United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: March 24-28, 2014

Date of Report: May 21, 2014

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Monitor

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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

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal to the Monitor and DOJ for review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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 new facility director, Olga Arciniega, 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 again available, responsive, and helped ensure that the monitoring team was able to conduct its activities as needed.

A brief summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and a full understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

Restraint

- Progress towards compliance had been made in regards to documentation and review of crisis intervention restraints. There were 59 restraints used for crisis intervention involving seven individuals between 9/1/13 and 2/28/14. Individual #181 accounted for 26 of the 59 (44%) restraints used for crisis intervention
- There were four instances of dental/medical restraint from 8/1/13 through 1/31/14 involving four individuals. Additional documentation provided by the facility, however, indicated that 100% of the dental exams were completed using general anesthesia. There was no evidence that IDTs were adequately discussing risks associated with the use of general anesthesia related to risk factors identified for each individual
- The facility reported that no individuals at the facility wore protective mechanical restraints (PMRs) for self-injurious behaviors. The facility had removed protective restraints for two individuals noted at the last visit.

Abuse, Neglect, and Incident Management

- Of 96 allegations investigated by DFPS, there was one confirmed cases of physical abuse and 12 confirmed cases of neglect. The facility reported that 11 other serious incidents were investigated by the facility during this period.
- There were 697 injuries reported between 9/1/13 and 2/28/14, including 10 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and were made available to IDTs for planning.
- While the incident management and quality assurance departments were placing a greater focus on identifying trends of incidents and injuries, it was still not evident that IDTs were proactive in revising supports and monitoring implementation following incidents.
- The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring and was still not adequately developing action plans to address trends of injuries and incidents.

Quality Assurance

- The QA program at EPSSLC continued to make progress. Of the 14 data inventories, 14 (100%) included data that could be used to identify trends as required in the wording of section E1; 7 (50%) included a wide range of data; 14 (100%) included what appeared to be key indicators; 4 (29%) described the data being collected; and 11 (79%) included a self-monitoring tool (or indicated that a self-monitoring tool was not used, with a rationale). None of the items were notated to be a process or an outcome indicator.
- The items in the QA matrix should, but did not, line up with the data list inventory, content of the QAD-SAC 1:1 meetings, content of the QA reports, and presentation at QAQI Council.
- QAD-SAC 1:1 meetings were accomplishing their primary goal: to review data items and data, review and analyze data, and review and create CAPs. Instead, they served as a forum for the department leader to provide an update on a variety of topics related to the Settlement Agreement.

- Continued work was done to improve the CAPs system, including the creation, management, and reporting of CAPs. Substantial compliance was maintained for E3 and achieved, for the first time, for E4.
- Of the 21 CAPs reviewed by the monitoring team, 21 (100%) appeared to appropriately address the specific problem for which they were created. There was, however, no criterion to judge when/if the overall CAP was being met. The facility should ensure that each CAP includes a plan to ultimately assess the problem originally identified.

Integrated Protections, Services, Treatment, and Support

- The facility had made little progress in developing an adequate IDT process for developing, monitoring, and revising treatments, services, and supports for each individual. Recent turnover in the QIDP department had impacted progress made during previous visits. The facility had replaced five of eight QIDPs in the past six months.
- Two annual ISP meetings were observed during the monitoring visit. Both IDTs were struggling with the statewide ISP planning process and what the resulting outcome should be. Both meetings observed were lengthy and did not result in a plan that would ensure meaningful programming and supports.
- The facility did not have an adequate system in place to ensure that plans were implemented and supports were monitored for efficacy. At ISP meetings observed, the IDT was unable to determine whether or not progress had been made towards outcomes or whether supports were effective.

Integrated Clinical Services

- The clinical services director served as the lead for this provision. She had only been in the position for four months prior to the compliance review and had many areas that required attention. Provision G had, therefore, not been the primary area of focus.
- She contacted all departments, not just the clinical departments, to discuss how each integrated with other areas. For each department, a list of activities, which demonstrated integration of clinical services, was created. The monitoring team observed many of these activities throughout the week of the compliance review.
- During the conduct of this review, the monitoring team found that many disciplines were not effectively collaborating to deliver services in and integrated manner. This was having an untoward impact on outcomes for the individuals.

Minimum Common Elements of Clinical Care

- There was no progress noted in this area. The monitoring team met with the clinical services director, who served as the center's lead, to discuss this provision. She had worked at the facility for four months at the time of the compliance review. As the clinical services director, the breadth of her responsibilities was expansive and section H was not the priority. She reported that she learned several important issues about the provision just days before the compliance review.

- Over the past four years, several staff have served in the lead role for section H. Although this provision addresses the fundamental concern of how the facility monitors the delivery of clinical services to ensure that assessments and treatments are timely and appropriate, EPSSLC has never sufficiently addressed the areas covered by this provision.

At-Risk Individuals

- The facility was in the process of retraining QIDPs and IDTs on completing the risk identification process. A large turnover in the QIDP department had necessitated new training on the risk process.
- The monitoring team observed the risk identification process at two ISP meetings and noted progress made with the risk identification process. Notably, each discipline presented relevant information during the risk determination process that was essential for determining risk in each area identified by the IRRF. Both teams engaged in integrated discussion regarding the identification of risks. Integration was less evident, however, in the development of supports to address risks.
- The facility continued to struggle with ensuring that all assessments were completed and available for review prior to annual ISP meetings. Without up-to-date assessment information, it was unlikely that accurate risk ratings could be assigned during annual IDT meetings.
- As noted in section F, the facility did not have an adequate system in place to monitor supports.
- Plans should be implemented immediately when individuals are at risk for harm, and then monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should meet immediately and action plans should be revised.

Psychiatric Care and Services

- Psychiatry services at EPSSLC made progress towards substantial compliance in some provisions, while others did not progress. In some cases, substantial compliance was not maintained.
- Half of the individuals received psychopharmacologic intervention (56 of 113, 49%).
- There were improvements in the consistency of psychiatric diagnoses across the evaluations of different disciplines, and there were improvements in the graphing, presentation, and analysis of data allowing for improved data decision making.
- There were noted improvements in the psychiatric participation in the development of the PBSP. The PSP or "Individual Mental Health/Behavior Plan" had been described via policy and procedure. Problems regarding its implementation and usage for individuals who should have had a PBSP were found.
- All individuals participating in psychiatry clinic had comprehensive psychiatric assessments completed via Appendix B. In addition, peer review indicated scores above the required 80 points.

