. <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. The monitoring team's comments on the state policy are in the previous monitoring report and are not repeated here. Also, given that the statewide policy was disseminated almost two years ago, edits may be needed. State office should consider this. There were EPSSLC facility policies that adequately supported the state policy for quality assurance. They remained unchanged since the last review. The QA director reported that facility QA policies would be updated as the QA program continued to develop. Given that one of the policies was the QA plan narrative, written almost a year ago by the previous QA director, a revision/update would seem appropriate at this time. QA department staff were trained in the current policies. Once the facility-specific policy (or policies) is updated, training should again be provided to QA department staff. Facility staff were trained in the QA policies via the town hall meeting system. These were meetings held five times each month with the same agenda at different times of day across a two or three day period so that every staff member would have multiple opportunities to attend. The QA data analyst presented a 15-minute session on the QA program in August 2013. <u>QA Department</u> Ms. Matthews was leading the QA program forward. She was serious about her role and worked closely with the facility director to improve the QA program. The Settlement Agreement Coordinator, Priscilla Munoz, in fulfilling her responsibilities, worked along with the QAD. Their collaborative efforts will be important for the success of the QA program and meeting substantial compliance with section E of the Settlement Agreement.	Noncompliance

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		QA staff meetings were held at least once each month. Topics were relevant, such as data collection and projects. There were no topics, however, related to professional development or to the field of quality assurance even though the self-assessment stated that educational components were discussed. The QA department staff had some changes since the last review. In addition to the QA director, there were two program auditors (one was new), a QA nurse (temporarily vacant due to the interim appointment of the QA nurse to another position at EPSSLCP, a data analyst (experienced), and an administrative assistant (newly hired). Overall, they continued to be a professional group who were involved in data collection (QA department tools and assessing inter observer agreement), attending meetings, and participating in projects as needed. The QA director and the facility director reported that they were wanting QA to be more involved in identifying problems, taking actions, and improving services and supports at EPSSLC. To that end, each of the 20 provisions of the Settlement Agreement was assigned to one of the program auditors or QA nurse. Further, the QA director told her staff that their role was to help the departments. <u>Quality Assurance Data List/Inventory</u> There was not yet a complete and adequate data list inventory at the facility though progress was made. It was good to see that many of the lists had additional or different items than at the time of the last review, such as for dental and pharmacy. There were 20 departments represented, including accounting, food service, etc., but not every Settlement Agreement section was represented (e.g., sections E, G, H, and U). The QA director reported that she worked with each section lead (usually during the QAD-SAC 1:1 meetings) to ensure the inventory was comprehensive and correct. She gave an example of multiple departments recently working together across two days to cross reference their lists. The data list inventory was not current. Even so, ongoing updating was evident to the monitoring team. The facility submitted the inventory dated 9/19/13, however, there should be an update date for each department/section of the inventory because they are not all updated on the same day. Further, if the QAQI Council is to periodically review these listings (e.g., every six months), the date of QAQI Council review should appear on each department/section of the inventory in addition to the most recent date of revision by the department staff. Columns for these dates were in the data list inventory at the time of the previous review, but had been deleted. Rather than having a date for each item, it might be easier to have two dates at the bottom of each department's listing inventory.	

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		The QAD and SAC need to ensure that the content of the data inventories are comprehensive and do not omit any important indicators. A plan to do so should be created, implemented, and reported on at the next onsite review. Some additional comments are below: • The quality assurance section of the data listing inventory contained 67 items. Most of these should be part of the appropriate department's listing inventory, such as duration of restraint, dental sedations, and various self-monitoring tools. If the QA director has a reason for keeping this list as is, that rationale should be explained to the monitoring team at the next onsite review. o The items that remain on this list should be (a) those that do not easily fit into one of the other departments (e.g., census), and (b) items regarding the performance of the QA department's activities, such as QAD-SAC 1:1 meetings, CAPs, etc. These items did not appear anywhere in the data listing inventory. • Items should not be duplicated in the data listing inventory unless there is a reason to do so and, if so, the rationale should be provided. • Consider having one data list inventory for each Settlement Agreement provision, or if more than one provision is included in a single list inventory, separate the contents by provision, if possible. <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. Even so, it was due for an update, given that it was written almost a year ago, the QA plan narrative itself called for an annual revision, it was written by the previous QA director, and some aspects of the QA program had changed since November 2012 (e.g., mock survey). <u>QA Plan Matrix</u> The QA plan matrix should contain the data from the data list inventory that are to be submitted to the QA department; these data are then included in the QA reports and presented to the QAQI Council. EPSSLC had a QA plan matrix. The monitoring team reviewed the 8/31/13 QA matrix. The EPSSLC QA matrix was comprised of two components. One was three pages long and listed the self-monitoring tools for each of the 20 provisions of the Settlement Agreement. There were no tools listed for sections E, G, or H. There were two tools for section L, seven for section M, and three for section T.	

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		The second component was a list of key indicators chosen by the QAQI Council. Items were identified as being presented monthly (12), quarterly (7), or yearly (2). The 20 provisions of the Settlement Agreement were also listed, each presented once per quarter. The list of key indicators was described as being fluid, that is, items were added or deleted based upon the data reported, topics from the three morning meetings, and/or other information from the facility director and QAQI Council members. The matrix contained slightly different items than what was on the QAQI Council schedule, perhaps due to this fluidity. For the 20 sections of the Settlement Agreement, a set of key indicators was included for N/A of the 20 (N/A%). The monitoring team decided to not provide a rating for this metric because more work needs to be done to tie together the data listing inventory, QA matrix, performance key indicator list, and QA report. For instance, for many sections of the QA report, only self-monitoring tool data were presented. There should be other data of interest to the QAQI Council in addition to only the self-monitoring tool data. For other sections of the report, additional data were presented (which was good to see), but these data were not included in the QA matrix. The monitoring team very much liked the system of identifying monthly-quarterly-annual performance key indicators. These items, however, should appear on the QA matrix for the corresponding provision, too. Data from the four components of the statewide trend analysis report were not explicitly included, but should be within sections C (restraint) and D (allegations, incidents, injuries). Of the 20, both process and outcome indicators were identified for N/A of the 20 (N/A%). The contents of the data listing inventories contained both process and outcome indicators, however, these did not appear in the QA matrix (what ends up in the QA report and presented to QAQI Council). Similarly, of these 20, in N/A (N/A%), the indicators provided data that <u>could</u> 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." Again, the contents of the data listing inventories could be used to identify information as specified in E1, but were not included in the QA matrix. Moreover, data <u>were not</u> being used in this manner for most of the sections. The exceptions were sections C and D, which looked at many (but not all) of these variables.	

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		The QA director should describe, possibly within her notes from the QAD-SAC 1:1 meetings: • How each section of the matrix sets the occasion for data to be used to identify the information above, and • How data were being collected and presented to identify trends across the variables described in the wording of this provision E1. The QA matrix should also include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement (or indicate that a self-monitoring tool was not necessary along with a rationale). The QA matrix listed self-monitoring tools for 17 of the 20 sections (85%), that is, for all except E, G, and H. All data that QA staff members collected were not listed in the matrix (but were in the listing inventory). The staff implemented tools for active treatment, mealtimes, and the 100% ISP document audit. An environmental checklist was done once per year, and the QA nurse conducted medical audits quarterly. If these tools are kept in the section E portion of the matrix, they could also be cross referenced under the appropriate department (e.g., active treatment). EPSSLC had a number of databases managed by the data analyst. These were included in the data listing inventory, but not in the QA matrix. If these databases are to be presented as part of the performance key indicators and/or as part of the section leader's quarterly provision presentation, they should also appear on the QA matrix (once the QA matrix is revised to adequately line up with the other components of the QA program). All satisfaction surveys were included in the QA matrix. • The statewide family/LAR satisfaction survey was not continued. An explanation was not provided, however, it may be that EPSSLC implemented this only once per year and the repeat date had not yet come around. Even so, facility management maintained an active relationship with families, formally via parent advisory council and parent association meetings, and informally via an open door policy. • There was no staff satisfaction survey conducted, however, the facility director conducted monthly town hall meetings and initiated an employee advisory council. • An individual satisfaction survey was not yet developed. Other ways of obtaining individual satisfaction are to review self-advocacy activities, review weekly home meetings, and consult with the HRO. The monitoring team recommends that the QA director talk with the HRO about individual satisfaction and if there are any concerns.	

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		o The self-advocacy program continued to be an active and regular part of the facility's activities. Gloria Loya, HRO, and Nora Padilla, QIDP, facilitated the group. It met every month, there was an agenda, topics were relevant, and skill development regarding independence and decision-making continued. • There was no community business satisfaction survey because it was annual survey not due until December 2013. Even so, the facility director had reached out to various segments of the community, including local advocacy groups. 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. As noted above, the QA matrix, data list/inventory, QA report, QAQI Council presentations were not yet lined up properly. This may be a good task for the QAD and SAC to work on together. <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 were: 1. Submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., at least once each quarter). 2. Reviewed or analyzed by the QA department and/or the department section leader. 3. Conducted as per the schedule. All three items can be determined during the facility's monthly QAD-SAC 1:1 meetings. <u>Self-Monitoring Tools</u> As the QA director and the department section leaders work towards improving their self-monitoring tools, the monitoring team recommends that they review the comments made in previous monitoring reports regarding these tools. Further, for the next onsite review, the QAD should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at the facility: 1. Content/validity: A description of how the content of the tools was 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	

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		sections of the Settlement Agreement. o The monitoring team was able to determine, from reviewing the QA reports, that the results of the self-monitoring tools were reviewed at QAQI Council for 17 of the 20 provisions (85%). Moreover, the facility reported that self-monitoring tools had recently been updated for sections F, M, N, and U. Section J was updated about a year ago. Sections O, P, and R were in the final stages of review. For section C, the original tool remained, but the staff modified the guidelines and criteria for scoring to make the tool more relevant. The goal of the facility director and QA director was to get rid of tools that were of no use. The QA director reported that every section had reviewed its tools and updated them (though the monitoring team could find no evidence of this). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The QAD and SAC need to ensure that the content of the data inventories are comprehensive and do not omit any important indicators. A plan to do so should be created, implemented, and reported on at the next onsite review. 2. Ensure the items in the QA matrix represent those process and outcome indicators that are most relevant to the section, and that they track data to identify trends as per the wording of this provision E1.	
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 gathering, organization, and analysis of data. Data from 16 of the 20 (80%) sections of the Settlement Agreement were summarized and graphed showing trends over time (all but sections E, G, H, and L), but few (2 of 20 [10%]) analyzed data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals. To make this determination, the monitoring team reviewed the monthly benchmark summaries and attached data, QA reports, and minutes from Admin IDT meetings. <u>Monthly QAD-SAC meeting with discipline departments</u> The content and format of these meetings continued to evolve over the past six months. In April 2013 and May 2013, the QAD recorded a paragraph or two describing the meeting(s) for that entire month. Meetings occurred for 12-13 (60-65%) of the provisions in each of the two months. In June 2013 and July 2013, there were three meetings each month. Across the month, all 20 of the provisions were covered at least once. No information was submitted for August 2013.	Noncompliance

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		In addition, a checklist of 10 items for discussion was created beginning in June 2013. It was not clear if this was to be completed each week or if one checklist was to be used for the entire month's worth of meetings. This should be clarified. Also, the criterion to score a check mark needs to be made clear, and there should be no blank boxes because the reader can not tell if it was blank because it did not occur at all, occurred but at an inadequate level, or if it was not required/not applicable. Once this is completed, the checklist can be used to create a metric of facility performance on these QA activities. This could then be included in the section E QA report and QAQI Council presentation. The monitoring team would welcome the opportunity to observe one of these meetings at the next onsite review. The QA director planned to have the assigned QA staff member program auditor attend these meetings, too. That seemed to be a good idea, too. Because the meetings were just beginning and the QAD and SAC were just beginning to provide structure and consistency to the meetings the following four metrics were not calculated for this review, but will be done for the next review. The content of these metrics can help the QAD and SAC determine what items to include in their agenda and checklist. 1. Since the last onsite review, a meeting occurred at least twice for xx of the xx (xx%) sampled sections of the Settlement Agreement. All five topics below were conducted during xx of the xx (xx%) meetings that occurred (the monitoring team counted one meeting per quarter in its data calculation for this report even though more than one meeting may have occurred). • Review the data listing inventory and matrix, • Discuss data and outcomes (key process and outcome indicators), • Review conduct of the self-monitoring tools, • Create corrective action plans, • Review previous corrective action plans. 2. Since the last onsite review, during xx of the xx (xx%) meetings, data were available to facilitate department/discipline analysis of data. 3. Since the last onsite review, during xx of the xx (xx%) meetings, data were reviewed and analyzed. 4. Since the last onsite review, during xx of the xx (100%) meetings, action plans and/or CAPs were created for systemic problems and for individual problems, as identified; or an indication was noted that a corrective action plan was not needed.	

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		Other QA-Related Meetings The section leader meeting described in the previous report continued. The monitoring committee also described in the previous report had been discontinued primarily because the topics typically discussed (e.g., meal monitoring) had now been incorporated into other more appropriate meetings and sections. QA Report In the last six months, a facility QA report (for dissemination at the facility and for presentation to the QAQI Council) was created for six of the last six months (100%). Of the 20 sections of the Settlement Agreement, 17 (95%) appeared in a QA report at least once each quarter in the last six months (all except for E, G, and H). Of the 17 sections of the Settlement Agreement that were presented at least once each quarter, none (0%) contained all of the components listed below. That being said, data were presented for self-monitoring data for 14 of the 17 (82%, all except L, O, and P), and some narrative analysis of the data, that was more than just a description of the data, was present for 12 of the 17 (71%). • 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 Other key/important data were presented for 7 of the 17 (41%), considering that some of the monthly and quarterly key performance indicators were really part of one of the sections. These 7 were C (began in September 2013), D, M (seven different topics), O, P, R, and T (obstacles). As noted above, the area for improvement is to show data and trends across the variables listed in E1 (or indicate clearly a rationale for not doing so). This occurred in none of the sections (0%) though there was some progress towards this for sections C and D. Some additional comments for consideration by the QA director are below: • The facility placed a lot of importance on this report because it drove the content of the QAQI Council presentations and discussion. This was good to see. • The system of monthly-quarterly-yearly performance key indicators was very	

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		good. Moreover, the items on these lists fluctuated based upon QAQI Council discussions, information from the morning meetings, and recommendations from senior management or department heads. • The QAQI Council should consider adding special work groups into the report. • 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, such as for each Settlement Agreement provision. The monitoring team recommends a simple, short, summary piece of data, such as the number of CAPs that are active at this time. • The introductory pages of the QA report are out of date and should be updated (e.g., reference to 70% criterion for an action plan). <u>QAQI Council</u> This meeting plays an important role in the QA program. The monitoring team attended a meeting during the onsite review and read the minutes of the monthly QAQI Council meetings from April 2013 through August 2013 (five meetings). There was an adequate description of the QAQI Council in the QA plan narrative. Since the last onsite review, the QAQI Council met at least once each month. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, including presentation of Settlement Agreement sections in an organized, scheduled manner. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes (and attachments/handouts) from the QAQI Council meetings since the last review did document or show that (a) data from QA plan matrix (key indicators, self-monitoring) were presented in 4 of the 5 (80%, the May 2013 minutes were not completed correctly), and (b) the data presented were trended over time for 4 of the 5 (80%). There was indication that (c) comments and interpretation/analysis of data were presented for most of the items (in the QA report and in the minutes) for 4 of the 5 (80%).	

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		Minutes from 0 (0%) QAQI Council meetings since the last review reflected if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. Because so much importance is placed upon the QAQI Council and QA report, the QAQI Council minutes should more accurately reflect discussion, concerns, actions to be taken, etc. The minutes across the five months varied in quality, contents, and detail. This should be improved. During one QAQI Council meeting observed by the monitoring team, there was active participation of participants other than the presenter for all (100%) of the reports/data presented during the meeting. Overall, the QAQI Council meetings were running well. <u>PITs/PETs</u> EPSSLC had four performance improvement teams (FST group, Mealtime improvement team, Weight group, UTI work group). These were called workgroups at EPSSLC. The work of these groups might be incorporated into the QAQI Council/QA report system. The QA director referred to these workgroups in her self-assessment. That is, that she reviewed the listing and status. The monitoring team, however, did not see any indication of this within the QA program (though the monitoring team did see indication of each of the group's work activity). <u>Corrective Actions</u> A lot of work was done to improve the corrective action system. The facility director worked closely with the QA director to improve this aspect of the EPSSLC QA program. As a result, the corrective action/CAPs system was better organized than at any previous onsite review. Moreover, the monitoring team heard frequent references to corrective action plans from many different departments during the course of the onsite week. The QA director now had: • A revised CAP form • A definition/description of a CAP • Graphs of completed/pending CAPs • CAPs database, 20 pages • CAPs action reporting documents, 1-2 pages each	

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		There were 41 active CAPs for 11 of the 20 sections of the Settlement Agreement as follows: • Nursing: 13 • Medical: 6 • Habilitation: 5 • Pharmacy: 5 • Placement: 3 • Dental: 1 • QIDPs: 1 • Records: 1 • Active Treatment: 1 • Psychiatry: 1 • Psychology: 1 • Other: 2 This showed that CAPs were being utilized across more of the facility's departments than during the last review. It was not clear why nursing had a majority of the CAPs. Further, there was not a clear indication that CAPs were considered for all 20 sections, that is, CAPs (or that there was no need for a CAP) were not discussed during monthly QAD-SAC meetings, in the QA report, and in the QAQI Council minutes for each section. The monitoring team does not require that there be a CAP for every provision, only that there is evidence of consideration. An adequate written description, however, did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP. The QA director and facility director said that the need for a CAP was often identified during QAQI Council, usually if there were trends in data. The QA director provided the monitoring team with a description of a CAP, but not with any type of criterion. It would be helpful to the QA program if criterion could be more defined. It should be a criterion that is easy to understand and useful to the QAQI Council members. It does not need to have a quantitative component. For example, previously at EPSSLC, a CAP was required for any self-monitoring tool item that scored less than 70%. This was not useful to the facility or the departments. Therefore, when considering the full set of CAPs and action plans, the monitoring team could not determine if they were developed/chosen following written description, policy, or procedure.	

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		Of the 41 CAPs reviewed by the monitoring team (100% of the total), all appeared to appropriately address the specific problem for which they were created, however, most failed to ultimately assess whether the problem had gotten any better. • Each CAP was developed to address a problem. A set of actions were listed, anywhere from 2 to 8 actions. Many of the actions were to develop a database, conduct training of relevant staff, implement regular monitoring and review, and incorporate the data into department reviews, sometimes into the QA report. This was all very good to see. The problem, however, was that the actions never led back to assessing if the original problem was getting any better. This seems easy enough to fix, that is, the QA director, when writing a Corrective Action Reporting Document should ensure that the list of actions includes ensuring the problem has improved (including criterion would also help with this [see below]). Based on these 41 CAPs: • All (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • 41 (100%) included the anticipated outcome of each action step. o However, there were no specific criteria to determine if the CAP was met, or if progress had occurred (0%). This was a serious problem in the CAPs program. Because the criterion was never specified, the reader cannot determine if the actions met the problem for which they were designed. An example of an outcomes worded poorly was "Clarity for the staff on PNMT referral process." • 41 (100%) included the job title of the person(s) responsible, however, only the 3 pharmacy CAPs included the name of the person responsible. • 41 (100%) included the time frame in which each action step must occur (i.e., a due date). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: • Fully implement the QAD-SAC department meetings, including defining and measuring what is expected to occur during each meeting. • Analyze data as per the wording of provision E1 when appropriate to do so; or if not, provide a rationale. • Ensure that QAQI Council meeting minutes are accurate and adequately thorough. • Ensure CAPs ultimately assess whether the problem for which the CAP was created had improved. • Include criteria for a CAP being met.	

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E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the CAPs tracking document of the 41 CAPs, all (100%) indicated to whom the CAP was disseminated. Thus, substantial compliance was found for this provision. However: • 0 (0%) included documentation about how the CAP was disseminated • 0 (0%) included documentation of when each CAP was disseminated, and • 0 (0%) included documentation of to whom it was disseminated, including the specific name and title. Three (7%) included only the name, and 38 (93%) included only the title. Given that the above three bullets were included in the set of metrics submitted to the state around the time of the last onsite review, these metrics should be addressed by the QA director by the time of the next review to maintain substantial compliance. The monitoring team and the QA director discussed easy ways of accomplishing the above within the current Corrective Action Report Document.	Substantial Compliance
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.	The 41 CAPs appeared to have been implemented (100%). This was based upon review of the Corrective Action Reporting Documents. As noted above, management staff rarely reported on CAPs-related activities at QAD-SAC meetings, in QA reports, and during QAQI Council presentations. The monitoring team, however, could not determine that all aspects of CAPs were implemented fully and in a timely manner. To address this, QAD and SAC might indicate status on the Corrective Action Reporting Document and/or as one of the items in the QAD-SAC meeting minutes. That is, for each CAP, indicate whether it was implemented in a timely manner, done fully, and modified if needed (this last variable is for section E5). When a CAP, and all of its actions, were completed within the target due date, the reader can infer that it was implemented fully and timely. For those not yet completed, however, the reader cannot determine whether it was implemented fully and timely. There was not yet an adequate system for tracking the status of CAPs. Of the 41 CAPs being tracked by the facility, 41 (100%) indicated the status label of the CAP (open, overdue, pending, complete), but did not indicate any detail regarding the actions taken, needing to be taken, etc. • The monitoring team could not determine the difference between an open cap and a pending CAP. Definitions were provided, but all 41 CAPs were labeled either complete or pending when they might have been open or overdue. A better system might be to only have complete, open (open but not yet past the due date), and overdue (i.e., open past the due date).	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility QA director did maintain summary information/data regarding CAPs and their status that was updated within the month prior to the onsite review. The QA director or section leader did present this information to QAQI Council at least quarterly. At EPSSLC, it was one of the quarterly performance key indicators. The QA director reported that she engaged in additional activities to manage the CAPs. She said that she reviewed the set of open CAPs at least once per week and she said that she brought the CAPs binder to the QAD-SAC department meetings. At these meetings, she wrote new information on the Corrective Action Reporting Form. The monitoring team has recommended that the QA director maintain and graph some simple data on CAPs/action plans. To that end, the QA director and data analyst created two graphs. This was great to see. One graph was a bar graph that showed the number of CAPs for each department. Showing that CAPs were being used across the facility was very good, however, this graph needs to be more explanatory, such as indicating if this was the total number of CAPs implemented since some date (e.g., beginning of fiscal year, rolling 12 month period). Also, many of the bars had no indication as to what department or topic they were assigned. The second graph had two lines, with two data points for each month. The lines showed number of CAPs completed and the number pending. Because the purpose of a line graph is to show trending that is useful to the QA director and QAQI Council, the monitoring team recommends that the graph be modified to show the following: • Number of open caps on the first day of the month (both current and overdue) • Percentage of these that were completed on the last day of the month. • Percentage of these that remained overdue on the last day of the month. These data can be part of the section E data list inventory and possibly the QA matrix, too.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The QA director reviewed CAPs each month with the responsible person/section leader. The monitoring team will be looking for: • Evaluation of the effectiveness of CAPs, including outcomes, timely completion • CAPs are modified when needed. • Modifications/results are discussed at QAQI Council. • Modifications are implemented as written fully and timely.	Noncompliance

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 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 QIDP Coordinator o Monitoring tool used to assess the quality of the ISP and the ISP meeting o List of all QIDPs and assigned caseload o A list of QIDPs deemed competent in meeting facilitation (1) 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 Draft ISPs and Assessments for Individual #125 and Individual #114 o March 2013 QIDP monthly reviews for: • Individual #45, Individual #85, Individual #33, Individual #60, and Individual #82 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #169, Individual #128, Individual #189, Individual #102, Individual #75, Individual #9, Individual #32, Individual #34, Individual #39, Individual #28, Individual #80, Individual #126, Individual #51, Individual #82, and Individual #152. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Alice Villalobos, QIDP Coordinator o Mario Gutierrez, Incident Management Coordinator o Michael Reed, Facility Investigator o Gloria Loya, Human Rights Officer o Carmen Molina, Director of Behavioral Services <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 9/18/13 o Morning Unit Meeting 9/18/13 o Morning Clinical Review Team Meeting 9/18/13

	o Annual IDT Meeting for Individual #125 and Individual #114 o ISPA regarding restraints for Individual #161 o Pre-ISP Meeting for Individual #65 and Individual #127
	Facility Self-Assessment: EPSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 7/8/13 with recent activities and assessment outcomes. The QIDP Director was responsible for the section F self-assessment. EPSSLC continued to use the statewide section F monitoring tool to assess compliance with section F. The self-assessment commented on findings from a monthly sample of Settlement Agreement Monitoring Tools (SAMTs) completed, as well as other activities for each provision. The facility was also observing ISP meetings, gathering information from the QDDP-Construction Assessment, reviewing completed ISPs, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. These are the same type of activities that the monitoring team looks at to assess compliance. The facility self-rated itself as being out of compliance with all provision items in section F. Justification was not clear for most of the ratings because data often indicated 100% compliance with items in the audit tool. Findings were generally a restatement of the provision item with a statement reporting that the facility was not in substantial compliance. For example, For F.2.a.4, the QIDP Coordinator noted: Based on findings from this self-assessment this provision is not in substantial compliance because not all have interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional in the SSLC and in community settings. Data from the self-assessment indicated 100% compliance with the samples reviewed. The facility needs to examine results of the self-assessment and determine if data gathered is an accurate measure for each provision item.
	Summary of Monitor's Assessment 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. The intention of limiting the monitoring teams' review to newer plans is to provide the state and facilities with more specific information about the revised process. There was positive progress evident with the new ISP process. At two ISP meetings and two pre-ISP meetings observed by the monitoring team, it was noted that significant progress had been made towards: • Integrating the risk identification process into the ISP process. At the ISPs observed, the risk discussion was to some degree woven into the discussion regarding the individual's preferences, daily schedule, and support needs. • Engaging in adequate discussions regarding community living options. This process had

	undergone significant improvements. IDTs were holding a much more integrated discussion with input from all team members. The facility transition specialist attended the meetings observed and was able to offer relevant information and respond to any concerns regarding community living options by other team members. • Assessing each individual's ability to offer informed consent and consideration of the need for guardianship. • Offering additional opportunities for individuals to attend day programming in the community. IDTs observed were moving in a positive direction. To move forward towards compliance with the many provisions in section F, the monitoring team recommends a focus on the following activities during the next six months: • All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and available to all team members for review. • When new assessments are recommended, IDTs need to meet to review recommendations and incorporate any recommended changes in supports into the ISP. • IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection. • Outcomes should be developed based on each individual's known preferences that encourage greater exposure to a variety of activities (particularly in the community) and lead towards the acquisition of new skills based on known preferences and needs. • All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress. Likewise, data collected regarding incidents, injuries, and illnesses should be used to alert the IDT that supports are either not being implemented or are not effective and should be revised.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings in the new format and two pre-ISP meetings. The QIDP facilitated the meetings. IDT meetings observed were good examples of facilitation that ensured that team members participated in the meeting. All four QIDPs had excellent facilitation skills that kept the meeting focused and moving. They all encouraged participation by all team members present. Progress continued to occur and was evident, with regard to the facilitation of meetings.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last six QIDP monthly reviews, individual's daily schedule, Special Considerations list, and ISP Preparation Meeting documentation as available. A sample was requested of the most recently developed ISPs from each residence on campus, and the eight most recently developed plans were selected for review. Therefore, a variety of QIDPs and interdisciplinary teams (IDTs) had been responsible for the development of the plans. The facility had eight QIDPs. Each had a caseload of 13-15 individuals. Two of the eight QIDPs had recently resigned. The facility used the statewide Q Construction Facilitation Training in conjunction with a competency tool used to assess competency in facilitation skills. Only one (13%) of eight QIDPs had been deemed competent in regards to facilitation skills via this tool. Information about the other 7 QIDPs was not reported to the monitoring team. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the QIDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QIDPs used this template to draft portions of the ISP prior to the meeting. The QIDPs 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. A sample of IDT attendance sheets was reviewed for presence of the QIDP at the annual IDT meeting. QIDPs were in attendance at all annual meetings in the sample reviewed. QIDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found the QIDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. While the facility was in substantial compliance with the requirement that one person on the IDT facilitate development of an ISP, 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.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Good progress had been made towards developing an ISP that integrated all identified supports and services and focused on the individual's strengths and preferences. To move forward, the facility needs to focus on monitoring progress/regression and revising supports and services when needed. The facility will need to demonstrate that QIDPs were taking action when the monthly review process or other data note a change in status or a lack of progress.</td><td></td></tr>
<tr><td>F1b</td><td>Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.</td><td>DADS Policy #004.1 described the Interdisciplinary Team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QIDP, 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 identify the individual's preferences, strengths, and needs. This information should assist the IDT in determining key team members. EPSSLC was using the pre-ISP process to identify assessments to be completed prior to the annual ISP meeting and team members that should be present at the annual ISP meeting.

The facility had made progress in beginning to use the ISP Preparation Meeting to identify team members for participation in the ISP meetings, and had a working system to track and trend the resulting data.

The facility was tracking data on attendance at IDT meetings. Data gathered for presentation to the QAQI council indicated fair presence and participation by relevant team members. Attendance by the pharmacy staff, physician, DSP, and psychiatrist, when deemed relevant by the IDT remained low, as did participation by the individual and family members or LARs. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings in the month preceding the onsite visit (August 2013).

<table><tr><th>Team member</th><th>Attendance by relevant team members</th></tr><tr><td>Individual</td><td>31%</td></tr><tr><td>Family/Advocate</td><td>39%</td></tr><tr><td>LAR</td><td>50%</td></tr><tr><td>Active treatment/Recreational Staff</td><td>83%</td></tr><tr><td>Dental services</td><td>95%</td></tr><tr><td>Dietician</td><td>98%</td></tr><tr><td>Direct Support Professionals</td><td>66%</td></tr><tr><td>Home Manager</td><td>53%</td></tr><tr><td>Local Authority</td><td>85%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Occupational Therapist	100%
Pharmacy Services	56%
Primary Care Provider	44%
Program Developer	89%
Psychiatrist	52%
Psychologist/Behavior Analyst	90%
Nursing Services	99%
Speech Therapist	92%
Vocational Services	70%

Review of a sample of ISP attendance sheets confirmed that there were key staff missing who were identified at the ISP Preparation Meeting as relevant participants at eight of nine (89%) of the annual meetings in the sample. The sample included Individual #80, Individual #126, Individual #28, Individual #39, Individual #34, Individual #75, Individual #102, Individual #189, and Individual #128.

- At the annual ISP meeting for Individual #80, all recommended team members were in attendance at the annual ISP meeting.
- At the annual ISP meeting for Individual #126, there was no participation by her LAR.
- The PCP, DSP, and active treatment staff did not attend the annual ISP meeting for Individual #28.
- At the annual ISP meeting for Individual #39, there was no participation by the individual and his LAR. Pharmacy services, vocational services, and active treatment staff were not at his annual meeting.
- Individual #34's dental staff and home manager did not attend his annual ISP meeting.
- Individual #75's program development/active treatment staff, home manager, and LA were not present at his meeting.
- Individual #102 and his LAR did not attend his annual meeting. His psychologist, nurse, and program developer/active treatment staff did not attend his annual ISP meeting.
- Individual #189 did not attend his annual ISP meeting. His day program staff, and LA also were not present at the meeting.
- Individual #128's DSP, dental staff and pharmacy staff did not attend her meeting.

The annual IDT meeting for Individual #114 was held the week of the monitoring team's visit. The individual's wheelchair was being repaired the day of his annual meeting, so he was unable to attend. The IDT should have considered moving the meeting to his home or rescheduling the meeting so that he could participate.

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process.</td><td></td></tr>
<tr><td>F1c</td><td>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.</td><td>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 gathered data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments from 3/1/13 through 7/31/13 indicated that assessments were not routinely submitted prior to ISP planning meetings. For 57 individuals who had annual ISP meetings during this period, zero (0%) had all assessments recommended completed prior to the ISP meeting.

Data were reviewed on timely assessment submission for June 2013 and August 2013 There was an overall monthly compliance was between 7% and 100% for June 2013 and between 50% and 100% for August 2013. Data showed a significant increase in timely submission between June 2013 and August 2013. The chart below shows findings from that review.

<table>
<tr><th>Assessment</th><th>Submission Rate August 2013</th><th>Submission Rate June 2013</th></tr>
<tr><td>Clinical</td><td>50%</td><td>7%</td></tr>
<tr><td>CLOIP</td><td>77%</td><td>36%</td></tr>
<tr><td>Dental</td><td>100%</td><td>100%</td></tr>
<tr><td>Food Services</td><td>100%</td><td>57%</td></tr>
<tr><td>OT/PT</td><td>83%</td><td>64%</td></tr>
<tr><td>SLP</td><td>100%</td><td>21%</td></tr>
<tr><td>Nursing</td><td>100%</td><td>71%</td></tr>
<tr><td>Pharmacy</td><td>100%</td><td>92%</td></tr>
<tr><td>Program Development</td><td>50%</td><td>20%</td></tr>
<tr><td>Psychiatry</td><td>100%</td><td>100%</td></tr>
<tr><td>Psychology</td><td>100%</td><td>20%</td></tr>
<tr><td>Recreation</td><td>86%</td><td>44%</td></tr>
</table>

A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. Zero (0%) of seven individuals had all assessment recommended in the PSI completed at least 10 days prior to the annual IDT meeting.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		• Individual #128 did not have a psychological update, annual physical, or vision assessment prior to her annual meeting. • Individual #189 did not have a psychological update or annual physical prior to his annual ISP meeting. Her OT/PT and communication evaluations were not submitted 10 days prior to her ISP to allow for the IDT to review the assessments prior to the meeting. • Individual #102's functional skill assessment was completed after his ISP meeting. His communication assessment, nursing assessment, annual physical, and psychological update were not completed 10 days prior to his annual ISP meeting. • Individual #75's annual physical and functional skills assessment were completed after his annual ISP meeting. His CLOIP was not completed 10 days prior to his annual meeting. • Individual #9's functional skills assessment, annual physical, communication assessment, and vocational assessment were completed after his annual ISP meeting. His nursing assessment, CLOIP and nutritional assessment were submitted late. • Individual #34's functional skills assessment, annual physical, and communication assessment were submitted after her annual ISP meeting. • Individual #39's functional behavior assessment, functional skills assessment, annual physical, psychiatric assessment, and psychological assessment were submitted after his annual ISP. His nursing assessment was not submitted 10 days prior to his ISP. The facility needs to continue to expand opportunities for individuals 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. The facility continued to utilize the Functional Skill Assessment (FSA) to identify priority training. The recommendation section of the FSA was not being completed. As noted in previous reports and in section S of this report, the FSA was, by itself, not adequate for capturing this information. Although the list of preferences for each individual was fairly comprehensive, the list of strengths included in ISPs in the sample usually offered little information to build on. The list of strengths typically included general statements, such as can feed himself, has a good appetite, can ambulate, and can toilet independently. The facility was not yet in compliance with this item based on the data available. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months	

#	Provision	Assessment of Status	Compliance
		1. 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. 2. 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 considerable progress made in integrating assessment recommendations into support plans when available to the team. The monitoring team observed the annual ISP for Individual #125 and Individual #114. Assessments had been completed prior to the ISP meeting and were used to develop outcomes for the upcoming year. QIDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and information from assessments is used to develop plans that integrate all supports and services needed by the individual. There was no evidence that the team met when assessments were completed after the ISP meeting to integrate recommendations into the ISP. Plans were not always updated to include changes in supports that occurred after the annual ISP. For example, • Individual #128 had a VNS implanted after her annual ISP meeting. Her IHCP was not updated to include the VNS as a support to address her risk for seizures. Her IHCP had an outcome that stated she would have "no episodes of constipation and impaction." Her QIDP monthly review noted that in June 2013, she was seen by nursing due to a "large emesis." She was referred to the clinic for further assessment of emesis and constipation. Her IHCP was not updated with any recommendations following that assessment. • Individual #189's psychological update evaluation recommended that he be referred for psychological testing. There was no indication that the evaluation was completed, or if completed, that the team met to review recommendations. • Individual #28's IDT met on 5/13/13 to a recommendation regarding BUE tremors. The team agreed to gather data on the frequency of tremors then reconvene the IDT to review data and make recommendations. There was no evidence that the IDT met again to review the data. The QIDP noted in her July 2013 monthly review that an email was sent to PT to request a positioning assessment because DSPs and nursing reported that she was leaning to the side during mealtime and medication administration making it difficult for her to eat and take her medication. There was no evidence that an assessment was	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed or that the team met to discuss recommendations. o Following the onsite review, the facility reported that an ISPA had indeed been held in July 2013 to review the helmet and gait belt and update the PNMP. The IHCP, however, had not been updated which could lead to confusion among staff regarding which supports should be implemented to address her risk for falls. Further, there was some confusion regarding which PNMP was the most current one. The PNMP submitted to the monitoring team was not the most current. Staff need to be clear on which supports should be provided to minimize risks. • Individual #51 had an action step in his IHCP to refer him to medical for consideration of allergy testing. There was no documentation indicating that this had been completed, or if completed, that recommendations had been reviewed by the team. A review of assessments and ISPs indicated that recommendations from assessments were not included as actions in all ISPs. Examples where assessment results were not incorporated into the supports and services developed by the IDT included: • Individual #102's nursing assessment indicated that he should wear TED hose to address his high risk for circulatory disease. His IHCP did not include TED hose as a necessary support to address his risk. His nutritional evaluation recommended physical activity as indicated by PT. His PT evaluation did not include consideration of physical activity to address weight gain. His ISP did not include discussion or action steps regarding appropriate physical activity to address his risk. His communication assessment indicated that he would be provided with theme based talking photo albums and DSPs would be trained on how to use the books to facilitate interaction. His SAPs did not incorporate the use of talking photo albums into teaching strategies. • Individual #189's OT/PT assessment recommended a SAP for greater independence by self-propelling himself in his wheelchair for 10 feet. This recommendation was not incorporated into his SAPs. • Individual #75's communication assessment included a recommendation to periodically check his ears to ensure he does not have pain that can turn into aggressive behavior. This recommendation was not included in his ISP or IHCP. • Individual #34 had vocational outcomes to attend the prevocational program in the morning and work on offered task. Her vocational assessment recommended attending the vocational program in the afternoon. The assessment included preferred vocational activities. Her preferred activities were not included as options in her SAPs. • Individual #30's ISP contained information obtained from the annual medical summary and examination and listed the current medical problems, however,	

#	Provision	Assessment of Status	Compliance
		there was no evidence that his health and behavior problems and risks were integrated into the active treatment plan and program. For example, there were no planned interventions to address the physician's recommendation to be re-evaluated by the psychiatrist regarding Lithium. 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. The facility was not yet in compliance with this provision. To move forward, QIDPs will need to ensure that all recommendations from assessments are used to develop and revise supports as needed.	
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 mandated that a Living Options discussion 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. As part of the 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 annual ISPs observed for Individual #125 and Individual #114, team members discussed providing supports in a less restrictive environment. • Both teams engaged in discussion regarding what supports would be needed in a community setting and any barriers to living in the community. • Both QIDPs asked for recommendations from all team members regarding optimal placement. Good discussion was observed at both meetings. • The LA and the transition specialist were at the ISP meetings and were able to address any questions or concerns regarding community living options. The facility was providing additional opportunities for individuals to participate in day programming in the community. Although little documentation was found regarding specific training occurring in the community, it appeared that most individuals at the facility were engaged in some type of community programming. The opportunity for community day activities was good to see and was noted in previous monitoring reports as well as in section S of this report.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Eight ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #128, Individual #28, Individual #75, Individual #189, Individual #126, Individual #80, Individual #34, and Individual #51. Two (25%) of the ISPs included meaningful training opportunities in the community. Community based outcomes for most individuals in the sample consisted of generic opportunities to visit in the community with little or no opportunity for training or meaningful integration. For example: • Individual #128 only had outcomes to visit community providers, attend the multipurpose center, and participate in outings in the community as scheduled. • Individual #189 had one community based outcome to increase exposure to the community. He was to be given the opportunity to visit community group homes once per year. • Individual #102 had a community based outcome to go to Hobby Lobby monthly. While this was based on his preferences and interest and offered exposure to the community, the IDT stopped short of developing measurable training outcomes in the community based on his interests and needs. • Although Individual #34's ISP did not offer specific measurable training to be implemented in the community, the team did develop outcomes to determine her interest in new activities based on her preferences with instructions to DSPs for documenting her reaction. This was positive. The team should consider developing additional action steps for training if she shows interest in new activities. For example, staff were to document her interest in attending the movies. If she shows interest in going to the movies, then additional outcomes could be developed regarding choice/decision making skills (choose a movie), communication skills, money management, relationship building, etc. ISPs that included specific measurable training objectives to be implemented in the community: • Individual #75 and #51 both had an outcome for money management to be implemented 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 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.	

#	Provision	Assessment of Status	Compliance
		There was little focus on providing supported employment or volunteer opportunities for individuals at the facility. The sheltered workshop should be a job training site with a goal to support individuals to work in the community. Meaningful job training was not observed in the vocational program. None of the ISPs in the sample included outcomes developed to increase opportunities to explore job opportunities in integrated work environments.	
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;	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. It will be necessary for all assessments to be completed prior to the annual ISP meeting to ensure the team will have information necessary to determine prioritized needs, preferences, strengths, and barriers. In the ISP meetings observed, IDTs engaged in discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting, and developed plans to include the individual's preferences throughout the day. As noted in F1c, IDTs were still not doing a good job of developing a list of each individual's strengths that would allow for building on those strengths. Lists of preferences included a much broader range of activities and were individual specific, which was good to see. IDTs, however, were still not developing action plans that would expand on those preferences by providing opportunities to explore new activities, particularly in the community. As noted in F1e, additional opportunities to try new things should lead to the identification of additional preferences.	Noncompliance

#	Provision	Assessment of Status	Compliance
		ISPs in the sample provided few opportunities to gain exposure to new activities and learn new skills. As noted in F1e, 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. In a review of eight recent ISPs, two (25%) offered specific training to be provided in the community. While the community was often listed as a possible training site for outcomes, training was not designed specifically for functional training in the community. As noted in F1e, outcomes for training offered opportunities for visits in the community, but few were focused on gaining specific skills. For many of these individuals, community awareness had been identified as an obstacle to living in the most integrated setting, but IDTs did little to develop community integration strategies that would address these obstacles, including use of community settings to teach skills that would support successful community living or integrate preferences identified by and for the individual into SAPs. To move in the direction of substantial compliance, the monitoring team recommends that the facility focuses on developing outcomes to address barriers to service and supports being provided in a less restrictive setting.	
	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;	A sample of ISPs, IHCPs, and skill acquisition plans (SAP) 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 very few outcomes written in a way that staff could measure progress towards completion or that provided enough information to ensure consistent implementation. None (0%) of the plans in the sample included a full array of measurable outcomes. Outcomes to address health and risk, included general instructions (i.e., follow PNMP, weigh weekly), but did not include specific indicators to be measured. SAPs to address learning new skills often used general behavioral indicators (i.e., attend, participate) that were not specific enough to be consistently measured. For example: • Individual #102 had action steps in his IHCP to address his high risk for circulatory disease. He had a positive history of DVT to both lower extremities. His IHCP included action steps PRN blood pressure and vital signs. There was no indication how often his BP or vital signs should be monitored or what symptoms might trigger a need to monitor. An instruction sheet for direct support professionals was included in his IHCP, but was not specific enough to ensure consistent monitoring. It also included instructions to take his blood	Noncompliance

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		pressure and temperature as ordered or requested. • Individual #34 had outcomes to "attend pre-vocational workshop" and "work on offered task." In order to gather consistent data, the SAPs should identified specific behavioral indicators for staff to document based on skill deficits identified by her vocational assessment or functional assessment. Her vocational assessment indicated that she was able to complete task at the workshop with prompting. It was not clear what action on her part would demonstrate successful completion of this outcome. • Individual #80 had an outcome to participate in bed-making program. One of his action steps was "will attend bed making and participate in duties." The strategies that staff would employ were to "prompt him in attending bed-making and to participate in the duties he has." It was not clear what supports staff would need to provide, what data staff would gather, what his duties were, and what level of participation would be considered a successful attempt. As noted in F1d, recommendations from assessments were not always used to develop training strategies. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Section M and section I also address the writing of measurable strategies to address health care risks. 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.	
	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 the individual's 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 integrated all services and supports was still an area with which the facility struggled. 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. Assessments and recommendations will need to be available for review by the IDT prior to annual	Noncompliance

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		meetings. As noted in F.1.d, the facility did not have an adequate system in place for ensuring that assessment information was integrated into the ISP. The revised ISP meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. The facility had made significant progress in developing comprehensive ISPs that integrated all supports and services. However, as noted throughout section F, assessment information was often not available prior to the ISP meeting. Further, it was not evident that recommendations from assessments obtained after the annual ISP meeting were integrated into the ISP. 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. 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;	<u>Method for implementation</u> As discussed in F2a2, action steps in the sample of ISPs reviewed did not include clear methodology for implementation in some cases. 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. IHCP action steps were generally brief statements of action to address the risk. Most did not include methodology or criteria for monitoring effectiveness of intervention. For example: • Individual #51 had action steps to address his risk for constipation, including encourage fluids, document bowel movements, and follow nursing protocol for constipation. To consistently provide supports to address his risk, the staff would need to know the frequency and type of fluids to be offered, the prompts needed to encourage him to drink, when to notify nursing when documenting bowel movements and specifics of the nursing protocol (which was not attached to his plan). • Individual #189 had action steps to address his risk for constipation including	Noncompliance

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		"monitor food/fluid intake and output" and "monitor BM." Parameters were not given that would signify a change in risk status or a need for revised supports. <u>Time frame for completion</u> Outcomes in the sample reviewed generally included a specific completion date. Examples where this did not occur, however, included: • The completion date for all outcomes in Individual #169's ISP was listed as "ongoing." • Individual #126 had four outcomes in her ISP that listed the completion date as "2014." • The completion date column was left blank for Individual #80's IHCP. • Individual #34's IHCP included 12 outcomes with no projected completion date. <u>Staff responsible</u> All SAPs and IHCPs in the sample included designation of which staff would be responsible for implementation of the outcome and which staff would monitor the plan. The facility was not in compliance with the requirement for identifying methods for implementation and time frames for completion.	
	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. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. Many of the outcomes in the ISPs reviewed were functional at the facility, but often were not practical or functional in the community and did not allow for individuals to gain independence. None of the ISPs in the sample included adequate outcomes for functional participation or integration in the community. For example, there were no outcomes to shop in the community for food to prepare a meal, complete transactions at a community bank, pick up prescriptions at the pharmacy, seek membership at a gym or library, or take a community art or fitness class. As noted throughout section F, there was very little measurable training occurring in the day habilitation programs. Vocational outcomes were not found that would develop vocational skills needed for community employment. Vocational skills were often taught in relation to jobs at the facility, but would not necessarily translate well in a community work environment. For example, individuals at the facility had part-time schedules for work or day activities. Lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch to eat at their work sites or in the vicinity of their activity or vocational setting. These low	Noncompliance

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		expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. To move forward, IDTs will need to accurately identify needed supports and services needed to gain independence and function in a less restrictive setting through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy 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, type of documentation, and person responsible for reviewing progress. Integrated Health Care Plans included similar information. The data to be collected and frequency of implementation was found on the SAP, IHCP, or on the ISP outcome summary. As noted throughout F2a, IDTs were still struggling with developing measurable outcomes with methods that would allow for consistent data collection to permit the objective analysis of progress. SAPs, ISP outcome summaries, and IHCPs now included the person responsible for data collection and the person responsible for review of that data. As noted in other sections of this report, IDTs were still developing general action steps such as "monitor weight" without including criteria that would trigger a review of supports or change in status. Outcomes will need to be measurable in order to permit objective analysis of the individual's progress.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision 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. As noted in F1, adequate assessments were often not completed prior to the annual meetings. When assessments were recommended by the team, it was not evident that the ISP was revised to include recommendations once the assessment was completed.	Noncompliance

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		To move forward, the facility will need to ensure that recommendations from various assessments are available to all members of the IDT prior to the annual ISP meeting, and then are integrated throughout 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 16 out of 16 (100%) records reviewed. The facility reported that 116 (100%) of 116 ISPs were within 30 days of development over the past year. The facility needs to ensure that all plans are comprehensible to staff assigned to implement the plan and staff can clearly communicate what supports should be provided and what data should be gathered. As noted above, outcomes and action steps were not always written clearly enough to ensure consistently implementation and data collection. 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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. All outcomes should be written in clear, measurable terms.	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 team shall meet to determine if the ISP needs to be modified, and shall	Teams were required to meet to review any incidents, significant injuries, or changes in status immediately when determined necessary. Each discipline was assigned responsibility for reviewing specific services and supports in the ISP. QIDPs were responsible for reviewing the overall plan. The facility had a QIDP monthly review process to review all supports and services. It was not evident that an adequate review process was in place to ensure that the review of supports and services led to timely implementation of assessments or changes in supports when necessary. An adequate review process was not in place for any of the ISPs in the sample. For example, • The QIDP monthly review of services for June 2013 for Individual #169 indicated that no data were available for review for three of her outcomes. Outcomes included in her IHCP were not reviewed. • The QIDP monthly review of services for June 2013 and July 2013 for Individual #80 indicated 0% progress for leisure and relationships outcomes. The QIDP did not comment on lack of progress or need to revise supports. Notes regarding his bed making outcome in July 2013 indicated that percentages were pending.	Noncompliance

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	modify the ISP, as appropriate.	His IHCP outcomes were not reviewed. • The QIDP monthly review for May 2013 for Individual #189 showed no data available for his living options and leisure outcomes. Two other outcomes showed 0% progress with no comments regarding lack of progress. His IHCP outcomes were not reviewed. Monthly reviews were not submitted for June, July, or August 2013. • Individual #39's QIDP monthly review for August 2013 had brief statements regarding progress for some outcomes, but still lacked sufficient detail to support that consistent implementation of outcomes was occurring. Review of his money management SAP for June 2013 indicated that no data were available. He had an outcome to be offered choices of activities while at the park. The QIDP noted 0% progress. It was not clear if this meant that the opportunity was not offered to him or if he did not choose an activity. • The April 2013 QIDP monthly review for Individual #28 was not completed until 6/15/13. It indicated that no data were available for review of her outcomes. The monthly reviews for May 2013 and June 2013 also indicated that no data were available for review. It was unclear whether or not outcomes had been implemented for the three month period, whether staff failed to document implementation, or whether no progress had been made. • March 2013 QIDP monthly reviews for Individual #45, Individual #85, Individual #33, Individual #60, and Individual #82 all documented no data available for each outcome reviewed. As the facility continues to progress toward developing person-centered plans for all individuals at the facility, QIDPs need to keep in mind that ISPs should be a working document that will guide staff in providing supports to individuals with changing needs. To move forward towards compliance, 1. Plans should be updated and modified as individuals gain skills or experience regression in any area. 2. QIDPs 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.	In order to meet the Settlement Agreement requirements with regard to competency based training, QIDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document. The facility had been trained by the state office on developing and implementing the ISP. QIDPs were still learning to use the new statewide ISP format. As noted throughout	Noncompliance

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	Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	section F, adequate plans had not yet been developed for a majority of the individuals at EPSSLC. The facility was providing 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 or did not include recommended support strategies from assessments. Informal interviews throughout the facility indicated that staff were generally able to describe supports and services developed through the ISP process. A review of data collected regarding implementation indicated that data were often missing or the status of outcomes could not be determined. See comments regarding the monthly review process in F2d. To move forward, the facility will need to ensure that plans are available and training on new or revised supports occurs within 30 days of development.	
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 ISPs were available in 16 (100%) of 16 individual notebooks in the sample. Data provided by the facility indicated that 116 of 116 (100%) ISPs developed in the past year were filed within 30 days after the annual ISP was held. The monitoring team requested a list of ISP dates with the date the ISP was due, the date the meeting was held, and the date the ISP was filed (document V.10). The facility did not provide information needed to verify timeliness of ISP meetings and filing dates.	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	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 assurance 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. As noted in regards to the facility's self-assessment process, it was not clear that accurate data were being gathered and analyzed. Little progress had been made	Noncompliance

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	provisions of this section.	towards developing an effective quality assurance system to identify problems with the ISP and implementation.	

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 Dental Clinic o Psychiatry Clinics o Patient Care Meetings o Incident Management 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 a few 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. Overall, the self-assessment did not provide a valid measurement of the status of the facility with regards to

	the Settlement Agreement. It did not measure the right things. For example, for provision G1, the self-assessment looked at the patient care meeting minutes for results of evaluations to assess individuals with risk for pneumonia, aspiration, and clinical status changes. Annual and Quarterly Medical Summaries were reviewed to determine if they were completed within the appropriate timelines. None of these items addressed the integration of clinical services. The following are a few examples of potential clinical outcome measures that could have been used as part of the self-assessment process. • The number of individuals with weight changes who were identified, reviewed by the weight committee, had plans implemented, and demonstrated positive outcomes as a result of the changes. • The number of individuals receiving suction toothbrushing and those who demonstrated subsequent improvement. • Individuals with decreases in the use of restraints as a result of plans developed by psychiatry and psychology. 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 interim clinical services director served as the lead for this provision. She had only been in the position for three months prior to the compliance review and had many areas that required attention. Provision G had, therefore, not been the primary area of focus. In terms of preparing for the compliance review, her efforts were directed towards demonstrating how medical services integrated with other areas. The monitoring team explained that this provision addresses the integration of all clinical services. There were no major integration initiatives and no policy was developed to assist the facility in moving towards substantial compliance with this provision. Even so, the monitoring team observed some very good examples of integration of clinical services. In some cases, however, care was fragmented and lacked integration. Moving forward requires that this provision address all clinical service areas and that adequate attention is afforded to assessing the actual outcomes of integration and not just the discussions that occur in the various meetings.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	To determine compliance with this provision, the monitoring team reviewed state procedures, conducted interviews, completed observations of activities, and reviewed records and data. During the conduct of this review, examples of integration of clinical services were observed. There were also several instances in which integration needed to occur, but did not. The following are examples of integration that were noted: • EPSSLC conducted daily clinical meetings, incident management meetings, and unit meetings. The meetings were conducted in the morning and ran continuously using a consistent format for documenting and tracking current, ongoing and follow-up problems thereby ensuring the integration of communication between the various disciplines. • 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. The monitoring team observed no participation of the medical staff in this process. • 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. The intent of the meeting was 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, however, the documentation of committee discussion and actions was incomplete and not well-organized. As discussed in section L, the lack of physician input in the discussion had a negative impact on the overall outcome of the meeting attended by the monitoring team. There continued to be some concerns related to weight loss that met criteria for referral but was permitted to continue without PNMT intervention (also see section O). • The PNMT worked well together for assessment and follow-up though the IDT. The PNMT RN consistently attended morning medical meetings and PNMT members attended IDT meetings as needed. There was documentation of participation by the psychiatrist in one PNMT meeting, but the PCPs did not participate. Most of the referrals to the PNMT were self-generated and a number of cases were cited in section O in which referrals were not made in a timely manner. There were very clear referral guidelines in place to assist the IDTs in recognizing when referral was indicated. • Suction toothbrushing was a collaboration between dental clinic, habilitation services, respiratory therapy, and nursing services. • The members of the IDT, inclusive of psychology, nursing, pharmacy and habilitation services, were generally present for quarterly psychiatry clinics or	Noncompliance

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		when other psychiatric clinical consultation occurred. • Psychology and Psychiatry – Integration of psychology and psychiatry improved. Psychologists and psychiatrists appeared to have improved interactions during the psychiatry clinics observed. There were several areas in which the monitoring team noticed that the collaborative work between the clinical areas required improvement: • ISP Process – As noted in section L, the primary medical providers did not attend the annual ISPs and other clinical meetings that would have benefitted from the input of the medical providers. The providers had the important role of presenting 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. • Medication Variance Committee - The primary medical providers did not participate in any of the important committee meeting observation during the week of the compliance review. Participation was notably absent in the medication variance and pharmacy and therapeutics committee meetings. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility should have each clinical service area draft a policy describing how they will achieve integration with other clinical service areas. The policy should define how success would be measured. 2. The center's lead should address the concerns outlined in the comments above. 3. DADS should develop and implement policy for provisions G1.	
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.	A total of 50 consults completed after March 2013 and included in the active records of the record sample were reviewed: • 35 of 50 (70%) consultations were documented in the IPN <u>within five working days</u> The providers usually included a brief summary of the consult. The summaries usually were limited to one or two lines and many did not document the significance of the findings. The most recent entries included a statement of agreement or disagreement. The notations did not consistently specify which consult was being addressed. As noted during the previous compliance review, it was never clear if the recommendations were being referred to the IDT for integration with current supports and services. Additionally, the reason for the consultations was not always clear and even when the	Noncompliance

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		reasons were clear, adequate information was frequently not provided. The Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations and whether to refer the recommendations to the IDT for integration with existing supports. State policy required that an entry be made in the IPN explaining the reason for the consultation and the significance of the results within five working days. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The monitoring team recommends that IPN documentation include (a) the required summary statement regarding the reason for the consult and significance of the findings, (b) agreement or disagreement with the recommendations, and (c) the need for IDT referral. Clinically justifiable rationales should be provided when the recommendations are not implemented. It is further recommended that that the PCPs always notify the IDT when there is a disagreement with the recommendations of the consultant since further discussion may be warranted. The monitoring team also recommends that for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g., Surgery Consult, 1/1/13). 2. DADS should develop and implement policy for Provision 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. The self-assessment did not provided the type of information that would have assisted the facility in determining the status of each provision item. This was largely due to the fact that the facility lead was not very familiar with the provision. In moving forward, the monitoring team recommends that the facility lead 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 all seven provision items. The monitoring team agreed with the facility's self-assessment.

	Summary of Monitor's Assessment: There was no progress noted in this area. The monitoring team met with the interim clinical services director, state medical services coordinator, and ADOP to discuss this provision. The interim clinical services director served as the facility lead. She assumed the position only four months prior to the compliance review. In the absence of a facility medical director, there was a need to prioritize the work that needed t be done and addressing provision H was not a priority item. However, provision H addresses the important topic of how the facility monitors the delivery of clinical services to ensure that assessments and treatments are timely and appropriate. Provision H is therefore worthy of greater attention. There had been numerous staff serving as lead during the past 18 months, so a lack of progress was not unexpected. The facility lead focused on the medical department for this provision, so it was clear that a great deal of work needed to be done. The facility had not developed a local policy and state policy remained in draft. The state medical services coordinator shared with the monitoring team a comprehensive set of proposed draft guidelines that addressed each provision item with an operational definition, a method of assessing compliance, action steps for assessing compliance, and compliance targets. Overall, this was a reasonable approach and should serve as a good start for moving forward with the development of a facility policy for section H.

#	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 facility did not address all of the requirements of this provision item. The facility lead presented information on annual and quarterly medical assessments. The other required assessments were not addressed as part of provision H1 nor were interval assessments, however, data on the other scheduled assessments were tracked through the QA department. 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 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The medical staff was completing Quarterly Medical Summaries. All of the active records included a current QMS. • Quarterly Drug Regimen Reviews were completed in a timely manner and overall quality was adequate. There were no deficiencies identified in the documents submitted to the monitoring team. • Annual Dental Assessments – Compliance with timely completion for the six-month review period was 55%. The facility reported a compliance rating of 100%. There were significant concerns related to the quality of dental documentation. Further discussion is found in section Q2. • Regularly scheduled quarterly and annual nursing assessments were present in all but one of the 13 sample individuals' records. The individuals' nursing assessments revealed that although there was some improvement in certain sections of the nursing assessments, the assessments failed to provide one or more components of a complete and comprehensive review of the individuals' past and present health status. The assessments also failed to adequately document the responses to interventions. • The PNMT conducted assessments for individuals referred to the team. For this review period, two assessments were submitted for review, but only one was completed in a timely manner. These assessments resulted in a series of recommendations for the IDT and the PNMT to address collaboratively. Follow-up was also collaboration, as PNMT members attended IDT meetings when the individual they supported was scheduled for review. • Therapy assessments (OT/PT/SLP completed a single assessment) were completed annually for individuals provided direct and indirect supports and services or in the format of a Comprehensive Assessment. These were also completed when a change in status was identified by the IDT, post-hospitalization, or by referral for an identified need. A consult assessment was completed and documented previously as a stand-alone assessment, but currently and more effectively in the IPNs. • Though there had been some regression in the timeliness of OT/PT assessments over the course of this review period, it was noted that since 6/14/13, the on-time percentage was 92% and that 100% of the 64 assessments completed for ISPs between 3/1/13 and 8/21/13 had been completed prior to the ISP. This reflected a significant improvement and stabilization of this issue over the course of this review period. There also had been some slight regression in the content aspect of the OT/PT assessments, specifically related to the identification of the recommended frequency of compliance and effectiveness monitoring as well as the schedule for re-assessment. Two of the 12 assessments had omitted one or both of these elements. Otherwise, the content elements continued to be addressed appropriately.	

#	Provision	Assessment of Status	Compliance
		• Psychiatry clinic was timely with regard to completion of quarterly medication reviews. They had completed a large percentage of Comprehensive Psychiatric Evaluations, however, there were deficits in that two of the three individuals admitted to the facility during the current monitoring period did not have a comprehensive psychiatric evaluation performed per Appendix B. • Functional assessments were completed for all individuals with PBSPs and annual psychological assessments were completed for all individuals; however, some individuals continued to not have initial psychological assessments <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating on noncompliance. To move in the direction of substantial compliance 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 accepted standards of practice).	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The monitoring team assessed compliance with this provision item by reviewing many documents, including medical, psychiatric, and nursing assessments. • Generally, the medical diagnoses were consistent with ICD nomenclature. The diagnoses were generally consistent with the signs and symptoms of the disease. • 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 some examples of documentation of specific criteria exhibited by an individual indicating a particular diagnosis.	Substantial compliance
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.	There was no compelling evidence that EPSSLC was utilizing the state issued clinical protocols and medical management audits to assess compliance. It had been completed only once at the facility in September 2012. The facility had no systems in place to measure the timeliness and appropriateness of interventions, largely due to the lack of clinical indicators. The facility's assessment of this provision was determined by reviewing the completion of annual and quarterly medical summaries. The H1 draft guidelines indicated that facility staff would utilize the clinical pathways, guidelines, and protocols to govern treatments and interventions as appropriate. Additionally, the draft guidelines stated	Noncompliance

#	Provision	Assessment of Status	Compliance
		that the facility was responsible for providing education and development of the clinical staff with regards to the guidelines and protocols. Assessing compliance with a given protocol will require that a measurable standard or metric – clinical indicators - be developed. The minimum common elements of clinical care could be applied to many conditions such as diabetes mellitus. Medical, nursing physical therapy and dietary all contribute to the planning and treatment for individuals diagnosed with diabetes mellitus. EPSSLC lacked a mechanism for adequately assessing the effectiveness of the care that was provided. Clinical indicators are helpful in objectively determining if treatments and interventions are timely and clinically appropriate. They also provide a quantitative basis for quality improvement, or identifying incidents of care that trigger further investigation. The monitoring teams findings for compliance with the standards of care in diabetes mellitus and other medical conditions is discussed in Section L1. Changes to the PNMP were made very quickly in most cases. Some were noted on the same day or within 24 hours of the ISP. In the case of direct therapy, the quality of documentation was inconsistent with generally accepted standards. Measurable objectives for direct therapy provided were not always identified and were not generally integrated into the ISP or ISPA. However, initiation of interventions was noted in a timely manner from the date of referral. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the facility must monitor a full range of treatments and interventions. Indicators should be developed based on the state protocols and other common medical conditions. The development of clinical guidelines can be an infinite process. Therefore, the facility will need to develop protocols and monitor those conditions determined to have the greatest impact on health status. Conditions that affect many individuals or those that have presented medical management challenges should be considered. Medical audits, hospital and emergency department data, and the sick call roster have the potential to provide insight on how prioritization should occur.	
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	The facility did not make much progress in this area. The proposed guidelines stated that the facility would ensure that identified clinical indicators measure the response to treatment and interventions and data would be monitored to determine the appropriateness of the interventions. The actions steps to achieve this centered on development of clinical indicators by the clinical disciplines for seven acute and chronic	Noncompliance

#	Provision	Assessment of Status	Compliance
	interventions shall be determined in a clinically justified manner.	health care conditions. The development of indicators for the seven conditions was a good starting point. As discussed in Section H3, additional indicators are needed. Once guidelines are established and indicators are identified, the facility will have a more objective means of assessing treatment. Many of these processes should occur within the medical department. The determination of the appropriateness and efficacy of medical care must be made by a physician through the development of audit tools. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of 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 the accuracy of the data in some instances was questionable and, as noted throughout this report, it was clear that at least within the medical department, the data were not being reviewed. The state office proposed guidelines indicated that the health status was discussed in the annual ISP and ISPA as identified by the IDT and a plan was developed to address the needs of the individual. Additionally, the facility tracked data in development of the identified health plan. The monitoring team was concerned about the lack of medical involvement in the development of the health plans given the lack of participation in annual ISPs. The facility must monitor both acute changes and chronic long-term disease by linking the current monitoring systems. Monitoring health status requires a number of processes, reviews, and evaluations due to the need to monitor both <u>acute changes and chronic long-term disease</u>. The monitoring team noted several components that would contribute to monitoring health status: • Risk assessment • Periodic assessments (medical, nursing, therapies, psychiatry, and pharmacy), • Acute assessments via sick call • Reports of acute changes via the daily patient care meetings, incident management, unit meetings, and change of status meetings • ISPA Process • Medical databases (preventive care, cancer screenings, seizure management) • A medical quality program would be the designated quality program and would report certain data elements to the QA/QI council.	Noncompliance

#	Provision	Assessment of Status	Compliance
		With appropriate execution of these systems, an individual's care and monitoring could be assessed across this continuum of activities. However, the monitoring team identified a number of concerns related to current processes and systems: • Risk identification and mitigation continued to present challenges for most disciplines. • Medical assessments did not clearly identify risks and therefore frequently lacked an appropriate plan of care. • Physicians did not participate in ISPs • Clinical data were inaccurate • The facility did not have a medical quality program Developing a comprehensive format to monitor health status will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The effective monitoring of health status requires proper oversight of risk assessment and provision of medical care. It will be difficult to monitor long-term status without the appropriate medical quality program. Moreover, a robust medical quality program will require oversight by a medical director/physician designee familiar with such processes. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The process for inclusion of the medical providers in the ISP process should be addressed. 2. Data integrity must be improved. 3. A medical quality program should be developed.	
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.	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. At the time of the compliance review, there was the potential to track some changes via the daily patient care meetings, unit meetings, ISPAs, and other meetings discussed above. Clinical indicators would provide the objective means of assessing the adequacy of the treatments and intervention. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 state medical services coordinator, who served as the state lead for Section H, also prepared a set of draft guidelines for Section H. The facility had not developed any local policies. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, a state policy related to Provision H should be developed. EPSSLC will need to develop a local policy based on state guidelines.	Noncompliance

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o 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 individuals with serious injuries in the past year 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 individuals 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 individuals who received enteral feeding o List of individuals with chronic and acute 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 Data reports regarding the submission of assessments for IDT review prior to annual ISP meetings o Draft ISPs and IRRF for Individual #125 and Individual #114. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews: • Individual #169, Individual #128, Individual #189, Individual #102, Individual #75, Individual #9, Individual #32, Individual #34, Individual #39, Individual #28, Individual #80, Individual #126, Individual #51, Individual #82, and Individual #152.

	Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDIPs in homes and day programs; o Alice Villalobos, QDIP Coordinator o Mario Gutierrez, Incident Management Coordinator o Michael Reed, Facility Investigator o Gloria Loya, Human Rights Officer o Carmen Molina, Director of Behavioral Services Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 9/18/13 o Morning Unit Meeting 9/18/13 o Morning Clinical Review Team Meeting 9/18/13 o Annual IDT Meeting for Individual #125 and Individual #114 o ISPA regarding restraints for Individual #161
	Facility Self-Assessment: EPSSLC submitted its self-assessment. Along with the self-assessment, the facility submitted an action plan that addressed progress towards meeting the requirements of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility planned to engage 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 appeared to have an adequate self-assessment process in place to identify problems and develop action plans for improvement. They were now gathering and compiling data using the section I statewide audit tool. Findings from the audit tool were similar to findings from the monitoring team's review. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed.
	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. While good progress had been made on meeting substantial compliance, through an improved understanding of the risk process by IDTs, the facility was not in compliance with the three provisions in section I. The monitoring team saw some progress in section I in each of the three provision areas, and observed the risk identification process at two ISP meetings.

	• The facility was taking a more integrated approach to looking at risk. This was particularly evident at the two ISP meetings observed and at the morning clinical review meetings. • At both annual IDT meetings observed, the IDT held an integrated discussion regarding risk levels and supports needed to address risks identified. • The ISP/Risk identification process was much less fragmented. There was still room to improve this process, but overall, good progress was seen in integrating the risk identification process into the ISP. It was still evident that some important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decision regarding appropriate interventions. Without adequate assessments completed prior to the meeting, it was difficult to make clinical determinations in regards to risks. Teams were not using the IHCP to track the completion of assessments and document resulting recommendations. 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 reviewing supports following a change in status, but failing to document when assessments were completed and recommendations were implemented. To move forward with section I: • The facility needs to continue to focus on ensuring that all relevant team members are present for meetings and that assessments are completed prior to the discussion of risks. • Plans should be implemented immediately when individuals are at risk for harm, and then monitored for efficacy.

#	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. IHCPs were designed to provide a comprehensive plan that will be completed annually and updated as needed. The monitoring team observed 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. IDTs were utilizing the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP). In both meetings, team members appropriately added information to the discussion regarding rationale for each risk rating. Overall, both teams engaged in good discussion and assigned appropriate risk ratings. Action	Noncompliance

#	Provision	Assessment of Status	Compliance
		plans were developed to address all medium and high risks. The state policy required that all relevant assessments be 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. As noted in section F, the submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals. . A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. Zero (0%) of seven individuals in the sample had all assessment recommended in the PSI completed at least 10 days prior to the annual IDT meeting. Without current assessment data available, IDTs cannot accurately assess risks. While progress had been made in the risk process, it will be imperative that relevant assessments are submitted prior to the annual IDT meeting and that all recommendations are integrated into the IHCP.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The 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 implemented, monitored, and revised when significant changes in individuals' health status and needs occurred. It was not evident that the facility was consistently gathering and analyzing data that might signify a change in status. The monitoring team requested a list of all emergency room visits and hospitalizations during the past year. The facility struggled with compiling accurate data to submit to the monitoring team. This raised concerns regarding whether or not the facility was using data to drive decisions regarding risks. As noted in section F, data were often not available for review by the QIDPs. Again, this raised the question of whether or not IDTs were using data to identify when individuals might have a change of status that would require a change in supports to mitigate risk factors. A sample of records was reviewed to determine if a determination of risk resulted in an assessment of current services and support, risk ratings, and/or plan revisions. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended. Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization, the monitoring	Noncompliance

#	Provision	Assessment of Status	Compliance
		team was unable to determine what additional assessments were needed and/or conducted in response to the change of status. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. Thus, it was not possible to determine if assessments were completed or if recommendations from assessments were incorporated into supports and tracked for efficacy. For example, • Individual #28's IDT noted in May 2013 that she had exhibited an increase in tremors. The team recommended that DSPs begin documentation of tremors and then the team would reconvene when data were gathered to discuss the need for medical consultation. Follow-up to findings regarding the frequency and intensity of her tremors was not documented. • Individual #34's IHCP had an action step that stated "medical review for order to ambulate without oxygen indoors." Another action step stated, "medical to review if Aveeno can be added or substituted for moisturizer." There was no documentation available to indicate if a consultation was held and/or if the IDT implemented recommendations from that consultation. • Individual #189's IHCP included an action step to address his risk that stated, "Psychology will develop a baseline for SIB." It was not evident that a baseline had been established and shared with the IDT. • Individual #80's IHCP had an action step to address his risk for osteoporosis and fractures to "schedule BMD." The implementation date was 5/6/13. No further documentation was available to indicate if the assessment had been scheduled or resulted in recommendations for the IDT to consider. • An ISPA held on 7/23/13 for Individual #126 indicated that her team would meet to discuss weight issues. There was no indication that the team met or made a referral for further assessment. The monitoring team reviewed a sample of assessments from each discipline to determine whether or not an adequate assessment process was in place to address identified risk. Findings by discipline are summarized below, <u>Nursing</u> Based on a review of 13 records of which 13 had completed nursing assessments, IRRFs and IHCPS. Nine of 13 (69%) included sufficient nursing assessments to assist the team in developing appropriate plans sufficient to meet the individuals' health care needs. An example that did not contain documentation of this requirement was Individual #129. The assessment did not include sufficient information in the nursing summary related to the significant numbers of meals or frequency of exercise or weight gain over time, such as per quarter, semi-annually, and/or annually considering weight, cardiac, and gastrointestinal level of risk.	

#	Provision	Assessment of Status	Compliance
		Medical As noted in section L, none of the annual medical assessments reviewed included risk assessments or discussions by the primary medical providers. Given that primary prevention starts with the appropriate risk assessment, it stands to reason that identification of risk and discussion of risk mitigation should have a place in the annual medical evaluation of every individual. Psychology Based on a review of 13 functional assessments, 69% were found to be comprehensive and, therefore, useful for assessing risk. See K5 for a further discussion of functional assessments at EPSSLC. Psychiatry Psychiatry assessments were generally found to be adequate for identifying risk factors. See section J for additional comments regarding the assessment process. Integrated Risk Rating forms did not consistently include specific clinical data that would indicate when a change in status review was needed. Thus, the monitoring team was unable to determine if a change in status had occurred for most individuals in the sample unless a significant illness or injury was documented elsewhere in the record. For example, • Individual #34 had an outcome in her IHCP to address her risk for respiratory illness that stated "no episode of desaturation at rest." Action steps included continue "pulse monitoring at every shift." There were no instructions for gathering specific clinical data, so it would be difficult to identify a change in status. • Individual #189 had an action step to address his risk for cardiac disease. His action steps indicated "weekly weight monitoring." His IHCP did not include his acceptable range for weight. Without parameters stated, staff could not determine if supports were effective or when a change of status might occur that would signal a need to review supports. 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.	

#	Provision	Assessment of Status	Compliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner, if indicated by the risk status. According to data provided to the monitoring team (document VI.2), plans were in place to address risks for those individuals designated as high risk or medium risk in specific areas. All ISPs in the sample included general strategies to address identified risks, but again, not all assessments were submitted prior to the determination of risk ratings, thus, it was unlikely that risk ratings were based on current data. As noted in I2, IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. IDTs were not documenting when plans were implemented. Thus, it was not always possible to determine if IDTs implemented all recommendations from assessments within 14 days. Other examples were found where changes in supports were not implemented within 14 days. • Individual #128's IDT met following a PT assessment that recommended discontinuing use of her gait belt and helmet to address her risk for falls. These changes were not documented in her IHCP or PNMP. • Individual #18's IDT met on 11/20/13 for an emergency psychiatric clinic to discuss his increased aggression and SIB. IDT members noted that his behavior was often used for communication. The team recommended that the psychologist, SLP, and program developer meet to develop communication strategies. An ISPA dated 12/10/13 indicated that he was still showing aggression and SIB. The requested communication plan was still pending development. • Individual #126 was at risk for constipation. Her ISP dated 6/18/13 indicated that the nurse case manager should "measure her belly 2x per month." Her July 2013 monthly review indicated that data were not yet available and the plan would be implemented in August 2013. Additional notes in the monthly review indicated that she had expressed pain, had medication and meal refusals, and was treated for constipation weekly in July 2013. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Many of the 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 ancillary plan in place or instructions were too general (e.g., follow diet, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following: • Develop action plans with measurable criteria for assessing outcomes. • Document the implementation of action plans. • Document that clinical data is gathered and reviewed at least monthly. • Document action taken to revise supports when data indicates that current supports are not effective.	

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 and medical 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 examinations 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 three 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 newly prescribed psychotropic medications: Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses were revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons

	for the choice of the new diagnosis over the old one(s) o 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 Individual #140. Comprehensive Annual Psychiatric Medication Review for the following individuals: • Individual #151, Individual #32, Individual #120, Individual #10, Individual #99, Individual 23, Individual #60, Individual #114, and Individual #57. 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 List of individuals indicating whether a PBSP or a mental health plan is in effect. o Documentation regarding psychiatry attendance at BSP/peer review. o Number of PBSP or mental health plans signed by psychiatry. o Documentation of training provided to RN case managers regarding MOSES/DICSUS. o Revised data regarding Reiss Screens (including admission, baseline, or change of status designation). o Documentation regarding all psychiatry peer reviews performed during this monitoring period. o 10 examples of informed consent performed by psychiatry. o Documentation resulting from the ISP held 9/17/13 regarding Individual #161. o All data presented, doctor's orders, and physician's documentation for "Neuro-Psychiatry" clinic 9/17/13 regarding Individual #52, Individual #38, and Individual #109. o All data presented, doctor's orders, and physician's documentation for psychiatry clinic 9/18/13 regarding Individual #89 and Individual #148. o Documentation of post sedation level of compliance. o Total number of TIVA appointments in the previous six months. o Polypharmacy oversight committee meeting handouts 9/19/13. o Pharmacy and Therapeutics meeting packet 9/19/13. o All corrective action plans authored by psychiatry for the previous six months. o These documents: • Identifying data sheet • Annual Medical Summary and Physical Exam (Health Data) • Hospital section • X-ray/Lab section (for the last six months) • Psychiatry section (for the last six months) • MOSES/DISCUS (for the last six months) • Pharmacy section (for the last six months) • Consult section (for the last six months) • Physicians orders (for the last six months) • Integrated progress notes (for the last six months)

	• Consent section (for psychotropic medications) • ISP and ISP addendums/reviews/annual (for the past six months) • Behavioral Support Plan • Annual Nursing Assessment • For the following individuals: ▪ Individual #161, Individual #13, Individual #18, Individual #9, Individual #112, Individual #72, Individual #73, Individual #32, Individual #39, Individual #50. <u>Interviews and Meetings Held:</u> o Eugenio Chavez-Rice M.D. lead psychiatrist with Eustolia Garcia, L.V.N. and Rosina Bueno o Mary Ann Clark, R.N., Chief Nursing Executive o Giovanna Villagran, Pharm.D., Director of Pharmacy o Carmen Molina, LPC, BCBA, Director of Psychology o Howard Pray, D.D.S., facility dentist with Jennifer Pacheco, R.D.H. o Elaine Lichter, R.N., Interim Clinic Services Director with Laura Cazabon-Braly, M.D., LPC. o Laura Cazabon-Braly, M.A., LPC, Facility Director o George Zukotynski, Ph.D., BCBA-D, Discipline Coordinator Psychology <u>Observations Conducted</u>: o Observation of two psychiatry clinics including the following individuals: • Individual #89 and Individual #148. o Observation of ISP meeting for Individual #161. o Observation of Neuro-Psych clinic regarding: • Individual #52 Individual #38, and Individual #109. o Observation of individuals in workshop facility homes. o Psychiatry/Psychology weekly meeting o Observation of Pharmacy & Therapeutics meeting and Polypharmacy committee meeting o Behavior Therapy Committee and Psychology Peer Review o Morning Medical Meeting o Department head 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 all provision items. The monitoring team agreed with 10 of these: J1, J2, J3, J5, J7, J8, J9, J10, J12, and J15.

	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 demonstrate ongoing efforts to reduce reliance upon the use of multiple medications for pretreatment sedation. 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. Also, it was concerning that all individual's receiving dental services were receiving TIVA. The facility must demonstrate ongoing efforts to reduce the need for TIVA or other sedation. The monitoring team did not agree with the facility self-assessment regarding J6 because there were issues with regard to the utilization of the Appendix B format for new admissions. Specifically, two of three individuals admitted during this monitoring period did not have Comprehensive Psychiatric Evaluations performed in this format as is required by the Settlement Agreement. Initial evaluations must be performed in Appendix B format. In addition, peer review documents revealed scores below the necessary cutoff. The monitoring team did not agree with the facility self-assessment regarding J11 because review of the medical records did not reveal adequate justifications for polypharmacy. The facility must ensure a thorough facility level review of polypharmacy regimens and appropriately justify polypharmacy for each individual meeting criterion in order to reach substantial compliance. The monitoring team did not agree with the facility self-assessment regarding J13 because a review of a sample of 13 records revealed varying quality in documentation for the psychiatric reviews and omissions of the initial comprehensive psychiatric assessment via Appendix B in two of three individuals newly admitted to the facility. In addition, the new "Quarterly Psychiatric Medication Review" omitted required elements including 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. The monitoring team did not agree with the facility self-assessment regarding J14 due to the inadequate informed consent practices. In order to obtain substantial compliance, it is necessary that the prescribing practitioner disclose to the individual or their LAR all information necessary for informed consent, documenting appropriately. It is also necessary that the facility utilize standardized information regarding specific psychotropic medications, providing this information to the individual or their LAR.

	Summary of Monitor's Assessment: Psychiatry services at EPSSLC made progress towards substantial compliance. Half of the individuals received psychopharmacologic intervention (60 of 116, 51%). The facility had acquired additional psychiatric resources increasing from 1.0 to 1.2 FTE for the majority of the monitoring period. The psychiatrist providing 0.2 FTE had, however, terminated services at the facility as of July 2013. The quarterly psychiatric assessment document had been revised, however, there were items omitted from this document, including 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. 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 one psychiatric clinic, 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, QIDP, direct care staff, and the individual). A review of psychiatric documentation revealed improvements with timeliness of quarterly psychiatric medication reviews. There were noted improvements in the psychiatric participation in the development of the PBSP. Additional improvements noted in this monitoring period included the addition of the psychiatrist's signature on the document. Also, the "Individual Mental Health/Behavior Plan" had been described via policy and procedure. In J6, where the facility had previously achieved substantial compliance, there were noted deficiencies. Specifically, two of three individuals admitted to the facility during the current monitoring period did not have comprehensive psychiatric assessments via Appendix B. In addition, peer review indicated scores below the required 80 points. There were several areas where the facility was able to achieve substantial compliance ratings (J1, J2, J3, J5, J7, J8, J9, J10, 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.	Qualifications 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. The second psychiatrist, however, terminated his contract with the facility in July 2013. 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. Experience 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 34 additional months of experience, having started his current job 11/1/10. The part-time psychiatrist was interviewed during the previous monitoring visit. At that time, although he 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 was noted, specifically inpatient psychiatric treatment of both adult and adolescent patients. As this physician provided services during the majority of this monitoring period, this information remained pertinent for this monitoring report. Monitoring Team's Compliance Rating Based on the qualifications of the psychiatrists at EPSSLC, this item was rated as being in substantial compliance.	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	Number of Individuals Evaluated At EPSSLC, 60 of the 116 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 for the majority of the monitoring period, an additional 0.2 FTE of psychiatric resources had been acquired. Concerns noted in previous monitoring	Substantial Compliance

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	psychiatrist.	visits with regard to the timeliness of quarterly psychiatric clinical reviews were not noted during this monitoring visit. A review of data regarding the dates of quarterly reviews revealed that all but one (i.e., 59 of 60 reviews) had been performed in the previous 90 days. Evaluation and Diagnosis Procedures Via the monitoring team's observation of one psychiatry clinic 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 had abated somewhat, given an overall reduction in rapid medication regimen adjustments. Clinical Justification In order to improve documentation regarding evaluating and diagnosing individuals in a clinically justifiable manner, as of April 2013, the psychiatric staff had revised the form utilized for quarterly psychiatric clinic, now titled, "Quarterly Psychiatric Medication Review." This form reviewed all the requirements of the agreement, including sections to document specific information in order to ensure all items were addressed. Tracking Diagnoses and Updates The psychiatry clinic had developed a tracking system to monitor diagnosis changes. In the intervening period since the last monitoring report, one diagnosis change was documented. This was a reduction since the previous monitoring visit, where there were nine 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 prior monitoring periods. A review of 13 individual's records revealed improvements in consistency of diagnoses among disciplines with 12 of 13 records noting consistency, likely due to the ongoing utilization of the Psychiatry/Psychology Integration Tool implemented in March 2012. Monitoring Team's Compliance Rating Based on the use of the "Quarterly Psychiatric Medication Review" that allowed for documentation of all necessary information, improvements in the timeliness of quarterly psychiatric clinical reviews, and appropriate diagnostic concordance between disciplines, this provision was rated in substantial compliance in agreement with the facility self-assessment.	

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J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Treatment Program/Psychiatric Diagnosis Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. 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 sustained improvements 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. This document, completed by psychology during psychiatry clinic, allowed for clear communication and delineation of expectations for each department. The monitoring team reviewed the active positive behavior support plan (PBSP), sometimes referred to as a behavior support plan (BSP) in the sample of 13 records reviewed. In all records reviewed, there was a current (within the past year) BSP or and "Individual Mental Health/Behavior Plan" included. The content of the PBSPs is reviewed in section K of this report. The facility had promulgated a policy and procedure document entitled, "Mental health Behavior Plan Policy and Procedures 2013." Per this document, "the Mental health Behavior Plan was created as an alternative to the standard PBSP…to be used when an individual is taking psychoactive medication, but intensive behavioral interventions are not warranted…designed to address the indicates…that are present due to a psychiatric diagnosis under Axis I and /or Axis II…gives instruction on what operational behaviors to look for that indicate symptomology [sic] of the diagnosis. It is also a tool to assist with the data collection of the indicators so that data based decisions can be made in regards to psychiatric treatment. Data is collected and compared to psychoactive medications to measure progress/response or lack thereof." It was noted in previous reports that 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. In the intervening period since the previous monitoring report, the documents had been revised to include a signature space for the psychiatrist. It was noted during this monitoring visit that the psychiatrist was an active participant in the development of both the PBSP and the "Individual Mental Health/Behavior Plan." Review of quarterly psychiatric medication reviews revealed sustained improvements in the risk benefit analysis for treatment with specific medications authored by psychiatry as discussed further in J10. There was also evidence of sustained improvements in the collaborative case formulations as noted in the examples reviewed in J6 and J8 below.	Substantial Compliance

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		Overall, there was a reduction in the percentage of individuals participating in psychiatry clinic who met criteria for polypharmacy. In the previous monitoring report, 60% of individuals participating in psychiatry clinic met criteria for polypharmacy. During this visit, this had been reduced to 58%. 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. Review of the quarterly psychiatric medication reviews revealed examples where additional nonpharmacological interventions were included. For example, in the record of Individual #13, additional strategies included, "maintain schedule…constant active treatment…attendance to workshop…nontraditional counseling weekly…swimming every week…outings…family passes…baseball, kickball." 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. <u>Emergency Use of Psychotropic Medications</u> 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 two incidents where emergency psychotropic medications were utilized involving two individuals (Individual #161 and Individual #109). The facility use of emergency psychotropic medication for individuals during periods of SIB/agitation/aggression had decreased, as there were four instances of emergency psychotropic medication utilization in the previous monitoring	

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		period. As was discussed with psychiatric and primary care staff during 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. This had resolved in the period since the previous monitoring review. Discussions with the facility psychiatrist revealed that currently, only single agents were being utilized for chemical restraints. In this period, in both chemical restraint periods, Lorazepam at doses of 4 mg (Individual #161) and 2 mg (Individual #109) were administered orally. <u>Monitoring Team's Compliance Rating</u> There were noted improvements to both the regularity of the psychiatric physician's participation in the development of both PBSP and the "Individual Mental Health/Behavior Plan." In addition, both documents had been revised to include the signature of the participating psychiatrist. There remained deficits in the identification of nonpharmacological interventions in the PBSP, however, review of the Quarterly Psychiatric Medication Reviews revealed inclusion of nonpharmacological interventions in addition to the PBSP. In addition, there were improvements with regard to a reduction in the utilization of chemical restraints, and when these were necessary, only single agents were utilized. Given these improvements, this provision will be placed in substantial compliance, 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	<u>Extent of Pretreatment Sedation</u> There was a listing of individuals who received pretreatment sedation or TIVA for either medical or dental clinic. This listing indicated a total of 57 instances of pretreatment sedation. Of these, there were 44 individuals who received TIVA, and 13 individuals received pretreatment sedation for a medical procedure. There were no individuals who received pretreatment sedation for dental clinic because all individuals requiring dental procedures received TIVA. Of the total of 57 instances, 17 (38%) were identified as enrolled in psychiatry clinic. The data indicated that, for pretreatment sedation for medical procedures, there were nine sedations utilizing one medication, three sedations utilizing two medications, and one sedation utilizing three medications. It was notable that the majority of the 13 instances of pretreatment sedation for medical procedures included individuals participating in psychiatry clinic (76%). As stated in previous monitoring reports, the facility must review its use of multiple medications during pretreatment sedation. This was discussed with facility staff during the monitoring visit. Staff indicated that the use of multiple medications	Noncompliance

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	medical services, and shall be monitored and assessed, including for side effects.	for pretreatment sedation had been discontinued. Data revealed that the last episode where two or more medications were utilized occurred in May 2013. <u>Interdisciplinary Coordination</u> Interviews with the dental department staff, psychology, pharmacy, primary care, and psychiatry, as well as observation of the Pretreatment Sedation meeting during previous monitoring visits, 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. <u>Desensitization Protocols and Other Strategies</u> A list of all individuals with medical/dental desensitization plans and date of implementation were requested. The monitoring team was provided with a list of 86 individuals who had a current desensitization plan. Of these, 71 individuals had a dental desensitization plan and 21 had a medical desensitization plan. Seven dental desensitization plans were received for review. In addition, four medical desensitization plans were received for review. All 11 of these plans were skill acquisition plans. Interviews with psychology staff and examples of desensitization plans provided for review revealed that desensitization was approached from a skill acquisition plan procedure only. A sample of seven 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. In addition, four medical skill acquisition plans were received. Again, 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	

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		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. Though see section Q of this report. <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 demonstrate ongoing efforts to reduce reliance upon the use of multiple medications for pretreatment sedation. 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. In addition, it was concerning that all individuals receiving dental services were receiving TIVA. The facility must demonstrate ongoing efforts to reduce the need for TIVA or other sedation.	
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	<u>Psychiatry Staffing</u> Approximately 51% of the census (a total of 60 individuals) received psychopharmacologic intervention requiring psychiatric services at EPSSLC as of 9/16/13. At the time of this monitoring review, there was one FTE board certified psychiatrist, designated as the lead psychiatrist. For the majority of the monitoring period, until July 2013, there was an additional 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.	Substantial Compliance

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	this section of the Agreement.	Administrative Support Psychiatry clinic staff included a psychiatric assistant 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. Determination of Required FTEs Per the facility self-assessment, the current facility census with a total of 60 individuals requiring psychiatric treatment, a ratio of 60 to 65 individuals for one full time psychiatrist, sufficient resources exist. 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 1.0 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. Monitoring Team's Compliance Rating As the facility had acquired additional psychiatric resources, present for the majority of this monitoring period, coupled with the decreasing population, this provision was rated in substantial compliance, in agreement with the facility self-assessment. As the resources did decrease during the latter part of this monitoring period, the current level of services must be maintained in order for this provision to remain in substantial compliance in the future.	
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 had completed comprehensive psychiatric evaluation per Appendix B on all individual's participating in psychiatry clinic. There were three Appendix B evaluations performed during this monitoring period, all of which were for individuals who were new facility admissions. Records of the three individual's most recently admitted to the facility were reviewed. These were Individual #149, Individual #151, and Individual #37. The record for Individual #37 did not include an evaluation per Appendix B. The record for Individual #151 did not include an evaluation per Appendix B, but rather a comprehensive annual psychiatric medication review document that did not include the items required via Appendix B.	Noncompliance

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		The record for Individual #149 included an evaluation that followed the Appendix B format. In general, relevant history was provided. There were sustained improvements in the collaborative case formulation. The document differed from those reviewed during previous monitoring visits, in that copious information from other disciplines (available via the ISP or other documentation) was not included. This was appropriate, and the document did refer the reader to other information. There were challenges, in that the laboratory section of this document was blank. In response to the document request for examples of Appendix B evaluations, one was provided for Individual #149. The remaining examples were "Comprehensive Annual Psychiatric Medication Review" documents regarding Individual #151, Individual #32, Individual #120, Individual #10, Individual #99, Individual #23, Individual #60, Individual #57, and Individual #114. These documents did not include the elements required per Appendix B, as they were essentially medication reviews. The psychiatric peer review process had continued, and there had been two reviews of EPSSLC psychiatric documentation during this monitoring period. The first review dated 6/11/13 revealed a score of 74, and the second dated 4/26/13 revealed a score of 78. The document reviewed was provided for the 4/26/13 peer review. The monitoring team agreed with the scoring by the reviewers. Per the rating form, a Comprehensive Psychiatric Evaluation must score an 80 or above in order to receive credit under this provision. There were reportedly no corrective action plans authored as a result of these peer reviews. <u>Monitoring Team's Compliance Rating</u> There were issues with regard to the utilization of the Appendix B format for new admissions. Specifically, two of three individuals admitted during this monitoring period did not have Comprehensive Psychiatric Evaluations performed in this format as is required by the agreement. Initial evaluations must be performed in Appendix B format. In addition, peer review documents revealed scores below the necessary cutoff. As such, this provision will be placed in noncompliance, in opposition to the rating in the facility self-assessment.	

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J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at EPSSLC who did not have a current psychiatric assessment, and for those individuals experiencing a change in status. <u>Reiss Screen Upon Admission</u> The facility had three new admissions for the previous six months (Individual #149, Individual #151, and Individual #37) and all were administered a Reiss screen (based on information provided to the monitoring team). Data indicated that these individuals were referred to and followed by psychiatry clinic. <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 56 individuals who would be appropriate for Reiss screening. Of these, 56 individuals had documented completed screens (100%). In addition, there were three individuals who received Reiss screens due to a change in status during this monitoring period. Per staff interviews, the facility psychiatrist reviewed all completed Reiss screens in order to determine if a referral to psychiatry clinic and a comprehensive psychiatric evaluation is necessary. A review of the data provided did not include information regarding which screens were positive and required additional evaluation. <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 the three Individual's who where new facility admissions. Per the facility policy entitled "Psychiatry Services" dated 11/30/12 revised 2/8/13, the process for performing Reiss screens for new facility admissions, current facility residents who were not participating in psychiatry clinic, and individuals experiencing a change in status were delineated. In addition, there was a process outlined for psychiatric review of the completed screens and referral to psychiatry clinic. <u>Monitoring Team's Compliance Rating</u> Given that all individuals who were not participating in psychiatry clinic had undergone baseline screening, and the delineation of the process for both completion of the Reiss screen, the review of the Reiss screen, and referral to psychiatry, the facility had reached substantial compliance for this provision, in agreement with the facility self-assessment.	Substantial Compliance

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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 revised 2/8/13 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 one psychiatry clinic, 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, QIDP, 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. There were improvements noted with regard to the presentation of data. Data were clearly graphed and data were current to the previous day. In addition, during clinic, psychology staff were noted to make attempts to interpret and analyze the provided data in order to assist the psychiatrist with making data driven medication adjustments. 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 psychiatry clinic observation, 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. A review of the psychological and psychiatric documentation for 13 individual records did reveal case formulations that tied the information regarding a particular individual's case together. These were included in the initial comprehensive psychiatric assessments, with updates or alterations to the case formulation included in the "Quarterly Psychiatric Medication Review." 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	Substantial Compliance

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		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 improvement 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 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 somewhat improved in the psychiatric clinic observed, and in the clinical documentation reviewed.	

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		For example, the "Quarterly Psychiatric Medication Review" regarding Individual #73 dated 6/28/13 stated, "we are waiting for more data…to determine if her polypharmacy is adequate or if we need to challenge some of her medications, but we will only do it if the data supports a response. Otherwise, we feel that with this combination the patient has had the best results up to the present time." <u>Monitoring Team's Compliance Rating</u> As there had been improvements in the integration of pharmacological and behavioral interventions via combined assessment and case formulation as well as improvements made with regard to reductions in rapid medication changes, and with regard to the use of data to drive medication regimen adjustments, this provision was rated in substantial compliance in agreement with the facility self-assessment.	
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. As stated in previous monitoring reports, in order 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. In the intervening period since the previous monitoring review, the PBSP document had been revised to include the signature of the participating psychiatrist. 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. Data provided revealed that the psychiatrist attended 22 of a total of 55 ISP meetings (40%) between the dates of 3/14/13 and 8/7/13. Interviews with staff revealed that due to changes in the requirements for psychiatry to provide information to the IDT prior to the ISP meeting, with a reported 99% compliance with submission requirements, psychiatry was no longer regularly participating in the ISP meetings. Psychiatry indicated that they	Substantial Compliance

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		now only attended ISP meetings, "when we are asked to." This was discussed with psychiatry clinic staff, reiterating the importance for psychiatric attendance and participation at ISP meetings whenever possible. Treatment via Behavioral, Pharmacology, or Other Interventions The review of 13 records did not reveal issues with multiple medication regimen adjustments highlighted in previous reviews. Documentation did reveal consideration of data when making medication adjustments as well as the identification of nonpharmacological interventions in addition to the PBSP. ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports The psychiatrist and psychology staff had sustained the improvements in 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 nonpharmacological interventions outside of the BSP. One issue noted during clinic was the psychiatrist's continued requests for additional data. This was concerning. Even in situations where there was adequate data for the physician to make data driven decisions, there was difficulty due to challenges with data analysis. As stated in previous monitoring reports, it would be beneficial for psychology staff to improve their analysis of the provided data in order to assist the psychiatrist in the decision making process. Monitoring Team's Compliance Rating To meet the requirements of this provision item, there needs to be an indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. Per the onsite review and document review, this process was occurring. The facility had improved with regard to achieving the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological in an effort to reduce the reliance on psychotropic medication. There was documentation that the psychiatrist was attending some ISP meetings, however, the percentage of attendance must improve. Given the improvements outlined above, this provision had reached substantial compliance in agreement with the facility self-assessment.	

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J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	Policy and Procedure A review of DADS policy and procedure "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 revised 2/8/13. Per this policy, this information was to be discussed, reviewed, and documented in the psychiatric clinical documentation. Quality of Risk-Benefit Analysis A current review of the records of 13 individuals who were prescribed various psychotropic medications revealed improvements in the risk/benefit analysis with regard to treatment with medication as required by this provision item. For example, format of the quarterly psychiatric documentation had been revised via the "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. For example, for Individual #161 the "Quarterly Psychiatric Medication Review" form dated 6/25/13 referred the reader to the comprehensive annual psychiatric medication review risk/benefit and to the quarterly psychiatric review of 9/25/12. The analysis then reviewed the specific risks and benefits associated with newly prescribed medications including Effexor and Artane. For Individual #9, the "Quarterly Psychiatric Medications Review" form dated 6/21/13 included an adequate risk benefit analysis for both Thorazine and Vyvanse. Additional medications prescribed, including Zyprexa, Trazodone, and Effexor were not addressed. The document also indicated that "if she were not to be on the psychotropic medications, she would likely become extremely self abusive with potential danger to self…the IDT agree that yes, there were non-pharmacological strategies that were less effective than medications, but not more dangerous." 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	Substantial Compliance

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		analysis could be undertaken in a collaborative approach during psychiatry clinic. This documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. <u>Observation of Psychiatric Clinic</u> During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed risks/benefits of medications with the IDT present in 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 QIDP, 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 #72 presented to HRC Committee 6/26/13 demonstrated improved documentation, individualized information, and need for continued improvement: • Zyprexa 10 mg in the morning for SIB was presented. • Objective information including SIB data was utilized, "SIB has increased significantly…has received several injuries to various parts of his body to include a spiral fracture on his right hand." • Some side effects of the proposed medication were documented. Significant side effects, including weight gain, metabolic syndrome, neuroleptic malignant syndrome, tardive dyskinesia, and leukopenia were not included in the documentation. • Non-pharmacological interventions were included.	

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		• The plan to monitor this individual's response to the medication was documented. • The individual's mother agreed with the plan. <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 substantial compliance because, "all individuals have documentation of whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medications and whether reasonable alterative treatment strategies are likely to be less effective or potentially more dangerous than the medications." There were noted improvements in the documentation of the risk benefit analysis for psychotropic medications. It was noted that this was occurring in the psychiatry clinical encounter in collaboration with the IDT. There was comparison of the use of medication to non-pharmacological alternatives. HRC documentation had improved, however, there were deficits with relation to the inclusion of specific medication side effects. As was discussed in J14 below, the facility must obtain standardized medication side effect profiles from pharmacy staff to ensure completeness. Given the overall improvements, this provision will be rated in substantial compliance. In order to maintain this rating, standard medication side effect information provided by the pharmacy must be utilized.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class,	<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 9/19/13 was reviewed. Per these data: • The total number of individuals residing at the facility meeting criteria for polypharmacy related to psychotropic medications had decreased from 41 individuals in September 2012 to 34 individuals in August 2013. • The total number of individuals who met criteria for antipsychotic polypharmacy had decreased from six in December 2010 to two individuals in August 2013. • The average number of psychoactive medications prescribed for any individual	Noncompliance

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	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 and met criteria for polypharmacy had remained about the same from 3.67 in December 2010 to 3.52 in August 2013. A review of the active psychoactive medication list by drug class listing for August 2013 revealed that there were two individuals meeting criteria for intraclass polypharmacy for antipsychotic medications, three individuals with intraclass polypharmacy for antidepressant medications, three individuals with intraclass polypharmacy for benzodiazepines, three individuals with intraclass polypharmacy for sedative medication (including Trazodone and Melatonin), and two individuals with intraclass polypharmacy under miscellaneous (Benztropine, Lithium, Guanfacine, Propranolol). This was a total of 13 individuals. In the previous monitoring report, this number totaled eight individuals. There were an additional 38 individuals with intraclass polypharmacy for seizure medications (note, not all of these individuals were also participating in psychiatry clinic). Due to changes in staffing in the pharmacy, the clinical pharmacist was no longer able to attend psychiatry clinic. It was reported, however, that clinical consultation did occur, as the psychiatrist had contacted pharmacy staff regarding specific medication issues. In addition, the clinical pharmacist reported that all orders received in the pharmacy were reviewed, and if there were potential issues, the psychiatrist was contacted prior to dispensing. Per a review of the active psychoactive medication list by drug class provided by the facility pharmacy, there were 34 individuals who met criteria for psychotropic medication polypharmacy. It is notable that as there were a total of 60 individuals in psychiatry clinic, 56% 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 35 individuals prescribed antipsychotic medications at the facility (a decrease from 36 individuals during the previous monitoring review). Of these: • Two individuals were prescribed two antipsychotics (decreased from three during the previous monitoring review). • None were prescribed three antipsychotics. There were 43 individuals prescribed anxiolytic medications (a decrease from 50 individuals during the previous monitoring period). • Of these, three were prescribed two anxiolytic medications (an increase from one during the previous monitoring period).	

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		There were 26 individuals prescribed antidepressant medications (data regarding the previous monitoring review were not available). • Of these, three were prescribed three antidepressant medications. Of the 76 individuals prescribed psychotropic/seizure medication of any class in August 2013: • A total of 52 individuals were prescribed two or more psychotropic medications from the same class. The majority of these individuals (38) 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 increased 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 noted that there was comprehensive review of an individual's case and pharmacological regimen, however, this did not include the psychiatrist's justification per se, as the review was authored and presented by pharmacy staff. It was noted during the facility level review meeting that this forum should be the place for a lively discussion regarding reviews of the justification for polypharmacy derived during psychiatry clinic. This element was missing in the facility level review process observed by the monitoring team. Review of polypharmacy meeting minutes for the previous six months revealed documentation of a review of the rationale for polypharmacy and discussion regarding the regimens. It was considered that the presence of the monitoring team in polypharmacy meeting may have disrupted the process of the review. Review of Polypharmacy Justifications Documentation regarding polypharmacy dated 3/13/13 for Individual #50 stated, "IDT has tried to reduce polypharmacy by tapering off the clomipramine, but [individual] became decompensated, aggressive, and agitated, and therefore was restarted on it…has been tried off Geodon and Latuda, which did appear to help considerably his behaviors, so therefore at this point, the three medications are required for stabilization of his behaviors." In this example, this individual's increased symptom experience with attempts to reduce the medication regimen was discussed, indicating the need for polypharmacy.	

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		Documentation regarding polypharmacy dated 7/24/13 regarding Individual #72 stated "has a mental health plan which is tracking SIB and agitation in one parameter. The graph clearly shows a response to an increased dose of Zyprexa of 10 mg…and later to the increase of 20 mg of Zyprexa…but we will continue tracking results and obtaining graphic data in order to make a better data driven decision and determination." While this polypharmacy justification revealed the indication for treatment with Zyprexa, other medications prescribed including Trazodone and Paxil were not reviewed and, therefore, this justification was incomplete. Documentation regarding polypharmacy dated 8/9/13 regarding Individual #39 stated, "the recent graphic data speaks of lack of response to Trileptal, so the IDT agreed to challenge and start a…gradual dose reduction." This justification indicated plans to taper Trileptal, but did not offer information regarding the additional mediations this individual was prescribed including Seroquel, Klonopin, and Paxil. As such, this justification was incomplete. <u>Monitoring Team's Compliance Rating</u> Per the facility self-assessment, the facility was in substantial compliance with this provision as, per the self-rating, all individuals receiving polypharmacy "have justification and documentation of clinical justification." As per the examples above, review of the medical records did not reveal adequate justifications for polypharmacy. The facility must ensure a thorough facility level review of polypharmacy regimens and appropriately 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 on the individual's current status and/or changing needs, but at least quarterly.	<u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> In response to the document request for a spreadsheet of individuals who 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 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. 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.	Substantial Compliance

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		Training 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 8/23/13 to two nursing staff members classified as "newly hired employees." In addition, there was documentation of seven staff who had received MOSES/DISUS Avatar training. 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. Quality of Completion of Side Effect Rating Scales In regard to the quality of the completion of the assessments, it appeared that for the set of scales reviewed (10 examples of each assessment tool), all were completed and included the signature of the psychiatrist. 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 remained cause for concern because there was no documentation indicating that previous scores were compared to current scores. A review of psychiatric documentation for 13 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. 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 three individuals with a diagnosis of masked TD or possible TD. Data provided for previous monitoring periods reported up to 14 individuals identified with a diagnosis of TD. TD has a chronic course and is an irreversible movement disorder, therefore, these data were questionable. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Medication reduction or the absence of the antipsychotic or metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. To this end, as reported in previous monitoring reports, the facility psychiatrist reviewed individual records over a period of 10 years to identify individuals with a history of a TD diagnosis as	

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		noted above. Implementation of Avatar In the intervening period since the last monitoring report, the facility had implemented the Avatar system. This was an electronic database where information, including MOSES and DISCUS, results can be stored. While this was a good step, there were issues with the Avatar system. Specifically, Avatar only allowed for inclusion of the basic form with ratings for each individual exam. It did not allow for documentation of the clinical review of the examination, nor did it allow for an electronic signature of the reviewer. As such, although the forms were uploaded into Avatar, the facility continued with paper documentation in order to allow for this. Monitoring Team's Compliance Rating 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 and previous monitoring periods, it was apparent that there was more attention paid to the clinical correlation of information obtained via the MOSES and DISCUS. Previously, there were issues with regard to timeliness of clinical correlation due to delays in quarterly reviews, however this had sustained improvement compared to a prior review period where quarterly clinics were being conducted simultaneously with IDT meetings. As improvements in this area had been maintained, this provision will remain in 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 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	Policy and Procedure 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 revised 2/8/13 outlined procedures for the completion of specific psychiatry related tasks, and now included more information regarding the process for psychiatry clinic. There remained some omissions specifically the use of the integration tool. A new quarterly medication review format entitled, "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, polypharmacy justification, treatment response/symptoms reduction, gradual dose reductions, psychological data interpretation and analysis, medical/behavioral issues, risk/benefit analysis, DISCUS, MOSES, laboratory data, weight assessment, significant social/environmental/medical	Noncompliance

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	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.	changes, case formulation, medical/psychiatric drug interactions, strategies to decrease psychotropics, restraints/hospitalizations, pretreatment sedation strategies/medications/occurrences and outcome, assessment, and plan). <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 13 individuals, there were treatment plans for psychotropic medication included in the more recent "Quarterly Psychiatric Medication Review." 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) were not included in the revised "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 during the majority of this monitoring period, the schedule did not allow for their consistent attendance or participation in the ISP process. Data revealed that psychiatry had attended approximately 40% of the ISP meetings during this monitoring period. 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, one psychiatry clinic (for a total of two individuals) was 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. In all instances, the data were up to date, and graphs were improved over previous monitoring reviews. Improvements were noted regarding exchange of pertinent information during the psychiatric clinic; 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,	

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		although relevant, was insufficient if the goal was to implement an evidence-based approach in evaluating medication efficacy. In the previous monitoring report, it was noted that there were improvements in collaborative case formulations documented via the comprehensive psychiatric evaluations. During this review, there were challenges, as record review revealed that two of three individuals admitted during this monitoring period did not have comprehensive psychiatric evaluations performed per Appendix B (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 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 for a portion of this monitoring period, 90-day reviews of psychotropic medication were timely. A review of data regarding the dates of quarterly reviews revealed that all but one (i.e., 59 of 60 reviews) had been performed in the previous 90 days. There remained difficulties with regard to documentation of 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 had improved at EPSSLC and, as such, was approaching the generally accepted professional standard of care and practice in psychiatric medication management practices. <u>Monitoring Team's Compliance Rating</u> A review of a sample of 13 records revealed varying quality in documentation for the psychiatric reviews and omissions of the initial comprehensive psychiatric assessment via Appendix B in two of three individuals newly admitted to the facility. In addition, the new "Quarterly Psychiatric Medication Review" omitted required elements including 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. Given the noted	

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		deficiencies, the facility remained in noncompliance for this item, in conflict with the facility self-assessment. In order to reach substantial compliance, the above noted issues must be addressed.	
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." In addition, it was reported that DADS was in the process of developing a statewide policy and procedure entitled "Consent for Psychotropic Medications." A draft of this policy was provided to the monitoring team for review. Pending the implementation of the DADS statewide policy, the facility had included the process for informed consent in the facility specific policy and procedure entitled "Psychiatry Services" dated 11/30/12 revised 2/8/13. With the latest revisions, this policy and procedure outlined the process via which informed consent for both emergency and routine treatment with psychotropic medications must be obtained. In addition, based on recommendations provided during the previous monitoring review, the "Consent for use of Psychoactive Medication for Behavior Support" form had been updated. The new form included space to log attempts to contact the LAR in order to obtain verbal consent via telephone. The form still did not include a space for the signature of the staff member responsible for obtaining informed consent (per generally accepted professional practice, this must be the prescribing practitioner). It was also noted that the medications side effects profile information was being typed into the document for each individual consent. It was recommended that in order to decrease clinic workload and ensure accuracy, that psychiatry clinic staff obtain standard medication side effects information from their facility pharmacy. <u>Current Practices</u> 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 were requested for review. These documents revealed that the facility was in the process of a transition from the use of previous forms and processes performed by nursing staff to the newly designed "Consent for use of Psychoactive Medication for Behavior Support" form. Of the 10 examples provided, two utilized the newly implemented form. Per interviews with facility staff, the responsibility for informed consent had shifted to psychiatry clinic as of 6/1/13.	Noncompliance

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		As discussed above, there were concerns with the examples utilizing the newly developed form provided for Individual #50 and Individual #18 with regard to the inclusion of medication side effect information. In both examples, only the most common side effects were included. As noted above, standardized side effect information, obtained via the pharmacy, should be provided to the individual or their LAR. Furthermore, in discussions with psychiatry clinic staff, it was reported that the responsibility for contacting the LAR and obtaining informed consent had been delegated to the psychiatric nurse. 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. In the previous monitoring review, concerns regarding the utilization of antipsychotic medication were discussed. At that time, of a total of 10 new medications prescribed, seven were antipsychotic medications. For this review, of the 10 new medications prescribed, three were antipsychotic medications. Mediation prescribing trends should be continuously monitored and reviewed by the facility. Monitoring Team's Compliance Rating This provision remained in noncompliance, in disagreement with the facility self-assessment, due to the inadequate informed consent practices noted above. In order to obtain substantial compliance, it is necessary that the prescribing practitioner disclose to the individual or their LAR all information necessary for informed consent, documenting appropriately. It is also necessary that the facility utilize standardized information regarding specific psychotropic medications, providing this information to the individual or their LAR.	
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	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 11/30/12 revised 2/8/13 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	Substantial Compliance

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	and a mental health disorder.	<u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> A list of individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder included 44 individuals. At the time of the previous review, there were 41 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 24 months. Records revealed that of the 44 individuals identified above, 38 were seen in Neuro-Psychiatry clinic in the previous six months. There were 6 individuals where there were no data provided regarding Neuro-Psychiatry clinic attendance. This was concerning. It was considered that this might have been a data error. In order to maintain substantial compliance ratings, data regarding Neuro-Psychiatry follow-up must be improved. Documentation from Neuro-Psychiatry clinic was reviewed. There was notation of collaboration between the neurologist and the psychiatrist in each of the three 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 a potential issue. For example, Individual #52 had undergone a taper and discontinuation of seizure medications given a questionable history of seizure activity. Due to this individual's level of agitation, it was not possible to obtain an EEG. Data indicated that in the absence of seizure medication, this individual experienced an episode where she urinated on herself, a potential sign of seizure activity. It was noted that at the time, this individual may have had a urinary tract infection, or her toileting schedule may have been disrupted. There was no documentation regarding the presence or absence of other symptoms suspicious for seizure activity. As this event was not adequately documented by staff that witnessed the incident, the clinical consultation was limited. In addition, during the clinic observation, there was discussion regarding a potential diagnosis of dementia for Individual #52, a 56-year-old female with a diagnosis of Down's Syndrome. This individual had reportedly experienced some deterioration in her functional abilities.	

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		Consideration of this diagnosis was not reflected in the clinical documentation. During this clinic, family members of one individual were present. 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 44 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. <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 continued 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 potential issues with data provided, where the dates of the most recent Neuro-Psychiatry clinical encounter were not included. In order to maintain a substantial compliance rating in upcoming monitoring visits, these data must be presented accurately, indicating that each individual requiring Neuro-Psychiatry clinical consultation received it within the calendar year. In addition, the need for staff training with regard to documentation of possible seizure activity, noted in previous reports remained an issue. This provision will remain in substantial compliance.	

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 Functional Assessments for: • Individual #39 (5/16/13), Individual #120 (5/2/13), Individual #148 (6/27/13), Individual #126 (5/8/13), Individual #9 (4/22/13), Individual #18 (5/10/13), Individual #52 (6 /27/13), Individual #10 (5/22/13), Individual #23 (4/24/13), Individual #128 (4/16/13), Individual #104 (9/3/13), Individual #7 (8/23/13), Individual #78 (9/9/13) o Positive Behavior Support Plans (PBSPs) for: • Individual #39 (5/16/13), Individual #120 (5/2/13), Individual #148 (6/27/13), Individual #126 (5/8/13), Individual #9 (4/22/13), Individual #18 (5/10/13), Individual #52 (6 /27/13), Individual #10 (5/22/13), Individual #23 (4/23/13), Individual #128 (4/16/13), Individual #119 (5/14/13), Individual #104 (9/3/13), Individual #7 (8/23/13), 112 (5/14/13) o Annual Psychological updates for: • Individual #7 (6/21/13), Individual #111 (7/16/13), Individual #99 (6/17/13), Individual #105 (6/27/13), Individual #144 (6/17/13), Individual #108 (3/25/13), Individual #17 (7/4/13), Individual #75 (6/25/13), Individual #51 (6/25/13), Individual #107 (1/31/13) o Six months of progress notes for: • Individual #39, Individual #120, Individual #148, Individual #126, Individual #9, Individual #18, Individual #52, Individual #10, Individual #23, Individual #128 o Psychological treatment plans and progress notes for: • Individual #13, Individual #7, Individual #10, Individual #37, Individual #120 o PBSP readability scores (Flesch-Kincaid) for: • Individual #10, Individual #9, Individual #7, Individual #104, Individual #39, Individual #119, Individual #23 o El Paso State Supported Living Center Provision Action Information Updated: 08/28/13 o Mental Health Plan Policy and Procedures, 2013 o Section K action plan, 8/29/13 o Spreadsheet of PBSP dates, consent dates and psychological updates, undated o Spreadsheet IOA, treatment integrity, and data collection reliability across all individuals with a PBSP o SAP Concepts and Definitions, 9/9/13 o Sample data cards, undated o Data card policy, 8/20/13 o Data cards, duration data collection, low frequency data collection o Data entry policy, 8/2/13

	o Behavior data change policy, 6/18/13 o Missing data card policy, 6/19/13 o Data card filing policy, 6/19/13 o Data card spot check form, 6/17/13 o IOA blank form, 7/2/13 o Treatment integrity monitoring policy, 6/17/13 o Treatment integrity, IOA, data collection reliability data sheet, 7/24/13 o Tier system criteria, 7/17/13 o Section K Presentation Book, undated o Data collection reliability, IOA, and treatment integrity data across all treatment sites for June, July, and August, 2013 o Session Psychology Services Referral form, undated o Summary of all treatment integrity and IOA checks for the previous six months o List of full psychological assessment dates for all individuals, undated o Monthly progress note format, undated o FBA/BSP Review form, 5/15/13 o Psychological Testing Referral form, 5/13 o Monitoring for Behavior Support Plan form, 6/17/13 o List of individuals who attended public school (one) o ISPs, ARD/IEPs, and EPISD progress notes for: • Individual #35 <u>Interviews and Meetings Held</u>: o Carmon Molina, Director of Psychology o Angelin Clarke, Associate Psychologist o Carmon Molina, Director of Psychology; Angelin Clarke, Associate Psychologist; Martha Davis, Associate Psychologist; Mario Rodriquez, Associate Psychologist o Joana Alferez, Director of residential services o Rosa Renteria, QIDP, EPISD Liaison, Alice Villalobos, QIDP Coordinator, Melissa Gongaware, ADOP <u>Observations Conducted</u>: o Peer Review Meeting o Staff present: Carmen Molina, Director of Psychology; Marisela Franco, Associate Psychologist; Martha Davis, Associate Psychologist; Mario Rodriquez, Associate Psychologist; Angelin Clarke, Associate Psychologist, Dr. Rice, Psychiatrist o Individual presented: Individual #18 o Neurology/Psychiatry Clinic o Individuals presented: Individual #52, Individual #38 o Psychiatry/Psychology Integration meeting o Psychiatric Clinic o Individual presented: Individual #89 o Observed treatment integrity session

	o Individual's plan: Individual #129 o ISPA for: o Individual #161 o Observations occurred in 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, the self-assessment included relevant activities in the "activities engaged in" sections. 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. Some provision items in this self-assessment, however, did not include activities that were identical to those found in monitoring teams 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 in 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 K2, K3, K4, K7, K8, K9, K10, and K11 were in substantial compliance. The monitoring team's review of this provision found K2, K3, K4, K7, K10, and K11 to be in substantial compliance and noncompliance for all other provision items. The reasons for the discrepancy concerning items K8 and K9 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 two additional items rated as in substantial compliance (K4 and K10). Additionally, the facility maintained substantial compliance on the four items (K2, K3, K7, and K11) that were in substantial compliance prior to this review. A summary of these improvements are listed below and described in detail below: • Establishment of a more flexible data system (K4) • Evidence of data-based treatment decisions (K4) • Monthly progress notes for all individuals with positive behavior support plans (PBSPs) (K4) • Evidence that in those instances when an individual was not making expecting progress, the progress note consistently indicated that some activity to address the lack of progress had occurred (K4) • Initiation of the collection of interobserver agreement (IOA) for every PBSP (K4, K10) • Demonstration that minimal frequencies and levels of data collection reliability and IOA were achieved (K4, K10) • Improvements in the number of individuals with PBSPs with current functional assessments (K5) • Development of a referral system to ensure that all individuals that need psychological services, other than PBSPs, receive them (K8) • Demonstration that all individuals with a PBSP had necessary consents (K9) • Expansion of the collection of treatment integrity to every PBSP (K10) • Demonstration that minimal frequencies and levels of treatment integrity were achieved (K10) The areas that the monitoring team suggests that EPSSLC work on for the next onsite review are: • Improve the quality of the functional assessments (K5) • Ensure that all psychological services other than PBSPs treatment plans contain a plan to generalize skills learned (K8) • Ensure that PBSPs are consistently implemented within 14 days of receiving consent (K9) • Ensure that every staff assigned to work with an individual, including float/relief staff, has been trained in the implementation of his or her 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	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all associate psychologists at EPSSLC who wrote Positive Behavior Support Plans (PBSPs) were board certified behavior analysts (BCBAs). Five of the five staff that wrote PBSPs (100%) either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. This is similar the last review when 100% of the facility's associate psychologists that wrote PBSPs were enrolled in or completed BCBA coursework. The facility maintained one BCBA that wrote PBSPs (the	Noncompliance

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	have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	department director). The department director provided supervision of associate psychologists enrolled in the BCBA program. EPSSLC and DADS are to be commended for their efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each associate psychologist's BCBA training and credentials. To achieve substantial compliance with this provision item, it is recommended that EPSSLC ensure that all associate psychologists who write PBSPs attain BCBA certification.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility continued to be in substantial compliance with this item. The director of psychology had a master's degree, was a BCBA, and had more than five years of experience working with individuals with intellectual disabilities. Additionally, under the 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 continued to be in substantial compliance with this provision item. EPSSLC continued its weekly internal, and monthly external, peer review meetings. In addition to the review of PBSPs requiring annual approval (i.e., Behavior Support Committee meeting), the internal peer review meetings provided an opportunity for associate psychologists to present new cases or those that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #18's functional assessment and PBSPs. The peer review meeting included active participation from all of the department's associate psychologists, and appeared to result in a clearer understanding of the environmental and biological variables affecting this individual's target behaviors. Review of minutes from internal peer review meetings indicated that the majority of associate psychologists in the department regularly attended peer review meetings. Additionally, meeting minutes from the last six months indicated that internal peer review meetings occurred weekly, and that once a month, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Finally, there was evidence of the implementation of recommendations made in peer review (e.g., Individual #13).	Substantial Compliance

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		Operating procedures for both internal and external peer review committees were established, and were consistent with this provision item. In order to maintain substantial compliance, EPSSLC needs to provide documentation that internal peer review consistently occurred weekly, external peer review consistently occurred at least monthly, and evidence of follow-up/implementation of recommendations made in peer review.	
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.	Since the last review, EPSSLC increased the flexibility of the data system, demonstrated the consistent use of data-based treatment decisions, and ensured that every individual with a PBSP had monthly progress notes that consistently documented activity (e.g., retraining of staff, modification of PBSP) had occurred to address the lack of progress. Additionally, the facility demonstrated that their data were reliable by developing a facility-wide inter-observer agreement (IOA) collection procedure, and demonstrating that minimal frequencies and levels of data collection reliability and IOA were achieved. Therefore, this item is now rated as being in substantial compliance. EPSSLC used data cards to collect target and replacement behaviors for all individuals with a PBSP or mental health plan. Direct support professionals (DSPs) were required to record a "yes" if the target and/or replacement behavior occurred during 60-minute intervals or a "no" if it did not occur during that interval. One advantage of the data card system was that it was easy for DSPs to access (they carried the cards with them at all times) and, therefore, increased the likelihood that data were recorded every hour. All DSPs interviewed by the monitoring team indicated that the data cards were convenient to use. Since the last review, the facility increased the flexibility of its data system by adding the capability to measure the duration of target behaviors for target behaviors where the duration of the behavior was the most meaningful measure (e.g., episodes of disruptive behavior), and the capability to collect antecedents and consequences of target behaviors to better understand very low frequency or new target behaviors. In subsequent reviews, the monitoring team will review the use of this new flexible data system to ensure that all measures are utilized as needed. As reported in the last review, the facility had begun recording data collection reliability to ensure 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 associate psychologist or psychology assistant who reviewed the data cards also provided performance feedback to the DSPs 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 August 2013.	Substantial Compliance

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		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 15 of 16 data cards reviewed (94%) were completed within the previous 60 minutes. This represented a dramatic improvement from the last review when 67% of data cards reviewed were completed within 60 minutes of the behavior occurring, and was consistent with the facility's data (93%). EPSSLC established goal frequency (i.e., how often it is measured) and levels (i.e., what are acceptable scores) for data collection reliability. They determined each individual with a PBSP would have two data collection reliability measures per month. Additionally, the facility established that data collection reliability measures would initially be at or above 70%. The facility indicated that as they developed their measures of data collection reliability, they would attempt to gradually increase their goal level to 80%. The monitoring team is supportive of this approach to improving the timeless of data collection at EPSSLC Data provided to the monitoring team indicated that data collection reliability frequency and levels established were achieved for June 2013, July 2013, and August 2013. For example, data collection reliability occurred twice a month for 95% of individuals with a PBSP in the month of August 2013. Additionally, data collection reliability levels averaged 93% for individuals with a PBSP in the month of August 2013. Another improvement was that EPSSLC recently began to collect IOA for every individual with a PBSP. 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. The facility established that IOA would be collected twice a month for every individual with a PBSP and the level would be at or above 70%. As discussed above concerning data collection reliability, the facility planned to gradually increase the goal level of IOA to 80%. June 2013, July 2013, and August 2013 data exceeded these goal frequencies and levels of IOA. For example, August 2013 data indicated that 89% of individuals with a PBSP had two IOA measures, and the average level of IOA was 91%. All the graphs reviewed by the monitoring team were simplified by reducing the number of data paths and adding of phase lines to mark medication changes and/or other potentially important events. The routine use of data to make treatment decisions also improved from the last review. In past reviews, current data were not consistently present at interdisciplinary meetings. During this onsite review, however, every individual discussed in psychiatry and neurology/psychiatry clinic had data current to the previous day, therefore, contributing to data based decisions concerning the use of	

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		medications or interventions. For example, in Individual #38's neurology/psychiatry clinic, the associate psychologist presented simplified graphs and current data. The treatment team noted an increase in self-injurious (SIB) behavior last month and the discussion quickly turned to the consideration of additional medication. The associate psychologist, however, had recent data that indicated that Individual #38's rate of SIB was zero for the first half of the current month. Based on the most current data, the treating psychiatrist decided to continue on his current medication regime. Monthly progress notes were available for 10 of 10 individuals (100%) with PBSPs reviewed. This represented another improvement from the last review when 88% of individuals reviewed had progress notes. Additionally, in every individual in whom progress was not occurring, there was evidence of action to address the lack of progress (e.g., modification of the PBSP, or retraining of staff). For example: • Individual #39's 3/7/13 progress note indicated that his lack of progress may be related to him not sleeping at night. The action to address Individual #39's lack of sleep was to begin sleep medications, ensure he was active during the day, and develop a sleep routine. In future reviews, the monitoring team will sample actions recommended to address the absence of progress to ensure that it had occurred. In reviewing six months of PBSP data for 14 individuals, seven (50%) indicated improvement, or stable and low levels, of severe target behavior, such as aggression or self-injurious behavior. This was consistent with the last review when 50% of the PBSP data reviewed indicated decreases or low stable levels of severe target behaviors. EPSSLC staff are to be commended for their progress on this provision item. In order to maintain substantial compliance with this provision item, EPSSLC needs to ensure that the data system is simple and flexible, and that all measures (e.g., frequency, duration) of target and replacement behaviors occur when necessary. Additionally, the facility needs to ensure that that goal frequencies of data collection reliability and IOA are achieved, goal levels of data collection reliability and IOA are achieved, and there is evidence that data were used to make treatment decisions in at least 80% of observed meeting. EPSSLC also needs to ensure that IOA and data collection reliability measures occur across all treatment sites and during both 1st and 2nd shift. Finally in order to maintain substantial compliance, the facility needs to ensure that at least 90% of individuals with PBSPs have monthly progress notes, including an indication of action to address the absence of progress.	