Psychological Care and Services

- The facility maintained substantial compliance on the six items (K2, K3, K4, K7, K10, and K11) that were in substantial compliance prior to this review, and demonstrated improvements in several additional items. These improvements continued development of behavioral systems to ensure that PBSP data are recorded in a timely fashion, are reliable, and PBSPs are implemented as written. The facility also improved upon the initiation of full psychological assessments, and the percentage of individuals with a PBSP having a functional assessment and a current full psychological assessment. PBSPs were consistently implemented within 14 days of receiving necessary consent.
- Areas that the monitoring team suggests that EPSSLC work on for the next onsite review are to ensure that all graphs are correctly labeled, all functional assessments contain all of the components discussed below, and all counseling services treatment plans/progress notes are consistently complete. The facility must also ensure that each individual that exhibits behaviors that constitute a risk to themselves or others has a PBSP, that all PBSPs contain all the necessary elements and are complete, 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

- Overall, there was minimal progress in the provision of medical services. The progress observed was primarily in the area of preventive care with increased compliance in cancer screenings. For the most part, individuals received basic medical services, such as vision and hearing screenings, hepatitis, and pneumococcal and influenza vaccinations.
- The management of specific medical conditions was more problematic. Diabetes care required improvement to ensure that care was timely. Individuals with pneumonia needed to be assessed to ensure that supports and assessments were appropriate.
- There was also some evidence that the facility needed to address antimicrobial stewardship within the facility. The facility did not have an infection control nurse at the time of the review. The active records had evidence that there were some issues with infection control practices and possible over use of antibiotics. The use of one drug was also problematic. Pseudoephedrine was prescribed to individuals with a history of behavioral issues and orders were written to use for up to 30 days.
- A new clinical services director had the vast responsibility of administrative oversight of the medical, pharmacy, and dental departments. She needed greater direction from the state medical services coordinator in executing her job duties relative to section L if she is to be effective in her role.
- The facility completed medical audits, however, the sample size was not adequate. Additionally, the most recent internal audits were conducted by the prescriber who provided the care. Another physician should have been used.
- The facility submitted several policies and procedures. Generally, the medical department did not have adequate policies and procedures and had no system to effectively manage the development, revision, and tracking of policies and procedures. S

- Obtaining information for this review was challenging. The lead physician was the sole primary care provider on campus. While she was available for interviews, there was no other practitioner to provide primary care services the first three days of the week.

Nursing Care

- Continued progress was evident, including obtaining substantial compliance in provision M6.
- The RN Case Manager Lead was in the process of developing tracking tools to effectively track all Comprehensive Nursing Assessments/Quarterly Nursing Assessments, IRRFs, and IHCPs, to ensure timely assessments. Also RN Case Manager had begun holding individual reviews with the RN Case Managers to ensure content and quality of the content of the assessments.
- The facility reported 100% of the individual's records were reviewed and found 99% were up to date with the Centers for Disease Control (CDC) recommended adult immunizations.
- The Nursing Department had completed 100% of the required training for nurses. The RN Educator developed educational tools to assist nurses in critical thinking and in the development of health care plans.
- The monitoring team observed 17 individual's medication administrations for 51 medications across six homes for consistently following:
    - acceptable standards of practice for medication administration
    - individual PNMP plan
    - infection control practices to include the individual self-participating or assisted by the DSP with his or her hand hygiene prior to the administration of medications

Pharmacy Services and Safe Medication Practices

- Overall, the facility continued to make progress in the provision of pharmacy services obtaining substantial compliance with 7 of the 8 provisions of section N. While the progress made in pharmacy services was noteworthy, the monitoring team remains concerned about the lack of physician leadership.
- Documentation of communication between the pharmacists and prescribers was maintained and the Intelligent Alerts continued to be effectively utilized. Moreover, the pharmacy department used the data generated by these processes to implement corrective actions.
- EPSSLC continued to complete the QDRRs in a timely manner. The process for assessing the risk of metabolic syndrome was enhanced and provided guidance that was more specific. However, the actual criteria for metabolic syndrome will need to be reviewed.
- The MOSES and DISCUS evaluations were completed by nursing staff and reviewed by the psychiatrist. The delays in psychiatry assessments, observed in the September 2013 compliance review, decreased, but documentation submitted

by the pharmacy indicated continued problems with timely completion. The facility's tracking data was not sufficient to determine overall compliance with the requirements for completion.

- The total number of ADRs reported remained relatively low. However, the pharmacy department did a considerable amount of work in this area in terms of educating the medical staff on the importance of ADR reporting. Physician reporting remained low even in the face of clear ADRs.
- The medication variance system made progress in a number of areas, including medication reconciliation, documentation, verification of variances, and improved attendance by the medical staff. There continued to be a lack of reporting of prescribing variances.

Physical and Nutritional Management

- Substantial compliance was maintained for provision O1, and met for the first time for O3, O4, O5, and O6. There was a fully constituted PNMT and the current members were consistent over the last year with the exception of the OTR. There were several new systems that permitted them to better track health status for individuals to ensure prompt referral and review for individuals that needed PNMT supports and services.
- Positioning continued to be improved, with few concerns noted, though transfers should be an area of continued focus over the next six months. There were overall improvements related to mealtimes. The mealtime coordinator system had been implemented, but continued monitoring was needed to ensure they actively embraced their role of oversight for staff in the dining areas.
- There was a significant failure in the case of Individual #25, where both the Mealtime Coordinator and the DSP did not recognize that most of the elements of the plan were implemented incorrectly. There had been numerous revisions to the training and monitoring systems based on careful review and analysis of the previous report and outlined in QA documentation. These also ensured significant gains in these areas.

Physical and Occupational Therapy

- There was continued progress toward substantial compliance in all aspects of provision P. Substantial compliance was maintained for P.1 and obtained for P.3, and continued efforts to improve the content of assessments and timeliness were noted.
- OT, PT, and speech now completed a combined Comprehensive Assessment and Assessment of Current Status. The assessments were exceptional as to content and the issues now were not related to comprehensiveness as they had come full circle since the baseline review.
- There were few direct intervention plans in place for individuals with OT/PT needs and those reviewed were not well documented with an assessment and discharge summaries.
- Consistent documentation of direct supports and review of indirect supports was needed, using the guidelines outlined in this report with regard to content.

- The therapy clinicians are excellent and truly dedicated. Early on in this process, the monitoring team encouraged them to integrate clinical services into the real life, daily routine of every individual and they have fully embraced this.

Dental Services

- EPSSLC made no progress in the provision of dental services. In fact, there was evidence that dental services deteriorated since the last compliance review. During that review, a number of serious issues surfaced and the facility did not appear to make any serious attempts to correct the issues in a timely manner.
- It could not be determined if individuals received adequate dental care because the documentation was inadequate and there was no evidence during this review that the deficiencies were corrected. The facility did not have a dentist at the time of the compliance review.
- The facility documented that during the reporting period, 55% of annual dental assessments were completed in a timely manner. This poor compliance score did not result in any particular corrective action plan.
- Oral hygiene continued to be tracked, but data showed that good hygiene ratings decreased and fair ratings increased. In February 2014, habilitation services and the dental department began collaborating to conduct monitoring in the homes related to positioning, equipment use, oral care, and education of the direct support professionals.
- The data submitted by EPSSLC were not reliable and this has been a cause for concern over a period of years. The reason for this is not clear. However, this report points out that the facility was currently not capable of providing accurate data related to the provision of dental services. This was evident with the data related to general anesthesia that required correction, the inaccurate failed appointments data, and the total clinic data that was obviously incorrect.
- It is of paramount importance that the use of general anesthesia at EPSSLC be clarified. At the time of the compliance review, based on data and interviews, it appeared that few options were available to individuals. Individuals either fully cooperated to have procedures done or general anesthesia (the most restrictive and invasive alternative) was utilized. While minimal sedation may not be appropriate for some individuals, it appeared that EPPSLC had taken the approach that it was not used.