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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.	There were improvements in this provision item. It was rated as being in noncompliance, however, due to the absence of full psychological assessments for each individual, and the absence of complete functional assessments for each individual with a PBSP. <u>Full Psychological Assessments</u> A list of all individuals and dates of their full psychological assessments indicated that 15 of the 116 individuals at the facility (13%) did not have an initial full psychological assessment. This is the same percentage of individuals that did not have a full psychological assessment in the last review. No full psychological assessments were reviewed in this report because none were completed since the last review. All individuals at EPSSLC should have a 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 25 of 27 individuals with a PBSP (93%) had a current (i.e., revised/reviewed within one year) functional assessment. This represents a substantial increase from the last review when 21% of individuals with a PBSP had a current functional assessment. A list of functional assessments' most recent review/revision dates indicated that all 25 functional assessments were completed in the last six months. Thirteen of those functional assessments (52%) were reviewed to assess compliance with this provision item. The last review only included two functional assessments that were completed in the previous six months. These discrepant sample sizes limit the value of comparisons of this review with those from the last report. Therefore, comparisons to the previous report will be omitted for the remainder of this provision item. All 13 functional assessments reviewed (100%) included all of the components commonly identified as necessary for an effective functional assessment. The quality of some of these components, however, was judged to be insufficient for the functional assessments to be as effective as they could be. Ideally, all functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated observations of the individual, and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect procedures can contribute to understanding why a target behavior occurred by conducting/administering questionnaires, interviews, or rating scales.	Noncompliance

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		All 13 functional assessments reviewed (100%) included appropriate indirect assessment procedures. Twelve of the 13 functional assessments reviewed (92%) utilized direct assessment procedures that were rated as complete. An example of a complete direct assessment procedure was: • Individual #78's functional assessment described direct observations of her engaging in SIB across four conditions arranged by her psychologist (a functional analysis) that suggested that her target behavior was maintained by automatic reinforcement. The one functional assessment rated as having an incomplete direct assessment (Individual #120) included direct observations, but none of those observations included an example of the target behavior and, therefore, did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. The psychologist noted that Individual #120 tended to not display his target behaviors in the presence of the psychologist, however the frequency of his targets appeared to be relatively high, therefore, other direct assessment methods, such as the collection of ABC (i.e., the systematic collection of both antecedent and consequent behavior) data should be attempted. It is recommended that all functional assessments include direct observation procedures that include observation of the target behavior (or an explanation why that was not possible), and provide information about relevant antecedent and/or consequent events affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. When comprehensive functional assessments are conducted, there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Nine of the 13 functional assessments reviewed (69%) included a clear summary statement. The other five functional assessments (i.e., Individual #120's, Individual #39, Individual #148, and Individual #18's) appeared to present several potential antecedents and consequences, but did not clearly identify the most important antecedent and consequences and simply concluded that many variables (i.e., positive attention, tangible items, escaping or avoiding unpleasant activities/situations and automatic reinforcement) are contributing to target behaviors. Clearly, there can be many variables affecting an individual's target behaviors. An	

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		effective functional assessment, however, will attempt to critically evaluate the role of those variables and identify (i.e., summarize) those antecedent and consequent conditions hypothesized to be most critical. Functional assessments that simply list every antecedent and consequent that could possibly affect a target behavior tend to be not very useful for developing an effective PBSP. An example of a functional assessment that appeared to do a good job of summarizing the most critical antecedent and consequent variables that would likely result in an effective PBSP was: • Individual #23's indirect measures of the functional assessment included reports that target behaviors were the result of escape from undesired activities, social attention, and access to preferred items. Direct observations suggested that target behaviors occurred most often when drinks were present, and occasionally resulted in Individual #23 getting access to drinks. The psychologist expanded the direct observation by "experimenting" with various types of drinks, and finally hypothesized that Individual #23's target behaviors were most likely to occur when coffee (or other dark colored drinks) was present, and were maintained by access to those drinks. This hypothesis resulted in an effective PBSP that included providing Individual #23 small portions of coffee when he appropriately requested it. Nine (i.e., Individual #126, Individual #9, Individual #52, Individual #128, Individual #23, Individual #10, Individual #7, Individual #78, and Individual #104) of the 13 functional assessments reviewed (69%) were evaluated to be comprehensive and clear. EPSSLC made progress in this provision item by ensuring that 93% of individuals with a PBSP had a current functional assessment. It is recommended that, over the next six months, the facility now focus on improving the quality of the functional assessments.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	EPSSLC's full psychological assessments were not current, therefore, this provision item was rated as being in noncompliance. None of the 103 individuals with full psychological assessment (0%) was conducted in the last five years. This compares to the last review when 1% of the full psychological assessments were completed 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.	EPSSLC continued to be in substantial compliance with this provision item. In addition to full psychological assessments, EPSSLC completed annual psychological updates. A spreadsheet provided the monitoring team indicated that current (i.e., reviewed/revised at least every 12 months) annual psychological updates were completed for all individuals at EPSSLC. A spreadsheet indicated that 58 annual psychological updates were completed in the last six months, and 10 (17%) of these were reviewed by monitoring team to assess their comprehensiveness. All 10 of the annual psychological updates reviewed (100%) were complete and contained a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status. Additionally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that all individuals admitted to the facility in the last six months had psychological assessments within 30 days of admission. In order to maintain compliance with this item of the Settlement Agreement, at least 90% of the individuals at the facility will need to have an annual psychological update, and at least 85% of those assessments will need to be judged as complete (i.e., contain a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status). Additionally, at least 85% of individuals admitted to the facility in the last six months will need to have a psychological assessment completed within 30 days of admission.	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, the monitoring team did not believe this item was in substantial compliance because the treatment plans for psychological services other than PBSPs did not consistently include procedures/plans to generalize skills learned. At the time of this onsite review, five individuals participated in counseling and/or psychotherapy. This represents an increase from the last review when two individuals received psychological services other than PBSPs. Treatment plans and progress notes for all five of these individuals (100%) were reviewed to determine progress with this provision item. The treatment plans reviewed included the following: • A plan of service • Goals and measurable objectives	Noncompliance

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		• 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 Two (i.e., Individual #7 and Individual #120) of the five treatment plans reviewed (40%) did not include procedures/plans to generalize skills learned. Improvements since the last review include the establishment of a referral system for psychological services other than PBSPs, the documentation of the need for these services in monthly progress notes, and the inclusion of a review of progress. Over the next six months it is recommended that EPSSLC ensure that each treatment plan have procedures/plans to generalize skills learned. In order to achieve substantial compliance with this provision, the facility will need to demonstrate that at least 85% of psychological services other than PBSPs contain the following: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	
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's self-assessment indicated that this item was in substantial compliance. Although there were improvements in this area, this provision item was rated as being in noncompliance because PBSPs were not documented to be consistently implemented within 14 days of receiving consent. A list of individuals with PBSPs indicated that 27 individuals at EPSSLC had PBSPs. In the last review, the facility had 43 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. DADS recently developed a policy on the use of mental health plans. 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.	Noncompliance

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	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.	During this review, the monitoring team did not encounter any examples of an individual who had a mental health plan, but for whom a PBSP would have been more appropriate. Individual #13 did not have a mental health plan or a PBSP, however, ISPA documentation and reports from the facility director and the director of psychology indicated that a new PBSP was being developed. A list of all PBSPs and the date of last revision indicated that all 27 were current (i.e., revised in the last 12 months). Additionally, this list indicated that all individuals with a PBSP (100%) had the necessary consents. This represented an improvement from the last review when 5% of individuals with PBSPs did not have the necessary consent. The self-assessment indicated that the facility reviewed five recent PBSPs and found that all of them were implemented within 14 days of receiving consent. Documentation provided the monitoring team, however, indicated that 19 of the 27 PBSPs (70%) were implemented within 14 days of obtaining consent. This represents an improvement from the last review when there was no evidence that PBSPs were implemented within 14 days of receiving consent. EPSSLC should ensure that all PBSPs are implemented within 14 days of receiving necessary approvals and consents. Seventeen PBSPs were completed/revised since the last review, and 14 (82%) of these were reviewed to evaluate compliance with this provision item. All 14 PBSPs reviewed included descriptions of target behaviors and, as found in the last review, all of these were operational (100%). All of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but two (i.e., Individual #120 and Individual #112) of these (14%) 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 was similar to the last review when 12% were judged to be inconsistent with the stated function. An example of a consequent intervention potentially incompatible with the hypothesized function was: • Individual #120's PBSP hypothesized that his disruptive/destructive behavior was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). The antecedent procedure was consistent with his hypothesized function and included encouraging him to communicate what he wanted. The consequent interventions in Individual #120's PBSP, however, included removing him from the environment following an episode of disruptive/destructive behavior. If avoiding undesired situations was reinforcing for Individual #120 (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of his disruptive behavior.	

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		Encouraging (and allowing) him to indicate that he wanted to leave the area BEFORE he engaged in physical aggression represented an effective antecedent intervention. After the targeted behavior occurred, however, Individual #120 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of his disruption and destruction is such that it is dangerous to maintain him in the activity or situation, then the PBSP should specify his return to the activity when he is calm, and again encourage him to escape or avoid the demand by using desired forms of communication (i.e., replacement behavior) before he engages in physical aggression. The PBSP needs to clearly state that removal of the undesired activity should be avoided following the target behaviors, whenever possible and practical, because it encourages future undesired behavior. An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #9's PBSP hypothesized that the function of her SIB was to gain others' attention and gain desired items. Antecedent interventions included providing her with staff attention for the absence of target behaviors every 10 minutes, and encouraging/reinforcing her for engaging in her replacement behavior (i.e., telling staff what she wanted) before she engaged in SIB. Her intervention following SIB included ensuring safety, but minimizing attention to Individual #9. 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 was consistent with the last review when 100% of replacement behaviors that could be functional were judged to be functional. When the replacement behavior requires the acquisition of a new behavior, it should be written as a skill acquisition plan (see S1). If, however, the replacement behavior is currently in the individual's behavioral repertoire (as appeared to be the case in the majority of PBSPs reviewed), the replacement behavior does not need to be written in	

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		the skill acquisition plan (SAP) format. As found in the last review, all 14 PBSPs reviewed (100%) included the reinforcement of replacement/alternative behaviors. Overall, 12 (Individual #120 and Individual #112 were the exception) of the 14 PBSPs reviewed (86%) represented examples of complete plans that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions clearly based on the results of the functional assessment. This was similar to the last review when 88% of the PBSPs reviewed were judged to be acceptable. In order to achieve substantial compliance with this provision item, the facility now needs to document that at least 80% of PBSPs are implemented within 14 days of receiving consent, and maintain the quality of the PBSPs.	
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.	Since the last review, EPSSLC expanded the collection of treatment integrity to every PBSP. Additionally, the facility achieved goal minimal frequencies and levels of treatment integrity. Therefore, this item is now rated as being in substantial compliance. At the time of the onsite review, IOA of target and replacement behaviors was collected for each individual with a PBSP. As discussed in K4, the facility established that IOA would be collected twice a month for every individual with a PBSP and the level would be at or above 70%. June 2013, July 2013, and August 2013 data exceeded these goal frequencies and levels of IOA. For example, August 2013 data indicated that 89% of individuals with a PBSP had two IOA measures, and the average level of IOA was 91%. Since the last review, EPSSLC also expanded the collection of treatment integrity from 74% to 100% of the PBSPs. Additionally, the facility established that treatment integrity would be collected twice a month for every individual with a PBSP and the level would be at or above 70%. As discussed in K4 concerning data collection reliability and IOA, the facility indicated that as they developed their measures of treatment integrity, they would attempt to gradually increase their goal level to 80%. June 2013, July 2013, and August 2013 data exceeded these goal frequencies and levels of treatment integrity. For example, August 2013 data indicated that 92% of individuals with a PBSP had two treatment integrity measures, and the average level of treatment integrity was 74%. Finally, the monitoring team observed the collection of treatment integrity, and found the treatment integrity tool and procedures to be appropriate for assessing if PBSPs were implemented as written. Target and replacement/alternative behaviors were consistently graphed. 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 (see K4).	Substantial Compliance

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		EPSSLC staff are to be commended for their efforts to achieve substantial compliance on this provision item. In order to maintain substantial compliance with this provision item EPSSLC needs to ensure that graphs contain target and replacement behaviors and are useful for making data based decisions. Additionally, the facility needs to ensure that goal frequencies and levels of treatment integrity and IOA are 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. Therefore, EPSSLC continued to be in substantial compliance with this provision item. The psychology department reviewed all PBSPs that were presented in peer review and the Behavior Support Committee to ensure that they were simple, clear, and written in a style that would promote staff understanding. The monitoring team reviewed 14 PBSPs written in the last six months and concluded that they were written in a manner that DSPs were likely to understand. The PBSPs reviewed, for example, were consistently brief and concise, contained a minimal number of target behaviors (the monitoring team's sample averaged 2.4 target behaviors per PBSP reviewed), and technical language appeared to be kept at a minimal. As an objective measure of the readability of PBSPs, EPSSLC monitored the reading level (using the Flesch-Kincaid Readability score) of a sample of PBSPs written in the last six months and determined that they averaged an 7.7 reading level. Finally, the monitoring team also asked several DSPs across all treatment sites if they could understand the PBSPs, and all DSPs indicated that the plans were simple, clear, and easy to understand.	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. No trainings of staff on a PBSP occurred during the onsite visit, therefore, the monitoring team could not observe the training of DSPs on individual PBSPs. During past reviews, however, trainings was been found to be very positive and thorough and included a review of the PBSP by a member of the psychology department, an opportunity for DSPs to ask questions covering varying aspects of the PBSP, and written questions pertinent to each individual's PBSP.	Noncompliance

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		The facility indicated that they maintained inservice logs on all staff training. They reported, however, that float staff were inserviced by the residential charge staff and they did not know the method used to train these staff. 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/relief staff, has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	
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 116 individuals and employed five psychologists responsible for writing PBSPs. Additionally, the facility employed two psychology assistants and three psychology technicians. One of these psychologists had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least four psychologists with BCBAs.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 5/15/13 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/Internal 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 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 #161 Individual #52, Individual #119 Individual #123 Individual #117, Individual #4, Individual #162, Individual #9, Individual #113, Individual #109 o Annual Medical Assessments the following individuals: • Individual #99, Individual #7, Individual #105, Individual #108, Individual #157, Individual #71, Individual #73, Individual #169, Individual #117, Individual #30, Individual #39, Individual #195, Individual #77, Individual #172, Individual #149

	o Neurology Notes for the following individuals: • Individual #24, Individual #25, Individual #59, Individual #1, Individual #75 Individual #115, Individual #84, Individual #89, Individual #125, Individual #172 <u>Interviews and Meetings Held</u>: o Elaine Lichter, RN, Interim Clinical Services Director o Pam Richards, DO, Contract Primary Provider o Maria G. Famatigan, MD, Contract Primary Provider o Ramesh Komaragiri, MD, Contract Primary Provider o Eugenio Chavez-Rice, MD, Psychiatry Director o Laura Cazabon-Braly, Facility Director o May Ann Clark, RN, Chief Nurse Executive <u>Observations Conducted</u>: o Daily Medical Provider Meetings o Neurology Clinic o Weight Committee Meeting o ISPA for Individual Acosta o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting
	Facility Self-Assessment: EPSSLC submitted three documents in support of its assessment: the Self-Assessment, Provision Action Information, and Action Plan. The facility's lead acknowledged that a great deal of work was needed to improve the self-assessment. The monitoring team agreed that overall, the assessment did not provide a valid measurement of the current status of the facility with regards to the Settlement Agreement because it did not measure the relevant areas of the agreement. Many of the tools used were also not reliable and yielded inconsistent results. This finding was particularly evident in the assessment of section L2. The self-assessment indicated that Round 7 of the internal and external audits completed, however, both the internal and external audits were not completed in accordance with state guidelines. Therefore, inter-rater reliability could not be accurately established. While the same records were audited, the internal and external audits were conducted more than three months apart. Not surprisingly, the results were not similar. The self-assessment for section L2 did not reflect the fact that the medical management audits were not completed as required. The intent of the self-assessment is to assist the facility in gaining knowledge of the areas that require improvement in order to achieve substantial compliance as well as acknowledge those areas in which progress has been made. Achieving these goals requires the accurate measurement of the right things. The facility lead should review the topics, and recommendations in this report. Future self-assessments should include, but not be limited to, the type of activities and assessments documented by the

	monitoring team. The monitoring team also noted that the Provision Action Information provided no comments for most of the provision items over the past two years. The action plan described a series of steps that would be taken to move towards substantial compliance. However, most of these were started just prior to the compliance review. The facility rated itself in noncompliance with all four provision items. The monitoring team concurred with these self-ratings.
	Summary of Monitor's Assessment: The medical department continued to face a multitude of challenges. During the March 2013 compliance review, the monitoring team was advised by state office that the provisions of the Settlement Agreement had not been addressed. Providing basic medical care had been the focus of the interim medical director. In May 2013, an interim clinical services director was appointed to administratively manage many of the issues related to the Settlement Agreement. Then, the interim medical director resigned in August 2013. There were three part time physicians, two of whom worked on contract and did not take call. While the facility had capable clinical staff, they were not involved in many of the processes of the Settlement Agreement. They did, however, respond to the direction of the interim clinical services director by completing Annual Medical Assessments, Quarterly Medical Assessments, documenting consults, and performing other duties. They performed in the clinical roles typical for physicians. There was no designated lead physician or medical director who was responsible for the development and oversight of health care services or who fully understood the regulatory requirements of a long term intermediate care facility and the requirements of the Settlement Agreement. This had been lacking at the facility for quite some time. While on the surface it appeared that progress was made, the mark was missed in many areas because the details of the Settlement Agreement and/or Health Care Guidelines were not given proper attention. This was unfortunate and probably the result of the lack of the consistent leadership by someone who was fully aware of the requirements of the Settlement Agreement. Overall, the primary providers did a good job with basic and preventive care. The core immunizations were provided, but additional attention was needed in this area. The required vision and hearing screenings were completed for all individuals reviewed. Compliance with colorectal cancer screening was very good. Screening for prostate cancer decreased and the reason was not clear because the facility did not change the guidelines. The documentation for cervical cancer screening was vague and there was a significant change in the number of individuals and type of data reported. Annual and quarterly medical assessments were current, however, the compliance for timely completion for annual assessments was quite low. Completion of the quarterly assessments was a notable

	improvement. The lack of assigned caseloads in the past resulted in issues with continuity of care. Even with the assignment of caseloads, the absence of any full time providers continued to present challenges, which were manifested in a number of ways. Physician participation in meetings was not optimal even when it did occur. The transitioning of caseloads between providers in health care historically presents opportunities for gaps in care. This was certainly the case at EPSSLC. Overall, however, many of the problematic trends appeared to be decreasing in the weeks leading up to the compliance review. There appeared to be less verbal orders associated with a lack of physician assessment. This may have been due to the part time physician assuming the on-call role. Documentation and follow-up of labs and consults was also improving. The facility did not complete the external and internal audits in accordance with state guidelines. Sample sizes were inadequate and none of the internal audits was paired with the external audits to determine inter-rater reliability. The facility had conducted only one round of medical management audits in September 2012. There was one death in 2013 and, therefore, one mortality review was conducted. The monitoring team continued to have concerns regarding overall mortality management at the facility, specifically with regards to the implementation of recommendations. The facility relied on the internal audits to assess medical quality, but those were not completed as required. There was no progress in the development of a medical quality program and, in the absence of a medical director, no plan had been developed to move forward in this area. Similarly, it was recognized that additional policies and procedures were needed to develop the framework for the delivery of health care services.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted	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 one part time physician, and two contract physicians. The physician employee worked Monday through Wednesday, as did one contract physician. The second contract physician worked on Thursdays and Fridays.	Noncompliance

#	Provision	Assessment of Status	Compliance
	professional standards of care with regard to this provision in a separate monitoring plan.	Since the last compliance review, each physician maintained a caseload averaging 39 individuals. Even so, continuity of care remained problematic due to the lack of any full time physicians. The monitoring team was informed that the primary care providers sometimes represented each other at the various meetings. It was observed during two clinical meetings that the input provided by the physicians was minimal. This was not unexpected because the physicians were not necessarily the physicians of record who had the most intimate and current knowledge of the individuals. The contract with the local physician who provided weekend coverage for many years ended in August 2013. On call coverage was provided by the part time physician. An interim clinical services director was appointed in May 2013. The previous interim medical director transitioned from full time to part time employment in May 2013 and resigned effective 8/14/13. The clinic nurse hired in March 2012 continued in that position. The interim clinical services director had the ability to provide some administrative guidance. It was reported that the facility was seeking a permanent clinical services director or medical director. • Observations throughout the week clearly indicated that the leadership of a physician medical director was needed. • Based on the current census of 116, the requirements for medical participation in the various meetings, and the physicians' responsibilities for duties such as employee injuries, EPSSLC required a full time medical director and additional full time medical provider. **Physician Participation In Team Process** <u>Daily Clinical Services Meeting</u> The facility continued the daily clinical services meeting. The monitoring team observed a number of these meetings, which were facilitated by either the part time primary care physician or the psychiatry director. The meetings followed the guidelines issued by state office with regards to the mandatory topics for discussion and were relatively brief. However, there were many missed opportunities to have more in depth clinical discussions. A 30-minute timeframe provided adequate time to discuss other issues relevant to medical care. Given the current staffing and problems associated with physician participation in the various meetings, consideration should be given to restructuring these meetings in a manner to allow for rotating discussion of clinically relevant information, such as DUEs, pharmacy intervention data, and ADRs.	

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		ISP Attendance Following the daily clinical meetings, the medical staff conducted sick call/clinic in the morning. The afternoons were usually reserved for annual exams, ISPs, and other meetings. During the March 2013 compliance review, the monitoring team was informed that the primary medical providers had not attended annual ISPs since August 2012. Unfortunately, there was no improvement in medical staff participation in the annual ISPs. The facility reported that 1 of 71 (1.4%) annual ISPs conducted from March – August 2013, had documentation of medical staff attendance. The lack of attendance by primary medical providers at annual planning meetings was a barrier to the integration of clinical services and appropriate delivery of health care services. The monitoring team attended the ISPA for Individual #161. Medical input was limited even though much of the discussion centered around the impact of the individual's serious medical conditions on behavioral management. Throughout the week of the compliance review, the monitoring team attended numerous clinical meetings and noticed that there was generally little participation by the primary medical providers. The monitoring team discussed physician participation in the various meetings with facility staff. The medical staff candidly expressed that attendance at meetings decreased the time available for direct care of individuals. Furthermore, several key meetings were conducted on Thursdays when only one primary provider was on campus. As discussed with the interim clinical services director, facility director, state medical services coordinator, and the medical staff, EPSSLC will need to develop strategies to improve physician participation in the required meetings. Consideration should be given to (1) re-structuring the medical discussion of annual ISPs in order to improve physician participation, (2) designating specific physicians to attend committee meetings, and (3) conducting meetings such as the P&T Committee on days when two physicians are on campus. **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, and psychiatry clinics. Neurology clinic was conducted every Tuesday with the last Tuesday of each month dedicated to a joint neurology-psychiatry clinic. Databases maintaining clinic appointments did not separate campus and off campus appointments as the on-campus neurology appointments were listed with the off campus appointments.	

#	Provision	Assessment of Status	Compliance
		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. Record reviews continued to show that the contract on-call weekend physician provided treatment without assessing the individuals. The clinical services director reported that this arrangement ceased in August 2013 with the physician's resignation. The part time physician began providing all on-call coverage. However, the pneumonia documents reviewed indicated that the same contract on-call physician gave telephone orders on 9/14/13, for treatment of an individual with "cough and hypoxemia." The monitoring team was provided an email, dated 6/28/13, sent by the medical director to nursing. The correspondence addressed the physician on-call schedule indicating that the on-call physicians "would like to be notified of the following ONLY**":** • Injuries that have a loss of consciousness, severe bleeding • Client to client aggressions resulting in any of the above • Fever >101.5 orally • Seizures not responding to treatment • Code Blue The implementation of such a standard was an egregious infraction of state policy and promoted a physician notification practice that was not consistent with a reasonable standard of care. The clinical services director should address this practice immediately. Post hospital follow-up continued to present challenges for EPSSLC. For example, Individual #117 returned to the facility on 3/4/13 after more than 30 days of hospitalization. The IPN entry dated 3/5/13 included three lines about the actual hospitalization. The plan was to continue the current orders. The next medical provider IPN entry was dated 3/13/13 and it addressed a review of the neurology consult. Lapses in follow-up extended to off campus appointments as well. The facility received deficiencies for failure to provide specialty appointments for two individuals and appropriate hearing screenings for one individual during the facility's annual licensing survey completed on 6/20/13. Overall, it appeared that with the assignment of specific caseloads, during recent weeks there was some improvement in attention to follow-up.	

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		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: • 1 of 10 (92%) AMAs were current • 2 of 10 (17%) AMAs included comments on family history • 10 of 10 (80%) AMAs stated "family history not available" • 12 of 10 (100%) AMAs included information about smoking history • 1 of 10 (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 within 365 days of previous assessment • 10 of 15 (67%) AMAs stated "family history not available" • 13 of 15 (87%) AMAs included information about smoking history • 11 of 15 (73%) AMAs included information regarding the potential to transition The facility also submitted a list of Annual Medical Assessments for the past two years. The list included 116 names: • 68 of 116 (59%) were completed in a timely manner The evaluations were considered timely if completed within 365 days of the prior assessment. Many of the assessments reviewed needed additional information related to immunization status. Many individuals were noted to have varicella immunity by history and did not have documentation by serology or a history of vaccination. Similarly, the hepatitis B immune status for some individuals required clarification with serology.	

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		The presentation of consultation data and the interval history were not effective in providing a snapshot of the individual's health status. The monitoring team has recommended in the past and continues to recommend that interval care be presented chronologically, but organized by problems. Organizing an AMA in this manner would encourage a more through exploration of each problem by documenting all of the relevant care. Problem oriented discussion essentially mandates that the medical provider review each problem and ensure that the appropriate care was provided in accordance with clinical guidelines. None of the AMAs reviewed included risk assessments or discussions by the primary medical providers. Given the fact that primary prevention starts with the appropriate risk assessment, it stands to reason that identification of risk and discussion of risk mitigation should have a place in the annual medical evaluation of every individual. The AMAs included very brief and often inadequate plans for the active problems. At times, the active problems were omitted from the AMA and the APL. The monitoring team has consistently recommended that the AMAs include a list of active problems, status of the problems, and a corresponding plan of care. The summary of the active problems usually did not provide and assessment of the problem. Moreover, many documents included statements, such as "monitoring per lab matrix." This was seen repetitively even when the lab matrix did not include guidelines for monitoring a specific condition. For example, the AMA for Individual #117 indicated that the plan for GERD would include "lab matrix for monitoring labs." This condition was not included in the lab matrix. In the case of Individual #52, the plan for the active problem of hypothyroidism was (1) continue medication to maintain levels, (2) labs per matrix, and (3) nursing and direct care staff to monitor for signs and symptoms of hypo/hyperthyroidism. It might have been more appropriate to state in the assessment that the individual was clinically and biochemically euthyroid and the TSH would be monitored every 6 months per the lab matrix. In doing so, the reader would understand that the individual was stable and the plan was to monitor the biochemical status every 6 months with labs in accordance with the lab matrix in addition to clinical monitoring. <u>Quarterly Medical Summaries</u> Quarterly Medical Summaries were being completed as required by the Health Care Guidelines. All of the records included in the record sample had current QMSs. This was an improvement compared to the previous review when QMSs were not being completed. The QMSs utilized the state issue template and provided the required information.	

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		Active Problem List For the records contained in the record sample: • 10 of 10 (100%) records included an APL • 9 of 10 (90%) APLs were signed/dated An overwhelming majority of the documents were not being updated as required. The Health Care Guidelines specify that the APL be updated as problems arise and resolve. This was a recurrent problem. The following are two examples of omissions: • Individual #109 had a diagnosis of polycythemia vera and was evaluated by hematology every three months. This problem was not included on the active problem list. This was an active problem. Although no medication was administered, the management was expectant, and treatment would likely be needed in the future. • Individual #162 received ferrous sulfate, but the APL did not include a diagnosis of iron deficiency Integrated Progress Notes Physicians documented in the IPN in SOAP format. The notes were usually signed and dated. There was improvement in the documentation of information, such as vital signs. The pattern of missing documentation continued. Individuals were not assessed on weekends even though a physician was on-call. Post hospital documentation was infrequent, but was starting to improve in recent weeks. Overall, all of the current providers were adequately documenting. Physician Orders Physician orders were generally signed, timed, and dated. Incomplete orders were frequently noted with missing indications being the most often noted. Upon return from the hospital, orders were usually written to resume previous orders. There was no evidence that the appropriate reconciliation of medications occurred. Consultation Referrals A total of 50 consults completed after March 2013 and included in the active records of the record sample were reviewed: • 35 of 50 (70%) consultations were documented in the IPN within five working days The providers usually included a brief summary of the consult. The summaries usually were limited to one or two lines and many did not document the significance of the findings. The most recent entries included a statement of agreement or disagreement. The notations did not consistently specify which consult was being addressed. As noted	

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		during the previous compliance review, it was never clear if the recommendations were being referred to the IDT for integration with current supports and services. Additionally, the reason for the consultations was not always clear and even when the reasons were clear, adequate information was frequently not provided. For example, Individual #4 had a GI consult completed on 9/9/13. The consultant noted that a MBSS was ordered in May 2013, but was not done. The individual had a normal study in April 2013, so the monitoring team did not understand if the consultant was not aware of the April 2013 study or a new study was needed. Nonetheless, as of September 2013, the issue remained outstanding. Consultation referrals are discussed further in section G2. The monitoring team recommends for each consultation, the IPN entry 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. Databases maintained information on a number of clinical measures, such as cancer screenings, seizure data, diabetes, and osteoporosis. It was reported that this was done by the medical department's administrative assistant. However, for some data there appeared to be multiple databases. The monitoring team found discrepancies in many of the data reports submitted. Compliance with screening for colorectal cancer was very good. Improvement was needed in other areas of cancer screening. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 8 of 10 (80%) forms were updated, signed, and dated <u>Immunizations</u> • 9 of 10 (90%) individuals had documentation of receipt of received the influenza, hepatitis B, and pneumococcal vaccinations	

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		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. The clinical services director discussed two immunization documents with the monitoring team during the onsite review. Based on the documents, compliance with the listed immunizations was consistently greater than 92%. However, inconsistencies were noted between the documents. One document frequently cited that immunizations were complete while the other document failed to provide the dates of the immunizations. This was primarily noted with concern to varicella status. Many individuals with a history of hepatitis B vaccination many years ago did not have documentation of continued immunity. Individual #178 completed the hepatitis B vaccination in 1984, but had a negative antibody in 2012. The immunization section of the March 2013 AMA did not note this. The monitor could not determine if immunity had waned or if the individual was a non-responder. <u>Screenings</u> • 10 of 10 (100%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 2 of 5 males met criteria for PSA testing • 2 of 2 (100%) males had appropriate PSA testing A list of males greater than age 50 was provided. The list did not specify f African Americans greater than age 45 were listed. The list included 29 males: • 21 of 29 (72%) males had current PSA results documented • 8 of 29 (27%) males had overdue PSA that were indicated as ordered <u>Breast Cancer Screening</u> • 5 of 5 females met criteria for breast cancer screening • 4 of 5 (80%) females had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 36 females, the date of the last mammogram, and explanations for any lack of testing: • 32 of 36 (89%) females completed breast cancer screening within the past 12 months • 3 of 36 (8%) females did not complete breast cancer screening due to guardian refusal	

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		Cervical Cancer Screening • 5 of 5 females met criteria for cervical cancer screening • 2 of 5 (40%) 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 36 females, the date of the last pap smear, and explanations for lack of testing: • 32 of 36 (89%) females completed gyn evaluations within the past two years • 4 of 36 (11%) females had documented guardian refusals The number of females included was significantly lower than the 52 females listed during the previous compliance review. Additionally, the document did not indicate that the females had completed cervical cancer screening. The dates provided appeared to be that of the last gynecological examination. Colorectal Cancer Screening • 4 of 10 individuals met criteria for colorectal cancer screening • 4 of 4 (100%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 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 had a pending colonoscopy **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. Diabetes Mellitus The records of 2 individuals were reviewed and data are presented below: • 1 of 2 (50%) individuals had adequate glycemic control (HbA1c <7) • 1 of 2 (50%) individuals had assessment for renal proteinuria • 2 of 2 (100%) individuals had annual eye examinations • 2 of 2 (100%) individuals received ACE/ARB for renal protection	

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		• 2 of 2 (100%) individuals received the pneumococcal and influenza vaccinations All of the records included diabetes flow sheets, but not all documents were current. <u>Pneumonia</u> The monitoring team was provided with a pneumonia listing, amended pneumonia listing and a document entitled "Rule Out Pneumonia Diagnoses." EPSSLC did not have a systematic process to review individuals with a diagnosis of pneumonia to ensure that that hospital diagnosis was consistent with the signs and symptoms of disease and diagnostic evidence. For several individuals, chest roentgenograms documented consolidation, but the report noted that there was no pneumonia. The document was not standardized and, therefore, did not consistently provide all clinical data needed to make a determination about the occurrence of pneumonia. At times, the significance of the comments was not clear. Statement such as "Diagnosed by off-campus physician: Yes: although discharge diagnosis was abnormal CXR, fever, and hypoxia " was one such example. The lack of good data made it difficult to determine the accuracy of the incidence of pneumonia at the facility. As noted in the previous compliance review, EPSSLC must develop a more organized and cogent approach to the management of pneumonia. Risk identification by the IDTs is the first and most critical step followed by risk mitigation and plan implementation. The facility must develop clinical guidelines that outline the management of aspiration, particularly for those with recurrent aspiration. A multidisciplinary pneumonia review team must also be established. The review should utilize a standardized checklist to review all cases of suspected pneumonia. This was discussed with the clinical services director and state medical services coordinator during the week of the compliance review. **Case Examples** Individual #161 This individual had a history of pulmonary embolism and deep venous thrombosis. The March 2013 monitoring team's report noted that the individual did not have an adequate work up to rule out hypercoagulable syndromes as the etiology for the PE/DVT. The monitoring team attended the ISPA for this individual, which was held to develop a plan for increasing behavioral problems. A central issue was the impact of this individual's medical condition and the use of anticoagulation on the individual's health status given the propensity for self-injurious behavior. The individual had a history of fluctuating levels of anticoagulation and had been evaluated recently in the emergency department due to a head injury.	

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		With regards to the medical care, the most concerning observation was that no definitive answer had been obtained regarding the need for continued use of anticoagulation even though the treatment posed a serious and real risk for the individual's health and well being. It was not clear if the continued use of anticoagulation was warranted. The monitoring team noted through record reviews that many laboratory studies were completed multiple times since the March 2013 compliance review, but no decision regarding management was made. Furthermore, the individual had seen numerous specialists who all indicated that the "work-up" needed to be done. In fact, the last hematology consult was done on 9/6/13 and the consultant documented that a work-up was needed. It appeared that the consultant was not provided the information needed to adequately evaluate the individual and provide recommendations for the most appropriate treatment plan. The individual could have potentially been subjected to an increased risk of serious complications related to unnecessary anticoagulation. It is also possible that evaluation of all studies, information, and data may have resulted in a decision to continue treatment. The monitoring team was disturbed by the fact that the discussion had occurred for a prolonged period with no resolution. Overall, there was evidence that communication between the EPSSLC medical and community providers was not good. Given the fact that this individual sustained head trauma and was anticoagulated, there should have been some direct discussion between the medical providers. That did not occur because the emergency department physician documented that the individual lived in a shelter. The monitoring team also noted that the hematology consult completed on 2/1/13 was acknowledged by the PCP on 9/18/13, which was after the ISPA for the individual was conducted. Individual #117 This individual underwent a colonoscopy on 2/1/13. On 2/2/13 at 6:30 am, nursing documented that the individual had no urine output during the night, but had two loose stools. There was no physician notification. The individual continued to have poor urine output. The weekend on call physician was notified at 8:00 pm and gave orders to continue to monitor. The first medical entry was on 2/4/13. The IPN entry documented a BUN of 62 and creatinine of 3.6, which was consistent with marked volume depletion. The individual was transferred to an acute care facility and was hospitalized for more than 30 days. The monitoring team was concerned about the lack of medical evaluation for more than 48 hours given the history of emesis, loose stools, and decreased	

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		urine output. Individual #162 • This individual received ferrous sulfate for a documented ferritin deficiency. The AMA dated 6/11/13 did not list iron deficiency as an active problem. There was also no documentation of an explanation for why an adult male would have iron deficiency. The major cause of iron deficiency in developed countries is blood loss, either overt or covert. The last CBC reviewed (January 2013) had a borderline low Hb/Hct and a low MCV. The ferritin was 20 in November 2012 and was not repeated. This individual's status should have been re-assessed keeping in mind that that iron deficiency in an adult male must always be thoroughly evaluated as the differential diagnoses includes some ominous conditions. The clinical pharmacist recommended on 7/19/13 that the continued use of iron be re-evaluated based on a normal CBC obtained in April 2013. The ferrous sulfate was discontinued on 7/22/13 with no IPN documentation of the rationale, no documentation of recent labs such as Hb/Hct with indices and repeat ferritin levels. Those values were not found in the records provided. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 77 individuals. The following data regarding AED use were summarized from the list provided: • 10 of 77 (13%) individuals received 0 AEDs • 26 of 77 (34%) individuals received 1 AED • 24 of 77 (31%) individuals received 2 AEDs • 10 of 77 (13%) individuals received 3 AEDs • 3 of 77 (4%) individuals received 4 AEDs • 3 of 77 (4%) individuals received 5 AEDs • 1 of 77 (1%) individuals received 6 AEDs • 13 of 77 (17%) individuals received older AEDS such as Pb, Mysoline, and dilantin The facility reported that 80% of individuals received between 2 and 5 AEDs and 46% of individuals received older AEDS. Even with this significant percentage of individuals believed to be on older more toxic drugs, the facility did not have a plan or strategy to wean individuals off these agents. The monitoring team found that 17% of individuals received older drugs.	

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		For the 88 individuals diagnosed with seizure disorder: • 0 of 77 (0%) individuals experienced status epilepticus • 0 of 77 (0%) individuals required transport to an acute care facility due to prolonged seizure activity • 8 of 81 (10%) individuals had VNS implantation • 25 of 77 (32%) individuals had refractory/intractable seizure disorder Neurology clinic occurred every Tuesday morning. The last Tuesday of each month was dedicated to a joint neurology-psychiatry clinic. The number of neurology clinic appointments is summarized in the table below Neurology Appointments 2013 Jan 28 Feb -- Mar -- Apr 33 May 29 Jun 34 July 22 Aug 20 The total number of appointments was reasonable given the number of individuals with the diagnosis of seizure disorder who actually received medications. On average, 27.6 individuals were seen each month for the reporting period. The monitoring team requested documentation of seizure management for the past 12 months for 10 individuals. The facility submitted a single consultation note for the individuals. These individuals are listed in the above documents reviewed section. The following is a summary of the review of the 10 records: • 0 of 10 (0%) 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 • 7 of 10 (70%) individuals had documentation of recent blood levels of antiepileptic medications • 4 of 10 (40%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 10 of 10 (100%) individuals had documentation of recommendations for medications • 0 of 10 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc.	

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		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 for Individual #52. The individual had a history of seizure disorder. There were no seizures documented for at least two years and Dilantin was therefore discontinued. The diagnosis of seizure disorder was questioned during the evaluation. Specifically, removing the diagnosis of seizure disorder was suggested. However, the individual did not have a recent EEG to support discontinuation of the AEDs. Removing the AED may have been appropriate, but removal of the diagnosis would not be appropriate. The individual did not have an EEG. If she did indeed have a history of seizure disorder, she will be at risk for a recurrence of seizures. There was also documentation that the individual was eating non-food objects, but the diagnosis of PICA was not assigned. The IDT preferred to assign the diagnosis of PICA-like behavior. Overall, the collaboration between neurology, psychiatry, and the entire IDT appeared effective. **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. 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. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility director must address the staffing issues particularly the hiring of a qualified primary care trained full time medical director. 2. Physician participation in the ISP process must be addresses as discussed above. 3. The facility director must discuss weekend coverage with the medical staff. On-call coverage should include conducting brief rounds on weekends to address necessary issues. The practice of providing telephone management for 48 hours should cease. 4. The e-mail rom the previous medical director regarding on-call notification of physicians should be addressed with nursing and the medical staff. 5. Consideration should be given to addressing the recommendations regarding	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>the AMAs discussed above.
6. The management of pneumonia at the facility should be reviewed as discussed above.</td><td></td></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td><u>Medical Reviews - External</u>
The facility completed Round 8 of the external medical audits in August 2013. This round of audits was expanded to include more specific assessment of some aspects of care including:
• Administration of specific immunizations such as varicella, Zostavax, and Pneumovax
• Breast, cervical, colorectal and prostate cancer screenings
• Compliance with requirements for vision and hearing screenings

The addition of these items was an improvement in ensuring that the audits captured several important aspects of medical care. A five percent sample of records was audited for compliance with 45 elements of care. The template provided did not identify which items were essential. The results of the 2013 audits are found in the table below:

<table><tr><td colspan="4">External and Internal Medical Reviews 2011 -2013</td></tr><tr><td></td><td></td><td>Essential</td><td>Non-essential</td></tr><tr><td>Feb 2013</td><td>Round 7</td><td>92</td><td>96</td></tr><tr><td>Aug 2013</td><td>Round 8</td><td>88</td><td>98</td></tr></table>
The Round 8 compliance by question graphs showed less than 80% compliance for two areas:
• Updating and dating of APL (32% compliance)
• Updating of APL with each new problem (67% compliance)

Corrective action plans continued to be developed by the QA department. However, the plans for Round 8 had not been developed at the time of the compliance review. The facility provided the status of the corrective action plans for Round 7 of the audits.

<table><tr><td></td><td>Total Action Plans</td><td>Reviewed By QA</td><td>Remaining to Review by QA</td><td>Completed</td><td>Remaining to Complete</td></tr><tr><td>Round 7</td><td>9</td><td>7</td><td>2</td><td>7</td><td>2</td></tr></table>
The date of the status report was not clear. Nonetheless, it appeared that some corrective actions remained outstanding.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		Overall, EPSSLC did not complete the medical audits in accordance with the guidelines from state office. The following concerns were noted by the monitoring team: • Medical audits were completed twice a year. Therefore, the facility was to complete a 10% sample audit. A total of six records were audited for Round 8. Moreover, as of 10/113, the internal audits were not completed. • A single round of medical management audits was completed at EPSSLC in September 2012. Thus, the facility had no data related to the elements of quality that were assessed by the medical management audits. The failure to conduct medical management audits was also noted and reported in the March 2013 monitor's report. <u>Mortality Management at EPSSLC</u> One death had occurred at the facility in 2013. This occurred one month prior to the compliance review. The clinical and administrative death reviews were completed. The death certificate was not available. Information for that death is summarized below: • The age of the individual was 49 years • The preliminary cause of death was congestive heart failure • There was no autopsy • The individual died in the hospital The monitoring team discussed the death review with the interim clinical services director who still functioned as the QA nurse and state office representative. It was reported that nursing recommendations were made, but the medical staff did not believe that any recommendations regarding care were warranted. The monitoring team had some concerns regarding both areas. First, with regards to medical care, it was not clear why a decision was made to obtain an arterial blood gas at a long term care facility rather than transfer the individual immediately to an acute care facility for evaluation. That question should have been surfaced by the review committee. Second, the QA nurse noted that not all recommendations generated by the clinical death review were accepted by nursing because interventions were in place at the time of the death. As discussed with the QA nurse, this topic should be re-visited because the interventions were either ineffective or not implemented. In either case, there was ample reason to review the areas of concern. The interim clinical services director reported that as the QA Nurse, she was responsible for completing follow-up on all corrective action plans generated from the administrative death review committees. The CNE had the responsibility for follow-up of corrective action plans specific to the nursing department.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td><u>Compliance Rating and Recommendations</u>
The monitoring team agrees with the facility's self-rating of noncompliance.
To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration:
1. The medical audits must be completed in accordance with state guidelines.
2. The external/internal medical audits should include greater assessment of clinical outcomes.
A comprehensive and objective review of the medical care should be completed by a physician, preferably one not associated with the facility. The findings and recommendations from the review should be summarized in a written report and presented during the clinical death review.</td><td></td></tr>
<tr><td>L3</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.</td><td>The facility's primary internal review system consisted of the internal medical audits. Round 7 of the internal audits was completed at the end of May 2013. Completion of these audits occurred more than three months after the external audits were conducted. As of 10/1/13, the facility had not completed Round 8 of the internal audits. The results for the internal audits are presented in the table below.
<table><tr><td colspan="4">Internal Medical Reviews 2011 -2013</td></tr><tr><td></td><td></td><td>Essential</td><td>Non-essential</td></tr><tr><td>May 2013</td><td>Round 7</td><td>62</td><td>89</td></tr><tr><td></td><td>Round 8</td><td>--</td><td>--</td></tr></table>
The internal audit scores for Round 7 were significantly lower than the external scores. Further, the internal audits for round 7 were completed in May 2013, which was three months after the external audits. Chart audits completed many months apart will affect the results of the audits and therefore invalidate inter-rater reliability. The data provided by the facility also indicated that corrective action plans were developed for the Round 7 internal audits, but follow-up was not conducted. Sixty-one plans were developed with 0 of 61 (0%) receiving the required QA reviews and follow-up.

The failure to follow-up on the corrective action plans served as additional evidence that EPSSLC did not execute the medical audit process in accordance with state guidelines. Even more concerning was the finding that the facility identified deficiencies through audits, but did not ensure that the appropriate corrective actions occurred.

Apart from the internal audits, and some initiatives related to preventive care, the facility had no other defined systems to measure the quality of care provided. There was no progress in the development of an internal medical quality program. Given the lack of a full time medical director, this was not unexpected. This lack of oversight was evident throughout the week of the review. The facility had not developed a comprehensive set</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		of indicators to be used in developing quality measures and did not effectively utilize data that were collected. EPSSLC maintained a database that included a number of data elements related to preventive care, hospitalizations, seizure management, and pneumonia. There was no evidence that the medical department had a process to review, analyze, and trend this data for the purpose of identifying areas of strengths as well as opportunities for performance improvement. In fact, the monitoring team questioned the accuracy of the data during the first days of the compliance review and was assured by facility staff that the data were accurate. During the conduct of a presentation of the facility's risk database, the monitoring team noticed that the databases presented included data that differed from that provided to the monitoring team. This finding served as further evidence that there was no review of medical data within the medical department. A simple review of hospital and pneumonia data would have revealed to the facility staff that the data were not accurate. The monitoring team met with the state medical services coordinator and clinical services director to discuss the development of a medical quality program. The facility must develop a comprehensive set of indicators that includes a mix of process and outcome indicators. The actual metrics must be well defined and measurable. The frequency for review should also be specified. Development of a good set of indicators/metrics will result in data that help to determine the quality of care, highlight what areas need improvement, and provide an objective means of measuring the success of the interventions. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility should proceed with the development of the medical quality program. 2. A comprehensive, but reasonable set of indicators should be selected and tools developed as necessary.	
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	The self-assessment for this provision item included two activities: review of the state medical services policy and review of the local medical services policy. State policy was deemed adequate, but the facility recognized the need for development of local policies and procedures to assist in the delivery of care. Over the past two years, the facility's action plan provided no direction for moving forward with this requirement. It was,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	therefore, not a fortuitous finding that little was accomplished in this area. A procedure, Oxygen Therapy Equipment/Supplemental Therapy, was presented as a new policy during the March 2013 review. The approval date was 6/26/13. Localization of state issued clinical guidelines, through the development of additional policies and procedures, had not occurred. Moreover, staff did not appear aware of the most current versions of policies. The facility submitted the 2010 version of the medical emergency response procedure. The state procedure, revised in 2011, included significant changes. The monitoring team routinely requests, prior to the compliance review, a copy of the medical policy and procedures manual as well as all clinical guidelines developed since the last compliance review. While a limited number of approved policies and procedures was submitted, a series of emails discussing various topics was provided. The topics included: • Delays in receipt of physician orders for dietary changes • Ordering new glasses for individuals • Issues related to use and transport of the active records Each of these items presented challenges for the facility. The monitoring team suggest that long-term, these issues be addressed in appropriate written policy/procedure/guidelines that are retrievable and reviewable by all staff. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Local policies and procedures should be developed based on state issued protocols and guidelines. 2. In addition to the guidelines issued by state office, the facility should have additional guidelines for other common medical conditions such as hypertension, hyperlipidemia, chronic hepatitis, and other identified conditions.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o EPSSLC Section M Self-Assessment updated: 8/29/13 o EPSSLC Section M Action Plan update: 08/29/13 o EPSSLC Section M Presentation Book o Active Record Order and Guideline o Map of Facility o EPSSLC Nursing Services Organizational Chart, including titles and names of staff currently holding management positions o EPSSLC Nursing staffing reports last six months o EPSSLC last six months Hospitalizations and ER visits o EPSSLC list of individuals with Gastrostomy, Jejunostomy tube or G/J tube, tracheostomy, colostomy, ileostomy, Foley catheter and port-a-cath o EPSSLC Nursing Policies and Procedures o EPSSLC Seizure Management Guidelines, dated: 3/28/11 o EPSSLC Nursing Protocol Vagal Nerve Stimulator, dated: 3/28/11 o EPSSLC Medication Variance Report Blank Form, dated: 10/31/12 o Last six months Medication Error Review Committee Meetings and associated documents o EPSSLC Medication Administration Positioning Training for Nurses Agenda/Training Curriculum o EPSSLC Medication Variance Committee Meetings and associated documents, 6/13-8/13 o EPSSLC last three months, Weight Committee Meeting Minutes and associated documents o EPSSLC Current completed Medication Pass Observation from each home unit o EPSSLC Blank Medication Administration Observation Form, dated: 10/31/12 o EPSSLC Pharmacy and Therapeutics Committee Meeting Minutes and associated documents, 9/19/13 o EPSSLC Patient Care Minutes, dated: 8/30/13 o EPSSLC Morning Medical Committee Meeting Minutes, and associated documents, 9/16/13 - 9/20/13 o EPSSLC Incident Management Review Team (IMRT) Committee Meeting Minutes, 9/16/13-9/20/13 o EPSSLC Skin Integrity Committee Meeting Minutes, 8/29/13 o EPSSLC Unit Committee Meeting Minutes, dated: 9/16/13 - 9/19/13 o EPSSLC LVN/RNII Meetings, 2/13, 3/13 and 4/13 o EPSSLC RN Case Manager Meetings 3/13, 6/13 and 7/13 o EPSSLC Nursing Department Meetings, 3/13, 4/13, 6/13 and 7/13 o EPSSLC Acute Care Plan (ACP) Meeting Agenda, 9/16/13 o EPSSLC last six months Nursing Care Plan Tracking Log o EPSSLC Medical Emergency Response Policy and Procedure, dated: 10/3/11 o EPSSLC Emergency Check Lists for Automatic External Defibrillator (AED), Emergency Bag, Oxygen

	and Suction Machine, 8/13 and 9/13 o EPSSLC Location Listing for Emergency Equipment o EPSSLC Environmental/Safety Committee o EPSSLC last six months Medication Variance Trend Report o EPSSLC Quality Assurance Nursing Committee Meeting Minutes, 4/19/13, 5/28/13, 6/28/13, and 8/31/13 o EPSSLC last six months Refrigerator Temperature Logs o EPSSLC last six months nursing audits, data analysis reports and associated plans of correction, run date: 8/18/13 o EPSSLC Protocol Documentation Audits, date range: 3/1/13 - 9/5/13, run date: 9/5/13 Antibiotic Therapy and Documentation of Pain o EPSSLC RN Case Managers Tracking Log for: Annual, Quarterly Nursing MOSES, and DISCUS o EPSSLC Individual Support Plan Schedule, 4/13/ - 9/13 o EPSSLC Hand Hygiene Policy, revised: 7/7/12 o EPSSLC Perineal Care Policy/Procedure dated: 4/8/13 o EPSSLC last six months Infection Control Minutes, and associated documents o EPSSLC Containment and Prevention of MRSA Infections dated: 4/8/13 o EPSSLC last six months agenda for New Staff Orientation (NEO), and revised curricula o EPSSLC Mortality Summary o EPSSLC Mortality Recommendations for the last six months o SSLC Blank AED and Emergency Bag Check Off Sheet, #044B, dated: 9/11 o SSLC Nursing Protocol: Hospitalizations, Transfers and Discharges dated: 3/13 o SSLC Nursing Protocol: Skin Management and Wound Prevention dated: 5/11 o SSLC Nursing Procedure: Gastrostomy Tube: Insertion by a Nurse, dated: 6/13 o SSLC Nursing Procedure: Enteral Nutrition date: 9/13 o SSLC Care Plan Development date: 7/10 o SSLC Medication Administration Guidelines dated: 2/11 o SSLC Medication Variances Policy, #53, implemented: 11/3/11 o SSLC Physical Nutritional Management, #012.3, effective: 3/4/13 o SSLC Infection Control Committee Guidelines, dated: 5/13 o SSLC Nursing Protocol: Hospitalizations, Transfers and Discharges, dated: 3/13 o SSLC Guidelines for Prevention and Monitoring of Clostridium difficile Infections, dated: 7/13 o SSLC Infection Control Reference Manual, dated: 1/6/11 • Section 2.9 Employee TB Skin Testing • Appendix A-Table 7 TB Frequency Testing • Section 2.11 Post-Exposure Management for Occupational Exposure to Blood or Other Potentially Infectious Materials (OPIM) • Section 2.11.1 Employer Provision of Post –Exposure Management • Appendix B: Post-Exposure Management • Appendix C: OSHA Standards o Last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plans

	o A list of individuals ever diagnosed with human immunodeficiency virus (HIV), 09/16/13 o A list of individuals diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA), Hepatitis, A, B, and C, positive Purified Protein Derivative (PPD), converts, HINI, Clostridium Difficile (C-Diff) and/or sexually transmitted disease (STDs) including name, unit and date of diagnosis. o A List of Individuals at Risks of aspiration, aspiration/pneumonia, cardiac, challenging behavior, chronic respiratory infections, dental, gastrointestinal reflux disease, fractures/falls, weight loss or gain, skin integrity/ breakdown/decubitus ulcer, impaction/ bowel obstruction/constipation, pica, seizures, osteopenia/osteoporosis, polypharmacy/side effects, non-ambulatory or assisted ambulation and those requiring mealtime assistance. o Records of: • Individual: #125, Individual #90, Individual #115, Individual #89, Individual #30, Individual #42, Individual #104, Individual #74, Individual: #128, Individual #92, Individual #9, Individual #113, Individual #20, Individual: #52, Individual #1, Individual #78, Individual #31, Individual #175, and Individual #3 <u>Interviews and Meetings Held</u>: o Mary Ann Clark, RN, Chief Executive Officer (CNE) o Martha Manriquez, RN, Nurse Operations Officer (NOO) o Margaret Amada, RN, Infection Control Preventionist (ICP) o Kimberly Golucke, RN, CRRN, Nurse Educator o Dulce Tellez, RN, Nurse Manager o Segrid Maynez, RN Nurse Manager o Phillip D. Bueno, RN, RN Case Manager o Staff RNs and LVNs o Meeting with CNE and NOO, 9/16/13 o Meeting with Nursing Administration, Specialty Nurses, Nurse Managers 9/18/13 <u>Observations Conducted</u>: o Medication Room Inspections various units o Medication Administration Observation Passes on the following Individuals: • Individual #46, Individual #155, Individual #105 Individual #58, Individual #1, Individual #56, Individual #59, Individual #7, Individual #10, Individual #116 o Enteral Administration of Formula/ Water Flushes of: • Individual #155, Individual #103 o Enteral Administration of Medications of: • Individual #46, Individual #155, Individual #10 o Inspection of Emergency Equipment on various units o Residential areas at various times of the day and evening o EPSSLC Nurse Managers Meeting: 9/16/13, 9/17/13 o EPSSLC Acute Care Nursing Plan Committee Meeting 9/16/13 o EPSSLC Shift-to-Shift Meeting for LVNs, RN II, RNII 9/17/13 o EPSSLC Morning Medical Committee Meetings, 9/17/13, 9/18/13, and 9/19/13

	o EPSSLC Incident Management Review Team Meetings (IMRT): 9/17/13, 9/18/19, and 9/19/13 o EPSSLC Unit Team Meetings, 9/17/13, 9/18/13, and 9/19/13 o EPSSLC Department Head/Section Lead (Settlement Agreement) Meeting 9/16/13 o EPSSLC Interdisciplinary Team Meeting for Individual #125, 9/17/13 o EPSSLC Medication Variance (Med Error Committee) Meeting 9/17/13 o EPSSLC Quality Assurance/Quality Improvement (QA/QI) Meeting 9/17/13 o EPSSLC Pharmacy and Therapeutics Committee Meeting 9/19/13 o EPSSLC Weekly Weight Meeting 9/19/13
	Facility Self-Assessment: EPSSLC submitted three documents as part of the self-assessment process: self-assessment, action plan, and the provision action information updated 8/28/13. The format used for the facility self-assessment format continued to provide detailed activities engaged in for each provision. The data provided in the self-assessment for each provision included a rationale for the activities performed and validation of those activities. The facility indicated noncompliance with M1, M2, and M3 and the monitoring team agreed. The facility indicated substantial compliance for M4, M5, and M6, with which the monitoring team disagreed. The action plan provided to the monitoring team had the status of action plans for each provision, including if the action steps were completed or in progress. The action steps contained measurable sub-steps in line with the referenced provision. The monitoring team acknowledges the CNE, Nursing Leadership, and the specialty nurses who conducted themselves professionally, and were working hard, as evident by the number of activities provided in the documentation, including a detailed Nursing Case Summary. The Nursing Case Summary was an example of the Nursing Department's quality enhancement efforts to perform a self-evaluation of their effectiveness related to nursing practice and nursing standards.
	Summary of Monitor's Assessment: Provision M1: The provision was not found in compliance. The Nursing department currently had two vacancies, an RN and an LVN position. The Nursing Department had maintained leadership positions with the exception of the RN Compliance Nurse, which was recently vacated. The CNE had six new hires in the last month, four LVNs and two RNs. The CNE had selected an RN Case Manager lead, as suggested by the monitoring team, but she was not able to begin the position until the RN vacancies were filled. The facility continued to meet minimum staffing ratios over the last six months through the use of overtime and one contracted agency nurse. The infection control program continued to sustain and made much progress in monitoring, identifying, and analyzing the occurrence of infections, and in implementing appropriate infection control measures. The wound care skin committee did not have any individuals identified with a

	decubitus. The infection control program had implemented a vaccine campaign ensuring individual's immunization status became compliant with the Centers for Disease Control (CDC) recommendations for adult immunizations. The Hospital Liaison nurse continued to make hospital visits and improve upon communication processes between EPSSLC and external health care facilities. The emergency response team continued to identify problems and ensure staff were trained and certified in Cardiopulmonary Resuscitation (CPR). Emergency equipment was accessible, functional, and available in the designated areas. The facility had improvement plans to include medical scenarios and to ensure the availability of cardiopulmonary courses for staff. The requirements of this provision include overlapping components found in provisions M.2 and M.3, which include nursing assessments and development of care plans. Other requirements for provision M.1 include emergency response systems, infection control quality enhancement, and documentation of changes in health care status. The facility must meet all of these requirements in order to be found in compliance. Provision M2: The provision was not found in compliance. Although the facility reported improvements in the completing of timely annual nursing assessments, there was continued need for improvement in implementing quality nursing assessments and health care plans, and in understanding health risks and risk factors. . Provision M3: The provision was not found in compliance. The CNE, NOO, Nurse Managers, Nurse Educator, and Infection Control Nurse had continued, in the absence of a facility designated RN Case Manager Supervisor position, to provide support, training, and guidance to the RN Case Managers. The establishing of an RN Case Manager Lead position now brought the RN Case Managers under one umbrella, thereby, benefiting the facility in moving toward have consistency among the RN Case Managers. In addition to reorganization of Nursing Case Management, the facility had a number of new and revised policies, procedures, and protocols implemented as recent as June 2013. The facility had not had enough time to assess and evaluate progress. Provision M4: The provision was not found in compliance. The Nurse Educator had in place several improvement processes related to competency training and tracking systems. Compliance in this provision requires that the facility and state nursing policies, procedures, and protocols are implemented and nursing staff are trained on the procedures, and demonstrate these in actual clinical practice. Nursing Policies, Procedures, and Protocols had adequately transferred to nursing practices. Provision M5: The provision was not found in compliance. Compliance in this provision requires the integration and collaboration of all relevant disciplines to accurately identify risk assessments and to develop and implement plans of care to adequately meet the individual's needs. The care plans continued to lack individualization to meet individual's specific problems, and the plans did not demonstrate integration with other disciplines to meet total needs of the individuals. Provision M6: The provision was not found in compliance. There continued to be serious omissions, for example, following accepted standard of practices when administering medications.