Communication

- There was continued, steady progress toward substantial compliance in all aspects of provision R, including maintaining substantial compliance with R1 and achieving substantial compliance with R2. There were currently two full time, very talented, speech clinicians on staff and a SLPA.
- Efforts to improve the content of communication assessments were evident.
- While the collaboration between psychology and SLPs was a developing strength, continued effort was indicated to ensure integration of the recommendations in the communication assessment into the PBSP.
- Consistent documentation of direct supports and review of indirect supports was needed.

- Activities observed in the group areas were excellent, with effective modeling by speech clinicians. The DSP staff did not appear to understand the purpose of this: to ensure that they need to integrate meaningful communication, learning, and social interaction into all activities throughout the day (i.e., not only during a special activity conducted one time a week with speech staff).
- Staff should be encouraged to get together to brainstorm how to do this creatively with existing materials, as well as, to identify new materials and activities that are functional, age-appropriate, and meaningful.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were improvements, such as a reorganization of the writing, monitoring, and training of SAPs, improvements in the quality of SAP maintenance and generalization plans, improved engagement monitoring tool, and continued support of public school students' educational programming.
- The facility needs to focus on ensuring that each SAP contains a rationale for its selection, has a plan for maintenance and generalization, and contains operational definitions and training instructions. SAPs and service objectives need to be differentiated. Engagement should be tracked across all treatment areas, trends reviewed, and acceptable levels of engagement in each treatment area established. Ensure that monthly SAP reviews consistently occur, graph monthly SAP outcomes, and ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are data based. The facility should track skill training in the community and establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community.

Most Integrated Setting Practices

- The facility made a lot of progress in section T. Eight provisions were found to be in substantial compliance. Many of the other provisions were close to substantial compliance. In the report below, the monitoring team details what needs to be done to put some of these "close" provisions into substantial compliance:
- Five individuals were placed in the community since the last onsite review. 11 individuals were on the active referral list. Of the 9 individuals who moved in the past 12 months, 1 had one or more untoward events that occurred within the past six months (11%), but this was a non-serious event that did not threaten the success of the placement.
- The APC, PMM, and TSs continued to do an outstanding job in working with family members and LARs to fully engage them in the educational, referral, and transition processes. As a result, a number of individuals were newly referred.
- Post move monitoring continued to be implemented as required and maintained substantial compliance. 12 post move monitorings for 5 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed-up when action was needed.

Guardianship and Consent

- This provision received no monitoring based upon the parties' agreement due to limited or no progress.

Recordkeeping Practices

- EPSSLC made good progress on provisions V1 and V3, and limited progress on V2 and V4. Fifteen of 15 (100%) individuals' records reviewed included an active record, individual notebook, and master record.
- The status of the active records maintained since the last review. About a dozen errors/missing documents were found per active record, plus there were errors in legibility, signatures, etc. Further, the number of documented errors was self-reported to be increasing in the facility's graph line (i.e., from 12 documented errors per record to 16 per record, September 2013 to February 2014).
- A daily 7-page observation note form was initiated since the last onsite review. Its use should be reviewed by the facility. Most SAPs did not have a data sheet in the individual notebook. If data were supposed to be recorded elsewhere, it should be indicated in the individual notebook.
- A master record existed for every individual at EPSSLC and all were in a format that was organized, manageable, and described in previous reports. All were converted to the most current format.
- Five quality assurance reviews (audits) were conducted in each of the previous six months. All of the reviews were done in a consistent manner, using their new 22-page tool, and were neatly and clearly documented.
- The system of actions following the conduct of the audits remained the same. The facility was obtaining some good data regarding the status of the unified record, changes over time, and corrections of errors. However, the information was not being reviewed adequately by the recordkeeping staff, QA department, in the QA report, or in the presentations to QAQI Council.
- For provision V4, they did more work on this than at the time of the previous review, however, their proposed activities for each of these six aspects of V4, although a good start, were insufficient.

Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o DADS Policy: Use of Restraints #00.1
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
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 List of individuals for whom general anesthesia was used to complete dental exams.
o Sample #C.1: 14 records of physical restraints 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 were:
<table>
<tr><th>Individual</th><th>Type of Restraint</th><th>Date</th></tr>
<tr><td>#181</td><td>Physical</td><td>1/29/14 @ 4:02 pm</td></tr>
<tr><td>#181</td><td>Physical</td><td>1/29/14 @2:56 pm</td></tr>
<tr><td>#181</td><td>Physical</td><td>1/26/14</td></tr>
<tr><td>#181</td><td>Physical</td><td>12/27/13</td></tr>
<tr><td>#181</td><td>Physical</td><td>1/21/14</td></tr>
<tr><td>#13</td><td>Physical</td><td>1/21/14</td></tr>
</table>
</td></tr>
</table>

#13	Physical	1/16/14
#13	Physical	1/14/14
#13	Physical	12/29/13
#149	Physical	1/19/14
#149	Physical	1/14/14
#39	Physical	1/22/14
#39	Physical	12/20/13
#109	Physical	1/2/14

- Sample #C.2 was documentation 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 and
    - Training on the use of restraint.

- Sample #C.3 was a sample of documentation for pretreatment sedation chosen from the last four medical/dental restraints including 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 desensitization plan.

Individual	Restraint type
#188	1/31/14
#23	11/19/13
#73	1/17/14
#32	11/20/13

- 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 zero. No sample used.

- Sample #C.5: Was selected from a sample of restraints that occurred off-campus. The facility reported only one restraint.

Individual	Date
#181	12/27/13

- 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:
  - PBSPs, crisis intervention plans, and individual support plan addendums (ISPAs) for:
    - Individual #31, Individual #181

	○ Sample #C.7 was not used. The facility reported that there were no individuals for whom protective mechanical restraints were used in the past six months. Interviews and Meetings Held: ○ Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; ○ Carmen Molina, Director of Behavioral Services ○ Martha Davis, Behavioral Specialist ○ Mario Gutierrez, Incident Management Coordinator ○ Alice Villalobos, QIDP Coordinator Observations Conducted: ○ Observations at residences and day programs ○ Incident Management Review Team Meeting 3/24/17/14, 3/26/14, and 3/27/14 ○ Morning Unit Meeting 3/24/14, 3/26/14, and3/27/14 ○ ISP preparation meeting for Individual #67 and Individual #157 ○ Annual IDT Meeting for Individual #88 and Individual #188 ○ ISPA for Individual #161 regarding restraints
	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 Director of Behavioral Services was responsible for the self-assessment process. She engaged in a self-assessment process that included a review of a sample of restraints, training documentation, ISPs, and other IDT documents regarding the use and review of restraints, and data collected by the facility regarding restraints. The facility assigned a self-rating of substantial compliance to C1, C2, C3, C5, and C8. The monitoring team agreed with the facility's substantial compliance ratings for C2 and C8. Compliance could not be confirmed with the requirements of C1 and C5 based on the sample reviewed. A change in the way that restraints were documented contributed to this finding. The facility was now documenting multiple restraints on one restraint checklist. It was no longer clear what behavior led to the restraint or what interventions staff attempted prior to restraint. For C3, the facility was still not ensuring that employees received annual training on the use of restraint.