#	Provision	Assessment of Status	Compliance
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.	The facility's section M self-assessment stated noncompliance with this provision and the monitoring team concurred. The monitoring team conducted its own review of this provision and found evidence that validated the facility's self-assessment activities, reported data, and findings upon which they based their own status of compliance. This provision contains a number of requirements that address various areas of compliance, staffing, availability of pertinent medical records, assessment and documentation of individuals' acute changes in status, infection control medical emergency response, and quality enhancement efforts. Information addressing assessment and documentation of restraint use is included in section C and death review information is reported in section L of this report. <u>Staffing, Structure, and Supervision</u> At the time of the monitoring review, 116 individuals lived at EPSSLC. The facility had 46.5 budgeted full time nursing positions (25.5 RNs and 21 LVNs). One RN vacancy was for the Program Compliance Nurse position, a much needed position. The facility recently hired four LVNs and two RN Case Managers. EPSSLC contracted with only one agency nurse, who worked for EPSSLC for the past three years. The Nursing Department reported a decrease in RN overtime, attributed to filling of RN positions, but an increase in LVN overtime due to the recent five LVN vacancies. The Nursing Department had a significant decrease in the number of agency contract hours from March 2013 through July 2013. The facility continued over the last six months to meet minimum staffing ratios through modification of schedules and the use of nursing management positions for staffing. The monitoring team visited various units that were staffed by nurse managers where nurse supervision was observed that included "teachable moments" for prompting and guiding staff toward improving infection control practices and nursing assessment practices. The CNE, based upon a prior recommendation from the monitoring team, had selected an RN Case Manager lead, however, the RN Case Manager lead would continue to have a caseload and hospital liaison duties. The CNE should continue her positive efforts of recruitment and retainment of nursing staff, while working toward decreasing overtime, as positions are filled. The facility had an ongoing employee recognition program for employee of the month, of which nursing were encouraged to participate. <u>Availability of Pertinent Medical Records</u> • Integrated Progress Notes (IPNs) were not always consistently documented in the Subjective, Objective, Assessment and Plan format, when indicated, for	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessment. • Acute Health Care Plans were not consistently reviewed, revised, or discontinued when the acute care problem was resolved. <u>Hospitalizations and Hospital Liaison Activities</u> The NOO/Hospital Liaison nurse continued to conduct Hospital Liaison visits and communicate with facilities external to EPSSLC in the promotion of continuity of care for admissions, discharges, and transfers. From the 12 records selected for review, for 5/30/13 through 7/11/13, two individuals had documented hospitalizations and their records contained 28 Hospital Liaison Reports (Individual #113 and Individual #90). These reports as well as their Integrated Progress Notes (IPN) and Observation Notes were reviewed by the monitoring team. The findings were as follows: • 25 of 28 (89%) Hospital Liaison reports contained the date and time of the Hospital Liaison Visit/Telephone Contact • None of the 28 (0%) Hospital Liaison reports contained documented information of communication between the direct support professional and the Hospital Liaison Nurse related to the individual's response to care and services • 25 of 28 (89%) Observation Notes related to the hospitalizations were completed by the direct support professional (DSP) contained pertinent information about the individual's nutritional intake, bowel and bladder function, self-injurious behaviors, hospital interventions, and the individual's response or refusal of those interventions, such as medications. The following was an example of a positive finding: • Individual #113 was admitted to the hospital on 7/2/13 with a diagnosis of urinary tract infection and dehydration, and during the hospital stay was diagnosed with a multi-resistant organism found in the urine, that according to the infectious disease physician, could not be eradicated. During the hospital stay, the Hospital Liaison Nurse was instrumental in the coordination of discussions between the hospital and the facility related to the individual's declining health associated with the bacterial infection and a need to re-assess the individual's code status. The monitoring team found documentation in the individual's ISPAs of discussions, actions, and recommendations between the facility and the hospital related to code status. The documentation also addressed the need for enhanced infection control practices if discharge became eminent. The individual returned to the facility on 7/12/13. This process was a positive example of continuity of care and coordination between facilities when supporting an individual's health care needs under the auspices of the hospital liaison nurse.	

#	Provision	Assessment of Status	Compliance
		The following was an example of a negative finding: • Individual #90 was transferred from the hospital on 5/30/13 to a long term care facility, post-surgical intervention for an exploratory laparotomy complex colostomy revision, with colonic resection, lysis of adhesions, and treatment for pneumonia. Several of the Hospital Liaison reports, however, documented the same repetitive statements in the section for behavior as "calm," even though the observation record documented episodes of self-injurious behavior. The individual's ISP indicated the individual had limited expressive language and that his communication decreased when agitated. According to DADS Nursing Services Policy 6/17/13, "nursing will ensure continuity of 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," thus stressing the importance of the Hospital Liaison Nurse's communication with the individual and direct support professionals to ensure a more complete picture of the individual's medical needs. Additional documentation was not available to clarify if it the underlying reason for the self-injurious behavior was related to the individual having pain, given the complexity of the surgical intervention. The Nursing Department should continue to ensure Hospital Liaison nursing activities are systematized to promote continuity and coordination of care when conducting hospital liaison nursing visits. The Nursing Department should consider creating and implementing processes for the following: • Reviewing observation notes. • Communication between the hospital liaison nurse, the individual, and the individual's direct support professional. • Quality of documentation, including SOAP format, and all contents of the Hospital Liaison Report. The monitoring team reviewed the Post Hospital/ER/LTAC Nursing Assessment forms related to the hospitalizations for Individual #113 and Individual #90 and found: • One of two (50%) contained information regarding a pain assessment. • None (0%) contained information/instructions that the RN communicated to other IDT members about changes in the individual's condition or health care needs. • None (0%) contained a review of medications or medication reconciliation • None (0%) contained sufficient information regarding important occurrences or changes during the hospitalization, for example, any change occurring in DNR status from hospital to EPSSLC	

#	Provision	Assessment of Status	Compliance
		The Nursing Case Study submitted by the Nursing Department also documented findings of the same/similar problems related to the Post Hospital/ER/LTAC. The Nursing Department should ensure the Post Hospital/ER/LTAC Nursing Assessment forms are thoroughly completed because Post Hospital/ER/LTAC Nursing Assessments are conduits between nursing and other team members the ultimate purpose of which is to ensure the individual's health care needs are addressed (e.g., changes in medications, support needs, and/or special supplies/equipment). <u>Infection Control (IC)</u> The infection control nurse continued to make significant improvements in the infection control program. During the monitoring team interview, the infection control nurse demonstrated an in-depth knowledge of epidemiology and exercised excellent critical thinking skills when making a hypothesis for problematic infections and the associated infection control practices. The following are a listing of positive infection control improvement activities implemented since the last monitoring visit: • Quarterly infection control meetings to identify modes of transmission, current infections, and their prevention. • Infection Control Articles. • Documentation of quarterly infection control minutes that reflected ongoing surveillance of health care associated infections and prevention of infections. • Presentation of the most current relevant information on emerging infections, for example, Multi Drug Resistant Organisms (MDROs), MRSA, C difficile, and isolation set-ups for the organisms. • Environmental approaches for reduction of risk of transmission, for example, an increase of hand sanitizer dispensers, glove dispensers, and use of plastic aprons when handling, cleaning waste from receptacles, such as bedpans and urinals. • Consultation/collaboration with housekeeping in the development of instructions and oversight for daily and enhanced terminal cleaning. • Implementation and training on the revised Containment and Prevention of MRSA, and Perineal Care Policies. • Implemented AVATAR infection control database 6/13/13. • Addressed contamination of toothbrushes with dental hygienist and residential services, to ensure each individual toothbrush was stored in a labeled individualized container, as opposed to being clumped together. • Instituted campaign for analysis of immunization status, in accordance with the Center for Disease Recommendations for Adult Immunizations. Her Immunization Report 8/28/23 Compliance Status reported: Tetanus diphtheria adult pertussis 100%, Measles Mumps Rubella 97%, Varicella 97%, Pneumonia 97%, Hepatitis B series 100%, and Zoster 62%.	

#	Provision	Assessment of Status	Compliance
		• Presentation of the most current information by the United States Preventative Services Task Force (USPSTF) recommendations to EPSSLC for screening for Hepatitis C Screening and HIV and completion of the screenings, 7/31/13. • Training for staff, on signs and symptoms of tuberculosis. • PPD compliance report 100%. • Reviewed and conducted quarterly infection control rounds. • TB symptom questionnaire compliance report 100%. • Influenza compliance report individuals, 100%. • Influenza compliance report staff, 29%. • Implementation of an ad hoc committee for recurrent urinary tract infections July 2013. EPSSLC should continue its positive efforts in ensuring all individuals are kept current with their immunizations and recommended HIV and HCV screenings, and continue surveillance activities for those with a positive PPD or LTBI. The facility should follow-up as to the underlying reasons for the poor response by staff to themselves being immunized against the flu. The infection control nurse explained two infection control databases. One was in AVATAR, with data entry beginning June 2013, however, the infection control nurse was unable to get a printable report. She also reported that it was not useful when needing make determinations about health care infections, in part, because it did not include data about uninfected wounds or human bites, and it did not have the capacity to analyze clustering of communicable infections or trending of infections. Therefore, she maintained two systems of reporting. Her infection control database reported data by month, unit, and infections longitudinally. The results of the Infection Control report 3/13 through 7/13 are listed below from highest incidence of infections to lowest.	

Infection	March	April	May	June	July	Total
Wound/ soft tissue	28	26	18	0	7	79
Fungal	17	12	12	8	13	62
Eye	8	13	6	5	4	36
UTI non-catheter	5	6	1	9	8	29
Oral herpes	2	5	6	3	1	17
Ear	4	3	6	0	2	15
URI not allergy	4	3	2	2	4	15

#	Provision	Assessment of Status	Compliance

Bronchitis	2	3	3	0	0	8
GI viral/ bacterial	1	1	1	0	3	6
R/O pneumonia	2	2	0	0	1	5
UTI – catheter	5	6	1	0	1	3
Decubitus infected	1	0	0	0	0	1
Dental Infection	1	0	0	0	0	1
STD	0	0	0	0	0	0
Lice/ Scabies	0	0	0	0	0	0
*Human bite	0	0	0	0	0	0

*Individual #104 had a human bite May 2013, but it was not captured in this set of infection control data.

The infection control nurse maintained a line listing of individuals with MDROs and in March 2013 began collecting clustering data using current and retrospective data from January 2013 through August 2013. The Infection Control nurse had prepared an impressive analysis and investigation of the clustering of infections. The analysis included investigation related to the clustering common source of infection, break in technique, and control activities, such as communication, and education with appropriate departments, such as residential, nursing, and housekeeping.

Due to a number of urinary tract infections, including those with Foley catheters, the facility instituted a weekly meeting in July 2013 to more closely evaluate the underlying reason for the urinary tract infections. The infection control minutes and UTI committee minutes had duplication of their discussions and action steps, for example the infection control minutes and weekly meeting contained an analysis of data, and actions taken for that analysis. The facility should consider following its own Infection Control Committee Guidelines, May2013, which guide the committee meeting frequency. Given that EPSSLC also had increased changes in other infections, for example, an increase of wound soft tissue infections from none in June 2013 to seven in July 2013.

The infection control nurse was, and will continue to be, limited in her ability to have a more robust infection control program without the auspices of a medical director/physician to provide leadership and make decisions about infection control policies, procedures, and preventative practices for EPSSLC. Also see section L.

#	Provision	Assessment of Status	Compliance
		The infection control committee should consider: • Standardized surveillance definitions for long term care. • Identify and delineate line listing of infections whether if infected, hospital acquired or community acquired. • Campaign strategies to improve upon hand hygiene practices. The facility should consider annual education and vaccine campaigns to encourage influenza vaccine of all healthcare workers, especially those caring for individuals who are considered to have high-risk health care conditions. The monitoring team recommended EPPSLC follow their own policy Infection Control Committee Policy, May 2013, which requires core membership members to attend. <u>Wound and Skin Integrity</u> The facility conducted quarterly Skin Integrity Committee Meetings chaired by the Infection Control Nurse, and attended by RN Case Managers and Dietary staff. According to the Infection Control Nurse, the facility recently put in place a skin integrity database that included a listing of individuals with decubiti, soft tissue infections, fungal infections, and dermatology consults. Reportedly, the facility did not have any unresolved decubitus. The Skin Integrity Committee minutes provided a line listing of individuals by diagnosis, treatment, and whether or not the diagnosis was a new onset, reoccurring, or resolved. The minutes documented that 35 of 116 (33%) individuals had one or more diagnosed skin integrity issues from the period of 1/23/13 through 8/17/13. Thirteen of the 35 (34%) were diagnosed with a fungal infection (tinea pedis, tinea curis, tinea capitis, and tinea corporis) and nine of these 13 (69%) were documented in the minutes as resolved. The Infection Control Nurse reported that progress in the number of resolved fungal infections was due to the consultative services of a dermatologist, education and training of staff, and use of prevention activities to prevent contact transmission, such as shower shoes worn by the individuals when showering. Although, progress was noted in a number of resolved fungal infections, the monitoring team was concerned with regards to those individuals identified as having soft tissue infections, such as cellulitis and the reoccurrence of those infections. The committee should continue to assess and evaluate the underlying reason for the reoccurring cases of soft tissue infections. The Skin Integrity Committee would benefit from physician involvement for discussions of underlying pathophysiology of skin integrity issues, specific to the individual's health conditions (also see section L). In addition, the committee should consider the addition of other specialty team core team members, for example a member from the Physical Management Nutritional Team.	

#	Provision	Assessment of Status	Compliance
		Weight Management The Nursing Department continued weekly weight committee meetings and the monitoring team attended the meeting on 9/17/13. The committee was hampered in its ability to make progress with the identification of health problems, or how existing health problems may have competed with the individual's ability to gain, maintain, or lose weight without input from a medical director/physician (also see section L). The monitoring team reviewed the Weekly Weight Committee Minutes over the last five months (3/1/13 through 7/26/19) and found individuals were maintained on the lists for months and contained action steps "continue to monitor," which were perplexing to the monitoring team as to what was expected to be monitored. Throughout the minutes and during the weekly weight meeting, examples continued of new and old unresolved issues for obtaining and documenting accurate weights. The EPSSLC weight committee was in need of much improvement. Assessment and Documentation of Individuals with Acute Changes in Status EPSSLC held three consecutive Morning Meetings: the Patient Care Meeting (medical), Incident Management Review Team Meeting (IMRT), and Unit Meeting, of which the monitoring team attended 9/17/13 through 9/19/13. Nursing staff attended each of the meetings. EPSSLC reported that a written polices or procedures for the Morning Meeting or Unit Meeting did not exist because a standardized meeting minute format was utilized. The meeting was conducted in a positive and productive manner to review, discuss, and assign follow-ups related to the 24-hour report, hospitalizations, emergency room visits, clinic referrals, infection control issues, and incidents. The meetings were good examples where preventive and continuity of care activities were included in the discussions and integrated plans were made with defined timelines to complete the activities. The minutes format provided a method to track individual acute health care changes in status activities through resolution. The monitoring team attended Nurse Manager Meetings on 9/16 /13 and 9/17/13. These occurred at the discretion of the CNE and followed the daily morning Unit Meeting, where findings or additional information from the Morning Meeting, Unit Meeting, IMRT, Unit Meetings, and 24 hour report were discussed and reviewed in more detail. These were reviewed related to the expectations of nursing assessment, planning and interventions, and nursing protocols, and implementation of associated acute care plans of care. Reportedly, nursing staff were revising the 24 hour report toward a more effective report form. The Nursing Department also held weekly RN and LVN meetings. The monitoring team attended the weekly RN and LVN on 9/17/13. The meeting took place between the end of day shift and the beginning of the evening shift. The unit nurses provided a status report for individuals who were being monitored in accordance with the protocol cards to further ensure that enhanced communication and integration between disciplines were occurring related to the individuals' acute care changes. For example, direct support	

#	Provision	Assessment of Status	Compliance
		professionals status of being trained on the acute health care plan. The nurse educator also took advantage of the meeting to communicate changes in policy and procedures and to further ensure opportunities for questions or to clarify policy statements related to the delivery of care and services. The monitoring team will review at the next meeting changes made to the 24 hour report and whether the tool was being effectively utilized for reporting acute care changes. The CNE and nursing leadership initiated, in June 2013, a system of random record selection to review Acute Care Plans (ACP) selected from physician orders. The team included the NOO, nurse managers, and nurse who reviewed the 24-hour report, IPN notes containing the assessment, Acute Care Plan (ACP), and associated instructions for staff. The monitoring team attended one of the meetings where it was evident that the focus of the workgroup was to ensure prompt identification and implementation of individualized nursing interventions and health care plans related to the acute care changes and stemming from the individuals' current or newly diagnosed health conditions. The Nursing Department had not enough time to evaluate the effectiveness of the process. The monitoring team will review at the next visit. Although a number of processes had been implemented, across the 12 records selected for an in-depth review by the monitoring team, there were examples omissions of documentation to sufficiently assess and monitor the individual's change in health care status. For example: Individual #1: On 9/5/13 at 11:15 p.m., a direct support professional notified the nurse that the individual had not voided during the 2-10 p.m. shift. The nursing entry of 9/5/13 did not contain information that the RN was notified. The next entry documented on 9/6/13 at 5:40 a.m., where a nurse documented an in-and-out catheterization was performed. The record was problematic for: • Omission of an initial physical assessment for urinary retention. • Omission of documenting the results from the in and out catheterization. • Omission of documentation of an acute care plan. • Omission of an intake and output record. • Omission of a complete verbal order for the number of hours, if no void. • Omission of documentation when contacting the physician for inclusion of relevant data, current medications, allergies. Ensure nursing assessments contain sufficient information to represent the individual's health status and interventions, and results from medication orders are documented. The facility may want to consider the use of a portable bladder scanner to more effectively	

#	Provision	Assessment of Status	Compliance
		and efficiently assess bladder distention. Individual #104: On 6/1/13, documentation by psychology included that the "individual had been agitated since last night when he received two major bites." Documentation was not available of the physician being notified until 6/3/13. On 6/3/13, an order (with omission of time) was written for topical antibiotic ointment to the bite on the left shoulder, with a start date of 6/3 13 and a stop date of 6/8/13. The record was problematic for: • Omission of implementation of antibiotic therapy protocol (for the topical antibiotic). • Omission the individual's current immunization status was reviewed. • Omission the individual's HBV status was reviewed. • Omission and documentation on the last day of the prescribed antibiotic therapy whether or not the disease/condition had resolved. • Omission to initiate and follow Infection Control procedures for any Human bite. • Omission of Acute Care Plan for the initial date of 6/1/13 was resolved. The CNE should ensure staff are adequately trained on assessing a human bite. <u>Mock Code Drills and Emergency Response</u> The monitoring team conducted unannounced inspections for completed emergency checklists, presence, and operational emergency equipment/supplies on various units and found the units inspected in compliance with the exception of Unit 512, where blanks were noted on the Emergency Checklist for two consecutive days. The Nurse Manager, in attendance, verified with the monitoring team that all of the equipment and supplies were present and operational. The Nurse Manager immediately put in place a plan of correction. The monitoring team suggested she also consider adding this task to follow the already-existing shift-to-shift daily medication drug counts rather than as a separate document/task. EPSSLC's Emergency Drill Compliance Report from March 2013 through July 2013 had an overall compliance of 98.83%. EPSSLC submitted its Corrective Action Plans (CAPs) dated, 8/12/13, 8/19/13, and 8/23/13, for the following: staff delinquent with Cardio-Pulmonary Resuscitation training (CPR), implementation for tracking CPR delinquent staff, increase the number of CPR courses offered, development of realistic medical scenarios for mock drills by the nurse educator, and the occurrence of compliance during mock drills. EPSSLC had not had enough time to evaluate the CAP. The monitoring team will review at the next visit with the exception of the 8/23/13 CAP reported as closed and with documentation of current compliance with EPPSLC staff current with training requirements for CPR.	

#	Provision	Assessment of Status	Compliance

Quality Enhancement Efforts

The Nursing Department initiated a Nursing Case Study for Individual #113. The purpose for the Nursing Case Study was to evaluate nursing practice and standards of nursing care to determine effectiveness of nursing care. The monitoring team met with the CNE Nursing Leadership and specialty nurses for a review of the contributions from the Nursing Case Study by members of nursing leadership and the specialty nurses. The Nursing Case Study was a positive example of nursing's assessing, planning, and emulating care and services for an individual and using their findings to identify their own problematic areas and to develop plans of correction.

The monitoring team reviewed the document request submitted for review, the EPSSLC Presentation Book M1, self- assessment, and last six months of nursing audits. The following table provides data for the period of April 2013 to August, 2013

Audits	April	May	June	July	August	Overall
Documentation of Antibiotic Therapy	89%	33%	33%	57%	100%	62%
Documentation of Pain	67%	75%	85%	79%	89%	79%
Documentation of Vomiting	[redacted]	38%	89%	78%	88%	73%
Documentation of Urinary Tract Infection	39%	86%	64%	73%	79%	68%
Documentation of Post Anesthesia Care	96%	[redacted]	100%	[redacted]	100%	99%
Documentation Respiratory Distress/ Aspiration	71%	71%	86%	67%	86%	86%
Documentation of Seizure	50%	60%	60%	99%	67%	67%
Documentation of Constipation	17%	37%	68%	56%	[redacted]	45%
Annual Nursing Assessments	85%	97%	98%	100%	[redacted]	95%
Annual Nursing Care Plans	72%	93%	87%	87%	[redacted]	81%
HGG I/Urgent Care	33%	92%	100%	83%	[redacted]	55%
Infection Control	94%	78%	81%	87%	[redacted]	85%
Pain Management	93%	43%	50%	75%	[redacted]	65%

#	Provision	Assessment of Status	Compliance

Real Time Audits						
Infection Control	88%	89%	[redacted]	75%	[redacted]	84%
Skin Integrity	55%	90%	76%	72%	[redacted]	73%
SOAP	78%	86%	92%	77%	[redacted]	83%

EPSSLC audits included an individual analysis for the total number of audits, and scored by individual questions. For example, of 10 infection control audits, six had appropriate interventions to limit the spread of infection. There were, however, disparities between the overall department level of compliance score and the overall QA Audits Compliance score. Thus, ensuring the continuation of inter-rater reliability remained important.

The Nursing Department recently implemented a monthly Nursing Quality Assurance Committee Meeting with goals of reviewing data for compliance, producing corrective action plans, and establishing a formal relationship with QA. The monitoring team reviewed the monthly minutes from June 2013 and August 2013. The meeting membership included the CNE, NOO, QA Nurse, NOO, Program Compliance Nurse, Infection Control Nurse, and Nurse Managers. The minutes had evidence that the Nursing Department and QA Nurse were working hand in hand to ensure quality audits. The QA Nurse, however, was assigned as Interim Clinical Services Director, which impeded the continuation of inter-rater reliability processes. Further, in June 2013, the Program Compliance Nurse position was vacated, which left another void. The minutes also indicated problems with validity of the data, for example total audits were greater than actual conducted, and scoring was incorrect on the tool, specifically the Nursing Assessment and Annual Nursing Care Plans.

Interestingly, the decline in documentation of the protocols was attributed to noncompliance with the protocol cards.

To move in the direction of substantial compliance, the monitoring team recommends that the Nursing Department:

1. Ensure nurses consistently document health care problems and change in health status, adequately intervene, and appropriately record and follow-up on problems to resolution, once identified.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>M2</td><td>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.</td><td>The facility section M self-assessment documented noncompliance with this provision and the monitoring team concurred.

The monitoring team validated the information in the facility's self-assessment through independent review of the information presented in section M Presentation Book and review of documents, meetings/interviews with CNE, nurse educator, NOO, and review of training records, and record reviews.

The facility self-assessment of 7/31/13 reported that two new RN Case Managers had been hired; previously the unfilled positions and the absence of an RN Supervisor had hampered the CNE to move forward with the selection of an RN Case Manager lead. The current caseload was one RN CM to 20 individuals, until such time the RN Case Managers are trained and can accept the caseload. Each RN Case Manager tracked his or her own MOSES-DISCUS forms and Nursing Annual and Quarterly Assessments. Each RN Case Manager, however, had a different format, which made it difficult to discern how effective the tracking tools were. The Nursing Department should ensure a uniform format and tracking system for oversight and supervision of MOSES, DISCUS, and Annual and Quarterly Nursing Assessments.

The facility's self-assessment results for this provision reported the following results for percentage of nursing assessments submitted on time

<table><tr><td>March</td><td>April</td><td>May</td><td>June</td><td>July</td><td>Totals</td></tr><tr><td>75%</td><td>67%</td><td>64%</td><td>71%</td><td>91%</td><td>74%</td></tr></table>
The monitoring team selected a sample of records to review for the Admission, Annual, and/or Quarterly Comprehensive Nursing assessments completed over the last three months, including the current month for Individual #89, Individual #30, Individual #9, Individual #90, Individual #128, Individual #115, Individual #104, and Individual #74. The monitoring team found:
• Seven of eight (88%) Annual Nursing Assessments were completed according to facility policy prior to the annual ISP.
• Eight of eight (100%) Annual Nursing Assessments included the date and name of the RN completing the assessment.
• Three of eight (37%) interventions were sufficiently summarized in Section XI of the Nursing Assessment Form.
• Four of eight (50%) overall nursing summaries adequately summarized the individual's health status in relation to the nursing Problem/Diagnoses as to whether their health conditions were improving, maintaining, or regressing, and as to the effectiveness of the health care plans.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		• Eight of eight (100%) Annual or Quarterly Nursing Assessments included the individual's active medical diagnoses. In addition to the Nursing Department improvement in timely Annual Nursing Assessments, several of the nursing assessments showed improvement in content. As noted above, the nursing assessments elements require improvement. To move in the direction of substantial compliance, the monitoring team recommends that the Nursing Department should: 1. Ensure the RN Case Managers are visible though making rounds, attending onsite clinic appointments, and to ensure a communication process that keeps the RN Case Managers aware of changes in health care status 1. Ensure RN Case Manager continue to received competency based physical assessment, and the nursing process.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The facility section M self-assessment documented noncompliance with this provision and the monitoring team concurred. The monitoring team validated the information in the facility's self-assessment through independent review of the information presented in section M Presentation Book, and review of documents, meetings and interviews with the CNE, nurse educator, and NOO, and review of training records, record reviews, observation on the units, and attendance at the Morning Clinical Meetings and Quality Assurance Meeting. The facility's self-assessment results for this provision reported the following results: • 88% of the RN Case Managers had training in the new IRRF/IHCP process. • Acute Care Review Committee was implemented. • June 2013: 36% compliance rating for the acute care plans, and July 2013: 51%. <u>Monitoring Team's Review of Acute Care Plans</u> The monitoring team reviewed the most recent Acute Care Plans (ACPs) for the following individuals: Individual #90, Individual #30, Individual #128, and Individual #115. There were 11 that were recently developed and implemented. These ACPs had minimal improvement in individualization, quality, and how the individual participated in his or her health care plan. Findings included: • Ten of 11 (91%) included the signatures of the Home Managers and Direct Support Professionals validating training on the individual's health care plan. • Five of 11 (45%) ACPs reflected active health care problems; the health care problems had been resolved. • Four of 11 (36%) were sufficiently individualized to meet the individual's needs to resolve the acute change in health status.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• One of the 11 (10%) contained statements of interventions on how the individual would participate in his or her healthcare interventions. • Seven of 11 (63%) contained baseline data that were sufficient to describe the acute care change in health status that led to the need for the health care plan. • Six of 11 (55%) goals sufficiently described the desired outcomes as a result of the acute care plan interventions. <u>Nursing Discharge Summaries</u> From the period of 4/25/13 – 5/17/13, there were three discharges: Individual #78, Individual #31, and Individual #175. The monitoring team reviewed the Nursing Discharge Summaries and as applicable most recent Nursing Comprehensive/Quarterly Nursing Assessment, ACP, IHCP and Immunization Record. The monitoring team found: • None of the three (0%) contained information that validated that agency staff were trained on the individual's health care plan. • Individual #175 reportedly had sleep apnea, with a recommendation to use Positive Airway Pressure (CPAP), (a special machine that has settings that require respiratory or nursing judgment and assessment to set). However, the Nursing Discharge Summary did not address how the recommendation should be implemented in the community. Further, Individual #175 had Down's Syndrome, but there was no educational component to train staff on this. The facility should evaluate the effectiveness of the Nursing Discharge Summaries to ensure that the Nursing Discharge Summaries address continuity of care. To move in the direction of substantial compliance, the monitoring team recommends: 1. The Nursing Department should ensure RN Case Managers completing Discharge Summaries are trained on completing a Nursing Discharge Summary and communication of the information to the receiving community agency prior to the individual moving to the community 2. The facility should develop discharge guidelines.	
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.	The facility self-assessment self-rated substantial compliance for M.4. The monitoring team disagreed with the facility rating because there was insufficient evidence that state and facility policies, procedures, and protocol training had adequately transferred to nursing practice to meet the individuals' health needs. The monitoring team validated the information in the facility's self-assessment through an independent review of the information presented in section M Presentation Book, review of documents, meetings/interviews with CNE and nurse educator, and a review of training records, and record reviews.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The nurse educator had been in the position six months. She had done an outstanding job in continuing to bring competency based education to the front lines through a number of hands-on and didactic trainings, inservices, and communication processes, such as the Nursing Monthly Newsletter. The training materials reviewed included applicable case scenarios for nurses to exercise critical thinking skills. The Nurse Educator ensured training materials and supplies met the needs of the training, such as the use of mannequins. Training was planned in advance to assure schedules and shifts were not disrupted. The following initiatives were instituted since the last review: • Monthly Nursing Department newsletter • Implementation of monthly competency procedures testing • Implementation of monthly protocol Poster Presentation • Implementation of a Preceptor Program for RNs and LVNs • Implementation of LVN focused physical nursing assessment • Developed competency skills for direct support professionals (e.g., bathing, peri-care) • Developed educational program to improve integration of risk in the IHCP, ACP • Developed documentation competency course • Development of Nursing Competency database • Participation with respiratory, dental, infection control nurse, for a joint curriculum for competency training for direct support professionals on dental care and suction tooth brushing • Revised Nursing Orientation Requirements to ensure inclusion of RN Physical Assessment, Medication Administration for Nurses, Nursing Documentation Guidelines • Conducted a facility Mock Survey for Medication Administration • Protocol Poster Presentations • Developed a written Annual Competency Schedule for Nurses • Established a procedure for referrals for remediation • Conducted other applicable facility trainings to staff other than nursing, for example Do Not Resuscitate (DNR), Colostomy • Role of the Nurse in the ICF-MR Facility • Educational Flyers for non-nursing staff for example Bowel Obstruction Prevention <u>Competency Based Trainings/Inservices offered by the Nurse Educator</u> • Last five Protocol Cards • Physical Assessment RNs • Documentation/Development of Nursing Care Plans • Urine Dipstick/Catheterization	

#	Provision	Assessment of Status	Compliance
		• Skin Management • Emergency Procedures and Equipment • Neurological/Diastat/REACT • Protocol Cards • Mosby Physical Exam Series, Chapters 13, 17, 21 and 22 • Medication Administration for Nurses • Medication Administration Observation Guidelines • Kangaroo feeding Pump • Competency of the month Procedure Testing • Clinical Indicators of Health Status Change • Comprehensive Nursing Review and Assessment Guidelines • Nasogastric Tube Insertion Procedures • Nursing Care of Patients with Urinary Tract Infections (UTI) and associated UTI Nursing Protocol <u>Policies, Procedures, Protocols and Guidelines</u> The Nursing Department reported the following policies, procedures, and guidelines had been implemented or were in process since the last review: • Medication Administration for Nurses • Blood Pressure and Vital Signs • Seizure Safety • Protocol Cards (Pain, Hypoglycemia, Fall/Suspected Fall, Emergency /Hospital Transfers/Discharges, and suspected fracture/dislocation • Gastrostomy Tube: Insertion by a Nurse • Nursing Procedure: Enteral Nutrition The Nursing Educator had updated the competency data base, which was reviewed by the monitoring for the period of May 2013 through August, 2013 as follows:	

Course	% Completion Rate LVN	% Completion Rate RN
Medication Administration (May)	100%	95%
*Enteral Nutrition (May)	96%	69%
Hospitalization/Transfer/Discharges(May)	100%	100%
Neurological Assessment (June)	96%	100%
Care Plan Development (June)	100%	100%
Documentation Guidelines (June)	100%	100%
Care Plan Development (May)	100%	100%
Annual Competency	100%	100%
Diastat Administration	97%	100%

#	Provision	Assessment of Status	Compliance

Protocol Cards		
Pain (July)	100%	97%
Post Anesthesia/REACT	100%	95%

*Enteral Nutrition target completion date was December 13

The monitoring team reviewed IPN notes for the last three months and current month to review for Individual #74 and Individual #52.

- Individual #74: On 8/27/13 at 9:00 a.m., a direct support professional reported to the nurse the individual's "cough." The individual was assessed and medicated with Tylenol for "discomfort for cough" by the nurse. At 11:00 a.m., a second entry contained P (plan) and stated, "continued with dry cough." The MAR for 8/16/13- 9/13/13 had omission of when the PRN (when needed) Tylenol was administered. The next available note was 8/28/13: the individual was seen in the clinic, diagnosed with an upper respiratory infection (URI), and prescribed Robitussin DM for cough and Loratidine for allergic rhinitis. The start date on the MAR was different than the actual date from the prescriber and the name of the drug was incorrectly transcribed on the MAR. The next entry by Nursing was 9/12/13. An Acute Care Plan was not available in the record nor were there instructions for the direct support professionals for reporting changes and responses related to the medical diagnosis of URI. The individual's ISP indicated a pain management plan was not needed because the individual was able to communicate or tell staff when in pain by using gestures and pointing. The nursing assessment had an omission of communicating with the individual to assess discomfort.
- Individual #52's IPN notes had numerous entries, where the individual's vital signs or partial vital signs were refused by the individual. This was perplexing because a few IPN notes included a temperature and respiration and a few IPN notes recorded only a temperature. Documentation was not consistent for second attempts to evaluate the vital signs. On 6/21/13 at 5:00 pm, the IPN documented a concern by an RN with regard to history and assessment of low oxygen saturations at night during sleep. The nurse documented factors associated with the assessment or lack of assessments for oxygen saturation up the nursing chain of command. Episodic events of agitation during the early morning hours of sleep were documented in the record. Over a period of months, the MARs reflected the individuals refusing oxygen saturation checks. On 9/10/13 at 3:00 p.m., the individual had an in and out catheterization, and the record had an omission for documenting the urine output. The individual's health was not consistently assessed or adequately documented. The monitoring team concerns included no entries of the refusals being reviewed or a referral to the IDT for discussion, to include acknowledgment of Down's syndrome.

#	Provision	Assessment of Status	Compliance
		The nursing educator made improvements in the system, for example ensuring competency based documented training was completed, however, for this provision to meet compliance, there must be evidence the education/training was sufficiently transferred in addressing and documenting health care problems. To move in the direction of substantial compliance, the monitoring team recommends: 1. Ensure education/training for nursing assessments, and that nursing protocols are adequately transferred to meet individuals' acute, and ongoing, health needs. 2. Ensure systems are in place to address orders and assessments that are ongoing, with a designated timeline to re-assess the effectiveness. 1. Continue the positive practice of educating nurses about individuals with intellectual and developmental syndromes, for example Down's Syndrome.	
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.	The facility section M self-assessment documented substantial compliance with this provision. The monitoring team conducted its own review through interviews, and review of section M Self-Assessment, section M Presentation book, and other documents. The monitor team disagreed with the facility's self-rating of substantial compliance. For example, care plans were not sufficiently individualized to meet the individuals' needs. Further, the plans did not demonstrate integration with other disciplines to meet the total needs of the individuals. The monitoring team attended the ISP meeting on 9/17/13 for Individual #125, during which the revised IRRF and IHCP were used. The facilitator led a positive and productive meeting. The individual and his relevant support team attended the meeting. During the meeting, the RN Case Manager effectively and efficiently presented and advocated for a review of the individual's current lab work especially given the individual's diet, when determining risk factors. Although the monitoring team found some positive improvements in the quality of the clinical data presented for each risk area, the IDT continued to need improvement in ensuring that relevant clinical data are analyzed and correlated with related risk ratings in their identification of each risk. The following are positive and negative examples found regarding the interdisciplinary processes: • The clinical risk data for constipation did not adequately report the individual's elimination patterns or the effectiveness of the current bowel management plan with laxatives and PRN suppositories. Also not reviewed was any polypharmacy or any correlation with the increase in seizures. • The clinical risk rating for seizure included insufficient information that addressed the frequency, duration, and treatment modalities. • The clinical risk data for dental did not contain sufficient information by the RN Case Manager. An example was the effectiveness and/or problems encountered with daily oral care.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The clinical risk data for fluid imbalance was rated as low although the IHCP (which was prepared by the RN Case Manager) documented that, due to gastrointestinal problems and emesis, the individual was at risk for dehydration. • The clinical risk data for respiratory was rated as low, but did not contain information for the most current date of the Yearly Individual Tuberculosis Health History/Assessment to adequately address current risk. The monitoring team reviewed five of the most recently completed Integrated Risk Rating Forms and Integrated Health Care Plans for Individual #30, Individual #9, Individual #128, Individual #20, and Individual #115. The findings included: • Three of five (60%) IRRFS adequately provided integrated clinical risk data to support each of the risk categories Two of five (40%) had IHCPs completed to address the risk ratings. The monitoring team reviewed seven Trigger Data Sheets and IPNs when triggers were identified from 8/1/13 through 9/17/13 for Individual #89, Individual #90, Individual #1, and Individual #115 and found: • Three of four (75%) of the individuals had August 2013 and September 2013 Trigger sheets present in the unified record. • Two of seven (29%) sheets had individualized triggers. • None of seven (0%) sheets were reviewed and initialed by the nursing staff daily on the 6-2 shifts as required. • None of the (0%) sheets were reviewed and initialed by the nursing staff daily on the 2-10 shifts as required. • None of the seven (0%) sheets were reviewed and initialed by the nursing staff daily on the 10-6 shifts as required. • Four of the seven (57%) were reviewed and initialed by the RN Case Managers as required. • Two of seven (29%) had one or more triggers marked from 8/1/13 to 9/17/13. o Individual #115 had the following: spit –up during or after eating/feeding, coughing immediately after eating pureed solids, coughing while eating pureed solids, and coughing after drinking a small amount of liquid. o Individual #115 had 31 triggers identified during 8/1/13 to 9/17/13. Of the 31 triggers, 20 (65%) had a corresponding IPN follow-up to the trigger notation. o Individual #90 had the following: excessive coughing, excessive throat clearing, emesis, and gurgly voice. o Individual #90 had 66 triggers identified during 8/1/13 to 8/31/13. Of the 66, 51 (77%) had a corresponding follow-up in the IPN note.	

#	Provision	Assessment of Status	Compliance
		The records reviewed above were derived from a cross-section of individuals with high risk ratings, who required daily monitoring and documentation of their triggers. The CNE should ensure systems are in place to adequately review the individual's Trigger Sheets and ensure a corresponding IPN note for each trigger identified. There was a CAP dated 9/1/13, by the CNE, for development of processes of reviewing RN Case Managers nursing assessment and IDT process (IRRF and IHCPs). To move in the direction of substantial compliance, the monitoring team recommends the Nursing Department: 1. Ensure consistency across all ISPs, IRRFs, and IHCPs processes, as well as among disciplines in order to achieve compliance	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The monitoring team validated the medication administration presented in the facility's self-assessment by conducting medication observation passes, reviewing documents, attendance at the Medication Variance Committee, and inspections/observations of medication rooms. According to the facility's self-assessment, the facility was in substantial compliance with M.6. The monitoring team disagreed based on continued serious problems (e.g., following accepted standards of practice for administration), and lack of a formalized system to provide oversight and supervision to minimize medication variances. The CNE reported plans were in process for a system using the criteria of two medication variances, however, the severity of medication variances was not considered. <u>Administration</u> The monitoring team reviewed 10 of the facility's most current medication observations passes across all units and found: 1. Seven of 10 (70%) medication administration observations passes documented presence and utilization of specific assistive and positioning equipment according to the PNMP 2. Seven of 10 (70%) medication administration observation passes documented that infection control practices were followed 3. Six of 10 (60%) medication observation passes documented that prompting or immediate re-training was provide because a NO was scored. The monitoring team conducted unannounced medication observation passes during various time of the day and evening on the following 9 of the facility's 10 homes: 506, 507, 509, 511, 512, 513, A-dorm, B-dorm, and C-dorm. A total of 20 observations were conducted. The monitoring team also interviewed 11 nurses. The monitoring team was accompanied by a nurse manager for all observations. The observations included	Noncompliance

#	Provision	Assessment of Status	Compliance
		administration of topical, oral, and crushed medications; medications administered via tube; and medications administered with different mediums, such as applesauce and thickened liquids. The observations were measured against the facility's Medication Administration Guidelines. Findings from the observati0ns were as follows: • 10 of 20 (50%) of the medication observation passes required prompting by the attending nurse manager for adherence to infection control practices, for example washing of hands or use of hand sanitizer prior to/during/between medication passes, glove exchange, wiping of the cart, and wiping liquid medication bottles after administering. • 13 of 20 (65%) of the medication observation passes required prompting by the nurse manager for a variety of other reasons. Examples included positioning, instructions to the direct support professionals, allergy verification, identification of the individual, and follow-up assessment for coughing. The accuracy of the medication pass audits that were regularly conducted by the facility was questionable because the monitoring team ratings were not in agreement with the typical findings of these medication administration pass audits. The Nursing Department should collaborate with the QA Department to facilitate audits that include inter-rater reliability of the medication pass observations. Even so, a very good example was worthy of noting. The monitoring team prepared to observe medication administration by gastrostomy tube on Unit 511 for Individual #10. The individual could not receive medications/fluids due to a high residual. The RN did an outstanding job of assessing the individual's gastrostomy tube. The RN followed infection control practices, before, during, and after the assessment; appropriately checked placement and residual; and exercised critical thinking skills when determining contributing factors for the residuals. The RN provided clear and concise instructions to the individual and the direct support professional, related to the residual. The RN responded to verbal questions regarding the individual's plan of care for residuals, which demonstrated the RN's knowledge and skill. Overall, two serious issues were identified with medication administration. • Absence of or lack of consistent infection control practices. For example, hand washing, prior to, in between, and during the administration of medications. Nurses required prompting during the observations, indicating that hand washing was not a typical basic standard practice among the nurses. • Failure to follow the individuals PNMP plan for positioning, which required prompts A copy machine, located beside the medication cart, began to print documents during	

#	Provision	Assessment of Status	Compliance
		medication administration. This distracted the nurse administering the medications and the individual receiving medications, too. The room was serving dual functions. Further, the medication carts were not conducive to administering medications or for maintaining security and storage of medications. During medication administration, the nurse had to step in the adjoining room to complete hand hygiene, returning to lock the cart with a key, and unlock the cart, all of which further required the nurse to wipe down the key, wipe down the cart, and again wash her hands before resuming the medication pass. The top of the medication cart was inadequate for medication administration. For example the top was crowded with a medication book and supplies needed to administer the medications, leaving inadequate space for the individual's medications and mediums. Nosey cups were placed on the emergency equipment cart because lack of a dedicated space for dirty utensils. The Nurse Manager reported the locking system was inoperable on one of the medication carts and had a current work order in for now more than two weeks. On another unit, the pill crusher was dirty and taped to hold it together. The Nurse Manager immediately requested another pill crusher. The facility should provide an environment conducive to administering medications because distractions and workarounds can adversely affect outcomes for individuals. The facility should obtain medication carts that efficiently optimize space, improve workflow, and promote safety where the individual's medications are stored, administered, and recorded. The Nurse Educator and a team of two nurses conducted a Mock Survey on 4/18/13 related to Medication Pass Observations and Medication Room inspections. The detailed report was reviewed by the monitoring team. The following problems were identified by the facility: • Failure to follow standard of accepted practices for medication administration, such as pre-pouring and pre-setting medications. • Failure to meet medication administration guidelines, such as not administering medication within allowed time frames. • Failure to follow infection control practices. For example, sharps and contaminated medicine were placed in a plastic disposable cup on top of a cart. • Failure to have a Sharps container on the medication cart for placing sharps. • Refrigerator problems. To quote from the report: "Only one temperature log, but two refrigerators" and "Nurse was unable to identify specific log for the specific refrigerator." • Orders on the MAR were unclear, for example, the specificity for the route of administration. The Nursing Department should continue with processes to identify failures or absences of standard nursing practices to ensure safe medication practice and performance measures that identify continued poor performance by nursing.	

#	Provision	Assessment of Status	Compliance
		Documentation The monitor reviewed the Universal Signature Sheet, IPN, Medication Administration Record (MAR), PNMP, and applicable Enteral Treatment record for Individual #103, Individual #105, Individual #56, Individual #59, Individual #7, Individual #46, Individual #1, Individual #155, Individual #10, and Individual #116. The monitoring team found: • Blanks (omissions) on the MAR. For example, Individual #105, 9/8/13, medications for treatment of Begin Prostate Hypertrophy and high cholesterol; and Individual #116, 9/16/13, medication for treatment high cholesterol, medication for treatment of gastritis, and treatment for vitamin D deficiency. • Initials on the MAR were not comparable to the Universal Signature Sheet. For example, the name and initials for Individual #1's MAR. • Orders on the MAR had an omission of the route of administration. For example, Individual #1's read, "Beneprotein 3 scoops in a.m. with h20 (water) flush," Individual #10's read, "250 ml h20 (water) with (the next word in the order was illegible) feeding each q am noon pm & hs." • Orders were written on the MAR were problematic for a potential medication error for example Individual #116, "FYI –please give Zoster (shingles) vaccine when available S/Q x1". The 9/13 MAR did not contain documentation to clarify whether the vaccine had become available or had been administered. The facility should consider identifying criteria for orders to be transcribed to the MAR versus orders that should not be transcribed to the MAR. Was the intent of the MAR for medications, or as a catchment document for all treatments, assessments, and tasks? For example, Individual #10 had orders for SPO2 (oxygen saturation) checks (other two words illegible on the MAR). The SPO2 order had an omission of parameters for the oxygen saturation. Storage The monitoring team conducted focused reviews of medication administration rooms and storage of medications. External and internal medications were separated and expiration dates had not expired. Scheduled drugs were secured under double lock and documents were present for accountability of the scheduled drugs. Biohazard containers were available for use. The medication rooms, however, were cramped and lighting was poor. The monitoring team requested and reviewed the refrigeration temperature logs. Refrigeration temperature logs were problematic. For example: • Logs for homes A, B, (one unit), and the Large Activity Room (LAR) for the month of August 2013 could not be located, attributed to the nurse who was responsible resigning without submitting the logs.	

#	Provision	Assessment of Status	Compliance
		• The monitoring team was not given a February 2013 temperature log • The documentation format was problematic because none of the forms were identified as A, B, or LAR. The format was absent for any temperature range to alert staff to report (although one report in April 2013 had a handwritten note "temperature range of 36-46" degrees). September 2013 provided a refrigerator temperature of "60 degrees, reset." Home 506 in August 2013 reported three days of temperatures ranging from 48 to 64 degrees. Medications and vaccines efficacy are dependent upon maintaining consistent recommended temperatures. The facility should ensure refrigerators consistently maintain recommended temperatures, which may require replacing current refrigerators. <u>Oversight and Monitoring</u> The monitoring team reviewed the most recently completed 10 medication variances for Individual #109, Individual #45, Individual #78, Individual #10, Individual #46, Individual #9, Individual #15 Individual #56, and Individual #35. The review included two medication variances for Individual #10. The monitoring team found: • Seven of 10 (70%) medication variances were omissions. Two were prescribing variances and one was due to wrong medication administered (expired). • A variance occurred on 7/26/13, but was not discovered until 7/30/13. The variance form documented that three nursing staff on four different days, had committed the variance, thus, applicable nursing standards were not followed. • Four of 10 (40%) medication variances were discovered within 24 hours of the variance; and of the remaining six, five were discovered five days or later. • Nine of 10 (90%) medication variances documented the severity of the variance. • None of 10 (0%) documented sufficient information for the cause and for any corrective actions taken. A CAP from the CNE that was dated 8/18/13 was reviewed. It addressed a section of the medication form to be completed by the nurse manager and the nurse involved in the variances, and the CAP was to "assure <u>each</u> medication variance discussed with the nurse involved to include a review of medication administration policy/procedures, circumstances surrounding the variance and measure to be taken to improve practice compliance." The impact of the CAP will be evaluated at the next monitoring visit. The monitor conducted a review of the April 2013 through August 2013 Medication Variances Meetings Minutes, associated data, and attended the 9/17/13 Medication Variance Meeting. The meeting was chaired by the CNE. The meeting core members were in attendance with the exception of a physician (also see section L). The Medication Administration minutes contained detailed information for new and old topics,	

<table>
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<tr><td></td><td></td><td>appropriate action steps, and documented for those items the status/completion of the items.

The facility reported medication variance data longitudinally by date, individual, shift, location of variance, department responsible for the variance, severity index classification, node of variance, type of variance, medication, and medication dosage. The report included analysis by variance type and discussion for the errors (e.g., “omission: nurses are not reading the MAR and/or performing three checks prior to administering”). A positive finding by the monitoring team was the collaboration between pharmacy and nursing to reconcile medications, accomplished through nursing shift to shift count of medications, and verification of medication bins by pharmacy.

Medication Variances by month 4/13- 8/13:
<table><tr><td>April</td><td>13</td></tr><tr><td>May</td><td>13</td></tr><tr><td>June</td><td>19</td></tr><tr><td>July</td><td>13</td></tr><tr><td>August</td><td>20</td></tr></table>
The facility should make quality improvements to minimize medication errors, for example, the development a process to track the number of days between the date of actual variance and the date of discovery.

Pharmacy and Therapeutics Meeting
The monitoring team attended the Pharmacy and Therapeutics Committee meeting on 9/19/13, which included a Retrospective DUE: Constipation associated with Calcium Supplement. The actions taken as result of the Retrospective DUE study produced a number of positive outcomes. For example, a 41% decreased use of PRN (when needed) suppositories for the treatment of constipation occurred. For more information related to the pharmacy and therapeutics committee refer to section N8.

To move in the direction of substantial compliance the monitoring team recommends that the Nursing Department and facility;
1. Ensure Medication Administration Guidelines, 2/11, are fully operational through re-training, and shoulder-to-shoulder observations. When/if re-trainings are ineffective or disregarded, performances measures are in place to address the performance.
2. Obtain current/new models of medication carts that optimize patient and medication safety.
3. Ensure that biologicals (vaccines, etc.) efficacy are consistently maintained through refrigeration units.</td><td></td></tr>
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		4. Support the nursing department to assure work space areas designated for administering medications are conducive to administering medications. 5. Ensure all stakeholders (i.e., those who administer, prescribe, and dispense) actively attend and participate in the Medication Variance Committee in accordance with facility policy. 6. Ensure lessons learned from medication variances are fed back into practice.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.2: Medical Care, 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 6/13 o EPSSLC Quarterly Drug Regimen Reviews, 10/11 o Record Sample for Section L o Pharmacy and Therapeutics Committee Meeting Minutes, 2013 o Medication Variance Review Committee Meeting Notes, 2013 o Polypharmacy Committee Meeting Minutes, 2013 o Adverse Drug Reactions Reports o Drug Utilization Calendar for the next 12 months o Drug Utilization Evaluations, 2013 o Quarterly Drug Regimen Review Schedule, 2013 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #4, Individual #9, Individual #104, Individual #109, Individual #169, Individual #113, Individual #114, Individual #117, Individual #31, Individual #33, Individual #82, Individual #85, Individual #90, Individual #123 Individual #119 Individual #43, Individual #162, Individual #52, Individual #134, Individual #28 o MOSES and/or DISCUS evaluations for the following individuals: • Individual #161, Individual #16, Individual #18, Individual #24, Individual #23, Individual #128, Individual #4, Individual #8, Individual #9, Individual #10, Individual #104, Individual #109, Individual #111 Individual #66, Individual #72, Individual #75, Individual #114 Individual #113, Individual #117 Individual #28, Individual #36, Individual #37, Individual #38, Individual #78, Individual #79, Individual #82, Individual #83, Individual #89, Individual #123, Individual #125, Individual #126, Individual #127, Individual #119, Individual #188, Individual #162, Individual #96, Individual #172, Individual #52, Individual #54 o Pharmacy Intervention Forms completed since the last compliance review o Pharmacy Department access database for pharmacy interventions and Intelligent Alerts o Medication variance data for the past 12 months o Pharmacy Department Staff Listing

	Interviews and Meetings Held: o Giovanna Villagran, PharmD, Pharmacy Director o Christina Molina, PharmD, Clinical Pharmacist o Elaine Lichter, RN, Interim Clinical Services Director o Pam Richards, DO, Contract Primary Provider o Maria G. Famatigan, MD, Contract Primary Provider o Ramesh Komaragiri, MD, Contract Primary Provider o Eugenio Chavez-Rice, MD, Psychiatry Director o May Ann Clark, RN, Chief Nurse Executive Observations Conducted: 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 submitted three documents as part of its assessment: the self-assessment, provision action information, and the action plan. 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. For Provision N1, the self-assessment reported a series of audits that addressed the dispensing of medications. The results indicated 100% compliance with nearly all items. This was slightly higher than that observed by the monitoring team. Provision N3 included several actives to determine compliance with requirements. The monitoring for metabolic syndrome was documented as 100% compliance. This addressed the presence of the discussion. The self-assessment should include some assessment of the quality of the comments. With regards to monitoring for metabolic syndrome, the self-assessment should note the documentation of the actual results and the clinician pharmacist's assessment of the significance of the findings. 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 monitoring team agreed with the self-ratings for provision N1, N2, N3, N4, N5, and N7. The monitoring team found provision 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. The most significant advancements were seen in the areas of communication between the pharmacists and prescribers. The pharmacy department transitioned documentation to the WORx system and fully implemented in Intelligent Alerts module in June 2013. As required, information was shared with the medical staff and discussions related to trends were discussed. EPSSLC continued to complete the QDRRs in a timely manner. However, some decline in the clinically applicability and relevance of the QDRR information was noted. The monitoring for metabolic syndrome risk was one very important area that was noted to need attention. Overall, the system was adequately executed. Polypharmacy, stat drug use, and the anticholinergic burden continued to be addressed in the QDRRs as required. As already noted, the facility will need to provide additional focus related to the use of new generation antipsychotic medications and the various aspects of monitoring. The medical staff usually accepted the recommendations of the clinical pharmacist. While recommendations were sometimes difficult to tease out of the comments section of the QDRR, each provider received a list of the QDRRs completed, which included recommendations for each individual. The pharmacy staff also conducted follow-up on the status of the recommendations. The MOSES and DISCUS evaluations were completed by nursing staff and reviewed by the psychiatrist. Increasing delays were seen in the psychiatry review of the documents and there was no evidence that the primary medical providers reviewed this information, even when the findings were abnormal. The pharmacy did a good job in completion and follow-up of DUEs. Documentation indicated that corrective actions were implemented when appropriate and were followed up to completion. The medication variance system appeared to make progress in the areas of medication reconciliation, however, the monitoring team had difficulty in assessing the overall progress because the facility did not provide sufficient data on the extent of each variance. This was noted in the previous monitoring report, was discussed with the CNE in March 2013, but was not addressed. Moreover, the facility did not have a truly multidisciplinary approach because medical representation by a primary medical provider was essentially non-existent.

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<tr><td>N1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.</td><td>The pharmacy director reported that prospective reviews were completed for all new orders through the WORx software program. The program checked the standard parameters, including therapeutic duplication, drug interactions, and allergies.

The policy Prospective Review of Medication Orders, revised in June 2013, described the dispensing process utilized in the pharmacy department. In addition to the standard processes and implementation of the Intelligent Alerts, the procedure noted the following:
1. Dispensing of psychoactive medications was addressed through the procedure Psychoactive Medication Pharmacy Review. Baseline labs for new orders were addressed through this process and not the Intelligent Alerts.
2. The pharmacy interventions were entered into WORx as well as the department's access database.
3. The list of medications requiring prospective lab monitoring was amended by the pharmacy director and/or clinical pharmacist.

EPSSLC fully implemented the use of the WORx system to track clinical interventions and prospective lab monitoring in June 2013. Thus, the Pharmacy Intervention Forms were no longer completed to document discussions between the pharmacists and prescribers. The monitoring team requested copies of all pharmacy interventions documented since the last onsite review and a copy of the log summarizing the types of interventions. The summary data provided is presented in the table below.

<table>
<tr><td colspan="4">Pharmacy Intervention/Intelligent Alert Summary 2013</td></tr>
<tr><td></td><td>Jan - Mar</td><td>Apr-May</td><td>June - Aug</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Contraindications</td><td>2</td><td>--</td><td>3</td></tr>
<tr><td>Indications</td><td>19</td><td>10</td><td></td></tr>
<tr><td>DDI</td><td>18</td><td>5</td><td>9</td></tr>
<tr><td>Duplication</td><td>5</td><td>3</td><td>5</td></tr>
<tr><td>Non Formulary Drug</td><td>12</td><td>10</td><td>--</td></tr>
<tr><td>Lab Monitoring</td><td>46</td><td>42</td><td>--</td></tr>
<tr><td>Not Available</td><td>26</td><td>17</td><td>--</td></tr>
<tr><td>Other</td><td>45</td><td>26</td><td>--</td></tr>
<tr><td>Order Clarification</td><td>--</td><td>--</td><td>58</td></tr>
<tr><td>Consult</td><td>--</td><td>--</td><td>4</td></tr>
<tr><td>Drug Information</td><td>--</td><td>--</td><td>1</td></tr>
<tr><td>Total</td><td>173</td><td>113</td><td>80</td></tr>
</table>

Order clarification addressed issues such as dosage form changes, strength, drug changes, frequency, and duration. The minutes of the Pharmacy and Therapeutics Committee documented discussions related to the pharmacy interventions. However, the medical staff was usually not present at the Pharmacy and Therapeutics Committee meetings.</td><td>Substantial compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		The WORx documentation noted the problem/concern, medication involved, discussion with prescriber, recommendations, acceptance/rejection, and follow-up when appropriate. WORx and record documentation provided evidence that the prescribers usually accepted the recommendations and took the appropriate actions based on the recommendations. 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 facility implemented the Intelligent Alerts module in June 2013. In addition to the required mandatory lab monitoring, EPSSLC prospectively monitored several additional drugs. At the time of the review, the facility conducted prospective lab monitoring for carbamazepine, digoxin, fenofibrate, lactulose, levothyroxine, lithium, primidone, statins, terbinafine, topiramate, valproic acid, vitamin D, and warfarin. The access database maintained by the department included data related to the intelligent alerts in addition to the pharmacy interventions. Discussions relevant to the IAs were documented in the Pharmacy and Therapeutics Committee meeting minutes. As previously noted, the medical staff did not routinely attend this committee meeting. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. In order to maintain substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The pharmacy director should continue to provide information to the medical staff regarding the areas of concern. The clinical services director/medical director should review data, noting trends, provider practice patterns, and areas of concern. Corrective actions, when warranted, should be implemented and followed to closure. 2. The pharmacy director should <u>collaborate with the medical staff</u> regarding any decisions to further expand the prospective lab monitoring medication list.	