	Summary of Monitor's Assessment: Based on a list of all restraint data provided by the facility, there were 59 restraints used for crisis intervention involving seven individuals between 9/1/13 and 2/28/14. The number of restraint incidents had increased since the last onsite review when it was reported that there had been 32 restraints during the review period. Individual #181 accounted for 26 of the 59 (44%) restraints used for crisis intervention. The three individuals with the greatest number of restraints accounted for 83% of the total restraints. A log of all dental/medical restraints provided by the facility included four instances of dental/medical restraint from 8/1/13 through 1/31/14 involving four individuals. Additional documentation provided by the facility, however, indicated that 100% of the dental exams were completed using general anesthesia. There was no evidence that IDTs were adequately discussing risks associated with the use of general anesthesia related to risk factors identified for each individual (i.e., drug interactions, cardiac issues, osteoporosis, aspiration risk). Furthermore, it was not evident that least restrictive interventions were considered or attempted prior to the use of general anesthesia. The facility reported that no individuals at the facility wore protective mechanical restraints (PMRs) for self-injurious behaviors. The facility had removed protective restraints for two individuals noted at the last visit. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C. Observations in the homes and day programs and interviews with staff were conducted the week of the monitoring visit to gain additional information. Although the facility remained out of compliance with six of eight provision items in section C, Some progress towards compliance had been made in regards to documentation and review of crisis intervention restraints. To move forward, the facility should continue to focus on: • Ensuring that restraint documentation clearly describes behavior that led to the restraint and documents all interventions attempted prior to the use of restraint. • Ensuring that nursing reviews for all restraint incidents are completed and appropriately documented following state policy guidelines. • Ensuring that restraints used to complete routine dental exams are the least restrictive intervention necessary and that less restrictive interventions have been considered or attempted. • Ensuring that IDTs engage in a thorough discussion regarding the risk associated with completing routine exams under general anesthesia for each individual. • Ensuring that all employees receive annual training within the required timelines.

<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.6),

<table>
<tr><th>Type of Restraint</th><th>March 2013-Aug 2013</th><th>Sept 2013-Feb 2014</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>32</td><td>59</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>2</td><td>0</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>34</td><td>59</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>6</td><td>7</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>1</td><td>3</td></tr>
<tr><td>Medical/dental restraints</td><td>13</td><td>4</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>10</td><td>4</td></tr>
<tr><td>Protective mechanical restraints</td><td>2</td><td>0</td></tr>
</table>

The facility was now documenting multiple restraints as one restraint incident when they occurred in succession, thus, it was difficult to compare restraint data from the previous onsite visit with more recent data. Five of the restraint checklists in the sample documented more than one restraint. In two of five instances, the individual was released because staff could not maintain a correct hold, then immediately restrained again.

<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 9/1/13 and 2/28/14) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 9/1/13 and 2/28/14. Sample #C.1 was a sample of 14 restraints for five individuals, representing 24% of restraint records over the last six-month period and 71% of the individuals involved in restraints. The sample included 14 physical restraints. Sample #C.1 included three individuals with the greatest number of restraints, as well as two individuals who were subject to some of the most recent</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		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. <u>Other Restraint Requirements</u> e. Based on document review, the facility and state 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 13 of the 14 records (93%), there was documentation showing that the individual posed an immediate and serious threat to self or others. a. The restraint checklist for Individual #181 dated 12/27/13 indicated that he was restrained three times within 75 minutes. The restraint checklist indicated that he was released from one physical restraint, then restrained again 66 minutes later. Staff did not describe behavior exhibited prior to the second and third restraints. When multiple restraint are documented on one restraint form, staff will need to document the behavior that necessitated the restraint for each restraint documented. • g. For the 14 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 11 (79%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. b. Restraint checklists for Individual #181 dated 1/26/14, 1/21/13, and 12/27/13 each documented more than one restraint. Staff did not document the behavior leading to the second restraint on the restraint checklists. • h. In 11 of the records (79%), 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. c. The restraint checklist for Individual #181 dated 1/26/14 indicated that he was released from one physical restraint, then restrained again eight minutes later. Staff did not describe interventions attempted between	

#	Provision	Assessment of Status	Compliance
		the two restraints. d. Similarly, Individual #181 was restrained on 1/21/14 for aggression towards staff. Staff failed to describe interventions attempted prior to a second restraint nine minutes later. When multiple restraint are documented on one restraint form, staff will need to document interventions attempted prior to each restraint in order to determine if staff attempted less restrictive interventions each time prior to using restraint. e. The restraint checklist for Individual #181 dated 12/27/13 indicated that he was restrained three times within 75 minutes. The restraint checklist did not document interventions attempted prior to the second and third restraint, thus it was not possible to determine if restraint was the least restrictive option. • i. Facility policies identified a list of approved restraints. • j. Based on the review of 14 restraints, involving five individuals, 14 (100%) were approved restraints. k. In 14 of 14 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. l. The facility reported that there were no individuals subjected to restraints classified as protective mechanical restraints (PMRs). 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. When multiple restraint are documented on one restraint form, staff will need to document the behavior that necessitated the restraint for each restraint documented. 2. When multiple restraint are documented on one restraint form, staff will need to document interventions attempted prior to each restraint in order to determine if staff attempted less restrictive interventions each time prior to using restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 14 physical restraint records involving the five individuals in Sample #C.1 were reviewed. Three individuals in the sample had a Crisis Intervention Plan that defined the use of restraint. a. For the individuals involved in physical restraint who had a Crisis Intervention Plan (Individual #181, Individual #13, and Individual #149), 11 of 11 (100%) 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		b. For the two individuals who did not have Crisis Intervention Plans, three of three (100%) restraints 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 was in substantial compliance with C2.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	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 20 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: • 23 of the 24 (96%) had current training in RES0105 Restraint Prevention and Rules. • 13 of the 19 (68%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training • 23 of the 24 (96%) had completed PMAB training within the past 12 months. • 17 of the 19 (89%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. d. In 11 of the records (79%), 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. (see C.1.h)	Noncompliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use	a. Based on a review of 14 restraint records (Sample #C.1), in 13 (93%) there was evidence that documented that restraint was used as a crisis intervention. See C1f. b. Three of five individuals in the sample had a Positive Behavior Support Plan in place.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	In review of Positive Behavior Support Plans for three individuals in the sample, 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, except for protective mechanical restraints for SIB. d. In 14 of 14 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders. The facility "Do Not Restrain" list only included one individual. At the annual IDT meetings observed, it was not evident that IDTs were engaging in adequate discussion regarding the risk associated with restraint for each individual at the facility. e. A list of all medical/dental restraints was requested by the monitoring team (II.9). The facility reported that four restraints were used to complete routine medical appointments from 8/1/13 through 1/31/14. A review of those four restraints, showed no evidence that the restraint used was not in contradiction to the individual's medical orders. The facility failed to report, however, that 100% of the individuals seen by the dental department in the past six months received general anesthesia for routine exams and dental cleaning appointments. It was not evident that IDTs were considering the risks associated with the use of general anesthesia for each individual in regards to other identified risks (i.e., medication interactions, risk for aspiration, cardiac disease) f. In 14 of 14 restraint records reviewed in Sample #C.1 (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. In reviewing documentation from Sample #C.3 for individuals for whom restraint had been used for the completion of medical or dental work: • g. Four (100%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC)) approval and adequate consent. • h. Four (100%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. Based on this review, the facility was not in substantial compliance with C4. To gain substantial compliance, the facility needs ensure that the IDT has discussed the use of restraint and strategies that might reduce the need for future restraint and ensured that the least restrictive intervention was used. The prevalent use of general anesthesia to complete routine dental exams should be further reviewed.	

#	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. Sixty-seven staff had been deemed competent to monitor restraints. This included the behavioral health specialists, campus supervisors, residential supervisors, and campus administrators.
		
		c. Based on review of document request II.19, staff who 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.
		
		Based on a review of 14 restraint records (Sample #C.1), a face-to-face assessment was conducted:
		• d. In 14 out of 14 incidents of restraint (100%) by an adequately trained staff member.
		• e. In 14 out of 14 instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint.
		• f. In 14 instances (100%), the documentation showed that an assessment was completed of the application of the restraint.
		• g. In 14 instances (100%), 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 13 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 12 (92%) of the instance of restraint. The exception was:
		  ○ Individual #39 on 12/20/13. (page missing from restraint documentation)
		• k. Monitored and documented vital signs in 12 (92%). The exceptions were:
		  ○ Individual #39 on 12/20/13
		• l. Monitored and documented mental status in 12 (92%). The exception was:
		  ○ Individual #39 on 12/20/13
			Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on documentation provided by the facility, one restraint incident had occurred off the grounds of the facility in the last six months. A sample of one restraint incident was reviewed (sample #C.5), for Individual #181. • m. Conducted monitoring within 30 minutes of the individual's return to the facility in zero out of one (0%). The restraint documentation did not indicate when the individual returned to the facility. The nurse completed an assessment 83 minutes after the restraint occurred. • n. Monitored and documented vital signs in one (100%). • o. Monitored and documented mental status in one (100%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months, • p. In three out of three(100%), the physician specified the schedule of monitoring required or specified facility policy was followed; and • q. In ___ out of ___ (n/a), the physician specified the type of monitoring required if it was different than the facility policy. r. In two out of four of the medical restraints (50%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Exceptions were: • Individual #23 on 11/19/13 – monitoring by the nurse was not continued with the frequency ordered by the physician. • Individual #73 on 1/17/14 – monitoring by the nurse was not completed with the frequency ordered by the physician. 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: 1. A licensed healthcare professional monitors and documents vital signs and mental status of an individual with the frequency ordered by the physician.	
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	A sample (Sample #C.1) of 14 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 14 (100%), continuous one-to-one supervision was provided; • b. In 14 (100%), the date and time restraint was begun; • c. In 14 (100%), the location of the restraint; • d. In 11 (73%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. See C.1.g.	Noncompliance

#	Provision	Assessment of Status	Compliance

	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.	• e. In 11 (73%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. See C.1.h.
		• f. In 14 (100%), the specific reasons for the use of the restraint;
		• g. In 14 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint;
		• h. In 14 (100%), the names of staff involved in the restraint episode;
		• Observations of the individual and actions taken by staff while the individual was in restraint, including:
		  ○ i. In 13 (93%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The restraint checklist for Individual #39 dated 12/30/13 did not include documentation of observation at release.
		  ○ j. In ____ (n/a) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint. The longest physical restraint in the sample was 10 minutes.
		  ○ k. In _____ (n/a), 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.
		• l. In 14 (100%), the level of supervision provided during the restraint episode;
		• m. In 14 physical restraints (100%), the date and time the individual was released from restraint; and
		• n. In 14 (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 14 records (Sample #C.1), restraint debriefing forms had been completed for 14 (100%).
		
		p. A sample of four individuals subject to pretreatment sedation for medical treatment was reviewed (Sample #C.3), and in two of four (50%), there was evidence that the monitoring had been completed as required by the physician's order or state policy. Exceptions were:
		• Individual #23
		• Individual #73
		
		q. In _____ (n/a - there were no chemical restraints reported), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the behavior specialist or psychiatrist, who assessed whether less intrusive interventions were available and whether or not conditions for administration	

#	Provision	Assessment of Status	Compliance
		of a chemical restraint had been met. The facility was not in substantial compliance with documentation requirements of this provision.	
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, three individuals were placed in restraint more than three times in a rolling 30-day period. This represents an increase from the last review when one individual was placed in restraint more than three times in a rolling 30-day period. Two of these individuals (Individual #13 and Individual #181) were reviewed by the monitoring team to determine if the requirements of the Settlement Agreement were met (the third individual was no longer at the facility at the time of the onsite review). PBSPs, crisis intervention plans, and individual support plan addendums (ISPA) that occurred as a result of more than three restraints in a rolling 30-day period were requested for both individuals. The monitoring team did not receive a PBSP or any ISPAs for individual #181. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. EPSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because not every individual who met criterion had documentation of an ISPA meeting following more than three restraints in a rolling 30-day period. Individual #13's ISPA minutes did reflect a discussion suggesting that a recent tapering of medications may have contributed to an increase in his physical aggression which provoked restraint. Additionally, the minutes of his ISPA reflected a plan to discontinue the tapering of medication. In order to achieve substantial compliance with this provision item, the minutes from at least 85% of the individual ISPA meetings following more than three restraints in a rolling 30-day period should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(b) review possibly contributing environmental conditions;	EPSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because not every individual who met criterion had documentation of an ISPA meeting following more than three restraints in a rolling 30-day period occurred. Individual #13's ISPA reflected a discussion of potential contributing environmental factors (e.g., noisy or crowded environments), and concluded that these did not contribute to his restraints. In order to achieve substantial compliance with this provision item, the minutes from 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should review possibly contributing environmental conditions, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item was rated as being in noncompliance because not every individual who met criterion had documentation of an ISPA meeting following more than three restraints in a rolling 30-day period occurred, and Individual #13's ISPA did not reflect a discussion of potential antecedents (e.g., over prompting, attending to other individuals, etc.) to the behaviors that provoke restraint. In order to achieve substantial compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should review potential environmental antecedents, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item was rated as being in noncompliance because not every individual who met criterion had documentation of a ISPA meeting following more than three restraints in a rolling 30-day period occurred, and the available ISPA did not reflect a discussion of the variables potentially maintaining the behavior provoking restraints, and suggestions for modifying them to prevent the future probability of restraint. In order to achieve compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should reflect a discussion of the variables maintaining the dangerous behavior that provokes restraint. The ISPA minutes should also reflect an action to address this potential source of motivation for the target behavior that provokes restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(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;	EPSSLC's self-assessment indicated that this provision item was in substantial compliance. This provision item was rated as being in noncompliance because, at the time of the onsite review, Individual #181 did not have a PBSP to address the behaviors provoking his restraint. Individual #13 had a PBSP. The following were found: • This PBSP specified the objectively defined behavior to be treated that led to the use of the restraint, • This PBSP specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, and • This PBSP specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint • This PBSP contained interventions to weaken or reduce the behaviors that provoked restraint that was based on the functional assessment results. Both Individual #13 and Individual #181 had a crisis intervention plan. The following was found: • Both crisis intervention plans reviewed (100%) delineated the type of restraint authorized, • Both crisis intervention plans reviewed (100%) specified the maximum duration of restraint authorized, • Both crisis intervention plans reviewed (100%) specified the designated approved restraint situation, and • Both crisis intervention plans reviewed (100%) specified the criteria for terminating the use of the restraint. In order to achieve compliance with this item a PBSP and crisis intervention plan will need to be presented for each individual having more than three restraints in a rolling 30-day period. Additionally, at least 85% of these individuals' PBSPs and crisis intervention plans will need to contain the above components.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a	EPSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because there was no PBSP for Individual #181. In order to achieve compliance with this item, there will need to be evidence that each individual with three or more restraints in a rolling 30 days had a PBSP that was implemented as written (i.e., treatment integrity level of at least 80%).	Noncompliance