#	Provision	Assessment of Status	Compliance
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.	Twenty-two 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 period. All subsequent review periods will be set in three month increments from the initial review period…" The monitoring team reviewed the 2013 QDRR schedule submitted by the facility and found no deficiencies related to timely completion. Review 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. Staffing changes in the department resulted in the transfer of responsibility for completion of the QDRRs. The current pharmacy director previously completed the QDRRs. Upon assuming the position, she began training the clinical pharmacist to complete the evaluations. Thus, the vast majority of evaluations reviewed were those completed by the clinical pharmacist. Overall, the content of the evaluations was adequate. The monitoring team observed some decline in the content and clinical applicability of the QDRRs compared to the previous compliance review. Several of the concerns were related to issues seen in previous reviews and commented upon in previous reports: • The QDRR Report did not include comments on every medication included in the monitoring report. The reports continued to list that monitoring was appropriate and consistent with the standards of care and lab matrix. This statement appears to refer to the frequency of the monitoring. However, the QDRR must address abnormal findings and this was not consistently done. The facility submitted worksheets for the sample of QDRRs submitted, however, worksheets were not a part of the final report included in the active records resulting in the omission of relevant information. • The monitoring for metabolic syndrome risk failed to actually assess the risk. The comments usually included the dates for HbA1c and lipids, but did not provide the results. Moreover, there was no discussion of abnormal findings. In some instances, this resulted in comments that were not clinically relevant. Individuals with abnormal findings and a diagnosis of diabetes mellitus	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		continued to have discussions related to risk of metabolic syndrome even though the comments should have focused on medical management of diabetes mellitus. • The QDRRs did not address inappropriate indications. This was primarily noted in the prescription of psychiatric medications. • At times, the QDRRs did not address important monitoring elements. In the case of Topamax, the lab matrix required weight monitoring, but this was not noted in the comments. Moreover, monitoring for the complications of metabolic acidosis, as recommended by the manufacturer, was not consistently seen. The lab matrix required periodic BMPs as part of this requirement. • Renal protection with the use of ACE/ARBs was not included in the documentation of diabetes monitoring. The following are a <u>few examples</u> of the clinical issues surfaced through review of the QDRRs: • Individual #43, received topiramate. A low CO2 was noted in the worksheets, but there were no comments in the report. The drug manufacturer recommends periodic monitoring for the complications associated with metabolic acidosis. The CO2 level serves as a screening for the development of metabolic acidosis. The drug manufacturer considers this an adverse drug reaction, but the facility did not report such occurrences as <u>suspected ADRs.</u> • Individual #82, 5/31/13: This individual received topiramate, but did not have documentation of weight. The last BMP was dated 5/30/13, but the CO2 level was not noted. • Individual #104, 6/21/13: The last EKG was dated 11/11. There was no recommendation to obtain the required EKG. Notwithstanding the issues highlighted, the QDRRs were generally completed in accordance with state and facility guidelines. The evaluations were well done, completed in a timely manner, and provided valuable information to medical providers and the IDTs. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. In order to maintain substantial compliance, the monitoring team offers the following recommendations: 1. The monitoring team continues to recommend that he <u>QDRR Report</u> 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. 2. The clinical pharmacist should provide laboratory values relative to monitoring	

#	Provision	Assessment of Status	Compliance
		for metabolic syndrome. There should be some statement regarding the risk as well as recommendations, when appropriate, for risk mitigation.	
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. The effectiveness of the medications was not consistently documented as noted in previous compliance reviews. 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 for all conditions. The clinical pharmacist usually noted that the use of polypharmacy was consistent with the standards of care. In many instances when polypharmacy was noted, the clinical pharmacist made comments related to justification of polypharmacy. There were opportunities to provide recommendations for reduction of polypharmacy particularly in the management of chronic constipation. 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 for 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. Each QDRR, which was completed for an individual receiving new generation antipsychotics, included comments related to metabolic and endocrine risks. However, for some key criteria, such as glucose and lipid monitoring, the comments were limited to the dates of the studies. This approach resulted in a failure to provide substantive comments on the actual risks as well as transition to discussions related to diabetes management. As seen in the previous	Substantial Compliance

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		compliance reviews, several QDRRs noted that BPs was not documented in accordance with the requirements of the facility's protocols. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. In order to maintain substantial compliance, the monitoring team offers the following recommendations for consideration: 1. When appropriate, the clinical pharmacist should make recommendations for reduction of polypharmacy. 2. The clinical pharmacist should provide specific values for the parameters related to the monitoring for metabolic risk. Additionally, there should be comments on the significance of the values relative to the overall risk for metabolic syndrome.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Compliance for this provision item was assessed based on the provider's responses to both prospective and retrospective recommendations. Documentation, such as the clinical intervention forms, IPN entries, and physician orders indicated that overall, the providers accepted the recommendations made by the pharmacists during the prospective and retrospective reviews. Prescriber response to prospective reviews is detailed in section N1. The QDRR pharmacy recommendations were included within the recommendations and comments section and at times continued to be difficult to identify. In recent months, the pharmacy department added the term "specific recommendations" to indicate issues that required the attention of the prescribers. The clinical pharmacists continued the practice of providing the medical staff with a summary of QDRR recommendations and alerting them when additional follow-up or actions were needed. The medical staff usually agreed with the recommendations made by the clinical pharmacists. When recommendations were not accepted, comments were provided on the reports to explain the decision. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance.	Substantial Compliance

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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: Twenty nine MOSES evaluations were reviewed for timeliness and completion: • 28 of 29 (97%) evaluations were signed and dated by the prescriber • 26 of 29 (90%) evaluations documented no action necessary • 2 of 29 (7%) evaluations documented actions taken, such as drug changes and monitoring • 9 of 29 (31%) evaluations had a delay of two weeks or more before the physician review was completed Twenty six DISCUS evaluations were reviewed for timelines and completion: • 26 of 26 (100%) evaluations were signed and dated by the prescriber • 24 of 26 (92%) evaluations indicated no TD was present • 2 of 26 (8%) evaluations indicated the presence of TD • 3 of 26 (6%) evaluations had a delay of two weeks or more before the physician review was completed All documents reviewed were completed by the psychiatrist at EPSSLC. At times, the psychiatrist also made additional comments based on the medical/psychiatric assessments. While the psychiatrist considered the findings documented by the reviewers, the primary providers did not acknowledge or address abnormal findings. 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. Problems with the timelines were noted in the previous compliance review, with 9 of 61 (15%) evaluations demonstrating a delay of two weeks ore more. It appeared that there was a continued need for additional work in order to meet the requirements for timely completion. Some documents were not dated. Moreover, it was noted that the facility submitted only one of the evaluations for several individuals when both were required. In most instances, the monitoring team was able to determine, through documents, such as emails, that the un-submitted documents were overdue. Overall, 12 of 55 (22%) evaluations reviewed had significant delays. The sample size for this review was slightly reduced because the facility did not submit the required number of evaluations. There was overlap because several of the evaluations submitted were reviewed with the record	Substantial Compliance

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		sample. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. In order to maintain substantial compliance, it will be necessary to address the following areas of concern: 1. There must be improvement in the timely completion of the evaluations. The prescriber review must be completed in accordance with facility policy and procedure. This timeline should be no greater than two weeks. 2. The primary providers are responsible for the provision of all health care services. They should be aware of and acknowledge the presence of all medication side effects. 3. The neurology consultant should be provided the MOSES and DISCUS evaluations for review as part of the clinic procedure.	
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. Training continued in New Employee Orientation in addition to annual refresher training. Twenty-six ADRs were reported during 2012. Eleven ADRs were reported from January through July 2013. Six of the eleven ADRs were reported since the last compliance review. The ADR policy was revised to include the Hartwig severity assessment scale. Since this threshold is primarily utilized in hospital settings, the criteria need to be adjusted for a long-term care facility. For EPSSLC, a Level 4 reaction could potentially correspond to reactions that required ED evaluation or hospital admission since the original scale criteria included the ADR as the reason for the admission. The current policy did not outline the threshold for review, such as hospitalization or emergency department assessment. Additionally, the policy did not provide guidance for the review by specifying the participants and additional steps. The ICA should focus on analysis of systems, which requires review by a multidisciplinary panel with medical, nursing, pharmacy, and QA representation. For example, if an ADR is associated with an allergic reaction that required hospitalization or a prolonged emergency department stay, an intense review should be conducted to determine if the event was preventable. Most notably, there should be a review of the systems for identification and documentation of allergies. The review should be triggered by the threshold. The monitoring team noted many issues in the records related to allergy discrepancies.	Noncompliance

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		Individual #157 was started on diphenhydramine for a rash that was associated with antibiotic use, and eventually erupted over the entire body. Antihistamines were prescribed for 10 days and a change in the antibiotic treatment was required. This information was taken from the pneumonia listing, as it was not reported as an ADR. Individual #43 had a low serum CO2 that may have been associated with the use of topiramate. This was not reported as a suspected ADR. The drug manufacturer considers metabolic acidosis (a low CO2 may serve as a surrogate marker for metabolic acidosis) to be an adverse drug reaction. Individual #162 had elevated LFTs associated with terbinafine, however, this was not reported as a suspected ADR. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. Additional training is needed in understanding the criteria for reporting adverse drug reactions. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The pharmacy director should work with state office in clarifying the criteria for reporting Type A and Type B ADRs. (Though the state does not use the Type A and Type B terminology, the distinctions made by this type of classification system may be helpful to the facility.) Once this is done, the medical staff must receive additional training and understanding the importance and value in reporting ADRs. 2. ADR data should continue to be collected, analyzed, and trended. 3. The ADR policy should be revised to set a specific threshold for the Intense Case Reviews.	
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	In accordance with facility policy, EPSSLC continued to maintain a DUE calendar that was determined by the P&T Committee. As required, one DUE was completed each quarter. Supplemental DUEs were completed as deemed necessary. Since the last onsite review, DUEs were completed on benzodiazepines and proton pump inhibitors. A DUE on constipation associated with calcium drugs was presented during the Pharmacy and Therapeutics Committee meeting conducted the week of the compliance review. The DUEs were thoroughly done, included recommendations, and were presented during the P&T Committee meetings. The committee meeting minutes documented the essential	Substantial Compliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.</td><td>findings, recommendations, action steps, and follow-up.

<u>Compliance Rating and Recommendations</u>
The monitoring team agrees with the facility's self-rating of substantial compliance.</td><td></td></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.</td><td>The medication variance program demonstrated improvement in some areas. Progress was made in reconciling bulk and liquid medications and prescribing errors were being documented. The overall medication data provided to the monitoring team are summarized in the table below.

<table>
<tr><td colspan="12">Medication Variances 2012 - 20113</td></tr>
<tr><td></td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td></tr>
<tr><td>Admin</td><td>31</td><td>22</td><td>33</td><td>9</td><td>24</td><td>26</td><td>35</td><td>12</td><td>17</td><td>11</td><td>16</td></tr>
<tr><td>Disp</td><td>0</td><td>1</td><td>0</td><td>5</td><td>3</td><td>1</td><td>0</td><td>0</td><td>0</td><td>2</td><td>3</td></tr>
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<tr><td>Prescribing</td><td>5</td><td>1</td><td>4</td><td>6</td><td>2</td><td>2</td><td>6</td><td>4</td><td>2</td><td>4</td><td>0</td></tr>
<tr><td>Trans</td><td>2</td><td>4</td><td>1</td><td>3</td><td>4</td><td>1</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td></tr>
<tr><td></td><td>39</td><td>31</td><td>39</td><td>24</td><td>34</td><td>37</td><td>42</td><td>18</td><td>19</td><td>23</td><td>20</td></tr>
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Prior to the compliance review, the monitoring team requested data, including variance specific data and aggregate data. This was discussed onsite with the CNE who submitted the same data, which the monitoring team had explained, were inadequate. Specifically, as noted in detail in the March 2013 monitoring team's report, the data did not provide information sufficient to determine the magnitude of the variances. This was due to the system of reporting each incident as one variance. Thus, per state policy, a variance that resulted in multiple incidents over days, weeks or even months, was reported as one variance. The impact of missing one dose of medication, such as a multivitamin will differ distinctly from omission of an AED for several days. The spreadsheets reviewed could not differentiate between such errors. Without additional data, the monitoring team could not determine if the number of variances accurately represented the <u>magnitude of variances</u> occurring at EPSSLC.

The problems with the variance system extended beyond tallying the number of variances. Numerous issues effectively blunted the utility of the medication variance system:
• The Medication Variance Committee meeting minutes did not adequately outline the corrective actions taken to remediate variances. The comments were limited to one or two line statements, such as counseling and training.
• Physician errors were consistently documented as "PCP error in writing order." By definition, the prescription errors are errors of order writing. Such descriptions were redundant and provided no information on the types of</td><td>Noncompliance</td></tr>
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		prescribing errors or the magnitude of the variances. Even though there were several prescriber errors recorded, the documentation reviewed provided no discussion of an analysis of the data or how the errors were addressed. • Attendance records revealed there was no participation by any primary or psychiatric medical providers in the five Medication Variance Committee meetings conducted since the March 2013 compliance review, however, the psychiatry director was present for the meeting conducted during the week of the compliance review. In addition to work done by the Medication Variance Committee, a summary of data was also presented during the most recent P&T Committee meetings. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility's data should reflect the magnitude of the variances by indicating the drug(s) involved and the number of days the variance occurred. 2. The committee meetings should be multidisciplinary and therefore require consistent participation by a primary medical provider. 3. In accordance with state policy, each discipline should present variance data during the meetings and outline the corrective actions taken to address variances.	

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 Physical Nutritional Management Policy o Habilitation Therapy Services Policy o PNMT Staff list, back-ups, and Curriculum Vitae o Staff PNMT Continuing Education documentation o List of Medical Consultants to PNMT o Section O Presentation Book and Self-Assessment o Section O QA Reports o PNMT Evaluation template o PNMT Meeting documentation submitted o Pneumonia Committee meeting minutes o Weight Committee meeting minutes o Medical Meeting minutes o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o List of Individuals Discharged from the PNMT in the last six months o PNMT meeting review form template o PNM spreadsheets o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Completed Compliance Monitoring sheets submitted o Instructions for Monitors o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Documentation of staff training submitted o Hospitalizations for the Past Year o ER Visits o List of individuals who cannot feed themselves o List of individuals requiring positioning assistance associated with swallowing activities o List of individuals who have difficulty swallowing 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 submitted o APEN Evaluations for Individual #90, Individual #15, Individual #162, Individual #113, Individual #57, Individual #10, and Individual #93, o PNMT Assessments and ISPs submitted for the following: Individual #4 and Individual #32 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #125, Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15 and Individual #114 o PNMP section in Individual Notebooks for the following: • Individual #125, Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15 and Individual #114 o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #125,

	Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15 and Individual #114 <u>Interviews and Meetings Held</u>: o Leslie Ambruster, MS, CCC-SLP, Director of Habilitation Therapies o Blanca Ibarra, RN o Helga Carrion, RD, LD o Karin De La Fuente, MS, CCC/SLP o Jennifer Ochoa-Evers, OTR o Eric Herrera, PT o Various supervisors and direct support staff o MIT meeting o Weight Committee meeting o PNMT meetings <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o ISP Meeting for Individual #125
	Facility Self-Assessment: The self-assessment completed by Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director, was an excellent first effort. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team. Findings were generally reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The foundation laid over the last couple of years by Susan Acosta, the previous Director, was vital to the successful transition of leadership during this last six month period. Both of these professionals are commended for their strong dedication to the success of this department. Ms. Ambruster and the Habilitation Therapies staff were on track to ensure that progress is made for the next review. Progress had continued and the plan outlined was a sound one and combined with the findings of this report should guide them to make greater strides over the next six months. Benchmarks should be established in measurable terms and used to establish measures for success and progress. Though much continued work was needed, the monitoring team acknowledges the work since the last review. The facility rated itself in noncompliance with O.4, O.7, and O.8. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings. The facility rated itself in substantial compliance with O.1, O.2, O.3, O.5, and O.8. The monitoring

	team concurred with the facility's self-assessment of continued substantial compliance with O.1. The monitoring team did not concur related to O.2, O.3, O.5, and O.8 for issues outlined in the following report. While the system of training appeared to be sound, the extent of concerns noted, suggested that the translation of staff knowledge and training had not fully been integrated into their routine application to implementation. The system of monitoring did not appear to accurately reflect actual performance and revision and refinement was indicated. The approach to Mealtime Coordination was a good first step in infusing training with expectations to achieve more substantial system change. There were a number of other initiatives recently implemented that should contribute to positive change in the direction of substantial compliance in these areas.
	Summary of Monitor's Assessment: As in previous reviews, it was evident that a tremendous amount of work had been done in this area. The new Director demonstrated confidence during her first compliance review. She appeared to have the knowledge and skills, with the right balance of perseverance and patience, to move the department forward. There was a fully constituted PNMT. The PT and SLP members had been consistent over most of the monitoring team visits. The OT had been consistent across several reviews. The dietitian was new, though the previous one had been consistent since the baseline review. It was noted that there would be a replacement in that position again soon. The nurse was again new. In fact, since a nursing position was established for the PNMT, there had been a new nurse with each onsite visit. Ms. Ibarra appeared to be very capable. This was a key position relative to communication with others and to leadership of the team itself. There was clear improvement in streamlining the content of the weekly documentation maintained, but there was need to better organize it in a manner such that they could readily access information from a historical perspective and, most importantly, that it would become more user friend to the IDTs and medical staff. During the meetings observed, the team demonstrated excellent discussion and problem solving. After review of their documentation, it was evident that the assessments and other documentation did not clearly and concisely reflect that. Generally, mealtimes were consistent with the last visit. For example: • Some of the cottages still required prompts to have the Dining Plans out when individuals were eating. • The flow for serving individuals continued to be awkward in some areas, resulting in many individuals sitting at the tables for extended periods without their meal. In some cases, fluids were provided, but those were typically finished very quickly. This practice lends itself to potential behavior issues arising and also contributed to the poverty of participation and engagement as a part of the overall mealtime experience. • Texture and consistency issues related to bread, particularly for chopped were noted.

	• There were issues related to the preparation of thickened liquids, with two different recipes available to staff and variations across preparation techniques were noted. It was of concern that this had not been picked up via self-review across the many layers of monitoring that were supposed to be in place. • Staff generally followed the presentation strategies, but seemed to have less compliance with special techniques outlined in the plans, such as spoon placement. The Mealtime Improvement Team had been working well together to establish the state-wide initiative for Mealtime Coordinators (MTC). It was reported that 99% of DSPs had completed the classroom training and written test. Approximately 25% had been validated to date, and the goal was 100%. This was a great example of how the facility could proceed with the resolution of other PNM-related concerns. For the most part, positioning plans were followed, with only a minority of individuals who were not in proper alignment. Staff did re-position individuals before meals, or provide prompts to others to do so. Techniques use to accomplish this were not always effective. Transfers were not as consistent with generally accepted practice. Errors were noted with gait belt use for standing transfers. Staff did not permit sufficient weight bearing for stand pivot transfers and there were errors noted in the use of mechanical lifts. The Weight Committee had been established prior to the previous compliance visit and continued to be in place. This was in response to significant issues related to weigh identified by the monitoring team. Consistent with the last review, the monitoring team identified issues related to the organization of the meeting itself, as well as the documentation. There were issues identified within the meeting related to the system of weighing and measuring heights that should have been remedied a year ago as there continued to be many inaccuracies. There was a need to identify key clinical indicators that would be reviewed by the Committee. Again, there was a need for medical participation during the meeting because there were many questions that came up that required physician input to effectively impact the course of discussion, the identification of outcomes, the development of plans, and the course and the efficacy of intervention plans. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 12 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 the individuals who were assessed or reviewed by the PNMT over the last six months.

	Sample O.3 consisted of individuals who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to 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	EPSSLC used the state-issued PNM policy (#012.3, effective 3/4/13), though had not formally operationalized it. A document dated 3/14/13, PNMT Process, outlined the local process as implemented at the time of this review. An older PNM policy further outlined a similar process. • The facility did not have a single comprehensive PNM policy that addressed the scope of PNM issues outlined below, but rather, through a combination of facility policies, guidelines and procedural documents, generally outlined a complete and comprehensive system of Physical Nutritional Management. Though each of the following elements were not specifically outlined in those documents, these were clearly in practice at the time of this onsite review: o Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); o The annual review process of an individual's PNMP as part of the individual's ISP; o The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; o The roles and responsibilities of the PNMT; o The composition of the facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; o Description of the role and responsibilities of the PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); o The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; o Requirements for continuing education for PNMT members; o Referral process and entrance criteria for the PNMT; o Discharge criteria from the PNMT; o Assessment process;	Substantial Compliance

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	therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	o Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; o The PNMT consultation process with the IDT; o Method for establishing triggers/thresholds; o Evaluation process for individuals who are enterally fed; o PNMT follow-up; o Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; o A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: ▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, ▪ Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), ▪ Identification of monitors and their roles and responsibilities, ▪ Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, ▪ Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and ▪ Frequency of monitoring to be provided to all levels of risk. o A system of effectiveness monitoring; and o Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. ▪ Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; ▪ Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; ▪ Process for the Habilitation Therapies and the PMNT to present the identified systemic issue (e.g., Medical Morning meeting, QA/QI meeting); ▪ A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan). ▪ Process to determine effectiveness of actions taken, and revision of corrective action plans as necessary;	

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		▪ If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate, to measure the resolution of systemic issues. <u>Core PNMT Membership</u>: • The PNMT at EPSSLC included the appropriate disciplines as defined in the Settlement Agreement. Each was a part-time team member who had other clinical duties, with the exception of the nurse, which was a full time position. Team members included the following with start dates: o Blanca Ibarra, RN (6/17/13) o Helga Carrion, RD, LD (5/14/13) o Karin De La Fuente, MS, CCC/SLP (8/1/11) o Jennifer Ochoa-Evers, OTR (11/5/11) o Eric Herrera, PT (8/1/11) New members beginning during this review period included the dietitian and the nurse. Back-ups for each position had been assigned. <u>Consultation with Medical Providers and IDT Members</u> The current medical staff were listed as the physician consultants to the team (full names and titles were not provided): Dr. Don Apodaca, Dr. Pamela Richter, Dr. Ramesh Komaragiri, Dr. Famatigan, Dr. Juan Contin, Dr. Eugenio Chavez-Rice, Dr. Lujan, Dr. Pray, Dr. Hand The physicians at EPSSLC did not routinely attend PNMT meetings (only 2% of all meetings held), though they did attend some IDT meetings for individuals who were followed by the PNMT, as also did one or more PNMT members. Dr. Muthali, state office discipline coordinator, attended a PNMT meeting during the week of this onsite review at the request of the PNMT and the individual's physician for more in-depth problem solving (Individual #32). Physicians and the PNMT RN each also attended daily morning medical meetings, weekly weight committee meetings, pneumonia committee meetings, and others. Daily medical provider meetings were held every morning and the PNMT RN was the assigned representative at these meetings. Attendance was recorded for 93 of 97 meetings. Attendance by the PNMT RN was as follows: March 2013 (76%), April 2013 (71%), May 2013 (77%), June 2013 (55%), and July 2013 (76%). Attendance by the PNMT RD and/or the Habilitation Therapies Director was as follows: March 2013 (18%), April 2013 (6%), May 2013 (14%), June 2013 (40%), and July 2013 (0%). Overall attendance at these meetings for which attendance was recorded was approximately 90%. The reports from these meetings were discussed in order to update the status of individuals on their caseload, to track others with PNM	

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		concerns, and to identify individual who met criterion for referral to the team. The PNMT RN also served as the liaison between the PNMT and the physicians by personally meeting with them to discuss pertinent issues and to ask questions. For example, as of 9/1/13, the PNMT RN maintained the episode tracker and then presented results to the medical team during the morning meetings. While attendance at the meeting and physician review of PNMT assessments would be other excellent ways to gain the input of the medical staff, alternate methods to demonstrate availability of physicians to the PNMT were consistently noted. • For 19 of 51 meetings (37%), there was evidence of participation by IDT members in meetings (most typically the QIDP and/or the RN case manager), review of assessments, and other needed activities. PNMT members, however, routinely attended ISPs and ISPA meetings for the individuals they reviewed or who were referred to the PNMT. This provided significant opportunities for collaboration in assessment, planning, implementation of interventions and actions, follow-up, and monitoring. Documentation submitted (Section O and P Auditing and Monitoring, undated, document XII.23) indicated that there had been a state mandated change to the PNM process that required QIDPs and RN Case Managers to attend the PNMT meetings. IDT members consistently attended meetings from 3/5/13 through 5/2/13, but less so after that time. <u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members were as follows: • 5 of 5 core team members (100%) were currently licensed to practice in the state of Texas per license identification cards submitted. • 5 of 5 core PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines, though the RN had significantly less experience than the other team members. She was employed at EPSSLC in June 2013 and appointed to the PNMT at that time. She was licensed as a LVN in 2009, and then as a RN in December 2011. As such, she had practiced as a RN for less than two years. Her previous experience serving individuals with intellectual disabilities was as a private duty RN with an individual with a physical disability (10 months) and as a LVN (16 months) in that same setting. She also worked as a LVN (10 months in 2010) and as a therapy technician (five months in 2006) at El Paso MHMR. Collectively, the team members had approximately 76.5 years of experience in their respective fields and, together, more than 40 years with individuals with intellectual disabilities and physical nutritional management related concerns.	

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		• 4 of 5 PNMT staff (80%) had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferable to the population served within the past 12 months. The exception was the PT, though there were a number of courses listed without identification of the contact hours or CEUs. Numerous courses were attended by the team members including the following: • Wound Management (1 contact hour), Herrera, Ochoa-Evers, De La Fuente • TX Speech and Hearing Association Conference (13 contact hours) De La Fuente • Overview of the Nutrition Process (1 contact hour) Carrion • The China Study (15 contact hours), Carrion • Activities of Daily Living: Assessment and Intervention in the Clinic and at Home (6 contact hours), Ochoa-Evers • Issues in Evaluation and Treatment of individuals with Developmental Disabilities (10 contact hours), Ochoa-Evers • Wheelchair Seating Assessment: Determining Critical Features of the Body Support System (7.5 contact hours), Ochoa-Evers • Effective Wound Management (20 hours), Ibarra • Medication Administration (contact hours not listed), Herrera • Oral/Enteral (contact hours not listed), Herrera, Ochoa-Evers, De La Fuente • Dental Desensitization (contact hours not listed), Herrera, De La Fuente • Deaf Blindness (contact hours not listed), Herrera, Ochoa-Evers • Selecting the Ideal Seating System (contact hours not listed), Herrera, Ochoa-Evers, De La Fuente • IDT and HT (contact hours not listed), Ochoa-Evers • Risk Guidelines (contact hours not listed), Ochoa-Evers • Autism (contact hours not listed), Ochoa-Evers, De La Fuente • Communication and Behavior (contact hours not listed), Ochoa-Evers, De La Fuente • Data: Tracking and Trending (contact hours not listed), Ochoa-Evers • ISP Risk (contact hours not listed), Ochoa-Evers • Wheelchair (contact hours not listed), Ochoa-Evers • AAC for Adults in Medical Settings (contact hours not listed), Ochoa-Evers • Webinar – Positioning (contact hours not listed), Ochoa-Evers • Pressure Mapping – A Valuable Resource for Assessment (contact hours not listed), Ochoa-Evers • ILS (contact hours not listed), Ochoa-Evers • Addressing Neuro Tone in the Spine (contact hours not listed), Ochoa-Evers	

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		Additional continuing education was documented for each of the back-up team members (PT, OT, RD, RN, and SLP). Ongoing continuing education related to PNM and transferrable to the population served is essential to ensuring that an adequate level of expertise is maintained for all team members, individually and collectively via cross-training. <u>PNMT Meetings</u> • 51 of 51 PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (c) PNMT actions, and (d) follow-up. Statements related to (e) outcomes/progress toward established goals and exit criteria were not as clearly outlined on a consistent basis. These were clearly stated, however, in the individual progress reports documented by the team and included in the individual records. Meeting minutes were submitted for 3/5/13 to 9/19/13. There were both signature sheets and attendance tracking in the minutes. • Since the last onsite review, the team met twice weekly for 21 of 29 weeks (72%) and met once in the other seven weeks, well exceeding the criterion of meeting at least once weekly for 90% of weeks. Two additional meetings were identified as assessments and one was listed as training. A meeting was listed as held on 7/4/13 (document XII.4.b), but the meeting minutes indicated that no meeting was held on that day due to the holiday. No meetings were held on 3/21/13, 5/16/13, and 8/27/13. There was a total of 51 meetings during that time period for which minutes were submitted. • Based on review of the minutes, attendance by core PNMT members and/or back-ups for the meetings conducted during this time frame was: o RN: 48/51 (94%) by core member, 4% for back-up, 98% overall o PT: 49/51 (96%) by core member, 4% for back-up, 100% overall o OT: 40/51 (78%) by core member, 14% for back-up, 92% overall o SLP: 46/51 (90%) by core member, 8% for back-up, 98% overall o RD: 42/51 (82%) by core member, 16% for back-up, 98% overall Attendance was generally above criterion of 80% for core team and well above 90% overall, though slightly lower for OT, with no OT representation for four meetings. All core team members attended each of the additional three meetings designated as assessments (2) and training (1).	

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		The meeting minutes were maintained in a rolling text format and also included the following elements: • Member attendance • Individual reviewed (referrals and active caseload) • Level of PNMT involvement • PNMT goals • Discussion • Recommendations • Due dates • Date of next review These were not consistently reported: • Current weight • Ideal body weight range • Reason for referral Other issues tracked for review, discussion, and action included: hospitalizations, changes in health status, and weekly incident reviews (choking, aspiration, respiratory compromise, skin integrity, falls, weight, gastrointestinal concerns, and seizures) identified through Weight Committee, Daily Medical Meeting and IMRT findings and reports. Incident dates, risk levels associated with the incidents, level of PNMT involvement needed, recommendations, and due dates were not consistently and clearly addressed for each individual who experienced an incident in these categories. PNMT oversight tracking, PNMT data analysis, and discussion of training and policy/procedures were not clearly addressed per the documentation submitted. The general content appeared to be present across the minutes and, as previously recommended by the monitoring team, the PNMT had streamlined the level of detail included, but the format continued to not be user-friendly to others outside of the team. The PNMT itself would be hard pressed to be able to readily locate information, a specific incident or action. It was difficult to track completion of action steps recommended in the current rolling text format. As in previous reviews, the monitoring team recommended that the PNMT request formats used by other SSLCs for examples and adopt an action plan type of meeting minutes format. • The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns. This was integrated into the policies in place and evidenced in the monthly QA reports. There was a system of corrective action plans in the case that system issues were identified. They addressed the following: o Requirements that the QA matrix include key indicators related to PNM	

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		outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT are collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan): o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. Some examples of identified system issues addressed included PNMT referrals, the Mealtime Improvement Team, gait belt and helmet reduction, and routine maintenance of wheelchairs. Section O requires that the PNMP be reviewed at the individual's annual individual 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 PNMT. These aspects, outlined in O.1 of the Settlement Agreement, are reviewed in O.3 below. The monitoring team found EPSSLC in substantial compliance with this provision.	
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	<u>Identification of PNM risk</u> All individuals at EPSSLC identified with PNM needs (117 per the list submitted) were provided a PNMP, thereby ensuring that, as per the Settlement Agreement, 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") were reported to be provided a current PNMP. There were 61 individuals identified with no PNM needs. These lists were maintained and updated as required. Based on lists of individuals with identified PNM concerns, there were individuals who: (a) Required physical assistance for positioning associated with swallowing: 27 individuals and nine others who required verbal prompts, (b) Were dependent on others to eat: 19 individuals at all times and 15 others who required total assistance after a meal refusal, (c) Had difficulty swallowing: 79 individuals, and/or (d) Were considered to be at	Noncompliance

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	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.	medium or high risk of choking (approximately 94 individuals) or aspiration (approximately 83 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), each (100%) was listed with a PNMP. There were no incidents of choking documented since the previous review. Improvements were noted in the completion of the risk rating tools, as evidenced by the ISP attended during this onsite review and based on review of the IRRFs submitted. Action plans were not provided in the same manner as during the previous reviews. Rather, the plans to address specific health risk issues were included in the IRRFs and IHCPs (integrated plans developed collaboratively with IDT members) consistent with current state policy and practice. <u>PNMT Referral Process</u> Criteria for IDT referral to the PNMT at EPSSLC were included in the State Physical Nutritional Management policy as follows, though individual circumstances and risk levels would dictate more or less stringent criteria per the policy: • Two choking episodes in one year; • Two Aspiration Pneumonia diagnoses in one year; • Results of PNMT Nurse Post-Hospitalization Assessment for individuals diagnosed with any of the following: • Aspiration Pneumonia; • GI Issues • Fractures; • Skin Integrity; and • Seizures • New or proposed enteral feeding; • Unresolved vomiting (more than 3 in 30 days, not related to viral infection); • Significant/unplanned/verified weight loss or gain of • More than 5 pounds in one month; • 3 or more pounds per month for three consecutive months or 7.5% of body weight per month for 3 consecutive months; or • 10% of body weight in 6 months; • Any Stage III or IV decubitus, or any Stage II with delayed healing; or • Fracture of a long bone, spine, or hip	

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		The PNMT had a system for IDT referrals outlined in the policy. The IDT completed the referral form. The PNMT could also self-refer. There were no established timelines within which to review and determine a need for PNMT involvement. When services were indicated, a PNMT representative attended the ISPA to discuss recommendations. It was not possible to determine the number of individuals actually referred or self-referred in the last 12 months based on the documentation submitted. The list only identified individuals (11) as "active this quarter." The specific quarter was not documented and this list was not dated. Seven other individuals were listed as reviewed or discussed, but without active treatment required. Dates/reasons for referral were not included. Another list submitted related to the PNMTs active caseload listed 11 individuals. Individual #93, identified on the first list as referred to the PNMT, was apparently no longer active at this time and Individual #63 who was identified as not requiring treatment on the first list, was on the current active caseload per the second list. A Corrective Action Plan report, dated 8/19/13, documented that the PNMT had conducted a review of the referral process and reported that there were a number of issues. It was also reported that the referral source and date was not clearly evident in the documentation and that in September 2013, changes to this process were to be made. Further, during the course of this onsite visit, the monitoring team identified facility-wide issues of inaccurate data related to hospitalizations and pneumonia. One use of these data should be to assist the facility in recognizing when a referral to the PNMT was indicated, in other words, when an individual met the established criteria, or otherwise required the supports and services the team could provide. For example, the hospitalization list included those admissions only through May 2013 rather than the time of the review. Corrected lists were requested. A supplemental list was submitted that covered only 7/1/13 to 9/19/13, thus omitting any events in June 2013. None of the hospitalizations were for reasons that clearly met the criteria for PNMT referral, though Individual #90, who experienced three hospitalizations for PNM-related concerns, was listed on the current active caseload since 2011. The list of pneumonia occurrences initially included only a partial year list. A revised list was submitted for 8/1/2 through 9/19/13. Three individuals were listed with aspiration pneumonia: Individual #162; Individual #90 (2); and Individual #178. Individual #162 was also listed as referred and included on the current active PNMT caseload, though Individual #178 was not. • -- Individual #90 had been assigned to the PNMT active caseload since 11/17/11 due to risk of aspiration, weight loss, and intestinal obstruction, and was still assigned to the team at the time of the aspiration pneumonia diagnosed on 3/2/13. There was discussion on 3/5/13 related to his hospitalization on 3/2/13 and an individual review on 3/7/13. He had previously been reviewed by the team on 2/14/13, at which time the team was conducting monitoring activities to be able to establish baselines and determine his needs and supports. It was of	

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		concern to the monitoring team that an individual followed by the team for over a year did not have clearly identified needs and supports at that time. -- An ISPA was held on 3/7/13, where extensive discussion was documented and PNMT members were present. Recommendations were reviewed and follow-up was scheduled for 4/9/13. Neither the minutes nor the individual IPN by the PNMT on that date, reflected review of his health status, though it was reported that no significant changes were noted and that his weight was stable. Recommendations included that the RN would attend an unidentified type of appointment on 4/22/13 and that the PT would complete an evaluation after a podiatry consult. The purpose of either of these recommendations was not well documented by the PNMT. The PNMT Finalized Action Plan included very extensive data, but it was difficult to identify the interpretation of those. The next review was scheduled for 5/13/13. This was not conducted, but there was review of a hospitalization related to a colon resection on 5/16/13, with hospitalization from 5/15/13 through 5/20/13. -- Following this hospitalization, there was evidence of review by the PNMT, but his status and actions taken were addressed in the IPNs only and there was no evidence of these in the team minutes or an individual action plan document. This continued to emphasize problems with the current system of documentation by the team. • There was no evidence that Individual #178 had been referred. The criterion allowed that an individual experienced two episodes of aspiration pneumonia before referral to the PNMT was indicated, so as such, he had not met this criterion. The PNMT meeting minutes documented discussion on 8/1/13 during his hospitalization, but the recommended action was to monitor only at that time. On 8/6/13 the team documented further discussion. His prognosis was described as poor to guarded, with an acute illness due to underlying chronic hyperventilation. There were no recommendations. Though he was identified with aspiration pneumonia (8/2/13) on the list submitted, the only discharge diagnosis listed on the hospitalization list was hypotension (7/23/13 to 8/6/13). -- There was no evidence that the PNMT was aware of the aspiration pneumonia diagnosis and there was no further review of his status. Individual #178 was not included in the sample selected by the monitoring team so further review of this case was not possible. With the exceptions of Individual #52 and Individual #4, all the individuals currently on the PNMT caseload had been referred prior to this review period. Individual #162 was assigned on 1/28/13 and there was no evidence in the meeting minutes as to the date of assignment of Individual #115. Others had been assigned as far back as:	

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Name	Date Assigned
Individual #89	11/15/12
Individual #23	11/15/12
Individual #114	8/16/12
Individual #63	5/29/12
Individual #28	4/19/12
Individual #90	11/17/11
Individual #32	11/17/11, revised 8/23/12

Eight of these individuals were included in the Sample O.1 selected by the monitoring team. It was not clear why a number of individuals remained on the current caseload for such extended time periods. For example, the PNMT meeting minutes for 5/2/13 documented that Individual #89 had PNMT goals that included weight within his IBW of 117 to 143 pounds and no falls in the next three months (2/15/13). There was no evidence of review by the team before then. On that date, his goal was changed to 120 pounds or greater for three consecutive months, though there was no rationale documented. His weight at that time was not even reported. He was subsequently reviewed on 6/11/13 and 8/8/13, but there was no mention of the status of these goals, nor were they modified. Per the weight list (8/13/13), he was identified as within a normal weight range, but below 120 pounds, though the nursing assessment indicated that his weight was 120 pounds on 1/17/13. Subsequent weights were not available in his individual record. On 8/8/13, a recommendation was identified to obtain a lipid profile in order to justify or verify the current need for a low fat/low cholesterol diet. It was of concern that this had not been noted as a concern over the last nine months, particularly as one of his identified concerns had been weight. Further, there was no mention of the incidence of falls. The falls report (3/1/13 to 7/31/13) did not report any falls during that period, suggesting that he had met that the goal of no falls some time ago. Though there appeared to be a variety of other health concerns for Individual #89, many of these were not discussed by the PNMT and given the established goals, it was unclear why Individual #89 continued on the PNMT caseload. The purpose, measurable goals, status, and actions should be clearly, but concisely, stated with each review. Is some cases, the minutes held very few details, yet the IPN referred the reader to those. In other cases, the IPNs presented important details, none of which were in the meeting minutes.

- In 0 of the 12 individual records reviewed (0%) when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting.

It was noted that Individual #162 (not included in the Sample O.1), however, had been diagnosed with aspiration pneumonia on 1/23/13. It could not be determined whether this was subsequent to a previous incidence within the last 12 months. Either way,

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		Individual #162 was assigned to the PNMT on 1/28/13, well within the five day period. On the other hand, in the case of Individual #118, there was no evidence of a timely referral to the PNMT. The PNMT minutes documented on 8/22/13 that she had experienced a weight loss of five pounds in three weeks (no date range reported), but had maintained her weight at 55 pounds for three weeks (again no date range reported), well below her IBW of 70.2 to 85.8. Subsequently on 9/5/13, she was reported to have lost over two pounds in one week and weighed 52.5. On 9/12/13, it was reported that she had lost another pound and weighed 51.5, or three and a half pounds in three weeks, apparently in addition to the five pounds previously lost prior to 8/22/13, as she weighed 60.2 pounds on 7/6/13. This was well over 10% of her body weight pounds in two months clearly meeting the referral criteria. However, on 9/9/13, the IDT met and agreed to make a referral to the PNMT if she lost another 2% weekly for two consecutive weeks, meaning that this young woman, already well below her IBW, would be permitted to lose another two pounds or more before the PNMT would become involved. By 9/17/13, Individual #118 was reported to have lost 6.66 % of her body weight in two weeks, though her weight was reported as the same as 9/12/13. It appeared, however, that she had actually lost over 14% of her body weight since 7/6/13, in just over two months. Finally at that time, the PNMT decided to assign her to their caseload, though no IDT referral appeared to have been made. Plans for active interventions were made at that time, including a repeat five day calorie count and weights every other day. Individual #24, Individual #36, and Individual #189 had each lost more than five pounds in one month, but did not appear to have been referred to the PNMT. Individual #9 experienced an unplanned weight gain of more than five pounds and also was not referred. Clearly, the issues previously identified by the monitoring team related to weight issues, as well as, timely referrals to the PNMT, had not been resolved. The following metrics did not apply because there were no new tube placements for enteral nutrition during the last year. • __ of __ individuals who received a feeding tube (not on an emergency basis) since the last review (%) had been referred to the PNMT prior to the placement of the tube. • __ of __ individuals who received an emergency feeding tube placement (%) since the last review had been referred to the PNMT after the emergency feeding tube placement. Incidence of conditions in various PNM-related risk areas were not clearly tracked by the team and entered into the PNMT meeting minutes. It was likely that the individuals presented with concerns in these and other areas, however, it was not possible to track the incidence by problem because the discussions were organized by individual only.	

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		Consideration of at least the following issues for tracking was indicated: • Weight • Fractures • Falls • Skin Breakdown • Pneumonia • Choking • Hospitalizations/Change in Health Status • New Enteral Tube Placement • Other <u>PNMT Assessment</u> 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. Assessments submitted included Individual #4 and Individual #32. Individual #52 had been referred on 3/14/13 related to weight risks and it appeared that an assessment had been completed for her by 3/28/13 as indicated in the minutes. She was not included in the sample selected by the monitoring team and, as such, she was not included in the analysis that follows. • 1 of 2 PNMT assessments submitted (50%) were initiated at a minimum within five working days of the referral; • 0 of 2 PNMT assessments (0%) were completed in 30 days or less of the date of referral. The completion date could not be determined because the assessment was not dated by the PNMT clinicians. Based on review of two assessments included in the sample, comprehensiveness of the PNMT assessment components was as follows: • 2 of 2 (100%) contained date of referral by the IDT (or self-referral); • 2 of 2 (100%) 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. • 2 of 2 (100%) included recommended risk ratings based on the PNMT's assessment and analysis of relevant data; • 1 of 2 (50%) 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;	

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		• 1 of 2 (50%) 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, or indicated that the individual was independent with mobility and repositioning. The PNMT did not appear to consistently address positioning that may impact PNM status including during bathing and oral hygiene based on observations of these activities; • 0 of 1 (0%) contained evaluation of current assistive equipment. The assessments did not address mealtime and/or bathing equipment. • 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 a list of medications with potential side effects listed. This did not address drug/drug and drug nutrient interactions. Actual or suspected side effects were not identified, or ruled out if it was not an issue; • 0 of 0 (NA) identified residual thresholds, if enterally nourished. He did not receive enteral nutrition per the evaluations submitted. • 2 of 2 (100%) contained a tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation. The evaluation for Individual #32 reflected this, but information was included in the analysis section only. The assessment stated that a chairside assessment was indicated, but the observations were not reported. At the end of the assessment, when the "so what" of the findings should be analyzed, facts that appeared to come from mealtime observations were reported. All of the objective data obtained from all aspects of the comprehensive assessment should be reported. Then, all should be considered as the team analyzes their findings in order to identify primary issues and formulate a plan. • 2 of 2 (100%) contained information about the individual's current respiratory status based on a physical assessment. • 1 of 2 (50%) contained evidence of review/analysis of lab work; • 1 of 2 (50%) contained evidence of review/analysis of medication history over the last year and current medications, such as dosages, administration times, and side effects. Changes in medications and/or doses were not reported consistently. Start dates were not reported for Individual #4; • 2 of 2 (100%) contained evidence of observation of the individual's supports at their home and/or 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	

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		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 1 (0%) contained recommendations for measurable skill acquisition programs, as appropriate (Individual #32); • 1 of 2 (50%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. While there was information reported by the PNMT, the assessments were not well organized and as such, it would be difficult for the IDTs to discern this; • 1 of 2 (50%) contained measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT. The outcomes were identified, but there were no specific indicators for 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); • 2 of 2 (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and • 2 of 2 (100%) contained discussion as to whether existing supports were effective or appropriate; • 0 of 2 (0%) contained signatures of all core team members (or alternate), with dates of signature. Compliance with each of the 30 elements above was 100% for 19 of the 30 (63%). All others were rated at 50% or below. While the majority of the required elements were noted, the format of the PNMT assessments was difficult to follow to identify content, findings, and recommendations. In some cases, recommendations were documented in the body of the report, but not put into a comprehensive list at the end. The team should carefully review the format to determine if a more streamlined approach could be taken. Typically, the objective clinical data (includes review of medical history and current physical status) should be presented first. Next should be the "so what" of that information, that is, an analysis of the primary concerns or problems, the interrelatedness of these, and a formulation of a plan to address each of the identified issues. The analysis should describe the rationale for each of the actions or recommendations. The list of actions/recommendations should become a "to do" list of sorts, with assignment of responsibility and due dates. This may take place as the PNMT meets with the IDT to review the assessment and create the plan. The work EPSSLC was doing was excellent,	

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		but the objective data, the analysis and rationale for actions, and the recommendations were not well-reflected in their documentation. The Director should consider personally reviewing these to guide the team in making appropriate changes. Objective clinical indicators should be established for individuals followed by the PNMT as part of the assessment's recommendations because they may serve as clues for potential change in status. These should be integrated into the IHCPs. The IHCPs and PNMPs for individuals with physical or nutritional management difficulties require effectiveness monitoring of individual-specific objective clinical data to determine the efficacy of the interventions (of which PNMT interventions are a part). PNMT review would be necessary to determine if the plan was being implemented as written, staff were adequately trained, etc. If the team determined interventions were not effective, the IDT/PNMT should revise these interventions. Plans should be revised within 24 hours, or sooner if the concern was critical, when a change was indicated. This should be collaborative between the PNMT and the IDT. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs</u> There were eight individuals who were on the PNMT active caseload who were included in Sample O.1, as well as Individual #93, who had previously been reviewed by the PNMT. PNMT assessments and all other PNMT-related documentation had been requested with the individual records for each of the individuals in the sample. • PNMT Assessment (within last 12 months): Individual #32 and Individual #4 • Current ISP: Individual #23, Individual #63, Individual #4, Individual #114, Individual #115, Individual #32, Individual #89, Individual #90, and Individual #93 • Current IRRF: Individual #63, Individual #89, Individual #93, Individual #23, Individual #4, Individual #115, Individual #32, and Individual #90. It was noted, however, that the IRRF submitted for Individual #32, though current within the last 12 months, had been completed prior to the PNMT assessment dated 5/15/13. There was no evidence of a revised IRRF, related to PNMT findings. • Current IHCP: Individual #115, Individual #32, and Individual #90 • Current PNMP: Individual #23, Individual #63, Individual #4, Individual #114, Individual #115, Individual #32, Individual #89, Individual #90, Individual #93 Other documentation was extremely limited, and was submitted for Individual #32, Individual #23, Individual #63, and Individual #90 only. This included IPNs, PNMT Nurse Post-Hospitalization Assessments, action plans, and/or individual discussion logs for Individual #32, Individual #23, and Individual #90. While PNMT Nurse Post-Hospitalization Assessments were noted for a number of the other individuals, as well as, IPNs entered by PNMT members, these and the limited documents outlined above were	

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		insufficient to get a full picture of the PNMT process for the individuals in the sample. Further, the three individuals for whom individual discussion logs and action plans were submitted, contained so much information that was not well organized making it impossible to determine compliance with the following: • For ____ of ____ individuals (%), all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. Plans resulting from PNMT recommendations included the following components: • In _____of the _____ individuals' plans reviewed (%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment • In _____ of the _____ individuals for whom HOBE assessments were conducted (%), the HOBE recommendations were integrated into individuals' plans. • In _____ of the _____ individuals' plans reviewed (%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. • In ___ of the ___ individuals' plans reviewed (%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In _____ of the _____ individuals' plans reviewed (%), the plans included the specific clinical indicators of health status to be monitored. • In ___ of the ___ individuals' plans reviewed (%), the plans defined triggers. • In _____ of the _____ individuals' plans reviewed (%), the frequency of monitoring was included in the plans. <u>PNMT Follow-up and Problem Resolution</u> Again the documentation submitted was either incomplete or so difficult to navigate that compliance with the following metrics was impossible to determine: With regard to plan implementation: • In _____ of _____ individuals' documentation reviewed (%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. • In _____ of the _____ individuals' plans reviewed (%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps. • For ____ of ____ individuals, the actions outlined in the PNMT meeting minutes were clearly addressed within the time frames established.	

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		Each of the recommendations identified in the PNMT assessment was not clearly and consistently tracked through to completion for each individual reviewed. The format of documentation made it difficult to track both original recommendations and those identified as interventions and supports required as a function of ongoing review. Intervals of PNMT review were clearly stated, however, and these reviews appeared to occur on a timely basis as recommended. A system that addresses implementation of recommendations and other actions should be developed to permit the PNMT (meeting minutes) and others to readily review this information (IPNs). The IPNs were consistently entered by the PNMT, but did not accurately reflect actions taken, outcomes, and dates of completion. Guidelines for these should be developed. There were blank data sheets submitted in the Presentation Book including an episode tracker, trigger summary, and referral log. Because completed versions of these were not submitted, it was not clear how these were used. <u>Individuals Discharged from the PNMT</u> Six individuals appeared to have been discharged from the PNMT in the last six months. For individuals discharged by the PNMT: • There was limited evidence of ISPA meetings held to discuss the discharge of the individual from the PNMT to the IDT in ISPAs or PNMT documentation that clearly outlined the discharge rationale and plan. • Discharge summaries were not consistently noted that provided objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP. • 1 of 4 individuals included in the Sample O.1 had evidence of ISPA documentation and/or action plan (0%) included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. In the presentation book there were two documents titled "PNMT Follow-up D/C PNMT" for Individual #115 and Individual #39. Key information, such as the date of discharge, was not clear. In the case of Individual #39, it was stated that the PNMT would follow-up in six months related to recommendations made to his IDT due to a choking episode in December 2012. There was no evidence of a review in June 2013. The timeline of actions and review was confusing and the previous recommendations were not stated with the status of those also unclear. The recommendations as of 9/3/13 were very vague and included that the IDT should follow-up on the individual, PO intake, and IRRF to make modifications to clarify choking. The documentation for Individual #115 was somewhat better because it tracked the course of issues and actions.	

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		As stated in previous reports, an effective PNM program requires that the referral to the PNMT must occur in a timely manner, so as to capitalize on the collective expertise of the team members. There is urgency to complete PNMT assessments. Even so, some interventions may need to be implemented immediately, before the written report is finalized. It is critical that the assessments be completed in a timely manner. At this time, the EPSSLC PNMT appeared to understand this responsibility, though referrals from the IDT were not made in a timely manner. The team is commended for its hard work, expertise, and follow-up, though continued significant improvements related to the content and organization of the documentation of their work is indicated as outlined above. The facility self-rated this provision as in substantial compliance. The monitoring team did not concur. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Assessments should be initiated within five days of referral, completed within 30. 2. PNMT recommendations should be addressed by the IDT and documented via the ISP process, generally with an ISPA to integrate all findings (though this may be via the IHCP, PNMP and IRRF). While all recommendations may not be implemented by the IDT/PNMT, each should be discussed with rationale documented to accept these or not. 3. Meeting minutes should reflect status updates and actions taken by the team for each individual they review. This should provide them with an easy method to review their work and individual status without having to sort through IPNs. 4. Documentation should clearly identify the following: o Reason for referral o Clinical indicators identified for tracking o Measurable outcomes o Ongoing status of progress toward these, o Review of current health status o Due dates and person(s) responsible for all actions o Completion of all recommendations o Subsequent actions required. 5. A discharge summary should be completed that provides objective clinical data to justify the discharge. This may be via a report or IPN by the PNMT. All outstanding recommendations should be integrated into the IHCP with specific criteria established for referral back to the PNMT. An ISPA should be held to discuss the terms of discharge. 6. Address toothbrushing and bathing position via actual observations in the PNMT evaluations and OT/PT evaluations as needed for those who present with	

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		potential risk for aspiration, reflux, or other health concerns that may be exacerbated during bathing and/or toothbrushing.	
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 O.1, 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 for current ISPs (three did not have signature sheets): • Medical: 0% (0/12) • Psychiatry: 25% (3/12) • Nursing: 67% (8/12) • RD: 67% (8/12), though most were attended by the technician only • Physical Therapy: 33% (4/12) • Communication: 42% (5/12) • Occupational Therapy: 33% (4/12) • Psychology: 50% (6/12) • DSP: 33% (4/12) • Dental: 42% (5/12) • Pharmacy: 0% (0/12) Based on the documentation in the pre-ISP documents submitted (12), attendance was inconsistent as follows: • Individual #4: No pre-ISP submitted. • Individual #71: Only three staff were required to attend, though each listed was in attendance. • Individual #15: Of the disciplines listed above, eight were identified as required to attend the ISP. Of those, only five were in attendance. • Individual #115: No ISP attendance signature sheet or pre-ISP meeting attendance form submitted. • Individual #93: No pre-ISP meeting attendance form submitted. • Individual #125: No pre-ISP meeting attendance form submitted. • Individual #23: No pre-ISP meeting attendance form submitted. • Individual #114: Of the disciplines listed above, six were identified as required to attend the ISP. Of those, five were in attendance. • Individual #63: Of the disciplines listed above, nine were identified as required to	Noncompliance

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		attend the ISP. Of those, only six were in attendance. • Individual #32: Of the disciplines listed above, seven were identified as required to attend the ISP. Of those, four were in attendance. • Individual #90: Of the disciplines listed above, eight were identified as required to attend the ISP. Of those, six were in attendance. • Individual #89: Of the disciplines listed above, 12 were identified as required to attend the ISP. Actual attendance could not be determined because no ISP attendance sheet was submitted. For 5 of the 12 individuals included in Sample O.1, IDT Members Required for the Annual ISP Meeting forms were not included in the pre-ISP submitted and, for three others, no signature sheet was submitted with the ISP. Only one individual had attendance consistent with the requirements outlined in the pre-ISP. At least one representative from Habilitation Therapies attended nine of the meetings for those in the sample (all but Individual #115, Individual #125, and Individual #89). Despite these findings by the monitoring team, the facility tracking indicated that Dental, Nursing, and Habilitation Therapies attended 100% of the meetings and that Dietary attended 92.3% (reported in the self-assessment). The inclusive dates of these were not reported. A document included in the Presentation Book reported the Required Attended Percentage from 3/1/13 to 9/1/13. Nutrition services were reported with 98% attendance, OT with 100%, PT with 100%, and SLP with 91%. If this was accurate, the sample used by the facility was different than that used by the monitoring team. ISP dates for individuals included in this sample ranged from 9/28/12 through 6/28/13. As a number of these ISPs identified a Habilitation Representative, the attendance was somewhat skewed from that required by the pre-ISP. In eight cases where both pre-ISP attendance designations and attendance signature sheets were both available for review, actual attendance by the therapy clinicians was consistent with that designated in the pre-ISP in only four of eight cases (50%). • 11 of 12 PNMPs (92%) were reviewed by the individual's IDT in the annual ISP meeting. This generally included evidence of review, update/revision, effectiveness, and specified changes required with rationale. Only the ISP for Individual #15 was missing this information. PNMPs cannot be reviewed and revised in a comprehensive manner by the IDTs unless each of the key team members is present to participate in that process. The new pre-ISP process identifies which team members are required to attend the ISP meeting and the needs for review of the PNMP and other PNM-related issues should be considered when making this determination. Actual attendance should be consistent with these	

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		designations. PNMP Format and Content Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 12 of 12 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 12 of 12 individuals (100%) included a list of PNM risk levels and individual triggers. This was consistent with the previous review. • In 12 of 12 PNMPs (100%), there were large and clear photographs with instructions. Though the copies submitted were black and white, the originals were prepared in color. This was consistent with the previous review. • 12 of 12 PNMPs (100%) identified the assistive equipment required by the individual, though rationale or purpose was not consistently identified. This was consistent with the previous review. • In 11 of 11 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and/or pictorial instructions were provided. This was consistent with the previous review. • In 12 of 12 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. This was consistent with the previous review. • In 12 of 12 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was consistent with the previous review. • In 12 of 12 PNMPs (100%), bathing instructions were provided. This was consistent with the previous review. • In 12 of 12 (100%) PNMPs, toileting-related instructions were provided, including check and change. This was consistent with the previous review. • In 12 of 12 (100%) 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. This was consistent with the previous review. • In 12 of 12 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 12 of 12 individuals' (100%) Dining Plans were current within the last 12 months. This was consistent with the previous review. • 4 of 12 individuals had feeding tubes with no oral intake. 3 of 4 PNMPs/dining plans (75%) specifically stated that the individual was to receive nothing by mouth, when indicated. This was a decrease from 100% in the previous review.	

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		• In 12 of 12 PNMPs (100%) and 12/12 dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. This was consistent with the previous review. • In 12 of 12 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. This was consistent with the previous review. • In 12 of 12 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. This was consistent with the previous review. • In 12 of the 12 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 dining utensils. This was consistent with the previous review. • In 2 of 12 PNMPs (17%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. Equipment and positioning were frequently not addressed, but rather the dining plans were referenced. This was a decrease from 100% in the previous review. • In 11 of 12 PNMPs (92%), oral hygiene instructions were included, including general positioning and brushing instructions. This was a decrease from 100% in the previous review. • 12 of 12 PNMPs (100%) included information related to communication (how individual communicated and how staff should communicate with individual). The PNMPs reviewed were generally excellent, with comprehensive content in most areas. The plans used a very effective person-first approach (e.g., "I need a gait belt and staff assistance when walking long distances"). PNMP audits were conducted routinely and appeared to be generally effective in ensuring the content of these plans. Additional findings included the following: • 100% of the PNMPs contained at least 95% of the essential elements. • 90% of the elements were maintained at 100% since the last review. • 15% (three elements) reflected a decrease since the last review. Though there had been a slight regression for several elements, the PNMPs continued to be excellent. Review of the PNMP was documented for 92% of the ISPs for individuals in Sample O.1, but there were a limited number of IDT members present at the IDT meetings. 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	

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		comprehensive and timely assessment information. PNMPs cannot be reviewed and revised in a comprehensive manner by the IDTs unless each of the key team members is present to participate in that process. The new pre-ISP process identifies which team members are required to attend the ISP meeting and the needs for review of the PNMP and other PNM-related issues should be considered when making this determination. Actual attendance should be consistent with these designations. <u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u> • For individuals for whom the changes needed to be made to the PNMP, there was no consistent ISPA documentation noting that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. • For individuals for whom the PNMP was revised, the changes were consistently included in the PNMPs for staff training and implementation. Documentation in the IPNs of changes and effective dates for implementation were not consistently noted. The monitoring team did not concur with the facility that they were in substantial compliance with this provision. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. IDTs need to consider review of the PNMP and other PNM-related issues when determining who is required to attend the ISPs. The IDTs should be careful if designating a Habilitation Therapy representative only. 2. Attendance at the ISP should be consistent with the designations established in the Pre-ISP. 3. Address the areas of the plans that were deficient above (particularly related to positioning and assistive equipment required for medication administration). 4. Ensure that changes to the PNMP were documented via an ISPA. Documentation of those changes should also be completed by the therapists in the PNMP and IPNs.	
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	<u>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were readily available in the dining areas (with one exception for one individual) and PNMPs were included in the individual notebook. General practice guidelines (foundational training) were taught in NEO and in individual-specific training by the therapists and PNMPCs. Based on observations conducted by the monitoring team, it was noted that: • 34 of 49+ individuals' (69%) dining plans were implemented as written. • 47 of 63+ individuals' (75%) PNMPs related to positioning and mobility were	Noncompliance

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	and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	implemented as written or alignment and support were consistent with generally accepted standards. Based on additional observations: • 3 of 3 (100%) individual's oral hygiene plans were implemented appropriately or consistent with generally accepted standards. The monitoring team questioned the use of regular water for Individual #118 who was to be provided thickened liquids. The plan indicated that water could be used, but staff were to shake excess water from brush. • 6 of 13 (46%) individuals' transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards. • N.a. of n.a. (--%) individuals' bathing plans were implemented appropriately or consistent with generally accepted standards. No bathing was observed during this review and, therefore, this metric was not rated. Some additional comments: • The findings highlighted above, related to implementation and staff compliance, were not consistent with the findings reported in the self-assessment. It was reported that compliance ranged from 95.25% to 99.5% related to positioning and 97% to 100% for the quarter (April 2013 through June 2013). It was noted that indicators reported were very limited. It was further reported that anecdotal observations were not always consistent with the monitoring results. • A fruit dessert for Individual #189 had pieces that were one inch or more in size, though he was on a chopped diet. This was noted by the kitchen staff, the Mealtime Coordinator, or other staff at his table. It was brought to staff attention by the monitoring team and eventually corrected before he ate it. • Individual #52 was to have verbal reminders to slow down and encourage small bites. There were no staff at her table and she was observed taking large bites. • A number had incorrectly thickened liquids (e.g., Individual #89 and Individual #72). It was noted by the monitoring team that the recipe on the original container of Simply Thick and the recipe included on the back of the Dining Plans differed significantly in the amount that staff were to use. The Habilitation Therapy Director was present during this observation and initiated a process to begin to evaluate this problem. • Individual #23 had been provided the wrong spoon, per his Dining Plan. The staff attempted to correct this after he had already started eating his meal. He became angry and left the dining room. He had been seated at the table for an extended period before his meal was served, too, plenty of time for staff to note this error. • Individual #117 was served chopped bread that had been moistened excessively, so much that the pieces were stuck together in one large mound. He ate all of the	

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		bread in three bites, each very large without intervention from staff. • A number of stand-pivot transfers were observed in which staff did not allow the individual to come to standing/weight bearing before moving them to the target location. • Two staff attempted to use a mechanical lift to transfer Individual #6 from the mat table to his wheelchair. They had positioned the sling too low on his body and with the outside of the sling toward his body. They attempted multiple times without success to slide the stays into the pockets against his torso. They stopped the transfer and repositioned the sling only after prompting by the monitoring team. • Nurses were observed pushing Individual #90 in his wheelchair without footrests. This was against generally accepted standards for alignment and support, as well as, safety. They were going to weigh him and all of the equipment should have been present to get an accurate and consistent weight for his wheelchair. The majority of staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan, though most required some cues and prompts. Staff should not routinely need to refer to the plans to answer these types of questions. Review of the plans and risks should be done when the staff are initially assigned for the day, and reviewed prior to implementation. Staff should have an active knowledge of the individuals to whom they are assigned on any given day: • Staff are 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. • Staff should review plans just prior to implementation of strategies, particularly at mealtime and, as such, information should be fresh on their minds. An important initiative was reported to address concerns with staff compliance. The Mealtime Improvement Team had implemented Mealtime Coordinator training consistent with the statewide plan. All of the training had been completed at the time of this review and implementation had begun. In all but one home, the Mealtime Coordinator was not seen. The one young woman observed in this role was excellent and clearly understood her responsibilities. Once implemented, the Mealtime Coordinators will be monitored for their role performance by the home managers.	