#	Provision	Assessment of Status	Compliance
	targeted behavior; and		
	(g) as necessary, assess and revise the PBSP.	EPSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because there was no PBSP for Individual #181, and Individual #13's ISPA did not document that the treatment team reviewed his PBSP. In order to achieve substantial compliance with this provision item, 85% of the individuals who were placed in restraint more than three times in a rolling 30-day period should have evidence of a review (in the ISPA), and revision when necessary, of the PBSP.	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.	The facility had a restraint review system in place for all crisis intervention restraints. All restraints continued to be reviewed by the behavior specialist, unit directors, and IMRT. The facility had an IMRT restraint discussion documentation form in place to document the review of all restraints. The form included documentation of any problems with implementation and/or errors in documentation of the restraint. A sample of documentation related to 14 incidents of crisis intervention restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 13 (93%), 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. The exception was: o Individual #181 on 1/26/14 • b. In 13 (93%), 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 exception was: o Individual #181 on 1/26/14 • c. In 14 (100%), 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. • d. In 14 (100%), the review conducted by the restraint monitor and/or behavior specialist 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 restraint monitor, behavior specialist, and/or the unit director documented recommendations from their review for the restraints in sample #C.1. Follow up to recommendations was documented for 14 (100%) recommendations.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• f. Of the five referred to the team, in four (80%) appropriate changes were made to the individuals' ISPs and/or PBSPs. ○ The IMRT discussion form indicated that Individual #13's IDT would meet on 12/31/13 following a restraint incident on 12/29/13. There was no documentation that the IDT met. • A review of restraint documentation in the sample indicated that IDTs were following up on other recommendations (i.e., retrain staff, referral to the psychiatrist or PCP). Based on this review, the facility was in substantial compliance with review requirements.	

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:** Documents Reviewed: 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 EPSSLC Policy: Incident Management: Protection from Harm revised 11/18/13 o Incident Management Review Committee meeting minutes for each Monday of the past six months o Unit Meeting Minutes for the past six months o QA/QI report for the past two quarters o Abuse/Neglect/Exploitation Trend Reports for the past two quarters o Injury Trend Reports for the past two quarters 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 8/1/13 o All injury report for the past six months for any individual sustaining a serious injury o List of all ANE allegations since 8/1/13 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 ISP, ISPAs, and QIDP monthly reviews for Individual #111 o ISPs for Individual #181, Individual #84, Individual #49, Individual #79, Individual #65, Individual #109, Individual #81, Individual #125, Individual #46, and Individual #149. o Documentation from the following completed investigations, including follow-up:

Sample D.1.	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#43027163	Neglect (2)	Unconfirmed (1) Confirmed (1)	2/13/14 1:18 pm	2/13/14 5:00 pm	2/19/14
#43026622	Physical Abuse	Unconfirmed	2/13/14 4:04 am	2/13/14 1:40 pm	2/23/14
#43026254	Physical Abuse	Inconclusive	2/12/146: 6:55 pm	2/14/14 3:00 pm	2/22/14
#43021745	Emotional/Verbal Abuse (2) Physical Abuse (2)	Unconfirmed (2) Unconfirmed (2)	2/9/14 1:24 am	2/9/14 12:26 pm	2/19/14

#43021538	Physical Abuse	Unconfirmed	2/8/14 3:34 pm	2/9/14 11:45am	2/18/14
#43016026	Emotional/Verbal Abuse (2) Neglect (1)	Unconfirmed (2) Other	2/4/14 1:41 pm	2/6/14 1:05 pm	2/7/14
#43016635	Neglect (2)	Confirmed (1) Unconfirmed (1)	2/4/14 7:30 pm	2/5/14 3:52 pm	2/20/14
#43013085	Physical Abuse	Unconfirmed	2/1/14 9:02 am	2/1/14 3:38 pm	2/11/14
#43006282	Neglect	Unconfirmed	1/27/14 2:03 pm	1/28/14 5:45 pm	2/7/14
#43006819	Neglect (2) Physical Abuse (1)	Confirmed (2) Unconfirmed (1)	1/27/14 7:27 pm	1/28/14 5:00 pm	2/14/14
#43004937	Physical Abuse	Confirmed	1/25/14 9:53 am	1/25/14 6:46 pm	2/4/14
#43004155	Neglect	Inconclusive	1/24/14 1:30 pm	1/24/14 6:09 pm	2/7/14
#43000444	Neglect (2)	Confirmed (1) Inconclusive (1)	1/21/14 8:41 pm	1/23/14 11:50 am	1/31/14
#42904702	Neglect (4)	Unconfirmed (2) Confirmed (2)	10/17/13 10:34 pm	10/18/13 1:33 pm	10/31/13
#42917757	Neglect	Referred Back	10/30/13 1:07 am		11/8/13
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**	**Date/Time Incident Reported**	**Date Completed**	
#14-089	Serious Injury	3/9/14 5:45 pm	3/9/14 5:20 pm	3/13/14	
#14-065	Serious Injury	1/21/14 8:20 pm	1/21/14 8:30 pm	1/22/14	
#14-055	Serious Injury	12/21/13 4:57 am	12/21/13 5:00 am	12/23/13	
#14-005	Serious Injury Peer to Peer Aggression	8/14/13 12:05 pm	9/14/13 12:05 pm	9/17/13	

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Carmen Molina, Director of Behavioral Services

	○ Martha Davis, Behavioral Specialist ○ Mario Gutierrez, Incident Management Coordinator ○ Alice Villalobos, QIDP Coordinator <u>Observations Conducted</u>: ○ Observations at residences and day programs ○ Incident Management Review Team Meeting 3/24/17/14, 3/26/14, and 3/27/14 ○ Morning Unit Meeting 3/24/14, 3/26/14, and3/27/14 ○ ISP preparation meeting for Individual #67 and Individual #157 ○ Annual IDT Meeting for Individual #88 and Individual #188 ○ ISPA for Individual #161 regarding restraints
	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. For example, for D1, the facility reviewed policies, training records, and the database to track disciplinary action. The facility's review of its own performance found compliance with 21 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 19 of 22 provisions. Three of six items reviewed (due to the streamlined monitoring procedures in place for this section) were found to be in substantial compliance. The monitoring team did not confirm compliance with the requirements of D2c, D3i, and 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. The focus of the review should be on the quality of recommendations and follow up to issues noted during the investigation process and positive outcomes in reducing the number of incidents and injuries at the facility.

	Summary of Monitor's Assessment: According to a list provided by EPSSLC, DFPS conducted investigations of 96 allegations at the facility between 9/1/13 and 2/28/14, including 34 allegations of physical abuse, eight allegations of verbal/emotional abuse, one allegation of sexual abuse, 53 allegations of neglect, and no allegations of exploitation. Of the 96 allegations, there was one confirmed cases of physical abuse and 12 confirmed cases of neglect. The facility reported that 11 other serious incidents were investigated by the facility during this period. There were a total of 697 injuries reported between 9/1/13 and 2/28/14. These 697 injuries included 10 serious injuries resulting in fractures or sutures. This indicated an overall increase in the number of injuries reported the previous six-month period. Injury trends were being generated by individual and were made available to IDTs for planning. While the incident management and quality assurance departments were placing a greater focus on identifying trends of incidents and injuries, it was still not evident that IDTs were proactive in revising supports and monitoring implementation following incidents. The parties agreed that there would be no monitoring for 16 of the 22 section D provisions that were found to be in substantial compliance during the last three or more monitoring visits. During this review, the monitoring team found the facility to be in substantial compliance with three out of six provisions of section D that were reviewed. Provision items found not to be in compliance were: • D2c: The facility was still not ensuring that staff completed training on identifying and reporting abuse and neglect on an annual basis. • D.3.i: The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring. • D.4: The facility was still not adequately developing action plans to address trends of injuries and incidents.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with		

#	Provision	Assessment of Status	Compliance
	full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The state policy required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement. According to a list of all abuse, neglect, and exploitation investigations, there were 76 investigations involving 96 allegations of abuse, neglect, or exploitation conducted by DFPS at the facility between 9/1/13 and 2/28/14. From these 96 allegations, there were: • 34 allegations of physical abuse including, o 1 confirmed o 20 unconfirmed o 8 inconclusive o 1 unfounded o 1 referred back for further investigation o 3 unknown • 8 allegations of verbal/emotional abuse including, o 0 confirmed o 6 unconfirmed o 2 inconclusive • 1 allegation of sexual abuse including o 1 unconfirmed • 53 allegations of neglect including, o 12 confirmed o 28 unconfirmed o 4 inconclusive o 6 referred back to the facility for further investigation o 3 unknown • 0 allegations of exploitation	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		According to a list provided by the facility, there were 11 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included: • 8 serious injuries/determined cause, • 1 serious injuries from peer-to-peer aggression, • 1 serious injury/undetermined cause • 1 sexual incidents, • 0 choking incident, • 0 suicide threats, • 0 encounters with law enforcement, • 0 unauthorized departures, and • 0 deaths. From all investigations since 9/1/13 reported by the facility, 19 investigations were selected for review. The 19 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 (15 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (4 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. 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, six of six (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. All staff were required to wear a badge with reporting requirements listed on the back of the badge.	

#	Provision	Assessment of Status	Compliance
		Metric 2.a.5: Based on responses to questions about reporting, six of six (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 15 investigation reports included in Sample #D.1: • Metric 2.a.6: 15 (100%) 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. • Metric 2.a.7: 15 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o 15 of 15 (100%) indicated the facility director or designee was notified of the incident within one hour. o 15 of 15 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. o 15 of 15 (100%) documented that the state office was notified as required. • Metric 2.a.8: For the allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, 0 UIRs (n/a) included recommendations for corrective actions. Based on a review of four investigation reports included in Sample #D.2: • Metric 2.a.9: Four (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. • Metric 2.a.10: Four (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. • Metric 2.a.11: For unusual/serious incident for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folders (n/a) included recommendations for corrective actions. 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 19 investigation reports included in Samples #D.1 and #D.2, 19 (100%) contained a copy of the report utilizing the required standardized format and were completed fully.	

#	Provision	Assessment of Status	Compliance
		The facility was in substantial compliance with the requirements of D2a.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 12 of the 20 (60%) 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 20 (75%) 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		for annual training.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(g) Procedures for referring, as	The parties agreed the monitoring team would not monitor this provision because the	Substantial

#	Provision	Assessment of Status	Compliance
	appropriate, allegations of abuse and/or neglect to law enforcement.	facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.		
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 noted the date and time of initial contact with the alleged victim. (The one investigation referred back to the facility for further review were not used in this sample). o Contact with the alleged victim occurred within 24 hours in 12 of 14 (86%) investigations. Exceptions were DFPS cases #43016635 and #43000444. o Documentation showed that some type of investigative activity took place within the first 24 hours in all cases (100%). This included gathering documentary evidence and making initial contact with the facility. • For investigations in sample #D.1, 12 of 15 (80%) were completed within 10 calendar days of the incident. Extensions were filed for three investigations. The investigations not completed within 10 days: o Case #43016635 was submitted on the 16th day (AP was not available for interview).	Substantial Compliance

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		○ Case #43006819 was submitted on the 17th day (additional time needed for interviews). ○ Case #43004155 was submitted on the 14th day (the facility needed to gather additional documentation). • All 15 (100%) resulted in a written report that included a summary of the investigation findings. • In 10 of 15 (67%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. One of those cases resulted in a referral back to the facility for further investigation. <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 four of four cases (100%). • Four of four (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Four of four (100%) included appropriate recommendations for follow-up action to address the incident. The facility was in substantial compliance with the requirement of D3e.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness	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: • Metric 3.f.3: In 15 out of 15 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: ○ Metric 3.f.4: In 15 (100%), each unusual/serious incident or allegations of wrongdoing; ○ Metric 3.f.5: In 15 (100%), the name(s) of all witnesses; ○ Metric 3.f.6: In 15 (100%), the name(s) of all alleged victims and perpetrators; ○ Metric 3.f.7: In 15 (100%), the names of all persons interviewed during	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	the investigation; o Metric 3.f.8: In 15 (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 15 (100%), all documents reviewed during the investigation; o Metric 3.f.10: In 15 (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 15 (100%), the investigator's findings; and o Metric 3.f.12: In 15 (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 four out of four investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: o Metric 3.f.14: In four (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.15: In four (100%), the name(s) of all witnesses; o Metric 3.f.16: In four (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.17: In four (100%), the names of all persons interviewed during the investigation; o Metric 3.f.18: In four (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 four (100%), all documents reviewed during the investigation; o Metric 3.f.20: In four (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 four (100%), the investigator's findings; and o Metric 3.f.22: In four (100%), the investigator's reasons for his/her conclusions. According to the Incident Management Coordinator, the facility continued to document	

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		concerns in each review and requested a review of findings for any case that did not provide clear evidence to support the DFPS findings. Although a review of findings was not requested for any of the investigations in the sample, according to documentation provided by the facility, a review of findings was requested for some DFPS investigations conducted in the past six months. The facility was in substantial compliance with this provision.	
	(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 met at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements). • Metric 2.g.4: The facility Incident Management Review Team (IMRT) did not note any problems with any of the investigations in the sample. • Metric 2.g.5: The monitoring team did not identify problems with regard to sections D.3.e and/or D.3.f. Based on a review of the facility's IMRT data, for n/a (__%), the facility IMRT correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. • Metric 2.g.6: The facility returned no cases in the sample to DFPS for reconsideration for _____ (n/a), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry). The IMC reported that cases were returned to DFPS when the facility did not agree with findings or had further concerns. The monitoring teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. 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, • 15 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. (Three investigations in the sample were completed when there was not a facility director in place. All three were reviewed and	Substantial Compliance

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		signed off on by the IMC). • 15 (100%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In four out of four 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. The facility was in substantial compliance with investigation review requirements.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 3.i.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 3.i.2: The facility continued to track follow-up to recommendations in the daily IMRT meeting minutes. The meeting minutes included a date that recommended action was completed, but no evidence that a review was completed (to ensure protections were effective and/or continued to be implemented). The facility had implemented a 30/60/90 day tracking form to follow up on recommendations and ensure that protections remained in place. The form was included in investigation packets, however, had not been completed for any of the investigations in the sample. Recommendations from the IMRT meetings were typically a generic statement that the IDT would meet or the ART would meet for further discussion. A date was given showing that assigned team met, however, minutes did not reflect further recommendations or follow-up to those recommendations. 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 six cases: • Four DFPS cases: #43027163, #43006819, #43004937, #42904702;	Noncompliance