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		The monitoring team concurred with the facility that they were not in compliance with this provision. The rate of errors observed continued to be too high and the facility's self-monitoring for staff compliance was not consistent with the monitoring team's observations. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Fully implement the Mealtime Coordinator system. 2. Ensure there is further focus on transfer and re-positioning techniques to improve staff performance in these areas.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Class time included several days (a total of approximately 24 hours) to address the PNMP, lifting and transfers, and dining plans and eating skills. The content, based on review of the curriculum materials, was very comprehensive. The curriculum for communication is addressed in section R of this report. There was a presentation of foundational skills, with modeling by the trainers, to new employees. Practice time was provided with coaching by the trainers and then new employees were required to take a combination of written tests and were checked off on specific skills, using the checklists. Employees were expected to pass all essential elements of the core competencies. New employees were required to pass written examinations with a minimum of 80% accuracy. The new employee was required to demonstrate competency of foundational skills by safely performing every step, on every foundation skill, without coaching from the validator or other new employee. It was stated that the new employee was permitted to use the practice checklist through the validation process. Staff were coached and retrained up to three times until competency was established. There was no clearly stated action taken in the case that a new employee was not able to pass the check-offs. Shadowing was then conducted for a seven-day period prior to new employees being permitted to work independently on their assigned homes. They were not assigned a caseload, but were allowed to assist existing staff in the implementation of foundational skills in that home. During that time, staff were trained for each PNMP and Dining Plan on the assigned home as well as, individual specific (non-foundational skills) competencies, generally by the PNMPCs. Competency check-offs (validation) was conducted for foundational and non-foundational skills for individuals in their assigned home. Again new employees were given up to three attempts to successfully pass each of these and when they successfully passed each of these they were assigned a caseload and permitted	Noncompliance

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		to work without restrictions. Again, there was no written provision related to staff who were not able to do so. After successful completion The PNM related core competencies (i.e., foundational skills) were comprehensive. There did not appear to be any competencies related to reading a PNMP or Dining Plan, but rather these were determined by a written test. Competency check-offs included the following per the documentation submitted: • Food texture • Liquid consistency • Repositioning • Positioning in bed • Stand-pivot transfer • Two-person manual transfer • Lifting • Mechanical lifts • AFOs • Gait belt • Gait trainer • Angle Finder None were related to mealtime assistance techniques. Even though EPSSLC considered mealtime assistance techniques to be a individual-specific competency, there are very basic, generally appropriate techniques that should be demonstrated and taught in NEO. These strategies promote safety and greater participation and independence. Variations may then be taught as individual-specific strategies. Some examples include: • midline head position with presentation, • presentation of utensil or cup more toward chin level rather than nose or mouth level to prevent head/neck hyperextension, • spoon placement to the lower jaw rather than to the upper jaw and scraping food off using the teeth or lip, • waiting for lip closure before withdrawing the spoon, • presentation of the cup to the lower lip rather than the upper jaw, • waiting for lip closure on the cup • hand-over-hand assistance There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. The PNM-related core competencies (i.e., foundational skills) included in the NEO training appeared to be comprehensive. There were a number of associated knowledge and skills-	

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		based competency check-offs for most of this content. • 100% of new employees successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. <u>PNM Core Competencies for Current Staff</u> • 100% of current staff that required training successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. All staff attended annual refresher training. Staff were re-trained and retested until competence was established. • 100% of staff responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. • 100% of current staff that required training had completed annual refresher competency-based training and performance check-offs (no delinquencies reported from March 2013 through July 2013) though other documentation reported that there had been six of over 560 staff delinquent (only 1%) for a single aspect of the training. Refresher training was required for DSPs, nurses, and others in the areas of swallow safety and thickened liquid preparation, dysphagia and eating behaviors, lifting people, and physical management. <u>Individual-Specific Training</u> The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. There was also a system of partner homes. All staff had demonstrated competence in the core foundational skills through NEO and refresher training. Non-foundational training was completed for all staff in each partner home for the individuals who lived in each home. Supervisors then used that pool of staff for pulled staff assignments to ensure that staff were properly trained. Non-foundational training was also provided to staff who supported individuals in the community-based day programming. • Per the system in place, 100% of the staff assigned to individuals in the samples selected by the monitoring team were trained related to the PNMP prior to the provision of services. • Per the system described, 100% of the staff assigned to individuals in the samples selected by the monitoring team had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) for high–risk individuals prior to the provision of services. • 5 of 5 staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan.	

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		• The facility had a process to validate that staff responsible for training other staff are competent to assess other staff's competency. <u>Other Training</u> Additional training was conducted by Habilitation Therapies staff during the Town Hall meetings monthly. Various PNM-related topics (theme-based) were addressed based on findings of monitoring or other issues as indicated. As described above, extensive training had been provided for all staff for the role of Mealtime Coordinator. The facility self-rated substantial compliance with this provision. The monitoring team did not concur due to the observations of numerous compliance errors. The extent of concerns noted suggested that the effectiveness of the current system of training was limited and revision and refinement was indicated. Further, it was of concern that though training was ongoing related to thickening liquids, none of the staff had identified the discrepancies in the recipes used. This was clearly confusing for staff and resulted in improperly thickened liquids To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Carefully audit the level of coaching provided for check-offs. It is important that trainers do not "teach to the test" in order to pass staff (after up to three attempts) rather than permitting them to fail and providing retraining and re-testing at another time. This would not establish actual competent skill performance. 2. Audit the training provided and the skill check-off process to ensure that the system is sound. The practice of permitting staff to use the practice check-off sheets provides prompts that may be impacting the establishment of competence.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> • Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. • Monitoring tools included adequate instructions. • The staff conducting monitoring were competent in the areas they were monitoring. The PNMP monitoring process did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, based on the following: • 50% of the monitoring forms focused on oral intake (meals and snacks) • 0% of the monitoring forms focused on bathing	Noncompliance

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		• 0% of the monitoring forms focused on medication administration • 0% of the monitoring forms focused on Oral Care. • 100% of the monitoring forms focused on positioning EPSSLC did not use of the Universal Compliance Monitoring Form developed by the state. The elements of that form were very general and it made it difficult to identify more discrete issues for tracking and analysis. Monitoring forms addressed individual PNMP, mealtime, and communication, as well as, home mealtime monitoring. The PNMP monitoring was designed to include all aspects of the PNMP and did not specify which was aspect was observed (wheelchair, bed). This made tracking specific issues difficult to ensure individual and/or systemic change. Each of the monitoring tools had instructions for completion by the monitors. The monitoring team requested compliance monitoring forms that were completed for individuals included in Sample O.1 for the last three months. There were 147 forms completed by the PNMPCs from April 2013 through August 2013 across the 12 individuals. Forms were submitted for different areas: • Mealtime (48) • PNMP (48) • Communication (50), analyzed in section R below • Home Mealtime (1), not included as it was for the entire home rather than an individual Monitoring was completed across all shifts for each area. Completion was as follows: • 58 forms (60%) were completed on first shift. • 24 forms (25%) were completed on the second shift. • 0 forms (0%) were completed on the third shift. • 14 forms (15%) had no time designation. Compliance scores were calculated for 100% of the forms submitted. Mealtime monitoring scores were as follows: • 100%: 25 • 90%: 9 • 80%: 11 • 70%: 3 Compliance scores were calculated for 100% of the forms submitted. PNMP monitoring scores ranged from as follows: • 100%: 17 • 90%: 17	

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		• 80%: 12 • 70%: 2 It was noted that staff could perform the transfer improperly and still be scored in compliance based on the current form and scoring process. Further, staff could perform the transfer improperly and the equipment could be missing or broken and still be scored in compliance. This skewed the facility's perception of compliance. In 18 cases, the monitor did not observe a transfer for the individual. In some cases, staff were permitted to verbally describe the transfer, rather than demonstrate this skill. This is a very critical aspect of PNMP implementation and again skewed the perception of compliance. As described above, there were issues related to staff performance of transfers. There was a discrepancy between monitoring completed on first versus second shift and, as such, second shift staff were observed less often, and not at all on third shift and again this skewed the findings of the monitoring. There was no evidence that monitoring was conducted for aspects all aspects of the PNMP on a routine basis, particularly tooth brushing, bathing, and medication administration. There was no clearly established frequency to conduct staff compliance monitoring, and specific recommendations for this were inconsistent in the PNMT and OT/PT assessments. Thus, the following metrics could not be determined: • For individuals in Sample O.1, PNM compliance monitoring over the past three months for __ of __ individuals (%), the frequency of monitoring occurred as per the individuals' assessment and/or the individuals' plans/IHCPs. • For individuals in Sample O.2, PNM compliance monitoring over the past three months for __ of __ individuals (%), the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. A system to ensure follow-up was conducted was implemented for failed monitoring (less than 80%). The homes were notified and re-monitoring was scheduled for two weeks later. It appeared that in most cases, the issues were resolved with compliance scored at 80% or greater for the second monitoring. • For the monitoring forms submitted, any problems or "no" responses were noted on 53 of the 96 monitoring forms. Of these, documentation of adequate follow-up was provided on the form for 23 (43%). • Overall observations by the monitoring team did not result in similar findings with regard to PNMP implementation as compared with the compliance data the facility's monitors reported. The facility indicated that they were in substantial compliance with this provision, but for	

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		the reasons outlined above related to concerns with the monitoring system, the monitoring team did not concur. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Identify and correct issues related to the monitoring process to include: • Monitoring frequency across shifts • Monitoring related to all aspects of the PNMP (transfers, tooth brushing, bathing, and medication administration, specifically) • Ensure that frequency of monitoring is specified and timeliness of completion is tracked	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>Effectiveness Monitoring</u> There was also a system established for routine evidence of effectiveness monitoring by the therapists. The therapists did not outline the recommended frequency of this in the OT/PT or PNMT assessments. Per the local PNM policy, individuals with PNM needs were to be monitored at least quarterly for effectiveness, or more often based on level of risk and the intensity of supports and services required. There were no guidelines for the clinicians for how to conduct these reviews and document their findings. In each case, there was an IPN that stated effectiveness monitoring was completed, though findings were inconsistently documented there. In some cases, the therapist never stated whether the supports were effective or not and in other cases, they only referred to compliance with implementation. These reviews of PNM supports should specifically address the effectiveness of the strategies as implemented and as related to health and/or safety concerns. Review of specific health concerns for which the specific strategy was intended to address should also be reviewed. • 0 of the 12 individuals' records contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans. Effectiveness monitoring should include programs across all environments and not only in the home. It was noted that separate notes were written for various aspects of the PNMP and rolling these into one review should be considered. The Habilitation Therapy department may want to consider using tracking logs that include supports and services provided. The therapists could use the PNMT Event Log to summarize the individual's health status for the period of review. The effectiveness monitoring spreadsheet could track findings and the timeliness of the monitoring in	Noncompliance

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		addition to the findings. The monitoring team concurred with EPSSLC's finding for noncompliance with this provision of section O. It was a concern that not all strategies would necessarily be reviewed using the current approach. For example, at the time of the observation, the therapist might observe positioning, but not necessarily transfers. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Audit IPN documentation to ensure staff were following the established guidelines. 2. Address effectiveness monitoring across all aspects of the plans or other indirect supports and services. These should occur across all environments and not only in the home. 3. Ensure the tracking system tracks timeliness of effectiveness monitoring as recommended, in addition to the findings.	
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>Evaluation of Individuals who Received Enteral Nutrition</u> The facility maintained and updated a list of individuals who were enterally fed. There was a list of individuals who received non-oral intake that identified approximately 15 individuals who received enteral nutrition (13% of the current census). Twelve were identified as NPO and the others received some level of oral intake. • 7 of 15 individuals who received enteral nutrition (Sample O. 3) were evaluated at a minimum annually based on the APENs submitted. • 5 of 7 individuals evaluated had an appropriate evaluation to determine the medical necessity of the tube since the previous review. None of the APENs, however, 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. • The APENs submitted were completed, but the actual discussion by the team related to the medical necessity of the team was not possible as the ISPs were not available for four of the individuals. For the three individuals included in Sample O.1, only one clearly addressed the medical necessity of enteral nutrition in the IRRF or ISP. • 0 of the 0 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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		Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition • Five individuals who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. They did not, however, 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. As previously stated, they also did not reflect adequate assessment by the dietitian. • 0 of the 0 individuals who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake (%) had a comprehensive plan outlining the treatment or return to PO process. • 0 of the 0 individuals' plans to return to oral eating were based on the results of the IDT's discussion and were integrated in the IHCP, ISP, and/or an ISPA. • 0 of the 0 individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. • 0 of 0 staff responsible for implementation of these oral intake plans (%) were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. • 0 of the 0 individuals' plans (%) were monitored as outlined in the plan. 0 of 0 individuals' plans were modified by the IDT. • For 0 of 0 of these individuals' plans, the IDT met and interventions were reviewed and changed, as appropriate, in a timely manner. 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. PNMPs 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. The monitoring team concurred with EPSSLC's finding for noncompliance with this	

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		provision of section O. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish protocol related to the completion of assessments on an annual basis to determine the medical necessity of all individuals with enteral nutrition. 2. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP/IRRF and IHCP as appropriate.	

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o EPSSLC client list o Admissions list o 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 templates 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 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 Documentation 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 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 Tracking Log o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to EPSSLC: • Individual #37 and Individual #151 o OT/PT Assessments, ISPs, ISPAs, and other documentation related to OT/PT intervention for the following individuals: • Individual #66, Individual #78, Individual #112, Individual #178, Individual #161, and Individual #67 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #125, Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15, and Individual #114. o PNMP section in Individual Notebooks for the following: • Individual #125, Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15, and Individual #114. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #125, Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15, and Individual #114. o Leslie Ambruster, MS, CCC-SLP, Director of Habilitation Therapies o Susan Acosta, DPT o Silnettra Barnhill, OTR o Carol Antonio, PTA o Joseph Alva, COTA

	o Jennifer Ochoa-Evers o Hab technicians and PNMPCs o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o ISP Meeting for Individual #125 o Treatment sessions for Individual #92 and Individual #189
	Facility Self-Assessment: The self-assessment completed by Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director, was an excellent first effort. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team. Findings were generally reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The foundation laid over the last couple of years by Susan Acosta, the previous Director, was vital to the successful transition of leadership during this last six month period. Both of these professionals are commended for their strong dedication to the success of this department. Ms. Ambruster and the other Habilitation Therapies staff were on track to ensure that progress is made for the next review. Progress had continued and the plan outlined was a sound one and combined with the findings of this report should guide them to make greater strides over the next six months. Benchmarks should be established in measurable terms and used to establish measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the work that was done since the last review. The facility rated itself in noncompliance with P.2 and P.4. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings. The facility rated itself in substantial compliance with P.1 and P.3. The monitoring team concurred with the facility's self-assessment of continued substantial compliance with P.1. The monitoring team did not concur on P.3 due to the observations of numerous compliance errors. The extent of concerns suggested that the effectiveness of the current system of training was limited and revision and refinement were indicated. Further, it was of concern that though training was ongoing related to thickening liquids, none of the staff had identified the discrepancies in the recipes used. This was clearly confusing for staff and resulted in improperly thickened liquids. See section O.5 above for recommendations related to staff training.

	Summary of Monitor's Assessment: As in previous reviews, it was evident that a tremendous amount of work had been done in this area. The OTs and PTs continued to work as a team, though there was vacancy for an OT in the Dorms area at the time of this review. The facility is to be commended for its efforts regarding the process used to examine the need for gait belts and helmets, eliminating many of these. The OTs and PTs clearly played a key role in that process. The wheelchair clinic continued to design appropriate wheelchairs using an effective evaluation process to identify properties needed for support and function then product matching to make that happen. Jessica Cordova achieved certification as an ATP (Assistive Technology Professional). The facility should take care to ensure that the loss of one of the fabricators does not impact productivity and timeliness for fabrication and repairs. The quality of assessments had generally been maintained with an ongoing improvement in the focus on skill acquisition and motor skill improvements, along with the continued focus on the clinical aspects of health and safety. It is critical, however, that these interventions be based on sound rationale, with measurable and functional objectives, with clearly stated performance criteria. Documentation showed that services were consistently provided and documentation was consistent, but the content of the documentation needed to be standardized to ensure quality. Though improvements were evident, the OT/PT supports and services were not consistently integrated into the ISPs. In general, habilitation leadership appeared to intuitively understand the importance of not only direct therapy, but also routine and consistent direct contact with individuals and direct support staff to model communication in varied environmental contexts that are meaningful and functional to the individual. The therapists appeared to recognize ways they can support individual goals, interests, and preferences by providing therapy supports to ensure that those visions are achieved. <u>Samples for Section P:</u> • Sample P.1 = 12/12 individuals for whom an individual record and the most current OT/PT/SLP assessment was submitted. • Sample P.2 = 2/3 individuals newly admitted in the last six months for whom a current assessment was submitted. • P.3 = 7/10 individuals who were provided direct OT and/or PT services per the list submitted.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>Assessments</u> Assessments submitted as contained in the individual records included the following: Habilitation Therapy Comprehensive Assessments OT/PT/SLP (dates listed were the assessment dates identified on the front page) • Individual #90 (1/30/13) • Individual #114 (8/19/13) • Individual #115 (4/17/13) • Individual #71 (2/11/13) • Individual #125 (8/30/13) • Individual #63 (1/14/13) • Individual #4 (5/31/13) • Individual #15 (5/25/13) • Individual #93 (8/6/13) • Individual #32 (10/8/12) • Individual #89 (10/30/12) • Individual #23 (8/9/13) Each of these was current within the last 12 months, though the assessment for Individual #63 was missing pages. Each assessment included content contributed by the OT, PT and SLP, though communication assessments were completed as a separate document and are reviewed in section R below. None of the individuals included in Sample P.1 had been provided an Assessment of Current Status. <u>Timeliness of Assessments</u> Three individuals were admitted to EPSSLC since 3/1/13. Comprehensive Evaluations were submitted for two of these (Individual #37 and Individual #151). • 2 of 2 individuals in Sample P.2 (100%) received an OT/PT assessment within 30 days of admission based on the Admission Activity list and the signature dates on the assessments. The third individual (Individual #78) did not require an assessment because was an extremely short-term discharge who returned to the facility after only a few days in the community. The following metric was not applied because EPSSLC did not use an OT/PT screening at the time of this review: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening (%), received a comprehensive OT/PT assessment within 30 days of identification. Typically, there are not a large number of admissions to EPSSLC. Therefore, the	Substantial Compliance

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		development of a strong, but brief, screening to rule out a need for assessment for individuals newly admitted (rather than the lengthier document currently used) may be considered. Regarding timeliness: • 6 of 12 individuals' OT/PT assessments or updates (50%) were dated as completed at least 10 working days prior to the annual ISP. This was a decrease from 78% in the previous review. In some cases, the assessment date on the front page in the heading was 10 days prior to the ISP due date, but the signatures were later and, as such, would generally be considered late. As suggested in the previous report, the date of the latest signature should be (and was now going to be) used as the submission date. • There were 69 assessments listed in the facility's tracking log for ISPs dated February 2013 through July 2013. Based on this log, 81% of the assessments were performed on, or prior to, the designated due date. Another log (submitted in the self-assessment) listed 64 individuals with ISPs with 80% considered to be on time. Since 6/14/13, the on-time percentage was actually 92% and reflected a significant improvement and stabilization of this over the course of this review period. Further, 100% of the assessments were completed prior to the ISP. • 12 of 12 assessments (100%) were current within 12 months for individuals who were provided PNM supports and services. This was consistent with the previous review. <u>OT/PT Assessment</u> Only current assessments included in Sample P.1 (12) were included in the following analysis. The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The assessment format and content guidelines generally required that these elements be in the assessments. Based on review of Sample P.1, the analysis for comprehensiveness of the OT/PT/SLP assessments was as follows: • 11 of 12 assessments (92%) were signed and dated by the clinician upon completion of the written report. This was the completion date considered for the metric above related to 10 working days before the ISP. This was an improvement from 91% in the previous review. • 12 of 12 assessments (100%) included medical diagnoses. This was consistent with the previous review. • 12 of assessments (100%) included medical history. This was consistent with the previous review. 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.	

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		• 12 of 12 assessments (100%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. This was an improvement from 0% in the previous review. • 12 of 12 assessments (100%) addressed health status over the last year. This was consistent with the previous review. • 12 of 12 assessments (100%) included a comparative analysis that clearly analyzed the individuals' level of health status compared with previous years or assessments. This was consistent with the previous review. • 12 of 12 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. This was consistent with the previous review. • 12 of 12 assessments (100%) included documentation of the relationship between the individual's risk levels and their performance of functional skills. This was consistent with the previous review. • 12 of 12 assessments (100%) listed medications and potential side effects relevant to functional status. This was consistent with the previous review. This should be limited to those side effects that may impact functional motor skill performance and should address whether the individual has experienced any of the potential side effects. • 12 of 12 assessments (100%) included individual preferences, strengths, and needs. This was consistent with the previous review. • 12 of 12 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). This was consistent with the previous review. • 12 of 12 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. This was consistent with the previous review. • 10 individuals in the sample required a wheelchair. 10 of 10 assessments (100%) provided a description of the current seating system with a rationale for each component and need for changes to the system outlined as indicated, also with sufficient rationale. This was consistent with the previous review. • 12 of 12 assessments (100%) included discussion of the current supports and services (including the PNMP) provided throughout the last year and effectiveness, including monitoring findings. This was consistent with the previous review. • 12 of 12 assessments (100%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. This was consistent with the previous review. • 12 of 12 assessments (100%) included discussion of the individual's potential to	

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		develop new functional skills. This was consistent with the previous review. • 12 of 12 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct OT/PT interventions and/or skill acquisition programs as indicated for individuals with identified needs. This was consistent with the previous review. • 9 of 12 assessments (75%) included a monitoring schedule. This was a decrease from 100% in the previous review. • 11 of 12 assessments (92%) included a re-assessment schedule. This was a decrease from 100% in the previous review. • 12 of 12 individuals' OT/PT/SLP assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was consistent with the previous review. • 12 of 12 assessments (100%) detailed the supports and services needed for successful community living. This was consistent with the previous review. • 12 of 12 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This was consistent with the previous review. Further findings revealed continued improvements related to OT/PT assessments as follows: • There were improvements in two (9%) of the elements. • There was regression in two of the elements (9%). • All others were consistent with the previous review, each at 100%. • The average for all 12 assessments was approximately 94%. o 4 of 12 assessments (33%) contained 100% of the 22 elements listed above. o 10 of 12 assessments (83%) contained 90% or more of the elements listed above. o 12 of 12 assessments (100%) contained 80% or more of the elements listed above. 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 individual's identified need. • 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 from the previous year and monitoring and re-assessment schedules.	

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		There was some regression in the quality of OT/PT assessments for this review period. During the previous review this provision was rated as in substantial compliance because 100% of the assessments contained at least 22 of 24 of the elements. This time only 83% of the assessments reviewed contained at least 22 of 24 of the elements. Further, the timeliness of assessments was of concern, which was calculated at 50% for the sample reviewed, but 81% based on the facility's tracking log. Since 6/14/13, the on-time percentage was actually 92% and 100% of the 64 assessments completed for ISPs between 3/1/13 and 8/21/13 had been completed prior to the ISP. This reflected a significant improvement and stabilization of this issue over the course of this review period. The facility self-assessed this provision as continued substantial compliance. Though the monitoring team noted some regression in the areas of quality and timeliness, there was also a change in leadership and other personnel changes. It appeared that the department was back on track to make continued improvements and, as such, the monitoring team concurred with continued substantial compliance at this time. It is expected that resolution of the identified issues with regard to the essential elements and on-time completion of OT/PT assessments 10 working days prior to the ISP will be effectively addressed over the next six months, including: To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure that assessments are completed by the due dates (10 days prior to the ISP). 2. Ensure that each assessment contains a clearly stated assessment schedule and outlines the intervals for compliance and effectiveness monitoring. 3. Because each individual received a comprehensive assessment, the facility should begin to consider the completion of updates (Assessment of Current Status) 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 metric described above. This assessment should not have to be as lengthy as the existing comprehensive assessments so as to permit further delivery of services and improved timeliness of assessments. 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 and may also be appropriate in case of changes in status.	

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P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	<u>Direct OT/PT Interventions:</u> There were 10 individuals listed as participating in direct OT and/or PT from February 2013 through July 2013. Seven were selected for review in Sample P.3. • For 1 of 7 interventions for individuals (14%), the current OT/PT assessment or consult identified the need for OT/PT intervention with rationale. o There was no assessment of consult submitted for Individual #66 describing the justification for direct PT and establishing the measurable outcomes. o There was no evidence of a PT assessment related to his posture per an ISPA held on 3/1/13 for Individual #112. A TLSO was fitted and trialed, but there was no supporting assessment or documentation to justify this support. An ISPA on 5/6/13 referenced this, but only after it had already been fabricated and implemented. o There was no adequate OT assessment related to initiation of skilled OT services for Individual #161 on 3/11/13. o There was no evidence of a PT assessment to initiate intervention for Individual #178. o There was no adequate PT assessment to justify direct services for Individual #90. • 5 of 7 individuals had direct intervention plans (71%) implemented within 30 days of creation of the plan, or sooner as indicated by the individual's health and safety. o The annual assessment recommended direct PT for Individual #67 on 3/11/13. There was no evidence that this was implemented until 6/28/13. • For 1 of 7 individuals (14%), there were objectives related to functional individual outcomes included in the ISP or ISPA (though even these were not measurable in the sense that performance criteria were clearly stated). o For Individual #66, the goal statement included three distinct objectives; none of these included performance criteria, so it was not clear when the objectives would be achieved. o There were no established objectives of any kind outlined for Individual #161 or Individual #178 related to skilled therapy services. No ISPAs were submitted related to these services. o The performance criteria stated in the SAP for Individual #90 would permit him to perform the skill one time and achieve the objective. A baseline was stated, but the IPN documentation referred to varied data and did not clearly link to the SAP. • For 0 of 5 individual's record (0%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner.	Noncompliance

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		o There was no evidence of discharge documentation for Individual #66. The notes related to direct PT initiated in March 2013 merely stopped without a summary clarifying the rationale and plan. o Direct PT appeared to be ongoing for Individual #67 as of 9/16/13 per the documentation submitted. o There was no evidence of discharge documentation for Individual #161's OT intervention. o Documentation related to direct PT for Individual #178 merely stopped as of 7/18/13. o Direct PT appeared to be ongoing for Individual #90 as of 9/17/13. The system for documentation was fairly inconsistent for each of the individuals reviewed. While an assessment or consult to identify the need for OT or PT intervention was not consistently noted, a number of individuals had a SAP document that outlined the intervention to some extent. The rationale and plan with measurable and functional objectives was not noted in most cases. Some documentation was in the IPN section, other documentation was typed and reportedly filed in the Habilitation Therapy tab of the individual record. In some cases, a handwritten IPN note also referenced the typed note, and in some cases this information was duplicative. In other cases, a reference to a typed notation was documented in the IPN, but there was no evidence of this. In some cases, when the PTA provided the intervention, there was evidence of review and a monthly progress notes completed by the PT (e.g., Individual #90). For Individual #78, the annual assessment indicated that direct therapy was not indicated, though she was identified as participating in direct therapy per the list submitted. There was an indication on the list that supports had been discontinued, but there was no evidence of a discharge summary with rationale. Though there was a SAP related to indirect interventions, there was no evidence of a consult or other documentation related to direct therapy. Progress notes/IPNs: • 0 of 7 individuals receiving direct OT/PT Services (0%) were provided with comprehensive progress notes (IPNs) at least monthly that contained each of the indicators listed below: o 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); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress.	

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		While documentation was typically noted for each session of direct therapy, the content of the documentation as a whole was weak and inconsistent. There was a clear need for established documentation guidelines for the clinicians, per generally accepted standards. There were monthly notes by the therapy assistant for direct intervention, but did not adequately included the elements listed above. For the most part, though outcomes were identified, they were not stated in measurable terms and the subsequent notes did not document specific progress related to any identified criteria. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O.3 above regarding PNMP format, content and integration into the ISP and Section S for skill acquisition plans. Implementation of PNMPs is addressed in section O.5. <u>Integration of OT/PT Interventions, Supports and Services in the ISP</u> Review of the ISPs submitted was as follows: • 87% (12 of 12) of the ISPs submitted were current within the last 12 months. • 75% (8 of 12) of the current ISPs had attached signature sheets. • 13% (1 of 8) of the current ISPs with signature pages submitted were attended by both the OT and PT. • 25% (2 of 8) were attended by PT only. • 25% (2 of 8) was attended by OT only. • 38% (3 of 8) of the current ISPs had no representation by an OT or PT. This was for Individual #90, Individual #114, and Individual #15, each of whom had identified OT/PT needs. Pre-ISP meeting documentation was requested for each individual in Sample P.1, though documentation was submitted for only 10. Documentation for team members required to attend the ISP meeting was included for seven of these. Of these, ISP meeting attendance was consistent with the pre-ISP for four individuals. For Individual #114, a SLP attended rather than the OT. For Individual #32, a PT attended instead of the OT. For Individual #89, attendance by the OT, PT, and SLP could not be determined because no sign-in sheet was attached to the ISP (11/14/12). The IDT's decision-making related to attendance by the OT and/or PT was not clear from the pre-ISP document and was not always consistent with the individual's abilities or needs (Individual #63, Individual #32, Individual #90, Individual #114, Individual #15, and Individual #125). During the week of this onsite visit, though only the OT was listed as required to attend the ISP for Individual #125, all three disciplines were in attendance.	

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		The self-assessment, which presented data for the tracked participation of OT, PT, and SLP in ISP meetings, reported that attendance was 100% for OT and 100% for PT from 3/1/13 through 9/1/13. There were only two ISPs in Sample P.1 held during that time period for which a pre-ISP document and ISP signature sheet were submitted. Each of these (100%) documented attendance by therapy clinicians as outlined in the pre-ISP document. Further: • For 5 of 8 individuals (63%), an OT or PT attended the ISP meeting if the individual was receiving any direct or indirect OT/PT service, or if not, adequate justification was provided. • For 6 of 12 individuals in Sample P.1 (50%), the ISP addressed recommendations outlined in the current OT/PT assessment. Many recommendations were generally-referenced rather than individually-designed, particularly in the review of the PNMP. • For 4 of 8 individuals in Sample P.1 (50%) who had an OT and/or PT consult assessment/update, an ISPA addressed recommendations. There were a number of these consults that did not require a change to the existing supports, or were minimal and would not justify an ISPA. • For 12 of 12 individuals reviewed in the sample for whom individual records were selected by the monitoring team (100%), the PNMP was updated within 30 days of the ISP. • For 7 of the 8 individuals (88%) for whom skill acquisition programs were recommended in the OT/PT assessment, these were addressed in the ISP. In some cases, however, the IDTs determination to not implement a recommended SAP was not well justified (e.g., Individual #71 and Individual #115). A SAP was recommended for Individual #125 in the most current annual OT/PT assessment and was discussed during the ISP meeting held during the onsite review. • For 0 of 8 individuals (100%), the ISP/ISPAs contained measurable objectives related to interventions. Because each ISP was inconsistent across format and content, it would be difficult for staff to be able to readily locate information when attempting to use the ISP as a resource. The information included in the IRRF was more consistent and more accessible. In response to a request for a list of SAPs for indirect interventions by OT or PT, the facility stated that the Habilitation Therapists made a recommendation or collaborated on the development of a related SAP that did not require direct skilled therapy. Monitoring of these was completed by the QIDPs in collaboration with the Program Developers. There was, however, no database to readily access this information. Indirect services (generally related to the PNMP) were documented in the IPNs. Effectiveness monitoring for this was addressed in section O above.	

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		This element was self-rated to be in noncompliance and the monitoring team concurred with the self-assessment. To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Rationale in the pre-ISP process for therapist attendance or non-attendance at the ISP needs to be sound and clearly supported. 2. OT and PT supports must clearly be outlined in the ISP. In the case that interventions are initiated outside the scheduled annual ISP, an ISPA must document initiation of the service, report progress and termination with rationale.	
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.	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.	The facility did not have a comprehensive OT/PT policy or set of policies and procedures that included all of the following elements: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; • Identification of monitors and their roles and responsibilities; • Definition of a formal schedule for monitoring to occur; • Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requirement that results of monitoring activities in which deficiencies are noted	Noncompliance

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		are formally shared for appropriate follow-up by the relevant supervisor; • Identification of the frequency of assessments; • Definition of how individuals' OT/PT needs will be identified and reviewed; and • Requirements for documentation for individuals receiving direct services. Roles and responsibilities of OTs and PTs were generally outlined. The system of monitoring of individuals with PNM and OT/PT needs were outlined in both the PNM and OT/PT policies. The system for referral was via physician's orders and the IDT process outlined in other facility policies and clearly in practice based on review of the individual records. Frequency of assessments or requirements for documentation for supports and services and discharge from direct intervention were not clearly outlined in the documentation submitted. <u>Monitoring System</u> The facility implemented a system for the adequate monitoring of PNMPs. Staff compliance monitoring for implementation of PNMPs and the condition and availability of adaptive equipment was implemented at EPSSLC. This was addressed in sections O.6 and O.7 above. There was also a system established for routine evidence of effectiveness monitoring by the therapists. This should be documented routinely in the IPNs, however: • Based on review of the individual records submitted, quarterly effectiveness monitoring was documented at least quarterly for 0 of 12 individuals in the sample (0%). IPNs were reviewed for all individuals in Sample P.1 from 1/1/13 through the time of the onsite review to determine the frequency of effectiveness monitoring and if it was consistent with the recommendations in annual OT/PT assessment. o Effectiveness monitoring was not conducted consistently or as outlined in the assessments for any individual in the sample. In some cases, the IPN designated as a review of effectiveness, only addressed staff compliance for implementation. Evidence of effectiveness monitoring by OT and/or PT was noted for eight of the 12 individuals, though in one of those cases, it was conducted only one time in nine months (Individual #114). The four with no monitoring were Individual #23, Individual #71, Individual #90, and Individual #4. Preventative maintenance checks were conducted at least quarterly for individuals who had wheelchairs, gait trainers, and adapted chairs. Another database logged in the modifications and repairs. There were a number completed prior to the report date and date issued to fabrication. It was not clear how that was possible and was presumed to be	

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		data entry errors. Most appeared to be completed on the same day, or within 24 to 48 hours. More extensive work related to a new system or modification took more time. A very few required up to a week or more, with all requiring less than a month, though there were six listed as incomplete as of 8/1/13 (repair mealtime chair on 6/13/13, hip guide for wheelchair on 7/22/13, bedrail padding on 7/25/13, seat back modification on 7/26/13, work order modifications on 7/29/13, and repair calf/footrest on 7/29/13). • Based on review of the maintenance log, individuals for whom assistive equipment was noted to be in disrepair or needing replacement (100%), equipment was repaired or replaced within 30 days unless justification was provided, or unless the issue impacted the individual's health or safety, then action was taken within 48 hours. • For 100% of the individuals observed, positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. It was noted, however, that the majority of gait trainers observed in the Dorms area were not clean. This element was self-rated to be in noncompliance. There was a comprehensive policy that outlined essential elements related to monitoring and OT/PT supports and services. There was a system of staff compliance monitoring, though compliance with this was reviewed in section O.6 and O.7 above. While there was an established system of effectiveness monitoring, compliance with this at least quarterly was not substantially in compliance with the monitoring team's expectations and the established facility policy. To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Adjust tracking of maintenance activity to reflect routine maintenance checks as well as problem-oriented work orders with dates received and dates completed in order to effectively track the timeliness of completion. 2. Establish benchmarks and a tracking system and schedule for quarterly effectiveness monitoring by OTs and PTs. 3. Conduct audits and staff training as to the process expected for effectiveness monitoring.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15.1: Dental Services, dated 8/15/13 o EPSSLC: Facility Operational Dental Services State Policy, Chlorhexidine Use/Definition, 4/11/13 o EPSSLC: Facility Operational Dental Services State Policy, Suction Toothbrush/Chlor., 4/11/13 o EPSSLC: Facility Operational Dental Services State Policy, Suction Toothbrush/Biotene, 4/11/13 o EPSSLC: Facility Operational Dental Services State Policy, Equipment Maintenance, 4/11/13 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 Annual Dental Exam/Summaries for the following individuals: • Individual #118, Individual #161, Individual #79, Individual #50, Individual #60, o Comprehensive Dental Examinations for the following individuals: • Individual #8, Individual #149, Individual #189, Individual #126, Individual #42, Individual #81, Individual #17, Individual #80, Individual #35, Individual #129 o Desensitization plans for the following individuals: • Individual #32, Individual #50, Individual #184 o Complete Dental Records for the following individuals: • Individual #83, Individual #35, Individual #19, Individual #23 Individual #81, Individual #114, Individual #118, Individual #155, Individual #74, Individual #125 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

	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) provision action information. For each provision item, a numbered list of activities engaged in to conduct the self-assessment was provided. The results of each activity were listed. Based on the results, a self-rating was determined. The self-assessment utilized was based on a template issued by state office. The assessment was expanded to cover additional areas for review. The self-assessment was primarily a review of data that were collected by the facility. The assessment covered many of the areas assessed by the monitoring team. The primary problem with the self-assessment was the accuracy of the data. EPSSLC will need to address data accuracy to improve the quality and value of the self-assessment. 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: Individuals continued to receive dental treatment at EPSSLC. Some individuals received treatment off campus. There were no staffing changes and the facility continued to lack a dental director. Most individuals were seen in clinic or their homes for cursory annual exams and were scheduled for comprehensive exams under anesthesia. Even though the exam was cursory, they were not completed in a timely manner. There did not appear to be any effort to provide treatment with any intermediate forms of minimal sedation. It appeared that the staff believed the use of anesthesia was safe and a positive aspect of care. Thus, some individuals underwent general anesthesia for cleaning and x-rays. The monitoring team did not find documentation in the comprehensive exams done under anesthesia of complete exams inclusive of the intraoral, extraoral examinations, oral cancer screenings, etc. There was also no documentation that the direct support professionals/individuals were provided oral hygiene instructions at the time of the annual assessments. The facility provided emergency care during normal business hours when a dentist was in clinic, which was 10 days each month. EPSSLC did not comply with state policy, which required availability of emergency dental care 24 hours a day. The clinic staff reported that the medical staff would evaluate dental issues in the absence of a dentist. Documentation of radiographs and the need for radiographs was found only for those individuals who had general anesthesia. The facility dentist stated there was no definitive requirement for obtaining x-rays. Overall, additional treatment was provided to individuals over the past six months. This review highlights areas of clinical concern and areas of administrative concern. The lack of a facility medical director resulted in a leadership deficit in the clinic. Strong clinical and administrative leadership was needed. This lack of leadership was noted in previous monitoring reports, but the consequences were becoming more

	pronounced in the sense the facility was not making adequate progress. The clinic staff continued to be unaware of some of the basic requirements of the Settlement Agreement and the fundamental ICF regulatory guidelines. This impacted clinical care and the ability to assess the progress of the clinic. There continued to be problems reporting data. This was reflective of a lack of organization within the clinic. The state office representative reported that the clinic staff had not participated in the last few scan calls. There was no explanation for the lack of participation or why information was not disseminated by alternative means. The clinical issues should be further assessed by both the state medical and dental coordinators. The lack of medical and dental directors is adversely impacting the overall provision of dental services. The clinic had a lack of administrative leadership as well as a lack of consistent daily clinical leadership. In many ways, the EPSSLC clinic appeared disconnected from the other SSLCs with regards to many issues. These management issues were impacting the progress of the clinic and must be addressed in order to move toward substantial compliance with the Settlement Agreement.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	<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 a total of 10 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. EPSSLC did not have 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. Dental Clinic Appointments 2013 | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | | Preventive | 39 | 25 | 23 | 17 | 12 | 21 | 9 | 3 | | Emergency | 2 | 1 | 1 | 0 | 1 | 1 | 1 | -- | | Extractions | 3 | 2 | 2 | 4 | 1 | 3 | 0 | -- | | Restorative | 3 | 2 | 2 | 1 | 1 | 1 | 0 | -- | | Total | 39 | 37 | 53 | 47 | 47 | 40 | 33 | 11 | <u>Oral Surgery</u> 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. The individuals referred were generally those who were older or who had complex medical problems.	Noncompliance

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		Emergency Care Emergency care was available during normal clinic hours. The facility policy was revised to state that dental emergencies were seen by a dentist or a medical doctor. This revision did not meet the mandates of state policy, which was consistent with ICF regulations, which required "the availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist." The facility did not have any on call policy or other arrangement to ensure that dental services were available 24 hours a day. Individual could however be referred to the local emergency department for evaluation and treatment. Radiographs The monitoring team discussed the requirement for radiographs with the facility dentist. There was no specific frequency established for completion of radiographs at the facility. The monitoring team requested clarification from the state dental services coordinator who provided a written policy that was intended to be included in the next revision of the state dental services policy. This was an important step because of the high prevalence of periodontal disease in the population of individuals supported in the SSLCs. Oral Hygiene The facility continued to monitor the oral hygiene ratings of the individuals. The following data were reported in the self-assessment: Oral Hygiene Ratings (%) | | Good | Fair | Poor | | 2012 | 18 | 54 | 27 | | 2013 | 26 | 51 | 23 | The hygienists reported that they worked with the direct support professionals and provided training. The facility did not have a systematic approach to providing training in the homes. For example, the hygiene data were not reviewed to determine if there were trends or patterns in the homes that needed to be addressed. The staff stated they just selected homes and would eventually do them all. The facility provided documentation of oral hygiene training done with the direct support professionals. Record reviews also indicated that training was done with staff. There was little indication that the individuals received instructions regarding proper oral care. This was affirmed in the self-assessment, which reported that 11 of 36 (14%) of records indicated oral hygiene instructions were provided to individuals.	

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		Suction Toothbrushing Fourteen individuals received suction tooth brushing. The speech and language pathologists referred individuals to the dental clinic for evaluation by the facility dentist. The hygienists and respiratory therapists trained nurses to complete the procedures with Biotene. This was done twice a day and documented on the MARs. Training was conducted by the hygienists and respiratory therapists. Staff Training All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn. Data provided by the facility indicated compliance with the requirements for training. Ninety four percent of direct support professionals completed the refresher through iLearn. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility director must address the need to hire a dental director or provide appropriate administrative and clinical supervision in the dental clinic. The current dentist is present 10 days a month leaving the clinic with little supervision. 2. The facility must comply with the requirements to provide emergency dental care. This can be accomplished in a number of ways. The state dental services coordinator should provide assistance in this area.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to	Policies and Procedures The dental clinic revised a number of polices related to suction toothbrushing as well as equipment maintenance. The policies indicated that these were state policies. The monitoring team was not aware of state issued policy specific to the use of Biotene and Chlorhexidine. The monitoring team requested to review policies related to the guidelines for obtaining radiographs and general anesthesia. Those policies were not available for review. Dental Records Dental records consisted of an IPN entry, dental progress note, dental progress treatment record, treatment plan record, and dental summary. The Dental Progress Record was a duplication of the IPN entry. Both were done in SOAP format. As noted in the summary, the annual exams usually were very brief SOAP notes and Dental Summaries. This was observed in the March 2013 compliance review and	Noncompliance

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	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.	commented upon in that report. The state dental services coordinator informed the monitoring team via email that there was some confusion regarding the terms annual summary and annual exam. EPPSSLC was switching back and forth between formats and forms, but informed the monitoring team that they were using the new the Annual Dental Summary form. The monitoring team could ascertain very little about the specific care provided to individuals based on the documentation provided. The complete dental records were requested for a sample of individuals. The information was very similar for all individuals, therefore, two individuals will be used to highlight the findings observed in the records: To fulfill the request for the complete dental record, a total of six pages was submitted for Individual #35. The records submitted included: • Dental Summary, 8/13/13 • Treatment Plan Record • Dental Progress Note • Dental Progress/Treatment Record • IPN The Dental Progress Note included three SOAP entries with the following documentation: • 3/15/13, 7:00 S – General anesthesia Cancelled appt due to upper respiratory infection. Will reschedule when infection resolved. • 6/26/13, 7:20 S - General anesthesia O – Cooperation - fair OH - poor (lower anterior acutely inflamed) A - Exam BWs x 4 Cavitron scaling All treatments completed P - GA recall here June 2014 • 8/13/13 1:14 S - Seen in cottage for ISP exam O - Cooperation fair OH - fair A - ISP exam P - GA recall June 2014	

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		There was a corresponding Dental Summary dated 8/13/13. The summary required circling of responses to questions on behavior, oral hygiene periodontal type, caries missing teeth, mouth odor, inflammation, bleeding, plaque index, and tongue. The recommendation was made to have staff assistance /supervision. The annual exam was a brief exam done in the cottage in preparation for the individual's ISP. The actual treatment and examination was done months earlier. The documentation reviewed for both examinations did not document comprehensive intraoral and extraoral examinations. There were no comments on the oral cancer screenings. Risk ratings were not found in any of the discussions reviewed. Moreover, the dentist circled "yes" to the presence of dental barriers, but there was no discussion of the risk ratings or how they had been addressed in the past. The Dental Summary simply documented that the individuals required dental general for invasive dental care. The anesthesia records were not provided as part of the complete dental records. Finally, the Settlement Agreement requires the IDT have "dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions." The treatments that were needed and completed were not clear from the records reviewed. Six pages were submitted form the records of Individual #83. The Dental Progress Note included five SOAP entries. The following were the two most recent entries: • 4/3/13, 10:45 S - Brought to DC for annual exam O - Cooperation good OH fair A annual exam P GA recall here 2013 Dec • 8/13/13, 2:05 (and IPN) S - Seen in cottage for ISP exam O - Cooperation good OH fair to good A – ISP exam P - GA recall here Dec 2013 A corresponding Dental Summary dated 8/13/13 recommended staff assistance/supervision. The notes section indicated the individual liked the dentist and followed instructions, however, general anesthesia was needed once a year for invasive treatment. The annual exam IPN was not submitted.	

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		The Dental Progress Treatment note, dated 2/6/13, indicated that the dentist reviewed the consult of Dr. Reynolds. The records provided no indication to the IDT of the condition of the individual's teeth and oral health. There was no information provided about what occurred under general anesthesia, or the findings/recommendations of the consultant. The monitoring team is not clear on how the IDT was obtaining information because the necessary information was not being provided in the records. Following the onsite review, the facility reported that there were two community dentists that provided off-site dental treatment. Consultation sheets were to be placed in the dental section of the active record. <u>Annual/Comprehensive Assessments</u> In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months, along with the date of previous annual assessment, was requested. Assessments completed within 365 days of the prior assessment were considered to be in compliance. The available data were used to calculate compliance rates that are summarized below.	

Annual Assessment Compliance 2013						
	Mar	Apr	May	Jun	Jul	Aug
No. of Exams Completed	10	10	5	5	5	8
% Timely Completion	90	50	0	0	100	88

The self-assessment reported 100% compliance with completion of annual assessment in a timely manner. During the week of the compliance review, the monitoring team requested clarification from the state dental services coordinator regarding the requirements communicated to the facility with regards to annual exams. EPSSLC continued to calculate compliance based on the calendar month, but the monitoring team had been informed at other SSLCs that a directive was issued by state office to complete annual exams within 365 days due to ICF regulatory requirements. The EPSSLC staff reported they were never notified of this requirement, however, the self-assessment completed by the clinic staff reported, "36 of 36 evaluations were completed within 365 days." The monitoring team found a compliance rate of 55% for the reporting period of March 2013 through August 2013. Since this was not correct, there were obvious problems with data integrity within the dental clinic that need to be addressed by the facility director and state dental services coordinator.

In addition to assessing compliance with the timeliness of completion, the monitoring team reviewed the content of assessments. The Annual Dental Summary was used to document the annual examinations. The reports for five individuals were reviewed. The following is a summary of information found in the assessments:

#	Provision	Assessment of Status	Compliance
		• 5 of 5 (100%) assessments included an entry on cooperation • 5 of 5 (100%) assessments had entries for oral hygiene and periodontal conditions • 0 of 5 (0%) assessments included documentation of oral cancer screenings • 4 of 5 (80%) assessments included documentation that oral hygiene recommendations were provided to the individual and/or staff • 0 of 5 (0%) assessments documented the risk rating • 0 of 5 (0%) assessments documented x-rays or the need for x-rays. Communication from the state dental services coordinator indicated that the Annual Dental Summary was intended to be a record review done in preparation for the ISP. EPSSLC utilized this form to document the annual examination. In doing this, the annual examinations for the individual failed to document significant information, such as intraoral and extraoral exams, the need for x-rays, review of x-rays, and documentation of the provision of oral hygiene instructions to the individuals and staff. These were ICF regulatory requirements mandated in state and facility dental policy. Moreover, the annual exams failed to address risk ratings for the individuals and did not include any statement regarding a review of medical history, record review, or medication use. The IPN documentation of the annual exams were usually four line entries that did not provide the IDTs with any information regarding the condition of the individual's oral health. The lack of documentation for the actual annual exam was likely due to the brief nature of the exam. Almost all indicated general anesthesia was needed for a complete/comprehensive exam. In most SSLCs, the annual exam was the comprehensive exam. At EPSSLC, the exams completed under general anesthesia, in many instances, documented some additional information, such as the x-rays completed and work done, but did not provide much of the information that was required in order to meet the requirements of the Settlement Agreement. <u>Initial Exams</u> The facility submitted data for three individuals admitted since the last onsite review. Three of three (100%) individuals completed initial dental evaluations within 30 days. <u>Failed Appointments</u> The guidelines issued by state office required reporting of missed appointments and refusals. A missed appointment was one that was not attended by the individual because of reasons beyond his or her control. Refusals were appointments not attended because the individual stated he or she did not want to go. The failed appointments were the total number of missed appointments and refusals. The numbers as identified and	

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reported by EPSSLC in the document request are summarized in the table below:

Failed Appointments								
	Jan	Feb	Mar	Apr	May	Jun	July	Aug
Missed	3	7	1	0	0	0	1	1
Refused	1	0	0	0	0	0	00	0
Failed	4	7	1	0	0	0	1	1
% Failed	10	19	1.8	0	0	0	3	9
Total Appointments	39	37	53	47	47	40	33	11

The original document request did not report the missed and refused appointments for January 2013 and February 2013 and those data were not seen during the March 2013 compliance review. Interestingly, the failure rates for those two months were quite high and unexplained, though later the facility reported that some cancellations were due to provider schedule changes.

The facility continued to report no refusals, however, the monitoring team identified several SAPs that were written to address individuals who appeared have some type of refusal-like behavior. The SAPs described plans for having the individuals come to the clinic and have gradual exposure to the clinic and the staff. Status reports were not provided.

Dental Restraints

The reported data for the use of general anesthesia and anxiolysis is summarized in the table below.

General Anesthesia/Minimal Sedation						
	Mar	Apr	May	Jun	Jul	Aug
Gen Anesthesia	9	12	1	10	0	8
Oral Sedation	0	0	0	0	0	0

The following data were reported in the self-assessment

	2012	2013
General Anesthesia	70 (62.5%)	30 (100%)
Oral Sedation	42(37.5%)	0
Restraints	0	0
Total Appointments	112	30

During discussions with the facility dentist, he reported that pretreatment sedation was not used at EPSSLC because it was not effective and was not safest. The facility, therefore, did not attempt to provide treatment with anxiolysis/minimal sedation. That approach was reflected in the data submitted in the self-assessment.

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		In 2012, 70% of the dental procedures were accomplished with general anesthesia. At the time of the review, <u>all</u> dental procedures were completed under general anesthesia. This was a significant change in practice and the monitoring team noted that this practice had not been questioned y facility staff and it should have been. The questions should have been posed, not because the changes were necessary inappropriate, but because significant shifts in data should always be examined, even if just to ensure accuracy. The monitoring team had additional concerns. Upon noting the increasing reliance on the use of general anesthesia, a request was made for the policies and procedures related to pre-assessment, monitoring, and post-anesthesia monitoring. Following the compliance review, the monitoring team received the policies from the facility of the state dental coordinator with an explanation that these were being presented at EPSSLC for approval immediately. Thus, it the facility did not have an approved set of policies related to the use of genera anesthesia. The facility had taken a grave misstep in utilizing general anesthesia without developing and implementing a set of policies and procedures related to medical clearance, use of anesthesia, and post anesthesia monitoring. Many of these issues were also linked to the lack of a medical director who would have the ultimate responsibility for ensuring that dental practices were safely implemented into the overall health care services of the facility. The monitoring team does not disagree with comments that endotracheal intubation provides the safest form of airway protection for those who are at risk of aspiration when levels of sedation beyond anxiolysis are utilized. The monitoring team does, however, believe that additional guidelines for the use of general anesthesia are warranted to ensure that this procedure, which is not without risks, is not inappropriately or over utilized. The monitoring team strongly recommends that the state dental and medical services coordinators review: 1. scope of services provided at EPSSLC 2. indications for use of anesthesia 3. evaluation of individuals prior to anesthesia, and 4. post anesthesia monitoring of individual. <u>Strategies to Overcome Barriers to Dental Treatment</u> The facility continued to report that no individuals refused treatment, however, the monitoring team identified several SAPs that were written to address individuals who appeared have some type of refusal-like behavior. The SAPs described plans in which the individuals were being gradually introduced to the dental clinic and the staff with the goal of allowing treatment in the clinic. The current status of the plans was not provided.	

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		<u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The issues related to refusals as discussed above should be addressed. 2. The facility must address the use of general anesthesia as outlined above. 1. EPSSLC must comply with requirements for documentation of dental services.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Current SLPs, license numbers, ASHA certification cards, caseloads o Continuing education and training completed by the SLPs since the last review 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 Speech Language Pathology Screening template o List of individuals with behavioral issues and coexisting severe language deficits 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 individuals receiving direct communication-related intervention plans o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o NEO Communication Training Curriculum o Instructional Guides for AAC o Communication Assessment for individuals recently admitted to EPSSLC: Individual #37 and Individual #46 o Communication Assessments and ISPs for the following individuals: • Individual #5, Individual #188, Individual #7, Individual #42, Individual #169, Individual #73, Individual #9, Individual #34, and Individual #77 o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: • Individual #18, Individual #178, Individual #92, Individual #50, Individual #17, and Individual #6 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #125, Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15, and Individual #114. o PNMP section in Individual Notebooks for the following: • Individual #125, Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15, and Individual #114 o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #125, Individual #71, Individual #32, Individual #93, Individual #23, Individual #4, Individual #115, Individual #89, Individual #90, Individual #63, Individual #15, and Individual #114 <u>Interviews and Meetings Held</u>: o Leslie Ambruster, MS, CCC-SLP, Director of Habilitation Therapies o Patricia Bush, MS, CCC-SLP o Erika Alcantar, MS, CCC/SLP o Karin De La Fuente, MS, CCC-SLP o Rebecca Roberts, SLPA o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o ISP Meeting for Individual #125 o Treatment sessions for Individual #92 and Individual #189
	Facility Self-Assessment: The self-assessment completed by Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director, was an excellent first effort. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team. Findings were generally reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The foundation laid over the last couple of years by Susan Acosta, the previous Director, was vital to the successful transition of leadership during this last six month period. Ms. Ambruster and the other communication services staff were on track to ensure that progress is made for the next review. While there were minimal improvements and some regression, the plan outlined was a sound one and, combined with the findings of this report, should guide them to make greater strides over

	the next six months. Benchmarks should be established in measurable terms and used to establish measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the work that done over the last few months since the time of bringing on new, yet highly qualified clinicians. The facility rated itself in noncompliance with R.2, R.3, and R.4. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings. The facility rated itself in substantial compliance with R.1. There appeared to be a sufficient allocation of well-qualified and experienced speech staff resources, based on identified need. The monitoring team concurred with the facility's self-assessment of substantial compliance with this provision. This sound foundation should set the stage for improvements with the other provisions.
	Summary of Monitor's Assessment: There was continued, but limited and slow, progress toward substantial compliance in all aspects of provision R. This was likely due to the complete turnover in SLPs and Habilitation Therapies Director. That said, the new leadership and new speech clinicians appeared to have a clear understanding of how to proceed to ensure that individuals received appropriate and timely communication assessments and functional and meaningful communication supports. As Leslie Ambruster, the Director and a SLP herself, had significant experience in this area, the monitoring team is confident that she can lead the efforts to make more tangible progress over the next six months. Her plan was a good one, in part outlined in the self-assessment and QA documents: • To ensure a generalization of staff knowledge, appreciation, and respect for how key communication is to the quality of life and participation for the individuals who live at EPSSLC. • Refine and expand the content of the communication-related training curriculum. • Infuse real time modeling in to the everyday routines of individuals and staff. • Continue to provide individual-specific therapy to identify communication systems and strategies for implementation. All of the SLPs worked diligently to complete assessments and identify appropriate communication supports for individuals, including AAC. Assessments were not consistently completed 10 days prior to the ISP, but were consistently completed prior to the meeting. The content aspect of assessments, however, did not show progress in that 80% of the assessments reviewed contained more than 90% of the 24 essential elements and, moreover, 100% of the assessments contained 83% or more of the required elements. Improvements from the previous review were noted in 46% of the 24 elements. Nine others were maintained at 100%, consistent with the previous review. Minor decreases were noted for two elements and it was noted that approximately 70% of the assessments were completed prior to the ISP. It is critical that clinicians use what they learn from observing individuals in home, work, day program, and

	direct therapy into the documentation needed for completion of the assessments. The therapists are commended for the quantity of direct services they provided each week. Integration of communication into the ISP and real time coaching and modeling for staff are also keys to effective functional implementation. Maintaining equipment already provided to individuals was an ongoing and costly problem. Clear expectations from administration and supervisory staff regarding the care of these is essential in order that they are always available to the individuals who need them. Further, there was a need to expand the time available for staff training on communication. Currently, the schedule identified only two hours for deaf awareness and AAC. The monitoring team had concerns that a full day was allotted for orientation and mobility training for new employees. Given the current census, the number of individuals impacted by hearing impairment and visual impairment was minimal, but the impact of need for effective staff communication with all individuals was enormous for every individual and staff member. The amount of time devoted to orientation and mobility was extremely inconsistent with the clearly identified needs for communication supports. Staff training should be commensurate with that need. In general, habilitation leadership understood the importance of not only direct therapy, but also routine and consistent direct contact with individuals and direct support staff to model communication in varied environmental contexts that are meaningful and functional to the individual. The therapists appeared to recognize ways they can support individual goals, interests, and preferences by providing therapy supports to ensure that those visions are achieved. <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 LSSLC as most current. • Sample R.3: Individuals admitted since the last compliance review. • Sample R.4: Individuals with AAC systems selected by the monitoring team • Sample R.5: Individuals receiving direct speech services

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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	<u>Staffing</u> The current Habilitation Therapies Director, Leslie Ambruster, MS, CCC-SLP was a speech-language pathologist. She served as the only SLP staff therapist when initially hired in May 2013. She was appointed in mid-June 2013 as the Director. Her duties in both positions overlapped until 7/8/13, when the two full-time SLPs were hired. They had responsibilities related to communication, as well as dysphagia concerns: Patricia Bush, MS, CCC-SLP, and Erika Alcantar, MS, CCC/SLP. Karin De La Fuente, MS, CCC-SLP, was a PNMT member with no other caseload responsibilities and was not included in the review of this provision. Rebecca Roberts, SLPA, was hired as a speech assistant to both full-time SLPs.	Substantial Compliance

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	communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	There were three budgeted positions for speech staff, with one filled at the time of this review. Three others were listed as full-time contractors with two unfilled state positions. The FTEs were listed as three with a ratio of 1:39. Presumably this included the speech assistant. While the SLPA provided a very valuable service related to interventions, training, and monitoring, this was only under the supervision of an SLP and she was not able to conduct assessment per the state practice act. As such, based on the census at the time of this onsite review, the ratio was 1:58. That said, though the Director did not carry a specific caseload, she had extensive experience in the delivery of communication services and specifically in the area of AAC. Responsibilities of the communication therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to communication and dysphagia. The speech staff were assigned caseloads as follows (totals based on individual list by home and based on census of 116): • Erika Alcantar: Dorms/Systems A, B, and C Dorms (approximately 40 individuals). Her responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals. Since these individuals had significant needs in both of these areas, this was a reasonable caseload to sufficiently address those, particularly with assistance from the SLPA, speech therapy technicians, and PNMPCs. • Patricia Bush: Cottages 506, 507, 508, 509, 510, 511, 512, and 513 (approximately 76). Her responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals. Since some of these individuals overall presented with less significant communication and mealtime/dysphagia needs, this was a reasonable caseload to sufficiently address those, particularly with assistance from the SLPA, speech therapy technicians, and PNMPCs. • Rebecca Roberts: provided assistance and supports to both SLPs across the cottages and Dorms/Systems areas (as required and directed by the SLPs). There was no Master Plan with assigned priorities related to the severity of individual communication deficits and communication assessment/support needs, but rather 100% of individuals had received a Comprehensive Assessment and each continued to receive a Comprehensive Assessment or Update Assessment annually according to the ISP schedule. A Master Plan was identified as in development at the time of this review. It appeared that the action plan under development at this time was to increase the use of	

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		Environmental Communication Strategies in addition to the current level of optimal communication strategies and the communication dictionaries. This would be a first step in raising the level of supports and services to more sufficiently meet the identified needs. The list of individuals with PBSPs and replacement behaviors related to communication included 22 individuals identified with severe language deficits. Another list identified at least nine others with language deficits and behavior concerns. Eight of these lived in the Dorms/Systems area and the rest lived in the cottages. Without a Master Plan, it was not possible for the monitoring team to specifically determine the number of individuals with the highest communication needs per home, though clearly the majority of those living in the facility had some level of communication needs. Per a chart included in the QA report for the period 6/1/13 through 8/30/13, the delineation of individuals was reported as less than 20 who were identified as verbal, and the rest of the census as nonverbal or with limited communication skills. • EPSSLC provided an adequate number of speech language pathologists and speech assistants with specialized training or experience to provide communication supports and services based on the process established by the facility. These caseload assignments were reasonable based on need and the SLPA permitted a focus of the provision of ongoing supports and services needed for individuals with communication needs. <u>Qualifications:</u> • The facility documented appropriate qualifications for licensed SLPs. • 4 of 4 speech staff (100%) were currently licensed to practice in Texas as verified online. This was an improvement from 50% of SLPs. • 3 of 3 SLPs (100%) held current American Speech and Hearing Association (ASHA) certification. Leslie Ambruster, MS, CCC-SLP, Director of Habilitation Therapies was a SLP with documented experience including the following: • 16 years as a SLP and two years as a SLPA • 18 years in Special Education • 11 years as an Assistive Technology Specialist • 18 years of experience treating individuals with speech impairments, developmental delay, learning disabilities, intellectual disabilities, orthopedic impairments, autism, mental health concerns, and hearing and vision impairments. • Extensive experience as a leader and supervisor in school systems and in other	

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		state level roles The speech clinicians had a collective experience base of over 40 years in the provision of communication supports and services, including AAC, the completion of assessments, the development and implementation of communication plans, the provision of staff training, and monitoring of those plans with populations consistent with those living at EPSSLC. The current staff was clearly more experienced and qualified related to language disorders and functional communication as it applied to individuals with developmental disabilities and the current caseload at EPSSLC than in any previous review. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review: • 4 of 4 current speech staff (100%) had completed continuing education in the last year. This was consistent with the previous review. Continuing education attended by the clinicians for which contact hours or CEUs were provided that appeared to be relevant to communication included: • El Paso Speech Therapy conference, 10 contact hours (Ambruster, Alcantar) • TCASE Great Ideas Conference, 3 contact hours (Ambruster) • TSHA Annual Conference, 8 contact hours (Ambruster) • Ethical Practice in AAC Evaluation and Usage, 2 contact hours (Alcantar) • Get to the Core! Developing Functional Communication, 5 contact hours (Alcantar) • 9th Annual Together for Autism Conference, 10 contact hours (Alcantar) • Developing Communication Skills in Young Children, .20 CEUs (Roberts) • Communication Milestones, .15 CEUs (Roberts) • Spoken Language Development in Children with Autism Spectrum Disorders, .5 CEUs (Roberts) • Listening and Behavior, The Next Thematic Units for Speech Therapy, 4.5 contact hours (Roberts) • Augmentative and Alternative Communication for Adults in Medical Settings, .20 CEUs (Roberts) • Dysphagia – Beyond the Basics, .3 CEUs (Bush) Ms. Bush had attended a dysphagia-related course only for three contact hours during the last year. EPSSLC staff had demonstrated a keen understanding of the importance of relevant continuing education for each of their staff, as noted in previous reviews. As Ms. Bush had only been recently hired (July 2013), it was expected that she would also attend communication-related courses over the course of the next year. The intent of ongoing continuing education is to ensure that the clinicians attain and/or expand their	

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		knowledge and expertise related to the provision of communication supports and services, particularly related to AAC. The clinicians are encouraged to continue to seek continuing education courses beyond in-house training to continue to enhance their talents relative to the provision of communication supports and services. Inservices conducted by co-workers following attendance at formal continuing education courses is an excellent method to conserve resources, yet permit all staff to benefit from the information acquired. A system to track participation in continuing education was in place at EPSSLC, per the self-assessment. Each of the speech clinicians interviewed and observed appeared to recognize the key need for functional communication and the role of relevance, alternate access sites, environmental context, and meaningful contextual training opportunities as effective methods in the development of AAC for this population. They also appeared to understand the important role of the DSPs as communication partners. <u>Facility Policy:</u> There was a local policy related to communication. The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services, including the following components: • Roles and responsibilities of the SLPs. • Outlined assessment/update schedule including frequency and timelines for completion of new admission assessments, timelines for completion of Comprehensive Assessments, and timelines for completion of Comprehensive Assessment/Assessment of Current Status and assessments for individuals with a change in health status potentially affecting communication. • Criteria for providing an 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 plans/programs including frequency, data and trend analysis, as well as, problem resolution. Each of these was sufficiently addressed in the policy submitted and/or was a well established procedure currently in practice. Revisions of existing policies were in process. There appeared to be a sufficient allocation of well-qualified and experienced speech staff resources, based on identified need. The monitoring team concurred with the	

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		facility's self-assessment of substantial compliance with this provision.	
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 SLPs at EPSSLC were required to participate and contribute to a Comprehensive OT/PT/SL Assessment that included dysphagia, mealtime, and some limited communication information. They also completed the primary communication-related assessment as a separate document, either a comprehensive or update. Other assessments completed included speech only or OT/PT/SLP assessments on a referral basis. Completion of assessments was generally based on the ISP schedule, with less of a focus on the priorities established in this plan. ISP, dates, assessment due dates, and timeliness of completion were tracked in the tracking log. There were 69 individuals listed as provided an annual communication assessment. • 11 of 12 individuals (92%) in Sample O.1 were provided a communication assessment per policy, Master Plan and/or recommendations per previous assessments. A copy of the assessment for Individual #63 was not submitted with his individual record, though it was reported to have been completed on 2/6/13, 10 days prior to his ISP, per the tracking log. The self-assessment/monthly QA report identified the total number of assessments that were required to be completed from January 2013 through July 2013 (77). It was reported that all required assessments for this time period (100%) had been completed. The tracking log of assessments for ISPs scheduled from February 2103 through July 2013 identified that 69 individuals were provided a communication assessment. Of those, 43 (62%) were completed on or before the due date listed, though at least 18 of those completed after the due date were completed prior to the ISP. Those not completed prior to the ISP were completed within two to 20 days later, or on average within 9 days. The tracking log did not distinguish between whether the assessment completed was a comprehensive, an update, or a screening. Overall, approximately 62% of the assessments/screenings were completed 10 working days prior to the ISP, with 88% completed prior to the ISP. There was a gap in timely completion of assessments in late May 2013 through mid-July 2013 due to changes in staffing. Despite a complete turn-over in professional speech staff (with the exception of the SLPA), the on time record was very good and all individuals had been provided the annual assessment as required. There was a facility-wide system to track assessments and to notify Directors of assessments incomplete as of the due date. This system should assist in the management of, and improvement in, the timely completion of assessments for all departments. It was noted, however, that only the Habilitation Therapies Comprehensive Assessment was tracked, as departmental assessment and the communication assessment did not appear	Noncompliance

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		to be included in that data base. As reported in section P, 100% of the OT/PT/SLP assessments were completed as required for ISPs scheduled from 3/1/13 through 8/30/13. Only 11 of those were completed after the designated due date and 100% of those were completed prior to the ISP. <u>Assessments Provided</u> Communication assessments were submitted as requested for the following: • Sample R.1: 12/12 individuals. Though reported as completed, the copy of the assessment for Individual #63 was not available in his individual record. Assessments were submitted as follows (per date on signature page when available*): o Speech Language Communication Comprehensive Assessment 1. Individual #90 (2/6/13)* 2. Individual #32 (10/18/12)* 3. Individual #71 (2/19/13)* 4. Individual #89 (11/13/12)* o Speech Language Communication Update 5. Individual #125 (8/27/13) 6. Individual #93 (8/6/13)* 7. Individual #23 (8/27/13)* 8. Individual #15 (6/4/13)* 9. Individual #4 (7/12/13)* 10. Individual #114 (9/6/13)* 11. Individual #115 (4/26/13)* • Sample R.2: 10 individuals. Assessments were submitted as follows (per date on signature page when available*): o Speech Language Communication Update 1. Individual #5 (7/1/13)* 2. Individual #188 (7/10/13)* 3. Individual #7 (6/24/13)* 4. Individual #42 (6/17/13)* 5. Individual #169 (6/3/13)* 6. Individual #73 (5/27/13)* 7. Individual #9 (6/7/13)* 8. Individual #34 (7/12/13)* 9. Individual #77 (7/12/13)* 10. Individual #4 (7/12/13)* This was a duplication of Sample R.1 • 21 of 21 individuals (100%) in Samples R.1 and R.2 who received direct and/or indirect communication supports and services were provided an assessment or	

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		update current within the last 12 months. This was consistent with the previous review. As stated above, the assessment for Individual #63 was not submitted in his individual record as requested, but was listed as completed at least 10 days prior to his ISP. There were three individuals admitted to EPSSLC since the previous review. One of these, Individual #78, was discharged and readmitted within a 24 hour period, and as such, an admission assessment was not indicated. Initial assessments were submitted and included in Sample R.3 for Individual #37 and Individual #46. • 2 of 2 individuals admitted since the last review (100%) received a communication assessment within 30 days of admission. This was consistent with the previous review. • For 10 of 22 individuals (45%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. This was a decrease from 80% in the previous review. As full assessments were completed for individuals newly admitted to EPSSLC, the following metric did not apply: • If screenings were completed, ___ of ___ individuals identified with therapy needs through a screening (%), received a comprehensive communication assessment within 30 days of identification. <u>Communication Assessment:</u> Based on review of the sample of assessments submitted and included in Samples R.1 and R.2 (21 assessments, Individual #4 was duplicated in both samples), there were four individuals with comprehensive assessments and 17 updates current within the last 12 months. Despite the fact that these were identified as updates, these were very comprehensive documents with little variation from the format of the comprehensive assessments, thus, all were included in the analysis below. Sample R.1 included at least one assessment from both of the previous speech clinicians, as well as all three of the current ones. The assessments included in sample R.2 included assessments from Patricia Bush and Leslie Ambruster only. In order to achieve a good overall representation, assessments from both samples were included in the analysis of assessments as follows: • All assessments from Sample R.1 (12, scores for Individual #63 will be equal to "0" because the copy was not available in his individual record). ISPs current within the last 12 months were submitted for each of those. • The most current assessments from R.2 from both clinicians to equal a combined total of no more than five each from Sample R.1 and R.2 (Individual #34,	

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		Individual #188, Individual #9, Individual #169, Individual #42, and Individual #7). ISPs current within the last 12 months were submitted for each of those. None of the assessments reviewed had all of the essential elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team. The current state and local EPSSLC assessment format and content guidelines generally required that these elements be contained within the assessments. The comprehensiveness of the communication assessments were as follows: • 16 of 18 individuals' communication assessments (89%) were signed and dated by the clinician upon completion of the written report. This was a decrease from 100% in the previous review. • 17 of 18 individuals' communication assessments (94%) included diagnoses and relevance of impact on communication. This was improved from 90%. • 17 of 18 individuals' communication assessments (94%) included individual preferences and strengths. This was a decrease from 100% in the previous review, secondary to the assessment missing from the individual record (Individual #63). Though these were listed in most assessments, they were not consistently used to guide the development of communication strategies or AAC systems. • 2 of 18 individuals' communication assessments (11%) included medical history and relevance to communication. This was an improvement from 0%. All of the assessments documented extensive medical history. There was no discussion of the relevance of these to communication or statement that they did not impact on the individual's functional communication. The clinicians should consider reducing this section by including pertinent past medical history and health status over the last year only, with better analysis of whether the individual's function was impacted as a result. • 17 of 18 individuals' communication assessments (94%) listed medications and discussed side effects relevant to communication. This was a decrease from 100% in the previous review, secondary to the assessment missing from the individual record (Individual #63). • 5 of 18 individuals' communication assessments (28%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was an improvement from 0%. This element required the clinicians to determine whether any areas of risk would be impacted by the individual's communication skills or whether there was any other relationship between communication and areas of risk, such as challenging behaviors. Further, the inability to express the specific source of pain or discomfort, for example, would require special supports to ensure that staff could interpret other behaviors that might provide clues for intervention.	

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		• 14 of 18 individuals' communication assessments (78%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. This was a decrease from 100% in the previous review. Those assessments that did not, provided the clinical assessment findings only, with no perspective of functional communication. • 12 of 18 individuals' communication assessments (67%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was a decrease from 100% in the previous review. It did not appear from the documentation that the clinicians had conducted functional observations of individuals across their day, across a variety of environments, and across communication partners, in addition to their clinical assessments. Functional communication should be appropriately assessed in this manner. There were no clear statements as to where observations and assessment had taken place. • 14 of 18 individuals' communication assessments (78%) 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. The communication dictionary was identified and broadly described as to purpose and effectiveness, but updates and what specific changes were needed was not. This was a decrease from 100% in the previous review. • 14 of 18 individuals' communication assessments (78%) included discussion of the expansion of the individuals' current abilities. This was a decrease from 90%. • 10 of 18 individuals' communication assessments (56%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 50%. • 17 of 18 individuals' communication assessments (94%) included the effectiveness of current supports, including monitoring findings. This was a slight decrease from 100% in the previous review, secondary to the assessment missing from the individual record (Individual #63). • 16 of the 18 individuals' communication assessments (89%) 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. This was an improvement from 80%. • 3 of 18 individuals' communication assessments (17%) offered a comparative analysis of health and functional status from the previous year. This was an improvement from 0%. While improved, most assessments did not address the individual's health and functional physical status over the last year and whether	

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		any changes had impacted functional communication abilities in any way. • 15 of 18 individuals' communication assessments (83%) gave a comparative analysis of current communication function with previous assessments. This was a decrease from 100% in the previous review. • 14 of 18 individuals' communication assessments (78%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was an improvement from 0%. • 16 of 18 individuals' communication assessment (89%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was a decrease from 100% in the previous review. • 16 of 18 individuals' communication assessments (89%) had a reassessment schedule. This was a decrease from 100% in the previous review. • 8 of the 18 individuals' communication assessments (44%) supplied a monitoring schedule. This was a decrease from 100% in the previous review. In some cases only effectiveness monitoring was identified and in others only monitoring of SAPs. Still others did not address this at all. • 9 of 18 individuals' communication assessments (50%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was a decrease from 60% in the previous review. • 16 of 18 individuals' communication assessments (89%) made a recommendation about community referral and transition. This was a decrease from 100%. • 15 of 18 individuals' communication assessments (83%) included specific recommendations for services and supports in the community. • 16 of the 18 individuals' communication assessments (89%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was a decrease from 100% in the previous review. Additional findings related to the communication assessments were as follows: • 2 of 18 assessments contained 94% of the 22 elements listed above. • 7 of 18 assessments contained 83% or more of the elements listed above. • 14 of 18 assessments contained 70% or more of the elements listed above. • 4 of 18 assessments contained less than 70% of the elements listed above. • 0 of 23 (0%) of the elements listed above were noted for 100% of the assessments reviewed. • Improvements from the previous review were noted in 29% of the 22 elements. Decreases were noted for 14 elements. A system of assessment audits implemented by the department for the establishment of	

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		competency of the speech clinicians was well established and clearly effective. Findings based on this audit system identified a range of compliance from 87.75% to 96.2% compliance in January 2013 through April 2013 during which time only eight assessments were audited. No audits had been conducted since that time. • 13 of 13 updates (100%) were completed consistent with the established schedule, or the individuals' need. • 0 of 13 updates (0%) had an associated comprehensive assessment that was consistent with the established format and content guidelines. The format of the updates was somewhat confusing as some of the information from the previous assessment was typed in regular font and new information was typed in italics. This resulted in a very lengthy assessment rather than a streamlined update. The facility should consider that the Comprehensive Assessment remain in the individual record and updates report only that individual status continued to be the same or reported specifics related to changes. Comprehensive assessments could be repeated every three years based on need and updates would be conducted in the interim. Each of these would reference the original comprehensive assessment and remain filed with it in the individual record. When a new comprehensive assessment was completed, all previous assessments would be purged at that time with a new set of assessments filed in sequence. <u>SLP and Psychology Collaboration:</u> There were 31 individuals identified with behavioral issues and co-existing severe language deficits. • For 4 of 10 communication assessments in Samples R.1 and R.2 for individuals with identified challenging behaviors, there was discussion of the communicative intent of those behaviors in the Behavioral Considerations section. Eight of these individuals were identified as provided a PBSP (Individual #125 and Individual #169 did not by report). This section also reported behaviors observed by the SLP during the assessment, communicative behaviors noted and also described the target and replacement behaviors per the PBSP. There were 27 individuals with PBSPs with replacement behaviors related to communication. There were six individuals included in Sample R.1 for whom a PBSP was provided, per the communication assessment. It was noted, however, that only four of these actually had a PBSP (Individual #32, Individual #23, Individual #114, and Individual #63). As described above, assessments were available for only three of these. Only three PBSPs for these four individuals were submitted in their individual records (Individual #32, Individual #63, and Individual #23).	

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		• For 1 of 2 individuals (%) in Sample R.1 with available PBSPs and communication assessments, the communication strategies identified in the assessment were included in the PBSP. (Partially only for Individual #114). There were 24 meetings held to review PBSPs from 3/4/13 through 8/15/13 and a speech representative attended 22 (92%) of the meetings held, though only one was attended by a SLP. Participation in the review of PBSPs during these meetings was one opportunity to promote collaboration between psychology and the SLPs. The SLPA attended most of the other meetings. The SLPA would be qualified to listen to the meeting and bring information back to the SLPs but would not be able to contribute to clinical decisions that would impact the PBSP. It is understood that collaboration for assessment and development of PBSPs and communication plans may need to occur prior to the time of review by the Behavior Support Committee and, in that case, the facility is encouraged to document those efforts. Limited progress was made in this provision. The facility concluded that they were not in compliance with this element of section R, and the monitoring team concurred based on the findings reported above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop a plan, to include benchmarks to address the completion of communication assessments for individuals in a timely manner, while not reducing the current supports and services provided. 2. Initiate further collaboration with psychology to identify strategies to ensure integration of communication strategies in the PBSPs. 3. Initiate further collaboration with the QDIPs to ensure that essential elements related to communication and communication supports and services are reflected in the ISPs. 4. Ensure that the information in the communication assessment related to the PBSP was the most current. Ensure that the communication strategies are effectively translated into the PBSP and that there were no contradictory statements related to function or methods of communication.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in	<u>Integration of Communication in the ISP:</u> • For 5 of 12 individuals (42%), a SLP was in attendance at the ISP. Based on the pre-ISP documents submitted, a SLP was required to attend four of those, though six did not include a list of required IDT members. Actual attendance for those four meetings occurred as required, with the exception of Individual #89 (i.e., 75%). Attendance could not be determined for him as there was no attendance	Noncompliance

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	the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	sheet submitted. • For 8 of 12 individuals (67%), communication strategies identified in the assessment were included in the ISP. The strategies in the communication assessments for staff use were easily identified and for those six plans were fully translated to the ISP document for further reference. • In 8 of 12 ISPs for individuals with communication supports (67%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, strategies for staff use) were identified, though most of these were limited to the Communication Dictionary only. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for 4 of 12 (33%), as evidenced in the ISP. Some only mentioned the dictionary as a support but did not reflect IDT review. • 10 of 12 ISPs (83%) included a description of how the individual communicated, though a few were very limited. • 2 of 12 ISPs (17%) contained skill acquisition programs to promote communication. In the cases of Individual #125, Individual #114, the current ISP was related to a previous speech assessment not submitted so this could not be determined. • In 0 of 12 ISPs (0%), information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP was included. <u>Individual-Specific AAC Systems:</u> Approximately 71 individuals were listed with some type of communication system: picture communication sheets (15), communication lap tray (1), talking photo albums (8), and a call switch (1). These systems were generally portable, functional, and individualized. General Instructional Guidelines had been developed for the communication sheets and talking photo albums for staff reference, but there were no specific plans developed for the others. There were seven individuals who participated in direct communication therapy intervention at the time of this review, related to a variety of other AAC systems including PECS, a Dynavox Mystro, and a Go Talk 20, but these were not available to the individual for use outside of therapy sessions. Given the identified needs as observed by the monitoring team, however, this continued to be a small percentage of individuals who would likely benefit from communication supports. Eight individuals were provided with an environmental control switch. Communication dictionaries were also provided for a number of individuals at EPSSLC. The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This enhanced staff understanding of the individual and promotes consistent responses, but did not	

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		specifically enhance or improve the individual's expressive or receptive communication skills. The majority of the assessments for the individuals in Sample R.1 and R.2 provided an adequate assessment of the individual's potential for AAC use. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) should be utilized to identify appropriate AAC with the consistent use of training/teaching models to expose and promote interest and use of AAC across settings with attempts made for use in settings over time in order to spark interest, such as to request a favorite item, food, beverage, music, vibration, or massage. <u>General Use AAC Devices:</u> There were a greater number of general use communication devices including Put 'Em Arounds (27) and Wallboards (22). General Instructional Guidelines had been developed for the Put 'Em Arounds for staff reference. All of the general use systems noted during this onsite review were operational, though none were observed in use. A system of weekly maintenance reviews for individual and general use devices was implemented and documented in a spreadsheet. Revision of the existing wallboards to be more functional, meaningful, and appropriately located was planned for the near future. <u>Development And Implementation Of Functional Individual-Specific Assistive Communication Systems</u> • Observations were conducted of individuals with AAC systems (Sample R.4) in a variety of homes, day program environments, and direct therapy. Findings included the following: o 2 of 6 observations (33%): AAC devices present in each observed setting and available to the individual. The device used in therapy was not available to Individual #92 outside of that setting. o AAC systems for 1 of 6 individuals (17%) were noted to be in use in each observed setting. o AAC systems for 6 of 6 individuals (100%) were portable. o AAC systems for 6 of 6 individuals (100%) were functional. o For 0 of 6 individuals (0%), staff instructions/skill acquisition plans related to the AAC system were available. <u>Direct Communication Interventions:</u> There were seven individuals listed as participating in direct communication-related interventions provided by the SLP. Generally accepted practice standards for comprehensive progress notes related to communication interventions include:	

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		• 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 a comparative analysis of the individual's progress or lack of progress. Records related to the provision of direct intervention plans for six individuals were reviewed (Sample R.5). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow: • 2 of 6 individuals' direct intervention plans (33%) were implemented within 30 days of the plan's creation, or sooner, as required by the individual's health or safety. In the case of Individual #17, an intervention was to continue per his ISP dated 8/1/13, but a new SAP was not developed within 30 days. The same was true for Individual #50 and Individual #92. • For 6 of 6 individuals' records (100%), the current SLP assessment identified the need for direct intervention with rationale. These could be annual assessments or interim assessments completed during the year in response to changes in status or identified needs. • For 6 of 6 individuals' records (100%), there were measurable objectives related to individual functional communication outcomes included in the ISP. • For 6 of 6 individuals (100%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). While data were reported, in most cases actual progress was difficult to discern because there was very little comparative analysis of the data. • For 0 of 6 individuals (0%), there was a description of the benefit of the device and/or goal to the individual. • For 6 of 6 individuals (100%), consistency of implementation was documented. While attendance was reported, it was not consistent with the frequency outlined in the intervention plans. • For 0 of 6 individuals (0%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. As stated above, the clinical data were not sufficiently analyzed to discern progress with the stated goals. • For 0 of 2 individuals' records (0%) for whom direct intervention had been discontinued, termination of the intervention was well justified and clearly documented in a timely manner. • 0 of 6 (0%) individuals receiving direct Speech Services (Sample R.5) were provided with comprehensive progress notes that contained each of the	

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		indicators listed below: o Contained information regarding whether the individual showed progress with the stated goal. o Described the benefit of device and/or goal to the individual. o Reported the consistency of implementation. o Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. o Completed at least monthly. The daily session SOAP notes consistently reported data related to the goals. Prior to July 2013, these were stand-alone notes and were filed in the Habilitation Therapies tab with a brief marker note in the IPNs. Monthly summaries, though consistently completed through July 2013, did not provide a sufficient analysis of the data to clearly identify whether progress had been made or that changes to the plan were indicated. These appeared to be discontinued after June 2013 when documentation shifted predominately to the IPNs. The facility should consider data sheets to document session outcomes and continue with monthly summaries in the IPNs. <u>Indirect Communication Supports:</u> Indirect communication supports included PNMPs, communication dictionaries, and general use AAC. Programs for individuals who received indirect communication supports were reviewed as follows: • 12 of 12 individual's indirect plans (100%) were implemented within 30 days of the plan's creation, or sooner, as required by the individual's health or safety. • For 12 of 12 individuals' records (100%), the current SLP assessment identified the need for indirect intervention with rationale. • For 0 of 12 individuals (0%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. <u>Effectiveness Monitoring</u> This type of monitoring should address communication plans and AAC, dictionaries, and SAPS related to other indirect communication supports. The frequency of effectiveness monitoring may be based on individual risk or the intensity of supports provided, but should be conducted no less than quarterly (the annual assessment may serve as the fourth quarter review), and clearly stated in the communication assessment. This should address any changes in risk or status of the individual since the previous review and staff compliance, as well as whether the supports and/or strategies effectively met the intended need. Frequency should be included in the ISP with documentation in the IPNs. These notes should include the following:	

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		• Previously unresolved issues • PNM Risk occurrences since the previous effectiveness monitoring that impact communication • Purpose and function of the device or support • Presence and condition of equipment • Staff knowledge and compliance • Analysis of program effectiveness including progress, regression and maintenance as well as if the plan remained current and appropriate • Identification of issues with recommendations for changes as indicated including the person responsible and timelines for completion Though noted, effectiveness monitoring was not consistently conducted and the documentation varied significantly. In some IPNs, though identified as effectiveness monitoring, only staff compliance was reported. <u>Competency-Based Training and Performance Check-offs:</u> • EPSSLC had a system of comprehensive competency-based training regarding communication services. • Training provided: o Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. o Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Class time included two hours only to address deaf awareness and AAC. The content, based on review of the curriculum materials, was comprehensive. There was a presentation of instructional content and foundational skills, with modeling by the trainers, to new employees. Practice time was provided with coaching by the trainers and then new employees were required to take a combination of written tests and were checked off on specific skills, using the checklists. Employees were expected to pass all essential elements of the core competencies. New employees were required to pass written examinations with a minimum of 80% accuracy. The new employee was required to demonstrate competency of foundational skills by safely performing every step, on every foundation skill, without coaching from the validator or other new employee. It was stated that the new employee was permitted to use the practice checklist through the validation process. Staff were coached and retrained up to three times until competency was established. There was no clearly stated action taken in the case that a new employee was not able to pass the check-offs.	

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		Shadowing was then conducted for a seven-day period prior to new employees being permitted to work independently on their assigned homes. They were not assigned a caseload, but were allowed to assist existing staff in the implementation of foundational skills in that home. During that time, staff were trained on each PNMP and Dining Plan on the assigned home, as well as on individual-specific (non-foundational skills) competencies, generally by the PNMPCs. Competency check-offs (validation) were conducted for foundational and non-foundational skills for individuals in their assigned home. Again, new employees were given up to three attempts to successfully pass each of these and when they successfully passed each of these they were assigned a caseload and permitted to work without restrictions. Again, there was no written provision related to staff who were not able to do so. The NEO training curriculum had been revised as of 4/17/13. The training materials reviewed addressed most of the appropriate minimum foundational content areas listed below: • Identification of nonverbal means of communication. • Strategies to enhance individual participation in routines throughout the day • How to be an effective communication partner • Methods to enhance communication • Implementation of communication plans and programs • Benefits and use of AAC Competency tests and check-offs related to communication included the following per the documentation submitted: • General communication strategies • General AAC knowledge • Picture Communication Sheets • Picture Communication Board • Put 'Em Around • Sound Generating Device • Talking Photo album • 100% of staff had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. • There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. <u>Individual-Specific Competency-Based Training</u>	

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		The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. There was also a system of partner homes. All staff had demonstrated competence in the core foundational skills through NEO and refresher training. Non-foundational training was completed for all staff in each partner home for the individuals who lived in each home. Supervisors then used that pool of staff for pulled staff assignments to ensure that staff were properly trained. Non-foundational training was also provided to staff who supported individuals in the community-based day programming. • Per the system in place, 100% of the staff assigned to individuals in the samples selected by the monitoring team were trained related to the PNMP prior to the provision of services. • Per the system described, 100% of the staff assigned to individuals in the samples selected by the monitoring team had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. • 5 of 5 staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. • The facility had a process to validate that staff responsible for training other staff are competent to assess other staff's competency. <u>Other Training</u> Additional training was conducted by Habilitation Therapies staff during the Town Hall meetings monthly. Various PNM-related topics (theme-based), including communication, were addressed based on findings of monitoring or other issues as indicated. Consultants from Region 19 had a contract to work with EPSSLC related to the development of environmental communication strategies. They will be bringing in SLP/AAC specialists to model and coach with Habilitation and DSP staff. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though significantly improved, there was insufficient integration of communication supports and services into the ISP. The provision of direct communication therapy was a notable strength, though improvements were needed in the documentation of these interventions. The facility self-assessment was very accurate: • Given the high number of individuals who were identified as nonverbal or with limited verbal skills, the level of supports and services provided to these individuals appeared disproportionate to the need. This was documented by the	

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		monitoring team since the baseline visit and progress has been minimal since that time. • Data collection and documentation needed to be revised to more accurately reflect performance levels of individuals and the efficacy of the interventions implemented as per the annual assessments. • The Director was very motivated to ensure that environmental communication training was available for all individuals. This would ensure that communication opportunities were optimized, were most meaningful and functional, and occurred across the contexts of the individual's daily routine. • There was a need for increased direct intervention related to the identification of individuals who would benefit from a person AAC system. • The knowledge and skills of the DSPs related to the provision of AAC was very limited and extensive training was required. Each of these findings was consistent with those of the monitoring team. The first step in creating system change was the assessment of what currently was in place. Until now, there was a poverty of knowledge and expertise in the area of communication. The monitoring team was encouraged with Ms. Ambruster's leadership, knowledge, and skills and looks forward to positive growth in this area over the next six months. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Address the areas outlined in the self-assessment and summarized above. 2. Establish a system to track SLP attendance as described by the pre-ISPs. Negotiate identified errors before the ISP meeting. Be cautious when using only a Habilitation Therapy representative. Guidelines for IDTs should be provided to assist them in making the determination as to whether an SLP was needed at the meeting and how to address the identified needs for assessment. 3. Establish guidelines for the inclusion of communication supports in the ISPs to ensure that there is a clear description of how the individual communicates that includes AAC system and review of the communication dictionary where applicable. 4. Establish guidelines for documentation of direct speech therapy. 5. Carefully audit the level of coaching provided for training check-offs. It is important that trainers do not "teach to the test" in order to pass staff (after up to three attempts) rather than permitting them to fail and providing retraining and re-testing at another time. This would not establish actual competent skill performance. 6. Audit the training provided and the skill check-off process to ensure that the system is sound. The practice of permitting staff to use the practice check-off	

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		sheets provides prompts that may be impacting the establishment of competence.	
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>Compliance Monitoring of Implementation of Communication Supports</u> A system of compliance monitoring was established at EPSSLC using the Individual Communication Monitoring Form. This form addressed the following: • Communication system(s) were available. • Communication is in good working order. • Pictures and symbols were appropriate and individualized. • Staff implemented instructions correctly or could demonstrate or describe features and use of the equipment/systems • Identified who to contact with equipment problems. • Staff could correctly answer rotating drill questions. Completed forms for communication-related compliance monitoring conducted in the last three months were requested for the individuals in Sample R.1. There were 50 forms submitted completed from October 2012 through August 2013. Compliance was scored as follows • 100%: 38 • 90%-99%: 3 • 80%-89%: 6 • 70%-79%: 1 • 60%-69%: 2 When staff were scored at less than 80% compliance, there was evidence of re-training and follow-up for problems identified. The foundation for monitoring was of concern. The monitor was able to document a "yes" answer if the staff could verbally describe the system and its use. This greatly skewed the findings. As with other skills, compliance monitoring was intended to include observation of the staff performance of the skill by the monitor and to determine if it was performed accurately. This can only be appropriately accomplished during real time implementation. Explaining how something is done is very different from actually doing it in the context of the daily routine. Other findings included: • Monitoring of communication supports in general was inconsistently outlined in the assessment. • Frequency of Compliance Monitoring must be clearly established as per procedural guidelines (per individual, per staff, and/or random sample). This may be also individualized, as required, as recommended in the annual	Noncompliance

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		assessment or as needed in the interim. • Compliance monitoring should address implementation of all specific communication plans (including AAC) and communication strategies across implementation of activities. This may be better accomplished as the staff are engaging in other activities on the PNMP or implementing other SAPs. Equipment should be monitored for availability, condition, and working order and routine general check-offs for how to use the equipment. Communication dictionaries should be monitored for availability and whether staff understand how to use them. • As frequency was not clearly outlined, it was not known as to whether this occurred at the recommended frequency. <u>Other Monitoring</u> Maintenance checks were conducted routinely per the established schedule. The facility concluded that they were not in compliance with this provision of section R and the monitoring team concurred as described above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Review and revise the system of communication monitoring. The system may be broken down as needed to address specific outcomes as desired based on revision of the current processes in order to shape the system as needed. 2. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines. 3. Consider review of the current compliance monitoring forms to ensure the indicators are those that capture the status of the current supports and accuracy of implementation. 4. Track findings of both effectiveness and compliance monitoring. Ensure that these are included in annual communication assessments for individuals.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Individual Support Plan (ISPs) for: • Individual #39, Individual #34, Individual #169, Individual #102, Individual #75, Individual #13, Individual #35, Individual #189, Individual #128, Individual #126, Individual #28 o Skill Acquisition Plans (SAPs) for: • Individual #39, Individual #34, Individual #169, Individual #102, Individual #75, Individual #78, Individual #45, Individual #18, Individual #146, Individual #84 o Functional Skills Assessments (FSA) for: • Individual #39, Individual #34, Individual #169, Individual #102, Individual #75 o Preferences & Strengths Inventory (PSI) for: • Individual #39, Individual #34, Individual #102, Individual #169 o Vocational assessments for: • Individual #39, Individual #34, Individual #169, Individual #102, Individual #75 o Compliance/Desensitization dental plans for: • Individual #125, Individual #13, Individual #184, Individual #19, Individual #50, Individual #32 o El Paso State Supported Living Center Provision Action Information Updated: 08/28/13 o Habilitation, Training, Education, and Skill Acquisition Programs, 8/1/13 o Active treatment calendar for September, 2013 o Engagement, Dignity and Respect, and Group Management Observations form, 6/13 o SAP concepts and definitions, 9/9/13 o Section S QA report, September, 2013 o Section S Self-Assessment, 8/29/13 o Section S Presentation Book, undated o Section S Action plan, 8/29/13 o Summary of community outings, 2/13- 7/13 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 Interviews and Meetings Held: o Alice Villalobos, QIDP Coordinator; Carmon Molina, Director of Psychology; Angelin Clarke, Associate Psychologist o Guadalupe Azzam, Active Treatment and Day Programs Coordinator o Joana Alferez, Director of Residential Services

	Observations Conducted: o SAP peer review meeting o Active treatment meeting o September 2013 QAQI Council meeting o ISPA for: • Individual #161 o Observations occurred in various day programs and residences at EPSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals.
	Facility Self-Assessment: EPSSLC'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, that many items in the self-assessment could better reflect the activities that the monitoring team reviews as indicated in this report. For example, S2 of the self-assessment focused on ensuring that functional skills assessments (FSAs), and preference and strengths inventories (PSIs) were completed for each individual. These are important topics, however, S2 in the monitoring team's report also assesses if documentation exists that assessments were used to select individual skill acquisition plans. 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 EPSSLC to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other, and the monitoring teams report. EPSSLC's self-assessment indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the 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: • A reorganization of the writing, monitoring, and training of SAPs (S1) • A psychologist was added to the SAP peer review committee (S1) • Continued improvement in the community day program (S1) 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) • Ensure that operational definitions and training instructions clearly specify the level of assistance required (S1) • Ensure that SAPs and service objectives are differentiated (S1) • Increase the formal training opportunities (i.e., SAPs) in the community program (S1, S3) • 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) • Consistently document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • Graph monthly SAP outcomes (S3) • Initiate SAP integrity measures (S3) • Ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are data based (S3) • Track skill 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). The facility recently reorganized the writing, monitoring, and training of SAPs. At the time of the onsite review, SAPs were written by the qualified intellectual disabilities professionals (QIDPs). SAPs continued to be implemented by direct support professionals (DSPs). The DSPs were trained in SAP implementation and monitored by three 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. Eighteen SAPs across 10 individuals were reviewed to determine if they appeared to be functional and practical. In eight of the 18 SAPs reviewed (44%), the rationale appeared to be based on a clear need and/or preference. This represented a decrease from the last report when 59% of the SAPs reviewed were judged to be practical and functional. An example of a rationale that was specific enough for the reader to determine if the SAP was practical and functional for that individual was: • The rationale for Individual #75's SAP of washing his hands stated, that he had had conjunctivitis that was likely to be related to his incomplete hand washing In 10 of the 18 SAPs reviewed (56%), however, the rationale was not specific enough for the reader to determine if it was practical and functional for the individual. For example: • The rationale for Individual #75's SAP of purchasing a preferred item was that he will be responsible for purchasing a preferred item that he enjoys. 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.	Noncompliance

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		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 All of the SAP training sheets reviewed contained all of the above components. The quality, however, of the maintenance and generalization plans continued to be poor. 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. Only three of the 18 SAPs reviewed (17%) contained a plan for generalization consistent with the definition above. Although low, this represented an improvement from the last review when 0% of generalization plans reviewed were consistent with the above definition. Similarly, two of the 18 SAPs reviewed (11%) contained maintenance plans that were consistent with the above definition. This also represented a slight improvement from the last review when 0% of the SAPs reviewed contained acceptable plans for maintenance. An example of a complete generalization plan was: • The plan for generalization in Individual #39's SAP of participating in activities stated that he would be asked to participate in additional activities An example of an unacceptable plan for generalization was: • The plan for generalization for Individual #34's SAP of folding napkins stated, she "… will fold dinner napkins after they have been washed."	

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		An example of a maintenance plan that was consistent with the above definition was: • Individual #34's SAP of folding dinner napkins included a maintenance plan that stated that after completing the program, she will fold napkins prior to all meals. An example of an incomplete maintenance plan was: • The plan for maintenance for Individual #102's SAP of setting his table prior to meals stated, "Upon completing the program IDT will meet to review/revise the program." At the time of the onsite review, the facility used various training methodologies, including total task training and forward and backward chaining. As discussed in S3, however, several SAPs appeared to have unclear training instructions. For example, Individual #102's SAP of completing and mailing art projects to his sister did not clearly specify the level of assistance (e.g., verbal prompts, physical prompts) for training. Additionally, some training SAPs (e.g., Individual #39's SAP to participate in community tours) appeared to actually be a service objective (see definition below). In summary, it is recommended that EPSSLC 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. Additionally, it is recommended that all SAPs contain generalization and maintenance plans that are individualized and are consistent with the above definitions. Finally, ensure that operational definitions and training instructions clearly specify the level of assistance required, and that SAPs and service objectives are differentiated. A positive development was the recent addition of a behavioral psychologist to the monthly SAP peer review meetings. The monitoring team observed a SAP peer review meeting, and believes that the addition of the psychologist (i.e., someone who was trained in development of skill acquisition plans) will likely result in an improvement in SAPs. <u>Compliance and Dental Desensitization plans</u> Compliance and desensitization plans designed to teach individuals to improve oral hygiene and/or tolerate dental procedures were developed by the QIDPs, and an interdisciplinary team reviewed progress. Six of these plans were reviewed by the monitoring team. As recommended in the last report, compliance and dental desensitization plans were now incorporated into the new SAP format. As such, they shared similar strengths and weakness to the SAPs discussed above. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed	

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		in more detail in future site visits. Replacement/Alternative behaviors from PBSPs as skill acquisition plans 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 of communication skills. None of the replacement behaviors reviewed, however, represented the establishment of new language skills, therefore, SAPs were not required (see K9). 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 QIDPs. 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). As discussed above, however, there appeared to be some confusion between service objectives and SAPs. For example, during the SAP peer review meeting, some SAPs that were discussed were actually service objectives (e.g., the individual will go for a walk in the early evening). Also see above regarding community participation objectives really being service/participation objectives rather than skill acquisition plans. It is recommended that the facility review and clarify this distinction with the QIDPs. 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 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.	

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		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. Since the last review, the program expanded the number of community sites and included all individuals residing at the facility. As discussed in the last report, it is recommended the facility increase formal training opportunities (i.e., conduct SAPs) in the community program. As found in past reviews, the level of engagement on campus varied across treatment areas and observations. Some of this variation was likely due to the reduced number of opportunities for observation of engagement by the monitoring team. As a result of the increased number of community activities, the monitoring team often encountered empty cottages or ones with only a few individuals. Because the community provides numerous opportunities for meaningful engagement, the increased community activities are clearly a positive development. The reduced opportunities for observation on campus, however, do reduce the potential utility of the monitoring team's engagement data. The table below documents engagement observed in various settings throughout the facility. The average engagement level across the facility was 60%, the same as observed during the last review. 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 was recently modified and consisted of 23 observations that were marked yes or no by the observers. The observations covered several aspects of engagement, including the presence of appropriate materials, offering choice, etc. The active treatment monitors also conducted regular active treatment meetings to review the results of these observations with DSPs and supervisors from each treatment site. Additionally, the active treatment monitors collected individual engagement data during 10-15 minute observations. The active treatment and day programs coordinator indicated, however, that the definition of "engagement" was not consistent across all monitors. Additionally, although data from this monitoring were calculated, it was not apparent that data were used to objectively evaluate and improve individual engagement across the facility. It is recommended that the facility operationalize the definition of individual engagement (e.g., how long does an individual need to be engaged during a 15 minute observation to be rated as engaged?), and ensure that engagement data are summarized and reviewed to help target areas that require additional support to improve engagement.	

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		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. Engagement Observations: Location / Engaged / Staff-to-individual ratio 509 — 2/2 — 1:2 509 — 2/4 — 2:4 A, B, & C Dorm — 6/19 — 6:19 B Dorm — 3/10 — 2:10 Vocational workshop — 15/15 — 4:15 515 day program — 3/7 — 3:7 515 day program — 7/11 — 3:11 C Dorm — 4/12 — 3:12 A Dorm — 1/3 — 1:3 506 — 6/6 — 2:6 507 — 6/7 — 3:7 513 — 1/6 — 2:6 513 — 2/2 — 1:2 511 — 3/6 — 0:6 511 — 4/6 — 2:5 511 — 6/8 — 2:8 507 — 1/2 — 1:2 506 — 1/2 — 1:2 515 day program — 2/5 — 2:5 515 day program — 3/5 — 1:5 Vocational workshop — 5/8 — 2:8 Vocational workshop — 7/12 — 3:12	

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		507 | 4/6 | 3:6 507 | 5 /7 | 3:7 <u>Educational Services</u> EPSSLC continued to maintain an excellent relationship with the El Paso Independent School District (EPISD). Rosa Renteria, QIDP, continued to support and foster this relationship in her role as liaison to EPISD. There was only one individual at EPSSLC who was under age 22 and attended public school (Individual #35). Individual #35's previous QIDP attended his ARDIEP meeting last year and Ms. Renteria was scheduled to attend this year's in early October 2013. She had done a nice job of including his ARDIEP in his ISP over the past year. His ARDIEP contained objectives related to picture symbols, sign language, social behavior, and making choices. The ARDIEP was reviewed at the ISP meeting. The IDT then incorporated his ARDIEP by writing about it in the ISP narrative, and by including action plan objectives for SAPs for social behaviors and for sign language. Ms. Renteria reported that she maintained frequent communication with the public school classroom teacher via email and telephone, as needed. She described an issue at the beginning of the school year in which Individual #35 was aggressive on the school bus. She and the classroom teacher worked together to reduce the likelihood of another occurrence (and since then there hadn't been any). Report cards and progress notes were now being regularly reviewed as recommended in the last monitoring report. Ms. Renteria reported that she reviewed the progress note, but only wrote an ISPA if they had a meeting (rare). The monitoring team recommended to her that she include a note about her review of any school report cards/progress reports in her monthly review of the ISP.	
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 for the majority of individuals sampled. Although improving, only 54% of SAPs reviewed were clearly based on assessments. Therefore, this item was rated to be in noncompliance. EPSSLC conducted annual assessments of preference, strengths, skills, and needs. At the time of the onsite review, all individuals at the facility had transitioned from the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA).	Noncompliance

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		As discussed in the last review, 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. To assess compliance with this item, the monitoring team requested ISPs, FSAs, preference and strengths inventories (PSIs), and vocational assessments for five individuals. There was no PSI for Individual #75. All individuals should have annual assessments of preference, strengths, skills, and needs. Additionally, in order to be most useful for the selection and development of SAPs, assessments should be completed and available to team members prior to the ISP. EPSSLC did not provide assessment tracking data indicating that FSAs, PSIs, and vocational assessments were completed on time (10 days prior to ISP). Overall, these five individuals had a total of 13 SAPs, and seven of those (54%) had documentation that assessments were used to develop them. Examples of assessments that were used to develop SAPs included: • Individual #102's ISP and PSI documented that his SAP to complete and mail art projects to his sister was based on his preference of having a positive relationship with his family. • Individual #75's ISP documented that his SAP of purchasing sodas on an outing was based on his preference of going on outings and drinking sodas Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #34 had a SAP to fold dinner napkins, but nothing in her ISP, PSI, or	

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		FSA suggested that this was a practical and functional SAP for her. • Individual #169 had a SAP to turn on and off the faucet, but no mention in her ISP of any assessment results (e.g., FSA or PSI) that suggested that this was a functional SAP for her. • Individual #75's ISP indicated that his SAP of washing his hands was developed because he had a history of conjunctivitis, and that it was related to his incomplete hand washing. This represented an excellent rationale for this SAP, however Individual #75's FSA did not indicate that he incompletely washed his hands and, therefore, this SAP did not appear to be based on assessment results. • Individual #39's ISP stated he was not interested in employment and, therefore, a vocational SAP would not be developed. His vocational assessment, however, indicated that he wanted to work two days a week, two hours a day. In order to achieve substantial compliance for this provision item, EPSSLC needs to ensure that all individuals have assessments of individuals' preferences, strengths, skills, needs that are completed prior to the ISP. Additionally, there needs to be documentation of how assessments were used to select the 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 most integrated setting consistent with the individual's needs, and	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. The self-assessment indicated that SAP reviews were not consistently occurring at EPSSLC. No SAP data or monthly SAP reviews were available for review. It is recommended that monthly SAP data be graphed so as to increase the likelihood that decisions concerning the continuation, discontinuation, or modification of SAPs are data based.	Noncompliance

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		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 discouraging: • Individual #146's SAP of leisure activities appeared to be conducted as written, however, the DSP did not record the data following the completion of the SAP. Instead she began to work with another individual. When questioned about recording the data, the DSP indicated that she recorded the data at the end of the shift. • Individual #84's SAP of participating in activities did not clearly specify the prompt level to be used in training and, therefore, the DSP (and the monitoring team) were confused as to how to conduct the training. The only way to ensure that SAPs are implemented and documented as written is to conduct integrity checks. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written. Over the next six months, it is recommended that EPSSLC begin to graph SAP monthly data, and ensure that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs. Additionally, SAP integrity measures should be initiated in all treatment sites where SAPs are conducted.	
	(b) Include to the degree practicable training opportunities in community settings.	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 were, however, no data indicating skill-training activities occurred in the community. It is recommended that skill-training activities (i.e., SAPs) in the community be recorded so that trends can be tracked. Additionally, acceptable levels of both activities should be established. As discussed in S1, the community day program appeared to represent a wonderful opportunity to provide a model for training skills in the community. The monitoring team looks forward to seeing how this new, exciting program is utilized by the facility to achieve both meaningful individual engagement and community training. At the time of the review, no individuals at EPSSLC worked in the community. This is consistent with the last review when no individuals worked in the community.	Noncompliance

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 and again August 2013 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, August 2013 o EPSSLC policy lists, undated but likely August 2013 o List of typical meetings that occurred at EPSSLC, undated but likely August 2013 o EPSSLC Self-Assessment, 8/29/13 o EPSSLC Action Plans, 8/29/13 o EPSSLC Provision Action Information, most recent entries 8/28/13 o EPSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/16/13 o Community Placement Report, last six+ months, 3/1/13 through 9/13/13 o The APC's four-colored spreadsheet indicating IDT, individual, and LAR preferences and status of referral, 9/16/13 o List of individuals who were placed since last onsite review (4 individuals) o List of individuals who were referred for placement since the last review (3 individuals) o List of individuals who were referred and placed since the last review (0 individuals) o List of total active referrals (10 individuals, plus two that occurred during the week of the review) o List of individuals who requested placement, but weren't referred (5 individuals) • Documentation of activities taken for those who did not have an LAR (2) • Those who requested placement, but not referred due to LAR preference (2) o List of individuals who were not referred solely due to LAR preference (49) o List of rescinded referrals (2 individuals) • ISPA notes regarding each rescinding (2 of the 2) • Special Review ISPA Team minutes for each rescinding (0 of the 2) o List of individuals returned to facility after community placement (2) • Related ISPA documentation (0) • Root cause analysis (1)

	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 11 individuals who moved since 9/1/12, i.e., 1 year since placement, and for whom EPSSLC had information). Of these 2, 2 were resolved by the individual moving back to the facility. 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 (0 individuals) o APC weekly reports • Detailed referral and placement report for senior management (none) • Statewide one page weekly enrollment report (0) • Example of an email sent to the facility director, 9/6/13 o APC Department meeting minutes, weekly, 4/22/13-9/19/13 (7 meetings, there may have been more meetings than for which there are minutes) o Sample document showing status and next steps for individuals who are on referral list. Reported to be updated weekly or so, 9/13/13 o Referral status document for August 2013, for 5 individuals and other tabular information for April 2013 through August 2013 o Three emails to QIDPs regarding individuals who were referred for more than 180 days, June 2013 and July 2013 o Email and attachments regarding behavioral issues with Individual #51 o FST workgroup agenda and attachments, first meeting since March 2013, 9/18/13 o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, 9/7/13 ▪ Announcements, attendance sheets, evaluation information, and summaries • Community tours ▪ Tours, 4/4/13 to 8/30/13, 15 tours, 22 different individuals, some more than 1 ▪ One page descriptions of how individuals responded (for many but not all) ▪ Tour participation roster listing for all individuals at facility ▪ Various emails with QIDPs • Other activities for individuals ▪ Topics at monthly self-advocacy meetings • Work with local LA ▪ Quarterly meeting minutes, May 2013 and August 2013 (2) ▪ Trainings (none) • Work with local providers: ▪ Informing providers of individuals and families who were interested ▪ Ensuring facility was aware of all vacancies in provider homes • Facility-wide staff trainings/activities ▪ New employee orientation, 3/1/13-8/12/13, 40 staff

	▪ Town hall, all staff, 6/20-21/13 ▪ QIDP training, 8/12/13 (1) • Posters about community living, throughout the facility • For families: ▪ Family association meetings, 5/11/13 (1) ▪ Family education progress notes (5 individuals) • Special activities of transition specialists: ▪ Real estate listing styled postings about community provider group homes and day programs ▪ DVD, Parade of Community Homes, more than 1,000 photos in a slide presentation ▪ DVD of a former resident describing life in the community ▪ Documents and DVD regarding a potential new provider • Brochure and facility newsletter (1) • CLOIP and PP tracking tools o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred) o List of individuals who had a CLDP completed since last review (4) o Blank checklist used by APC regarding submission of assessments for CLDP, completed checklists in the CLDPs reviewed (none, it was part of CLDP) o DADS central office written feedback on CLDPs (1) o QA related activities • Section T QA reports, June 2013, September 2013 • Corrective Action Plans related to section T (4) o State obstacles report and SSLC addendum, FY12 data, 2/26/13 o Facility obstacles list, 1 page, 117 individuals, 8/13/13 o PMM tracking sheet o Post move monitoring helpful hints, May 2013 o Examples of documentation of day of move items o Transition T4 materials for: • (none) o ISPs for: • Individual #128, Individual #28, Individual #75, Individual #80, Individual #126, Individual #102, Individual #169, Individual #34 o Pre-ISP draft used during the pre-ISP meeting: • (none) o Draft ISP used during the ISP meeting: • Individual #125, Individual #114 o CLDPs for: • Individual #3, Individual #78, Individual #175, Individual #31

	o Draft CLDP for: • (none) o In-process CLDPs for: • Individual #105, Individual #100, Individual #195 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 #69: 90 • Individual placed by Mexia SSLC: 90 • Individual #95: 90 • Individual #3: P, 7, 45, 90 • Individual #78: P • Individual #175: P, 7, 45, 90 • Individual #31: P, 7, 45, 90, and additional monitoring between 45 and 90 <u>Interviews and Meetings Held</u>: o Antonio Ochoa, Admissions and Placement Coordinator o Luz Delgado, Post Move Monitor o Fernando Fraga, Helen Alvarez, Transition Specialists o Irma Condon, Alejandra Baquera, Nallely Ortiz, Jaime Garcia, Maria Frausto, and Deborah Cook staff, nursing, and administrators at Educare, residential and day hab provider <u>Observations Conducted</u>: o CLDP meeting for: • (none) o ISP and/or pre-ISP meetings for: • Individual #125, Individual #114 o Community group home and day program visit for post move monitoring for: • Individual #31 o Admissions placement department staff meeting, 9/19/13 o FST meeting, 9/18/13
	Facility Self-Assessment The APC's self-assessment was almost identical to the self-assessment presented during the last onsite review. Therefore, the monitoring team refers the APC back to the previous report where detailed commentary and suggestions were made. The APC reported that he would work on a new self-assessment for the next review.

	Summary of Monitor's Assessment EPSSLC continued to make good progress across most of section T. 4 individuals were placed in the community since the last onsite review. 10 individuals were on the active referral list, plus 2 others were referred during the week of the onsite review for a total of 12. The list of individuals not being referred solely due to LAR preference contained 49 names. 2 individuals returned to the facility after community placement. EPSSLC provided follow-up and remained involved with all individuals, as needed, even past the 90-day post move monitoring period for some. This was very good to see and demonstrated the facility's commitment to each individual. The FST work group was re-started and should address those cross provision requirements. Assessments were available for review for all of the 8 ISPs in the sample. Of these, some but not all of the assessments included an applicable statement/recommendation from the professional regarding community referral. Lack of availability of openings in the local provider community was identified as a systemic problem. The facility was working in a satisfactory manner to resolve and address this. That is, the APC and his staff were in frequent contact with providers so that providers were aware of who was referred for placement, timelines for transition, and possibilities for individuals from the facility to share the same home. As a result, three new homes were scheduled to be ready in the next few months. Providing education about community placements continued to be a strength of the APC and his staff, and the facility in general. Examples included the work done by transition specialists to find new and creative ways to inform staff and families about the quality of some of the providers in El Paso. Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. The discussions observed were individualized, including consideration of preferences and support needs. The LA and the transition specialists were very knowledgeable and contributed much information to the discussion. The living options discussion during the ISP continued to be a strength of the facility. The discharge assessments must better address the specific home, day, and employment sites and contexts into which each individual will be moving. The lists of pre-move and post-move supports had not improved from the last review. The lists of supports were surprisingly similar across the 4 CLDPs. A more organized system of quality assurance is required in order to obtain substantial compliance. 12 post move monitorings for 6 individuals were completed. All were completed on time, in the proper format, and were done thoroughly and completely. All six individuals were doing well. A number of problems in support provision were either discovered or fixed by the post move monitoring process.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	EPSSLC continued to make good progress across most of section T. The admissions and placement staff remained the same (one post move monitor and two transition specialists) and continued to operate under the leadership of Tony Ochoa, the admission and placement coordinator (APC). The number of individuals placed was at an annual rate of about 7%. Approximately 10% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 4 individuals had been placed in the community since the last onsite review. This compared with 7, 3, 4, 1, 1, 3, and 1 individuals who had been placed at the time of the previous monitoring reviews. o The number was lower than during the previous period, but typical when looking across the past few years. Placements were slowed because the local providers did not have any openings or vacancies. Three of the providers, however, were in the process of opening new homes that they had either purchases or leased and these should be ready in the next few months. Overall, the APC expected there to be 12 or so new bedrooms available for individuals from EPSSLC. Thus, the number of placements should be much higher by the next review. • 3 individuals were referred for placement since the last onsite review. Plus, two others were referred during the week of the onsite review for a total of 5. o This compared with 10, 9, and 6 individuals who were newly referred at the time of the previous reviews. o 0 of these 3 individuals was both referred and placed since the last onsite review. • 10 individuals were on the active referral list, plus 2 others were referred during the week of the onsite review for a total of 12. This compared with 12, 12, 8, 9, 10, 4, and 7 individuals at the time of the previous reviews. o 7 of the 10 individuals were referred for more than 180 days. This compared to 2, 3, 1, and 6 at the time of previous reviews. o 4 of the 7 individuals were referred for more than one year. This compared to 1 at the time of the previous review. o The increase in referrals that were more than 180 days and more than one year appeared to be due to the absence of community openings at this time. Moreover, 6 of the 7 required accessible housing due to their use of wheelchairs. • 5 individuals were described as having requested placement, but were not referred. This compared with 3, 4, 3, 2 individuals at the time of the previous	Noncompliance

		reviews. o Of the 5 individuals who requested placement, but were not referred, 2 individuals had an LAR who made this decision. o Of the remaining 3 individuals, 2 were not referred due, at least in part, to their legal status. Documentation was provided during previous monitoring team reviews. o Of the remaining 1 individual, a lack of consensus review was not conducted, but should be done, even though he was a relatively recent admission. • The list of individuals not being referred solely due to LAR preference contained 49 names. This compared to 15 and 10 individuals at the time of the previous reviews. o This was an accurate count. The APC devoted a lot of time to determine this. To do so, he read every ISP and created his own database. He had to read the content of every ISP because the obstacle checklist at the end of each ISP did not accurately reflect the reasons for non-referral. • The referrals of 2 individuals were rescinded since the last review. This compared to 3, 2, 2, and 2 at the time of the previous reviews. o Documentation (ISPA notes) was provided for 2 of the 2 individuals (100%) regarding the reasons for the rescinding. o 2 of the 2 were rescinded due to LAR or individual request. o 2 of the 2 had now been re-referred or were going to be re-referred. This was due to the work of the APC and his staff and the IDTs. o A review to determine if changes in the overall referral and transition planning processes at the facility, however, should also be conducted for the rescinded referrals. This can be done by the APC and his staff. If done and if actions were recommended, the monitoring team would look for indication of implementation of actions. • 2 individuals returned to the facility after community placement. This compared with 0 individuals at the time of all previous reviews. o A special review team was held for 1 of the 2. The review included improvements to be made for future transition planning for all individuals at EPSSLC. • 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, recorded, and graphed. These data were being obtained for at least a one-year period after moving. o Of the 11 individuals who moved in the past 12 months (and for whom information was available), 2 were reported to have had one or more untoward events that occurred within the past six months (18%).	

		These were the 2 individuals who returned to the facility. ▪ It is important for the reader to understand that many individuals who are placed have histories of challenging behavioral, psychiatric, and medical issues. Therefore, it is not unexpected that these issues might occur in the community. o Of these 2, the issues with 0 (0%) were successfully resolved. Of the remaining 2, all 2 returned to the facility. o EPSSLC provided follow-up and remained involved with all of the other individuals, as needed, even past the 90-day post move monitoring period for some. This was very good to see and demonstrated the facility's commitment to each individual. o Follow-up was done with the individuals and their IDTs, and adequate review was conducted for 1 of the 2 cases (50%). All cases should be reviewed to determine if changes in the overall referral and transition planning processes at the facility should be made. This should not be a complicated or overly time consuming activity. The benefits may be very helpful to the APC, PMM, and transition specialists. The monitoring team spoke at length with the APC and his staff about ways to do this that would be efficient and useful. A provider's use of the 911 emergency system was discussed as an example. If these reviews were done and if any actions were recommended, the monitoring team would look for indication of implementation of these actions. • 0 individuals had died since being placed since the last onsite review. This compared with 0 for all previous reviews. • 0 individuals were discharged under alternate discharge procedures (see T4). The monitoring team again recommends that simple graphic presentations would be helpful to the APC in looking at trends over time. The 5 pie charts described in the previous report remained and the monitoring team's comments continue to be applicable. Below are 15 graphs the monitoring team suggests be considered by the APC. • Number of individuals placed each month or monitoring period • 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. <u>Other activities</u> Two other referral and placement-related activities continued to occur regularly at EPSSLC. Both were described in the previous monitoring report. One was the almost-weekly meeting of the APC and his staff. Relevant topics were discussed, such as the status of referrals and placements, records and documents, upcoming meetings, and so forth. A detailed document, called Placement Progress, had the latest information on each referral. This appeared to be a well running part of the APC's program and likely contributed to the progress made during this period. The other was the FST meeting. It was initiated at the time of the last review, but had not continued until the time of this review. Attendance was the APC and his staff and the QIDP director. Because of the large overlap of these three sections, the monitoring team recommends that additional representatives from sections F and S also attend, especially perhaps some of the QIDPs. During this meeting, the APC reviewed some ISPs. This was a worthwhile activity because there was discussion about making some changes to the entries to demonstrate substantial compliance with more aspects of section T. <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. 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.

Ultimately meeting the requirements for this portion of T1a and for provision T1b3 will require that the APC work closely with the QIDPs and the QIDP coordinator. The APC and QIDP coordinator were starting to work closer together (e.g., FST committee).

At this point, the monitoring team believes that the facility should be able to meet these cross-provision requirements, specifically what is in T1a, T1b1, T1b3, and T1b2#1. These are for documenting professional determinations and team decisions, and for planning educational activities at an individual level, in a way that is measurable and individualized. Progress in these areas is noted in sections T, F, I, and S of this report.

The monitoring team requested a set of recent ISPs, attachments, and assessments. One was submitted for each of the 10 homes. Eight were selected for review by the monitoring team (see above under Documents Reviewed). These were from across the EPSSLC campus, for individuals with differing levels of needed support, and facilitated by six different QIDPs. The ISPs were from meetings held April 2013 to July 2013.

In assessments: Assessments were available for review for all of the 8 ISPs. Of these, all of the assessments for 0 individuals (0%) included an applicable statement and/or recommendation. On the other hand, some of the assessments for all of the individuals (100%) included an applicable statement/recommendation.

Statements were most regularly made in the habilitation, speech, and nursing assessments. All of the statements were positive about community placement, except for three. Two were from medical, but had no rationale (Individual #75, Individual #102). The third was from nursing; it provided a rationale (medical/fragile; Individual #102). Following the onsite review, the facility reported that the dental department was using an additional form to make this statement. The addition of a new standardized statement/requirement from DADS central office will likely result in a statement being present in all assessments. Below are some specific data for the 8 ISPs:

Discipline	# assessments	# with a statement
Medical	5 of 8	3 of 5
Nursing	7 of 8	7 of 7
Psychiatry	2 of 8	1 of 2
Psychology	6 of 8	5 of 6
Dental	5 of 8	0 of 5
Vocational	8 of 8	3 of 8
Speech	8 of 8	8 of 8
OTPT	8 of 8	8 of 8
Nutrition	7 of 8	1 of 7

		In the written ISPs: Of the 8 ISPs reviewed, 8 (100%) included an independent recommendation from the professionals (as a group) on the team to the individual and LAR. Of these 8, each professional's opinion was given and described in 5 (87%). It was done very well in 2 of these 5 (Individual #75, Individual #80). In 2 of the other 3, a general statement was made about all of the professionals (Individual #102, Individual #169). Observation of ISP meetings: Of the 2 ISPs observed, 2 (100%) included an independent recommendation from each of the professionals on the team. Individuals referred: In reviewing the 4 CLDPs, 4 (100%) individuals and/or LARs did not oppose transition to the community. <u>Referrals and Transitions</u> There were systemic issues delaying referrals (at the facility/local level) identified during this onsite review. This issue was the lack of availability of openings in the local provider community. The facility was working in a satisfactory manner to resolve and address this. That is, the APC and his staff were in frequent contact with providers so that providers were aware of who was referred for placement, timelines for transition, and possibilities for individuals from the facility to share the same home. As a result, three new homes were scheduled to be ready in the next few months. Providers were reported capable and willing to serve individuals with complicated medical and accessibility needs, as well as behavioral problems (though the return of Individual #37 to the facility questions the latter). 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 individuals on the active referral list via a periodic update by the APC to the facility director. The monitoring team, however, was not sure if this information eventually made it to other members of senior management. The monitoring team has the same comments and recommendation from the previous report for the APC to provide an occasional oral update to senior management. The weekly section department leader meeting seemed to be the best place for this to occur. Transitions were occurring at a reasonable pace (given the absence of community openings over the past six months). 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 a sample of 4 of the 4 individuals placed since the time of the last onsite review (the individuals whose CLDPs were reviewed), 1 (25%) were placed within 180 days of their referral, 2 (50%) were placed three months after 180 days, and 1 (25%) were placed more than one year after referral. o 3 of the 4 most recent placements occurred within 180 days. • Of the 10 individuals on the active referral list for community transition, 7 had exceeded the 180-day timeframe (i.e., 30% were within 180 days). o This compared with 2 individuals who were referred for more than 180 days during previous monitoring review. o Of these 7, 4 individuals had exceeded one year. This compared with 1 individual at the time of the previous review. • To reiterate from the above, the delays appeared to be due to the lack of openings in the community provider network. • There were reasonable activity and actions related to the transition and placement, and no long gaps of time with no activity, for 4 of the 4 (100%) individuals whose CLDPs were reviewed in detail.	
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 disseminated a draft for comment in August 2013. Thus, there was not a state policy that adequately addressed all of the items in section T of the Settlement Agreement. All facility-specific policies regarding most integrated setting practices remained the same as at the time of the last review. 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 obstacles to the individual's movement to the most	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. <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. 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.	Noncompliance

	integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	Of the 8 ISPs and 4 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. The APC and his staff reported that they were going to work on this via the FST work group. <u>Obstacles to Movement</u> Of the 8 ISPs reviewed, 8 should have had obstacles defined (0 were for individuals who were referred). Of these 8 ISPs, 6 (75%) identified obstacles, all of which were LAR preference. Of the 2 annual ISP meetings observed, an adequate list of obstacles to referral or obstacles to transition was identified for 2 (100%). However, both individuals were referred for placement during the ISPs. When obstacles are identified in an ISP, the ISP should also include an action plan to address/overcome any obstacles identified. The plans should be individualized, measurable, and include expected timelines. Of the 6 for which obstacles were identified, there were plans to address obstacles to referral for 1 (17%). There were plans to provide more education to the individual, but no actions that addressed the LAR concerns. Of the 2 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 2 (100%), in that, the individuals were now referred. It may be that IDTs are not specifically identifying what it is that is an obstacle to referral. If they did, perhaps an appropriate action plan would be developed. For example, in the ISP for Individual #15, it says that the IDT did not refer due to medical problems and because his sister/LAR needed to learn more. Individual choice, however, was marked as the obstacle. Similarly, for Individual #4, the ISP says that the IDT did not refer due to medical and medication problems, and due to LAR preference, however, only the LAR preference box was checked. The APC's multi-colored spreadsheet had probably the most accurate and up to date information regarding what the obstacles to referral really were. The ISP check-the-box formula seemed to be somewhat limiting. <u>Preferences of individuals and LARs</u> Of the 8 ISPs, 8 (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). All 8 of the 8 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%), in that both were described as having low understanding; this preference appeared to have been determined in an adequate manner for 2 (100%). Although not relevant to these two ISPs, an individual's low understanding should not necessarily result in a determination that the individual would not benefit from living in a more integrated setting. Of the 8 ISPs, 8 (100%) included an adequate description of the LAR's (or family member's) preference and how that preference was determined by the IDT (8), or indicated that there was no LAR (0). Of the 2 annual ISP meetings observed, there was an appointed LAR for 2. LAR/family member preference was discussed in 2 of these 2 meetings (100%). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Show that SAPs were developed (or at least considered) specifically for helping the individual prepare for his or her upcoming transition. 2. Ensure ISPs correctly identify obstacles to referral, and that there is an individualized action/plan to address each obstacle.	
	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 every one of these activities. Providing education about community placements continued to be a strength of the APC and his staff, and the facility in general. Examples included the work done by transition specialists to find new and creative ways to inform staff and families about the quality of some of the providers in El Paso. <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 8 recently completed ISPs: o 8 of the 8 (100%) had an individualized list of activities. o 5 of the 8 (63%) were in measurable terms. Others had statements that	Noncompliance

		would make it difficult to determine if the action had been engaged in, such as "as scheduled" and "as available." o 8 of the 8 (100%) included the LAR, as appropriate, based upon the content of the ISP. o 7 of the 8 (88%) adequately described how/if the previous year's plan was completed. It may be helpful to add some prompts or headers to the ISP shell to help the IDT address each of the above four open bullets. Moreover, given that one of the transition specialists attended every ISP meeting, he or she could help to ensure that the IDT always adequately addresses these four bulleted items. 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 held a provider fair within the past 12 months (September 2013). Data and evaluations collected from previous fairs were used to improve this fair. For example, it was held on a Saturday to accommodate families and others who might be working during a weekday fair. The APC and transition specialists did a lot of preparatory work and also did a wrap up with providers. Advocacy groups were invited to set up a booth, a former resident made a presentation about her experience, and a slide show of community homes was shown. Sign in sheets, survey results, and documentation of ongoing work on improving the provider fair led to EPSSLC meeting the standard for this item of T1b2. 3. Local Authority (LA) • Regular SSLC meeting with local 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. Two meetings occurred since the last review (May 2013, August 2013). The APC provided documentation regarding these meetings. The topics were very relevant to most integrated setting practices. LA training was offered, this time during the provider fair. In addition, the APC reviewed each CLOIP worksheet and incorporated that information into his referral status spreadsheet for each individual at the facility. In addition, the transition specialists maintained frequent contact with the local providers to inform them of individuals who were ready for transition. This	

		standard was met. 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: CLOIP-related activities are mentioned in the above item T1b2#3. 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 four people • Individual's response to the tour is assessed (describe methodology and indicators) EPSSLC status: The APC continued to work on making the system of tours manageable and appropriate for the individuals at EPSSLC. From 4/4/13 to 8/30/13, there were 15 tours, for 22 different individuals (some went on more than one tour). This was 19% of the population. The same appropriate system of documentation described in the previous report remained in place. As recommended in many previous monitoring reports, the APC had now developed a tracking list so that he (and the IDTs) could determine which individuals had gone on tours and which hadn't. Moreover, the transition specialists had recruited information from each QIDP regarding individuals on their caseloads who should be scheduled for tours. Thus, 100% of the individuals were considered for a tour and approximately 60% of the individuals were identified as needing to be scheduled for a tour. The others were not considered due to LAR preference or IDT determination due to the individual's medical status, ability to benefit from a tour, or counter-therapeutic nature of a tour. Given that only four individuals were identified as not being allowed to go on tours, the APC's database should indicate the reason why some individuals did not go on tours. The APC and PMM were organizing the tours, in collaboration with the LA, so this information should be helpful to them. Individuals appeared to be visiting homes that were appropriate to their needs (e.g., wheelchair accessible). This aspect of T1b2 met the standard. 6. Visit friends who live in the community EPSSLC status: Since the last onsite review, there were visits by individuals to friends who had moved to the community, if one considers that many of the tours, and especially many of the visits made by individuals who were already referred,	

		were to day programs and homes in which former EPSSLC residents now lived. Further, these opportunities were being considered by the APC and his staff as they planned tours and other educational activities. 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 and LARs/family members did occur: • At least once at self-advocacy meetings, 9/6/13 by the PMM. • At least once at the parents association meeting, 5/11/13 by the PMM. • Via sensitive, individual, discussions with families and LARs. The APC, PMM, and transition specialists each told moving stories about their work with families to help them understand the options that could be available to their loved ones. Examples included the families of Individual #79, Individual #6, Individual #49, Individual #18, and Individual #38. In some cases, the result was a referral. In others, it was a new consideration to learn more about community options. The staff documented on a new family education progress note. • Via creative, new ways of providing information to families, individuals, and staff o New posters throughout the campus o New brochures o Real-estate style listings o A 1,000 photo Parade of Homes slide show of community homes and day programs o Video of a former resident's presentation at the provider fair. 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 (other than during NEO), it was during the June 2013 town hall meetings, 299 staff attended. Since the last onsite review, educational activities for clinicians did occur at least once (during the town hall meetings). Since the last onsite review, educational activities for managers and administrators did occur at least once (for QIDPs on 8/12/13 and for the entire senior management during section leader meetings). Moreover, the transition specialists' attendance and active participation in every ISP meeting played an educative function for IDT members, too. The APC also invited new providers to make presentations at the facility (e.g., Rock House from Dallas area). EPSSLC met the requirements for this standard of T1b2.	

		9. Individuals and families who are reluctant have opportunities to learn about success stories EPSSLC status: Progress continued to be made as noted in the previous report. Documentation was provided via the family education progress notes. These options were made available to families, usually during the individual discussions held with the transition specialists or PMM. EPSSLC was very close to substantial compliance; the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Further develop the individualized education plans described in the first item of this list of 9, especially regarding the measurable objectives/outcomes. 2. Ensure that all individuals identified as appropriate to go on a community tour have the opportunity to actually do so.	
	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 ISP process, through provision of recommendations in annual summaries and IDT deliberation and consensus. There was a list of all individuals, their preference if known, and whether referred for placement. To meet substantial compliance with this provision item, the facility will need to 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 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 Based upon the written ISPs, this did appear to be occurring regularly, as also noted in T1a. • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o There was a thorough living options discussion during 2 of the 2 ISPs observed (100%) and an adequate description of a thorough discussion was evident in 8 of the 8 ISPs reviewed (100%). o The discussions observed were individualized, including consideration of preferences and support needs. The LA and the transition specialists were very knowledgeable and contributed much information to the discussion. o The living options discussion during the ISP continued to be a strength of the facility.	Noncompliance

		• 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 good statements about the decision made by the entire team for 8 of the 8 reviewed (100%).	
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 4 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. The CLDPs were in the newer format, which the monitoring team found easy to read. Initiation: 4 of the 4 (100%) CLDPs, and 3 of the 3 (100%) in-process CLDPs, were initiated right after the referral. The monitoring team looks for this to occur within 14 calendar days of referral. To make this evident, the APC and transition specialists entered the start date of the CLDP on the front page of the CLDP document under the "CLDP date" space. Timeliness: 4 of the 4 (80%) CLDPs, and 3 of the 3 (100%) in-process CLDPs included documentation to show that that ongoing activity was occurring for the individual's placement. Even though some placements took a long time, the reasons for the length of the transition were explained very well in the CLDP and attached documents. IDT member participation: 4 of the 4 (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). Coordination with LA: 4 of the 4 (100%) CLDPs included documentation to show that the facility worked collaboratively with the LA.	Substantial Compliance
	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	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 4 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. However, each of the CLDPs (100%) included some of these six activities.	Noncompliance

	provider staff.	• Training of community provider staff, including staff to be trained and level of training required. o (a) who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), ▪ This was not present in any CLDP. o (b) 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 ▪ This was not present in any CLDP. o (c) a competency demonstration component, when appropriate. ▪ This was included for 3 of the 4 (75%) CLDPs (all except for Individual #78). • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). o This was not included in any of the CLDPs. • Assessment of settings by SSLC clinicians (e.g., OTPT, psychology, training and recreation). o This was not included in any of the CLDPs. • Collaboration between provider day and residential staff is ensured. o This was not described in any of the CLDPs, but should be assured by the transition specialist. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). o This was not described in any of the CLDPs. <u>Day of move activities</u>: 4 of the 4 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and 2 of the 4 (75%) indicated the responsible staff member. Documentation regarding completion of some day of move activities (copies of emails) was provided for 4 of the 4 (100%). There should be some indication, however, that every item on the CLDP day of move list did indeed move with the individual. The emails did not provide this detail. <u>CLDP meeting prior to moving</u>: A CLDP meeting occurred for 4 of the 4 individuals (100%). A CLDP meeting was not conducted during the onsite review and an audio recording of a CLDP was not submitted to the monitoring team. The APC should ensure that CLDP meetings include these 7 components. 1. Attendance by all relevant IDT members, community providers, and LA 2. Individual preparation occurred prior to the CLDP meeting, if appropriate 3. DSP preparation occurred prior to the CLDP meeting, if appropriate to do so 4. Individual participation occurred, or was facilitated, if needed	

		5. There was active participation by team members 6. All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved 7. The post move monitor actively participated to ensure that supports were adequately defined and required evidence specified. During the onsite review, no other CLDP, pre-CLDP, or transition meetings occurred.	
	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 4 (100%) of the CLDPs, the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and by title for each support. In 4 (100%) of the CLDPs, the facility identified specific timeframes/specific dates for completion and/or implementation for each support. • Many supports had a template-type insertion of the deadline dates of all three post move monitorings rather than the date the support was to be put in place (or completed) by the provider (e.g., for first appointments with practitioners). This should be more thoughtfully checked in each future CLDP.	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.	4 of the 4 CLDPs (100%), included documentation that the plans had been reviewed with the individual and/or the LAR (or indicated that there was no LAR) as evidenced by • Signatures on CLDP • Narratives in the CLDP	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	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. For 4 of the 4 CLDPs reviewed (100%), all necessary assessments were completed. For 4 of the 4 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. For 4 of the 4 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting.	Substantial Compliance

		Each assessment should meet the following: • A summary of relevant facts of the individual's stays at the facility. o This was done sufficiently in 4 of the 4 (100%) assessments. In particular, for Individual #78, the nurse noted the correlation between her experiencing pain/discomfort and self-injury and aggression; and the physician included good discussion about seizures and menses. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o This was done sufficiently 4 of the 4 (100%) of 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 The APC reported that his staff worked with IDT members after they inserviced community staff prior to pre-placement visits to give them guidance on how to prepare their assessments. This was a new procedure and some improvements were observed. o The assessor needs to indicate how he or she might see the supports recommended being implemented in the new settings, that is, in the specific home and day program to which the individual was moving. General statements about what the individual would need in the community are not as helpful to the IDT. • 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 The comments immediately above apply to this bullet, too. To maintain substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The discharge assessments must better address the specific home, day, and employment sites and contexts into which each individual will be moving. This has been mentioned by the monitoring team in the past few monitoring reports and must be improved if substantial compliance is to be maintained.	
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	The lists of pre-move and post-move supports were identified in the CLDPs. EPSSLC had not made much progress in creating comprehensive lists for each individual. The lists of supports were surprisingly similar across the 4 CLDPs. Individualization was lacking. Thus, some supports seemed to be automatically included even if not relevant to the individual (e.g., employment for Individual #3). Typographical errors (e.g., Individual #31) and evidence that didn't line up with the support also made it appear that templated versions were not proofread for detail.	Noncompliance

	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 list of pre- and post-move supports should meet the following standards. • 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. ▪ This was demonstrated in 0 of the 4 (0%) CLDPs. Supports that required implementation of PBSP were insufficient because they did not include the important aspects of the plans, such as teaching replacement behaviors and engaging in ways to prevent the problem from occurring. o All safety, medical, healthcare, risk, and supervision needs addressed. ▪ This was demonstrated in 0 of the 4 (0%) CLDPs. Many support and service needs were addressed in the assessments and in training for staff, but not regular implementation. o What was important to the individual was captured in the list. ▪ This was evident in 2 of the 4 (50%) CLDPs. This was often all put into a single support, and usually only as training for staff, not providing the individual with these preferences. o The list thoroughly addressed the individual's need/desire for employment. ▪ This applied to 1 of the 4 CLDPs. The supports listed related to employment were adequate for 0 of the 1 (0%) (Individual #175). The importance of work and making money was mentioned many times throughout the CLDP and assessments, however, the single support to look for work was woefully inadequate. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included. ▪ This was included in 0 of the 4 CLDPs (0%). Having a support that merely says "continue to implement the BSP" was insufficient. o There were supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. ▪ This was seen in 4 of the 4 (100%) CLDPs. o There were ENE supports for the provider's <u>implementation</u> 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. ▪ Important aspects of the BSP, PNMP, etc. should have their own support to highlight their importance and help ensure that the provider carries out these important aspects. This was seen in 0 of the 4 (0%) CLDPs. Examples of what should have been	

		included were the interactional and positive reward components of PBSPs and the most important details of the PNMPs, dining plans, and nursing care plans. o Topics included in training had a corresponding support for implementation. ▪ This was evident in of 0 of the 4 (0%) CLDPs. • The wording of every support is in appropriate, measurable, and observable terms. o Supports regarding appointments were written adequately. The supports for provision of services and activities, however, were not written in a way that was measurable, so that the provider and PMM knew how much, how long, how many, etc. In other words, there was need for observable reportable outcomes and a criterion for each support. • Any important support identified in the assessments or during the CLDP meeting that was not included in the list of supports, should have a rationale as to why it was not included. o This was evident in 3 of the 4 (75%). o The facility did not maintain the excellent written descriptions of the IDTs deliberations at the same level as was highlighted in the previous monitoring report. • Every support should include 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 Evidence that the PMM should look for was included in all of the CLDPs (100%), however, improvements were needed. ▪ It was good to see that some called for the PMM to look at documentation, observe implementation, and interview staff. Doing these three activities is a very good way to be confident that the support was being provided. To help with this, the monitoring team again recommends that a checklist or check sheet be created. ▪ The supports, however, were missing any criteria to give guidance to the PMM. Perhaps the intent was that those items should be implemented every day 100% of the time, if so, some indication might be useful to the PMM. For some supports, such as outings or family activities, a criterion, such as once per month or once per week, should be included. Some supports had a number of items in them. Some examples of supports that were missing/not discussed in the CLDPs:	

		• Individual #175: getting employment, seeing mother, dressing nicely, riding her bike, keeping her routine, GERD, vision issues. • Individual #3: GERD, seizure/VNS, nursing care plans, important aspects of his PBSP. • Individual #78: adapting to her vision and hearing issues, replacement behaviors, preventing behavior problems, gait belt/wheelchair, GERD, communication strategies. • Individual #31: dining equipment usage. To further improve, the monitoring team recommends that the APC create a self-assessment for the pre- and post-move support section of the CLDP. He can use the above items to create this checklist for himself and his staff. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. o A pre-move site review was conducted for all individuals (100%). All 4 pre move site reviews were reviewed by the monitoring team (see documents reviewed) o 3 of the 4 (75%) indicated that the pre-move supports were in place. o Individual #78's placement failed during her transition even though the pre move site review was completed. She was placed far away from El Paso. This was not typical for the APC and his staff. Although a thoughtful transition was planned, including EPSSLC staff going along with her for a few days, the provider was reported to have been ill-prepared for the individual and as a result, the staff returned her to the facility rather than leave her in what they considered to be an unsafe situation. The facility reportedly had done a number of reviews and internal investigations of this and as a result (a) the individual was re-referred and many additional protections will be put into her next transition plan, and (b) the facility learned how to improve the way individuals are transitioned when they are to move anywhere outside of El Paso, such as ensuring that staff and clinicians who know the individual participate in the pre move site review, too. o The APC staff indicated that training was completed, but should provide detail indicating if all of the aspects detailed in the CLDP regarding this training occurred as per the CLDP, such as who, what, how, and documentation of competency. • Each of the nonessential/post-move supports needs to have an implementation date. o Each nonessential support in the CLDP did have an implementation date or referred to the "day of move."	

		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. At this point, the APC and transition specialists should be able to meet all of the criteria for a thorough and adequate list of pre- and post-move supports. Following the above comments regarding the 8 components of a comprehensive list, and the 3 additional characteristics will move the facility towards substantial compliance.	
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. New statewide tools for section T were still in development. The APC reported that he continued to like the living options discussion tool. The APC said that there would be improvements for the next onsite review because by then he will have new tools, be engaging in further QA facility wide activities (e.g., review and analysis of data, generation of actions/CAPs), and would be doing more data graphing and analysis. Even so, the APC and his staff were engaging in some quality assurance processes: • QAQI Council presentations. • QA report. • Corrective action plans. He had four that were either in process or completed. • QAD-SAC meetings. He reported that they were very useful. Data were reviewed, summarized, and analyzed for the living options tool. These data were included in the facility's QA program.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. This report included an addendum from each of the 13 facilities. This annual report had not yet been updated since the time of the previous monitoring review and, therefore, no new comments are provided here.	Noncompliance

	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.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 3/1/13 through 9/13/13. 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 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.	Substantial Compliance

	services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	EPSSLC maintained substantial compliance with this provision item. Since the last review, 12 post move monitorings for 6 individuals were completed (one of the individuals was placed from Mexia SSLC). This compared to 22 post move monitorings for 9 individuals, and 10 post move monitorings for 5 individuals at the time of the last reviews. The monitoring team reviewed completed documentation for all 12 (100%) post move monitorings. Of the 12 post move monitorings, 10 were completed by the post move monitor Luz Delgado, 1 was completed by the transition specialist Helen Alvarez, and 1 was completed by the PMM and transition specialist together. <u>Timeliness of Visits</u>: For the 6 individuals, 12 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team and by the post move monitoring reports, of the 12 required visits, 12 (100%) were conducted and 12 (100%) were completed on time. Of the 12 post move monitoring forms reviewed by the monitoring team, all 12 (100%) included dates showing that they were completed on time. <u>Locations visited</u>: For the 12 post move monitorings reviewed, 12 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited. <u>Content of Review Tool</u>: 12 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. 9 of the 12 were completed using the newest iteration of the post move monitoring form. Below, the monitoring team provides five comments regarding this form and EPSSLC's response/handling of these.	Substantial Compliance

		1. There was no explicit indication of what locations were visited by the PMM. The helpful hints document stated that all locations must be visited, but there was no requirement to report this. o The monitoring team could determine the sites that were visited by reading the report, however, it would be helpful if this was listed explicitly in the report. 2. The monitoring team could not determine what evidence the PMM was to look for, and what evidence the PMM examined "to assess whether supports called for in the CLDP are in place." a. The monitoring team recommends that the post move monitoring form include these three pieces of information for each pre- and post-move support: (a) what evidence was to be reviewed, (b) what evidence was reviewed, and (c) the due date. b. Examples of evidence to be reviewed are direct observation, staff interview, provider documentation, and daily checklists completed by the provider. The PMM should then specifically indicate what he or she observed and reviewed, and whom he or she interviewed. o For most, but not all of the supports, the PMM clearly indicated, in great detail, all of the evidence she looked at. o Given that the report form changed since the last review, the monitoring team will keep this provision item in substantial compliance, however, the PMM must indicate what evidence she used to assess the support. The report should clearly indicate what documents were reviewed, what was observed, and who was interviewed. For many supports, the monitoring team could not determine if the PMM based her findings solely upon staff reports rather than also looking for documentation and conducting observation. o Further, the PMM should make sure that at a minimum, she looks at everything required by each CLDP support. For instance, the monitoring team could not determine if the bulleted items for each community practitioner were indeed presented to the practitioner. 3. The monitoring team agrees with the helpful hints guidance for question 5, that is, when examining staff training, to not limit this to documentation. The monitoring team, therefore, recommends that question 5 be expanded to indicate that interview or observation of staff showed that staff were trained and knowledgeable. o The PMM clearly indicated that she also interviewed staff. 4. The helpful hints document required a narrative about direct observation of the individual. The monitoring team agrees with the helpful hints item for question 11 that requires a short comment be written regarding individual and LAR	

		satisfaction, and the PMM's overall opinion about the community home and day site. o The PMM reported her impressions of the individual's satisfaction in each report, but did not comment upon the LAR's satisfaction. 5. In the helpful hints document, the list of negative outcomes is not an all-inclusive list. It would be helpful to indicate that these are potential negative outcomes and others that might be identified should be reported and addressed. The post move monitoring report forms were completed correctly and thoroughly, as follows: • The checklist was completed in a cumulative format across successive visits for all 12 (100%) of the individuals who had more than just the 7-day review. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 12 of the 12 (100%). o The PMM should now provide detail in her report regarding whether she had evidence of all aspects of required training, such as who, what, how, and documentation of competency. o Also, as noted above, the evidence examined needs to be described in more detail (documentation, observation, and interview). • There was adequate justification for findings for each support in 12 of the 12 (100%). • Detail/comment was included in 12 of the 12 (100%) reports for most, but not every, support. • LAR/family satisfaction with the placement (0%) and the individual's satisfaction (100%) were explicitly stated in the comments section. • 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 and/or was specifically indicated at the end of the report in 12 of the 12 (100%). The monitoring team recommends that the PMM include the names of provider staff who were interviewed to help the reader understand which staff were interviewed during the post move monitoring. This was explicitly done in 1 of the 12 (8%), the most recently completed report. <u>General status of individuals</u> Based upon the monitoring team's review, of the 6 individuals who received post move monitoring, 6 (100%) transitioned very well and appeared to be having good lives. As discussed with the APC, a root cause type of review needs to be done of any individuals whose placements failed or who had the kinds of problems noted in T1a. This should have been done after the medication and support problems observed during	

		Individual #31's 45-day review, however, there must have been some of this type of review because a change was made whereby providers were now required to agree to provide medication at their own expense if needed. <u>Use of Facility's best efforts when there are problems that can't be solved</u>: In 7 of the 12 post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 6 of the 6 individuals (100%). For the most part, the problems were of a moderate level, such as carpet replacement, providing an electric razor, and allowing the individual more opportunities for walking around the day program. There was appropriate follow-up and correction for 7 of these 7 (100%) visits for 6 of the 6 individuals (100%). For example, Individual #69 was having behavior problems at school. As part of the PMM's 90-day review, she observed at school and made recommendations to the provider and IDT that a different teacher be found. As a result, the ISD looked into this and placed him in a new school with a new teacher and the individual was now doing very well. In another example, at the 45-day review, the PMM found that Individual #31 had not received her psychotropic medication, and had medical appointments missed. The PMM acted immediately to address the problem, including calling upon the APC, IDT, and LA. This serious problem was fixed as a direct result of the PMM's actions. In a third example, although not part of the official post move monitoring due to it being past the 90 days, the PMM remained involved with Individual #37 because he was having behavioral and psychiatric problems. The PMM worked with the provider and brought in EPSSLC psychology and other staff to help. Post 90-day follow-up was being scheduled for the individual who's 90-day occurred during the onsite review (Individual #31). Also, the APC and PMM reported that the PMM did occasional visits to individuals past the 90 days when issues had been resolved at the 90-day review, even if formal post move monitoring was no longer required (e.g., Individual #69). <u>ISPA meetings after post move monitoring visits</u>: An ISPA meeting should occur after every post move monitoring during which a problem or concern was noted by the PMM. An ISPA meeting was held and there were minutes/documentation of the meeting following 100% of post move monitorings for which an ISPA was appropriate to have been held (i.e., 2 of 2). However, for the others, there was no documentation of notification of the IDT that post move monitoring had occurred. The monitoring team recommends that the PMM notify	

		the IDT after each post move monitoring, even if it is to report that the individual was doing well, that there no concerns, and that in her opinion a meeting was not needed.	
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 at the home of Individual #31 for the 90-day review. 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 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 provider was Educare. The home was pleasant and spacious. The staff were professional, pleasant and very knowledgeable about the individual. The home, however, could use a number of cosmetic improvements, such as repair or replacement of broken and ripped furniture, repair of skylight, etc. To further improve her post move monitoring, the monitoring team recommends that she makes sure to read the detail of each support and think about what it is that she need to look at. For example, the individual had a support for brushing teeth three times per day as well as another support for a SAP for oral hygiene. These were two separate, albeit similar, supports. Also, the PMM can suggest that the provider put supports onto a check sheet or checklist for easier monitoring, such as the individual's ground diet and reward system.	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 determine fitness to proceed in a juvenile court proceeding. The	This item does not receive a rating.	

	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	There were no individuals to whom this provision applied during the past six months.	Not Rated

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Prioritized list of individuals without guardians who also lack functional capacity to render a decision regarding health or welfare o EPSSLC Self-Assessment and Provision Action Information for section U o EPSSLC Section U Presentation Book o Guardianship Committee Agenda 9/16/13 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans: • Individual #169, Individual #128, Individual #189, Individual #102, Individual #75, Individual #9, Individual #32, Individual #34, Individual #39, Individual #28, Individual #80, Individual #126, Individual #51, Individual #82, and Individual #152. o Draft ISPs and Assessments for Individual #125 and Individual #114. o A Sample of HRC Minutes o Documentation of activities the facility had taken to obtain LARs or advocates for individuals Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDIPs in homes and day programs; o Gloria Loya, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 9/18/13 o Morning Unit Meeting 9/18/13 o Morning Clinical Review Team Meeting 9/18/13 o Annual IDT Meeting for Individual #125 and Individual #114 o ISPA regarding restraints for Individual #161
	Facility Self-Assessment: EPSSLC submitted its self-assessment updated on 8/8/13. 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. Activities engaged in to conduct the self-assessment for U1 and U2 included: • Reviewed the state and facility guardianship policies. • Reviewed the priority list for guardianship to ensure it was updated at least semi-annually. • Reviewed a sample of 27 ISPs completed between February 2013 and July 2013 to determine if the

	ISP included discussion of the individual's ability to provide informed consent. • Reviewed 30 rights assessments completed between February 2013 and July 2013. • Reviewed completed section U and section F monitoring tools. The facility self-rated U1 and U2 as not in compliance. Findings from the facility self-assessment were similar to findings of the monitoring team for the two provisions of section U. The monitoring team agreed with the facility's noncompliance ratings for U1 and U2 and commends the facility for continuing to assess progress through the self-assessment process.
	Summary of Monitor's Assessment: The facility was using the DADS Determination on the Ability to Provide Informed Consent Checklist for determining the need for guardianship. IDTs were holding a much more in-depth discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued 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.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make	On 3/7/12, DADS State Office issued Policy #019: Guardianship. A second policy on consent remained in the development phase. The state is encouraged to finalize this policy because it should assist the facilities in moving forward with regard to the Implementation of the Section U Settlement Agreement requirements. The facility was using the DADS Determination on the Ability To Provide Informed Consent checklist to assess each individual's capacity to give informed consent. IDTs were responsible for reviewing assessment information and determining if a referral for guardianship was appropriate. The HRO was working closely with families, community guardianship providers, and the court to facilitate the guardianship process when IDTs determined a need for guardianship.	Noncompliance

#	Provision	Assessment of Status	Compliance
	determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The monitoring team observed the annual ISP for Individual #114. The team reviewed his rights assessment and engaged in a good discussion regarding his ability to give informed consent. The meeting was held, however, without the individual present. Attendance at ISP meetings is a good way for individuals to be involved and learn how to make decisions affecting their lives. By excluding him from his meeting, he missed the opportunity to be involved in making decisions regarding where he wants to live, how he wants to spend his day, and what new skills he would like to acquire. The team agreed that he did not have the ability to understand his options regarding programming, living options, and medical care. That being said, they then failed to develop training outcomes to address his decision making skills. Data gathered by the facility indicated that individuals were present at only 31% of the annual IDT meetings held during August 2013. The facility needs to examine this practice. IDTs need to keep in mind that inability to give informed consent can be impacted by limited exposure to decision making and self-advocacy opportunities, as well as limited communication options. IDTs were still not holding thorough discussions regarding each individual's ability to make informed decisions and possible training opportunities to improve decision making skills, even at the most basic level (e.g., simple choice making). The facility continued to maintain a prioritized list of individuals lacking both functional capacity to render a decision and a LAR to render such a decision. A guardianship committee was in place to review all referrals and ensure that IDTs had adequately assessed and appropriately referred individuals. A guardianship committee meeting was observed during the week of the onsite visit. Committee members were actively involved and held good discussion regarding each referral. Individuals referred for guardianship were prioritized by the committee. Individual #80 was listed as an adult with guardian, though according to his ISP, his guardianship had lapsed in 2011. His ISP, however, stated that his LAR will continue to sign consents for him. If in fact, his guardianship had lapsed, his previous guardian could no longer authorize consent. The IDT determined that he could not give informed consent, but did not have an adequate discussion regarding his legal status. Following the onsite review the facility clarified that guardianship had lapsed and the facility was well aware that the previous LAR would not sign consents until guardianship was re-instated. To move forward, the facility will need to: 1. Ensure an adequate assessment process is used to determine each individual's need for guardianship. 2. Ensure that the facility's priority list for guardianship is accurate based on information gathered at annual IDT meetings.	

#	Provision	Assessment of Status	Compliance
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.	New guardianship had been obtained for 20 individuals at the facility in the past six months. The Human Rights Officer was working closely with families, guardianship agencies, and local courts to expedite the guardianship process for those individuals deemed priority I for guardianship. She continued working with many current guardians to renew guardianship on an annual basis. This was all very good to see. The facility additionally had some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human rights officer employed by the facility. There was a guardianship committee in place to review all referrals to the HRO for guardianship and prioritized individuals by need. The facility continued to offer self-advocacy opportunities for individuals at the facility, through the self-advocacy group at the facility 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

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o EPSSLC facility-specific policies: • Recordkeeping Practices," dated 4/28/12 (a copy of the state policy) o EPSSLC organizational chart, August 2013 o EPSSLC policy lists, undated but likely August 2013 o List of typical meetings that occurred at EPSSLC, undated but likely August 2013 o EPSSLC Self-Assessment, 8/29/13 o EPSSLC Action Plans, 8/29/13 o EPSSLC Provision Action Information, most recent entries 8/28/13 o EPSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 9/16/13 o List of all staff responsible for management of unified records o Description of changes since the last onsite review, solely about the management of ISP assessments o List of other binders or books used by staff to record data (there were none) o Description of the EPSSLC shared drive, undated o Tables of contents for the active records (4/5/13), individual notebooks (4/15/13), and master records (4/5/13) o Documentation of new employee orientation, March 2013 to August 2013 o Documentation of current employee refresher training, March 2013 to June 2013 o Documentation of town hall training session on recordkeeping, July 2013 o Unified records committee: quarterly meeting minutes (one meeting September 2013) o "100% record audit" blank tool o Two policy spreadsheets: one listed all state and facility policies, and one listed the same information plus had columns regarding training. The first spreadsheet had newer policies than did the second spreadsheet. Both were undated. o Description of the unified record audit process o Blank tools used by the URC (table of contents tool and statewide tool), not updated recently o Criterion used by the URC for scoring the statewide tool o Draft, proposed new tool that combined the statewide tool and the table of contents tool o Blank V4 questionnaire o List of individuals whose unified record was to be audited by the URC, April 2013 to Augusta 2013 (0 to five per month) o Completed audits for 19 individuals, April 2013 to August 2013 (though 0 in August 2013) • Statewide self-monitoring tool • Active record and individual notebook

	• Master record • Various notes and lists, such as of ISP SAPs and consents o Emails requesting error correction for all 19 of the audits o Replies and further questions for these emails for 19 of the 19 audits o 12-pages per individual data called "Chart tab and documentation error breakdown" for 19 of 19 o 1-2 pages per individual data that summarizes the above 12-page reports for 19 of 19 o Completed V4 interview forms (5 sets, 2-5 interviews each set) o QAD-SAC benchmark monthly meeting brief notes, at least once each month, April 2013 through July 2013 o QA report for section V, June 2013 and September 2013 o Data graph of documented and undocumented errors, monthly, through August 2013 o Data graph of statewide tool, monthly, through August 2013 o Interobserver agreement results o Active records and/or individual notebooks of: • Individual #67, Individual #77, Individual #151, Individual #17, Individual #84, Individual #109, Individual #36, Individual #10, Individual #57, Individual #15, Individual #72, Individual #117, Individual #127, Individual #24, Individual #50, Individual #104, Individual #102, Individual #4 o Master records of: • Individual #151, Individual #66 <u>Interviews and Meetings Held</u>: o Priscilla Guevara, Medical Records Coordinator (MRC) o Melissa Hall, URC o Various DSP, nursing, and management staff <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area o MRC quarterly presentation to QAQI Council, 9/18/13 o Unified records committee, 9/17/13
	Facility Self-Assessment The content and procedures of the self-assessment were almost identical to the previous report with the exception of some expansion of V1. V1 now contained more of a quality review of the unified record by including the results of the V3 statewide tool. Although an improvement, it was insufficient because V1 looks at more than the contents of the statewide tool (e.g., the table of contents tool). These other aspects should be included. The best way to do so would be for the self-assessment to address each of the components of the unified record that are in the monitoring team's report. For V2, the self-assessment was identical to the previous report, and as noted in this report, no additional

	work had been done on V2. V3 should be a self-assessment of the quality review audit process, including, as reported upon by the monitoring team, the frequency, quality, and reliability of the process, as well as the analysis of data/findings and implementation of any actions as a result. For V4, self-assessment for each of the six components should be included. 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: The recordkeeping staff continued to work hard to have the unified records and recordkeeping practices move to substantial compliance. Most of their efforts were focused on aspects of the active record (e.g., assessment, individual notebooks) while other aspects of this provision received scant attention (e.g., improvements to the auditing process). The active records continued to improve. The 100% record audits continued to be conducted quarterly and ISP assessments and ISP documents were more frequently present in the record. The content of observation notes had improved. The simple tasks of properly and legibly signing and dating entries continued to be a problem. There were numerous examples of missing documents or misfiled documents Overall, the individual notebooks were in satisfactory condition. The facility had focused on improving these over the past couple of months and the results were evident. A master record existed for every individual and were in a format that was organized and manageable. Overall, the master records were in good shape, however, an adequate system to address missing documents was not in place at this time.. Quality assurance reviews (audits) were conducted in three of the previous six months (50%), that is, except July 2013 (four), August 2013 (one), and September 2013 (none). The reviews were done in a consistent manner and were neatly and clearly documented. The URC drafted a revised audit tool, but had not yet implemented it. She reported that it took approximately eight hours to complete each review. An adequate process was in place to notify staff of errors found during the audit, and the URC had an adequate process for tracking error corrections. Use of data to determine where actions should be taken was not yet in place. Provisions V2 and V4 received little/no attention since the last review.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The recordkeeping department at EPSSLC continued to make progress in some areas of section V. The department experienced staffing changes which made it more difficult for as much progress to have occurred as the medical records coordinator (MRC) would have liked to have seen. The department consisted of the MRC, URC, one clerk (there were two at the time of the last review and the one current clerk recently transferred to another position at the facility), and an administrative assistant (who was newly hired). At EPSSLC there were no home secretaries. Thus, the MRC, URC, and clerk were responsible for a great deal of filing and records management. Of note to the monitoring team was their responsibility for the thinning of the active records, appropriate sorting and filing of the thinned materials into the overflow files in their office, and movement of older overflow files (pre-2008) into marked boxes for storage in one of the buildings at the facility. Although a relatively simple clerical task, it was extremely time consuming. State policy and facility-specific policies remained the same since the last onsite review and, therefore, no new comments are provided here. Seventeen of 17 (100%) individuals' records reviewed included an active record, individual notebook, and master record. The table of contents and maintenance guidelines for all three components of the unified record were updated in April 2013. EPSSLC had made no facility-specific modifications, however, the active record table of contents might benefit from doing so. The MRC should be sure to follow state procedure when doing so. 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 and would likely contribute to further progress. These were: • New employee one-hour orientation sessions specifically about recordkeeping practices. From March 2013 to August 2013, 44 new employees received this training. • Annual refresher training for all staff. This was as a 30-minute refresher class for 73 staff from March 2013 to June 2013. It was replaced by training during the facility's multiple town hall sessions in July 2013. All but 11 staff attended these sessions and the MRC was following up individually with those 11. • A Unified Records committee continued to meet quarterly. Minutes indicated that relevant topics were discussed. • Participation in the new activities of the QA department. This was a new and somewhat slow-starting process for the recordkeeping department. See V3	Noncompliance

#	Provision	Assessment of Status	Compliance
		below for more detail about this. Over the past few years, the monitoring team has seen that the EPSSLC recordkeeping department makes the most progress when there is concerted emphasis and prioritization on a specific area. For instance, positive outcomes were seen when this occurred for (a) ISP assessment completion and submission, (b) submission of all relevant documents into the active record within 30 days of the ISP meeting, and (c) the quality of the individual notebooks. The facility should consider this type of approach to move forward with provision V. <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% record audits continued to be conducted quarterly and continued to result in many documents being present (based on monitoring team observation), however, no data were collected to support this. The audits were done quarterly by staff from the recordkeeping and QA departments. It was called the 100% record audit because they reviewed the presence of approximately 30 items in the active record of 100% of the individuals. • ISP assessments and ISP documents were more frequently present in the record. The facility had taken extensive efforts and had an extensive data presentation on the timeliness and submission of ISP assessments, and the submission of what they called the ISP packet (a set of seven or eight documents from the ISP, due for submission to the recordkeeping department by 30 days following the ISP). • The content of observation notes had improved. • Record availability was not reported to be a problem any longer. For example, in one home, one volume of one active record was not available, however, it was appropriately signed out (Individual #67). • Inconsistencies in what was in various sections of the active record had improved, most likely because of more regular and consistent submission of documents (especially ISP related assessments and documents) rather than due to any specific actions taken by the recordkeeping department. Aspects still in need of improvement. • Although legibility of entries had improved, the simple tasks of properly and legibly signing and dating entries continued to be a problem as found by the monitoring team and by the URC audits.	

#	Provision	Assessment of Status	Compliance
		• Missing/misfiled documents: The majority of documents were found to be in in place by the monitoring team, however, there were numerous examples of missing documents or misfiled documents. For example, Individual #40's observation notes for four months were in Individual #15's active record. One had all of medical consultations under one tab (Individual #151), some were missing SAP data sheets for many months (e.g., Individual #109), and one was missing an annual medical assessment (Individual #72). On the other hand, other active records had SAPs that were up to date (e.g., Individual #84). o The MRC and URC reported that missing documents were a big problem, especially frustrating to them because they had evidence of documents being in the active record and filed, but then upon later audit or search, documents were missing. Unfortunately, there were no data to be able to determine the extent of this problem. • Additions should be made to the table of contents and additional tabs should be added to the active record (if required), so that it is clear where documents used by EPSSLC should be filed. Examples included documents called educational summary, independent travel, ADL sheets, a tab labeled data recordings, and the admission and placement department's parent education form. • Nursing and habilitation had their own SAPs, but these were not indicated in the active record. There was confusion about what was to be submitted for filing and where it should be filed (i.e., under the discipline tab or under the SAP tab). • The IPNs maintained the improvement noted in the previous report, however, numerous full page body check forms were in many IPN sections. The MRC wondered if a sub-tab behind the IPNs would be a better place for these body check forms. The monitoring team suggested that she bring it to senior management meeting the next week. The monitoring team's review of active records showed approximately 10-12 errors per active record. The URC's quality assurance audits described in section V3 had similar findings. The monitoring team recommends that the facility consider a short-term "focus" on the active record, as had been done for the individual notebook, ISP assessments, and so forth. Further, in the past, the recordkeeping department conducted training (or retraining) sessions for staff, homes, departments, etc. when repeated recordkeeping problems were identified. This was discontinued about a year ago. <u>Individual notebooks</u>	

#	Provision	Assessment of Status	Compliance
		Individual notebooks continued to be used for all individuals and as per state policies. An individual notebook existed for each individual. Every individual notebook reviewed by the monitoring team contained the ISP, IRRF, and IHCP. Staff interviewed by the monitoring team appeared comfortable with, and knowledgeable of, the individual notebooks. For example, Xenia Perrien, house manager, said that individual notebooks were easy to work with and were the staff's handbook for working with each individual. She used Individual #50's individual notebook as an example to show where it contained instructions for how he was to be sitting, how behaviors were to be recorded, and descriptions of his risks and preferences. A question remained as to whether acute care nursing plans should be in the individual notebook. The MRC should take action to resolve this one way or the other. Overall, the individual notebooks were in satisfactory condition. The facility had focused on improving these over the past couple of months and the results were evident. As noted in section K and in V4, PBSP data were recorded up to date in 93% of the sample observed by the monitoring team. <u>Other binders/logs</u>: The facility solved the question of the pink/purple binders, raised in previous monitoring reports. To that end, the binders were eliminated and their contents added to the individual notebook. For the most part, this was working very well. Some staff, however, reported that the ADL sheets were now <u>less</u> accessible to them because, instead of all being in one binder, they were spread across each individual notebook. Other staff reported that it was working better to have everything about the individual in one place. The MRC should determine whether this is a topic worthy of being brought to senior management's weekly meeting. <u>Master records</u> A master record existed for every individual at EPSSLC and all were in a format that was organized, manageable, and described in previous reports. Overall, the master records were in good shape. A new minimum contents list was generated in April 2013. All of the master records were not yet converted, or reviewed, to ensure that all contents were present. This should occur over the next six months (rather than only doing so when the monthly V3 audits were conducted). The monitoring team noted in the previous report that an adequate system to address	

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		missing documents was in place. This did not appear to be the case at this time. Some non-optional items in master record checklists had no marking, had no explanation, and were not present (e.g., Individual #151). The recordkeeping staff said that they checked with the local authority to try to obtain missing documents, however, nothing was noted on the checklist in the master record. Further, the type of follow-up will need to vary depending upon the document. For instance, it is sufficient to note that an admission application could not be located at the facility or local authority for an individual who has lived at EPSSLC for many years. On the other hand, a missing birth certificate or social security card should indicate what actions were in process to obtain these rather than merely stating it could not be located. Also, when an item is checked, it should mean that the document was in the master record, not that it was located somewhere else in the facility. For instance, Individual #66's Medicaid card was reported to be in the reimbursement office, not in his master record. <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, though the tedious and time consuming task of doing so fell to the MRC and URC in a way that appeared to compete with their ability to attend to other recordkeeping tasks. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The monitoring team does not have an opinion regarding whether the recordkeeping department has enough staff and/or if the staff are appropriately prioritizing how to use their time, but recommends that facility management examine this. 2. Consider making the active record a priority focus area for a time-limited period. a. Address missing documents b. Finally solve the remaining IPN/observation note problem of appropriate signatures, titles, dates, and times. 3. Ensure the master record is accurate and missing documents are addressed.	
V2	Except as otherwise specified in this	Not all state policies were in place yet, though continued progress was evident. Only	Noncompliance

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	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.	provisions G and H did not yet have a state policy. EPSSLC submitted two documents for this provision. One was a list of all state policies with their associated facility policies. Policy numbers and effective dates were included. The second document contained all of the information from the first document (however, this information was not updated, such as policy numbers and effective dates; for example, see the section D policy dates). This document had additional columns listing the person responsible for training, who was required to receive training, and how often training was to occur. Although the content of this document was updated (e.g., new policies, dates, numbers), the document was the same as reviewed in the last report and the monitoring team's recommendations for the inclusion of additional informational columns had not been addressed. Recordkeeping staff reported that provision V2 had not received any attention since the last review. Please see comments in the previous monitoring report.	
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.	Quality assurance reviews (audits) were conducted in three of the previous six months (50%), that is, in every month except July 2013 (four), August 2013 (one), and September 2013 (none). Moreover, as noted in the previous report, only two were conducted in March 2013. The reviews for April 2013 through July 2013 were submitted and reviewed by the monitoring team (19). The review consisted of these components: • State tool • TOC tool • URC's notes • Individual notebook review • Master record review The URC was not re-auditing a unified record if it had been audited in the previous 12 months, as suggested in the previous monitoring report. The reviews were done in a consistent manner and were neatly and clearly documented. The URC painstakingly detailed each finding in the comments columns of the statewide tool and on the table of contents (TOC) tool. In addition, she listed a variety of information on a separate page to indicate consents, SAPs, etc. Two somewhat unique aspects of the auditing process seemed reasonable to the monitoring team. Behavior data cards/sheets were not checked as part of the individual	Noncompliance

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		notebook review because psychology managed that. The URC, however, looked for PBSP monthly reviews. SAPs for vocational skills were in the workshop. The URC sought them out and audited them there. Other aspects will require some attention from the URC and MRC: • Nursing and habilitation therapies were writing, implementing, and managing their own SAPs. This was fine and good to see. The URC, however, will need to determine how to audit these SAPs because they were not kept in the individual notebooks. • Missing SAP data were not considered to be errors, but should be. Consider this in somewhat the same way that the MAR is reviewed, that is, a blank needs to be explained. • The URC considered the bathing section of the FSA to meet the criterion for there being a water safety assessment. She should check with state office on this because that did not seem to be an adequate water safety assessment. • Reiss screen information was in the psychiatry update. The URC commented that psychiatry and psychology department needed, with her help, to figure this out. • The TOC form listed two items in psychiatry, an evaluation and an update. It was unclear to the monitoring team if this meant two different documents. This probably requires some clarification between recordkeeping and psychiatry. The URC had drafted a revised audit tool, but had not yet implemented it. To the monitoring team, it appeared to be not much more than pasting the state tool at the end of the TOC tool. Therefore, it may not provide any improvement to what she was currently doing. The URC reported that it took her approximately eight hours to complete each review. This was very lengthy and much longer than it was taking URCs at other facilities to complete their reviews. Interobserver agreement was conducted by the QA department and was regularly found to be high, which was good to see. The monitoring team learned that the QA department did interobserver agreement on all five unified records every month (even if the URC did not complete all five). This seemed to be more than necessary, that is, the purpose of IOA is to provide an occasional check on the reliability of the data being recorded by the URC. And, given that their comparison scores were regularly very high, perhaps the QA staff member's time can be put to other uses. After completing the audit, the URC implemented a very simple and straightforward	

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		process. She entered the statewide tool results into a database and a graph was generated of the results. The data were included in the MRC's QA report and QAQI Council presentations. For the TOC tool, results were entered into 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." A graph with a monthly data point was generated. The graph continued to have an ordinate of 700. This resulted in an inability to see month to month changes because most months had less than 100 errors. This can easily be fixed, as noted in the previous report. Also, the data analyst might work with the MRC and URC to make the month to month data points comparable given that the same number of audits were not conducted every month. The QA data analyst took the error databases and made two other data presentations for every TOC audit. One was 12 pages per individual, plus a graph of the data. The other was 1-2 pages per individual and listed only the errors along with an indication of whether each error was corrected. For example, Individual #96's audit showed 7 errors, 5 of which were documented errors (the other two were undocumented errors, i.e., not correctable). It also showed that the errors were corrected. Unfortunately, the MRC and URC did not appear to use these in any analytic or planned manner. Items in the statewide tool and TOC tool were not weighted, which was fine, however, when doing analyzing data, the MRC, URC, and data analyst should take this into consideration, especially when they ultimately calculate percentage of the tools that were done correctly. For instance, the items "photo present in active record" and "SAPs" are each single items. The SAPs item, however, involves much more than does the photo item. The result is that the total percentage scores will likely be over-inflated. Therefore, it will be important for them to "drill down" into their data to address those items that are most important. Following the audit, the URC sent an email to the responsible person regarding those errors that needed to be corrected (the monitoring team reviewed all of these and there were examples for all 19 of the audits). She then followed up on whether the errors were corrected over the subsequent weeks. There were lots of back and forth emails, with good follow-up by the URC (e.g., Individual #51), such as re-sending email prompts for corrections to be made approximately a month following the first email (e.g., Individual #7, Individual #188), looking in the active record to see if a document reportedly placed by a clinical staff was indeed placed (e.g., Individual #86), properly titling a document (e.g., Individual #151), and regarding missing SAPs (e.g., Individual #81).	

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		To conduct the reviews of the parts of the unified record that contained frequent handwritten entries (i.e., IPNs, observation notes), the URC made a photocopy of the previous three months. Then she marked up the photocopy in red ink to show every error (e.g., "title," "signature," "legibility"). Individual #99's were presented as an example. She also shared the marked up copies with the discipline leader. This was a very thorough and detailed way to provide specific feedback (although it may have contributed to the amount of time spent on each audit). The MRC was now participating in the facility's QA program. Over the next few months, however, the MRC's monthly (or more) individual meetings with the QA director and SAC should help her to move more rapidly to substantial compliance with all four sections of provision V. To date, not much was being accomplished, as evidenced by the minutes/notes for these meetings. The monitoring team recommends that the MRC (and URC) consider the following: • Develop a good set of data for the listing/inventory • Choose those data that are important to include in the QA matrix, QA report, and for presentation at QAQI Council. • At the current time, the QA report (and presentation to QAQI Council) only included the percentage scores from the statewide tool. Other important data collected by the department were not shared with anyone. This included the graphs of the number of errors and the percentage that were corrected. Other information/data was not summarized, graphed, or trended. Examples included the percentage of items completed correctly on each table of contents tool, and the results of the 100% quarterly record audits. • Use the data to identify problems, and thereby to develop actions (e.g., CAPs). Try to determine where certain problems are most prevalent (e.g., home, discipline department). This should be done for the major problems still plaguing the active records: o Signatures, titles, dates, and times of entries. o Missing documents. o Misfiled documents. • Include house managers (DSP IVs) and unit directors when solving problems with recordkeeping practices (as suggested by the facility director during the QAQI Council section V presentation by the MRC).	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely	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.	Noncompliance

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	utilize such records in making care, medical treatment and training decisions.	Since the last review, no further work was done to address provision V4, other than the continuation of the V4 interviews and the scoring of some items by the URC during her monthly audits. The reader is referred to the previous report for comments that continue to apply to the V4 provision at EPSSLC. The facility was in substantial compliance with none of the six items (0%). The MRC said that the V4 interview tool addressed all six parts of V4, but the monitoring team does not believe that to be possible. Below, the six areas of this provision item are 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: • 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 16 of 16 (100%) individual notebooks in the sample. • DSPs indicated that the individual notebooks were accessible to them. • Medical records were available to medical staff. • In one example, Individual #52's medical records were located with the area designated for medical records. • Records were accessible to the psychiatrist. • The active records were available to the habilitation therapy clinicians (OT, PT, SLP) <u>2. Data are filed in the record timely and accurately</u> For this item (#2), the monitoring team looks to see if the documents in the active record are up to date. This differs from the item immediately below (#3) for which the monitoring team looks to see if current data sheets are being completed expediently and correctly (e.g., behavior data sheets, seizure logs, PNMP logs). EPSSLC was somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews, however, should be used to satisfy this requirement, too. The monitoring team observed that: • Data provided by the facility indicated that 100% of the ISPs developed in the past year were filed within 30 days of development. • A sample of QIDP monthly reviews, however, indicated that data were often not available for review by the QIDP. See section F2d for details of that review.	

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		• A number of individuals who had been served by the PNMT did not have individual discussion log documents or PNMT assessments present in the active records. • Most of the habilitation therapy clinicians' IPNs were handwritten and completed at the time of the contact. Previously, this was done on a treatment note and filed in the habilitation therapy section. Fortunately, this was changed so that IPNs were now used for routine documentation. This was an appropriate system so as to provide key information for access by other team members. • Medical documents were for the most part filed timely and accurately. • Psychiatry documents were for the most part filed timely and accurately. • However, there were frequent omissions of date, time, and legibility. • Medical and nursing records were not in chronological order by date and time of occurrence. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> The monitoring team observed that: • 93% of data cards reviewed had timely data (see K4). This was a dramatic improvement. • There were improvements with regard to the accuracy of data collection per direct care staff and psychology staff. Psychology staff estimated a much greater accuracy in the data collection process. Data were up to date when presented to psychiatry, and graphs were improved and easier to interpret. • Four of 13 (31%) records contained blank/missing entries for individuals' health status information, such as the ADL Flow Sheet, Trigger Flow sheet, etc. • Blood pressures were frequently not recorded. • Habilitation therapy data sheets were not typically utilized for direct therapy, and many of the IPNs lacked a report of actual clinical data as it related to established objectives of intervention. <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 • There was clear review of the active record in the OT/PT and SLP assessments. • Some data in the records was not reviewed, but should be. For instance, the MOSES and DISCUS evaluations were filed in the active record, but were not initialed by the PCPs to indicate review. Furthermore, the evaluation sometimes alluded to signs and symptoms consistent with ADRs or other problems. • The IPNs were problematic because changes in acute care did not consistently consider and include pertinent information about the individual's applicable history, including previous response to treatment (current and recurrent).	

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		• Decisions for referral to the physician related to a change in health care status did not include prior baseline assessment information, for example, vital signs and bowel elimination patterns. • Integrated Progress Notes (IPNs) were not always consistently documented in the Subjective, Objective, Assessment and Plan format, when indicated for assessment. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> The monitoring team found • The V4 interviews provided some good information, but it was not summarized or evaluated in any manner. • Psychiatry clinic staff were noted to utilize other information with regard to making treatment decisions (e.g., psychology evaluations, data graphs, MOSES, DISCUS, nursing information). • Nurses, during the onsite review, were posed questions with regard an individuals' health care changes as to how they made determinations for physician referral or additional assessments were required. The reports varied, however, most reported following of physician orders. <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 intent of this item 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. The monitoring team found the following: • The active records were available during psychiatry clinic. • The active records were available during the PNMT meeting observed for reference and documentation as required. • The QIDP facilitator provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #125 and Individual #114. Data from assessments were entered into these two documents, so that team members could reference current assessments when developing necessary supports. The IDT, however, reported (in some cases) that data presented were not accurate. For example, a monthly weight chart was inserted into Individual #114's IRRF to support his risk rating regarding weight loss. His weight fluctuated over 30 pounds some months. The dietician reported that was inaccurate data. Accurate	

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		data were not available. • The monitoring team attended an ISP for Individual #125, where continuation of a risk rating required the review of current laboratory findings. The RN Case Manager, during the meeting, quickly provided the active record to the physician during the meeting, who reviewed the pertinent laboratory findings in order to proceed with making a determination about cardiac risk. This was good to see. • On the other hand, Individual #52's active record, although available on the unit, was not use to make ongoing treatment decisions about vital signs (i.e., temperature, blood pressure, pulse, respiration, and oxygen saturation) for making decisions regarding physician ordered treatments. • The active records were utilized during medical clinic appointments and neurology-psychiatry clinic. o The records, however, could have been utilized more. For example, during neurology-psychology clinic, there was speculation about whether the individual had a true diagnosis of seizure disorder. The participants did not review the record until the monitoring team asked about the results of the EEG.	

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
ART	Administrative Review Team
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

CMQI	Continuous Medical Quality Improvement
COS	Change of Status
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
DPN	Dental Progress Note
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
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EC	Enteric Coated
EC	Environmental Control
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
EOC	Environment of Care
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
GA	General Anesthesia
GAD	Generalized Anxiety Disorder
GB	Gall Bladder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
GI	Gastrointestinal
GIB	Gastrointestinal Bleed
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
HCV	Hepatitis C Virus
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 Case Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ICO	Infection Control Officer
ICP	Infection Control Preventionist
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
IPMP	Integrated Pest Management Plan
IPN	Integrated Progress Note
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
IRT	Incident Review Team
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
LTBI	Latent TB Infection
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
MIT	Mealtime Improvement Team
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
MTC	Meal Time Coordinator
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
OHI	Oral Hygiene Index
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
PNE	Pneumonia
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)
POC	Polypharmacy Overview Committee
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
PUSH	Pressure Ulcer Scale for Healing
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
QIDP	Qualified Intellectual Disabilities Professional
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
SBO	Small Bowel Obstruction
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
SIT	Skin Integrity Team
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
TLSO	Thoracic Lumbar Sacral Orthotic
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
VAP	Vascular Access Port
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