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		#43000444; #42917757; and • One facility investigations: UIR #14-065 Metric 3.i.3: For three out of three (100%) of the DFPS investigations (DFPS cases #43006819, #43004937,#42904702) reviewed in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented. Based on a review of a subsample of investigations (listed above) for which recommendations for programmatic action were made, the following was found: Metric 3.i.4: For one out of four of the investigations reviewed (25%), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator. DFPS case #42917757 documented that recommendations were addressed by the facility. The exceptions were: • For UIR #14-065, the investigator recommended that the individual's IDT meet to discuss behaviors that led to the serious injury and consider additional protections to discuss the injury. • DFPS case #43027163 included concerns by DFPS regarding malfunctioning golf carts in use at the facility. The facility UIR included a recommendation to inservice staff on the use and maintenance of golf carts and develop a system for documenting training. There was no documentation showing that the DFPS concerns or facility recommendations had been addressed. • The DFPS investigator for case #430004444 expressed concerns regarding staff knowledge of plans and implementation of plans. The facility investigator addressed the concerns with recommendations for training residential and nursing staff. The investigation file did not include documentation showing that training was completed. Metric 3.i.5: For zero out of six investigations (0%), 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 did not have a system to track outcomes from investigations. Based on identified issues with the implementation 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	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.		
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 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 4.2: Were conducted at least quarterly; • Metric 4.3: Did address the minimum data elements; • Metric 4.4: Did use appropriate trend analysis procedures; • Metric 4.5: Did provide a narrative description/explanation of the results and conclusions; and • Metric 4.6: Did not contain recommendations for corrective actions. The IMC reported that he reviewed data monthly, quarterly, and annually with the Risk Manager and made recommendations to address trends based on data analysis. Additionally, • Quarterly reports were submitted to the Quality Assurance Department. • When serious injuries occurred or individuals were identified as having a high number of injuries, a copy of individual injury data and trends were sent to the IDT and a special review was requested. Action plans resulting from these reviews were submitted to the Risk Manager to monitor effectiveness of the plan. • Data were provide to ISP facilitators for review at annual IDT meetings prior to the meeting. Metric 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 (CAPs) were not typically developed. When there were recommendations for corrective action, it was difficult to determine what specific action had been implemented, how it was being	Noncompliance

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		monitored, and what data were used to determine the efficacy of the plan. For example, • On 1/13/14, the IMRT minutes included corrective action to address a trend of injuries for Individual #111. Although the injuries were minor, the incident management department conducted an investigation to try to determine cause for her high number of injuries. The investigator suggested that many of her injuries due to SIB appeared to be related to a lack of engagement. The IMRT minutes reflected that the QIDP would implement a plan for monitoring staff and ensuring that Individual #111 was provided with daily meaningful activities. A review of her ISPAs and QIDP monthly monitoring forms did not indicate that a plan had been developed to address an increase in activities and there was no indication that her QIDP was monitoring for increased participation in activities. In fact, QIDP monthly reviews reflected very little engagement in activities. A review of the facility injury list indicated that the trend of minor injuries continued. Metric 4.8: Even when appropriate to do so, corrective action plans were not always developed both for specific individuals and at a systemic level. None of the investigations in the sample reviewed demonstrated that when a trend of similar incidents or injuries was identified, an adequate corrective action plan was developed and outcomes were tracked. Metric 4.9: The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion. Metric 4.10: The trend reports/minutes did not review, as appropriate, the effectiveness of previous corrective actions. There were no corrective action plans. Based on a review of quarterly trend reports and IMRT minutes: • Monthly and quarterly trend reports did not include action plans with specific outcomes related to trends identified. • Action steps were not included to address both systemic and individual trends. IMRT meeting minutes showed that occasionally action steps were developed to address trends, however, action steps were generic referrals to the IDT. From that point, it was difficult to assess the status of action steps. Metric 4.11: Zero action plans included in the monthly trend report (there were none) 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.	

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		Metric 4.12: For zero of the action plans reviewed (there were no action plans developed), the plan had been timely and thoroughly implemented. Metric 4.13: For zero action plans (there were no action plans developed), 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. The following example is from the set of investigations reviewed where the facility did not adequately address trends identified by the incident management department. • In five out of 15 (33%) of DFPS investigations in sample #D.1 the investigator noted concerns regarding staff training on plans that related to the allegation. In two of those, DFPS substantiated neglect on the facility for not insuring that staff were adequately trained to work with the alleged victim. A majority of the cases included specific recommendations to ensure that staff working the individual involved in the allegation were trained, however, there was no evidence that the facility was addressing staff training on individual plans on a systemic level or monitoring to ensure that training was effective when completed. The IMRC did not do a quarterly presentation to the QAQI Council (see section E of this report). The facility should ensure that this section is also presented. The monitoring team suggests that the IMRC consider reporting on the metrics from section D4 in his QA reports and QAQI Council presentations. To move forward, the facility will need to ensure that as trends are identified, 1. Measurable outcomes and action steps are developed, 2. Specific staff are assigned to monitor and document implementation, and 3. 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	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.		

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) o EPSSLC organizational chart, March 2014 o EPSSLC policy lists, undated, probably March 2014 o List of typical meetings that occurred at EPSSLC (not provided) o EPSSLC Self-Assessment, 3/4/13 o EPSSLC Action Plans, 3/4/14 o EPSSLC Provision Action Information, most recent entries for the most part were 2/2/14 o EPSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/24/14 o EPSSLC DADS regulatory review reports, 9/4/13-3/6/14 o List of all QA department staff and their responsibilities, February 2014 o EPSSLC QA department meeting notes, (2, both March 2014) o EPSSLC data listing/inventory, hard copy, 2/14/14 o Annual schedule for review of each Settlement Agreement provision, and monthly/quarterly key indicators, undated but most current o EPSSLC QA plan narrative, 1/30/14 o EPSSLC QA plan matrix, 1/30/14 o List tools used by the QA department staff (20, from section E inventory) and a set of blank tools used by QA department staff (7) o Sets of completed tools used by QA department staff (none) o Various data sets: • Trend analysis report, for four components, last two quarters, (through February 2014) • Sample printouts from 8 different databases • Lots of documents about the FSPI • Facility records audit data • Medical provider QA audit o Revised section M monitoring tools o Monthly QAD-SAC-1:1 meetings minutes, for all 20 sections October 2013 to January 2014 (4 months, none done after January 2014) o Sets of graphs of the QA department activities (included in QA reports) o EPSSLC QA Reports, monthly, October 2013 to March 2014 (6) o QAQI Council minutes, at least monthly, 9/30/13 to 3/12/14 (7 months, 7 meetings; two in January, none in February)

	• Handouts and agenda for meeting during onsite review, 3/26/14 o Monday department head and section leader meeting minutes, 9/24/13-3/6/14 (18 meetings) o PIT, PET, work group reports • Various documents for one of the PITs: mealtime improvement team o EPSSLC Corrective Action Plan documents • Various descriptions of aspects of the CAPs program, February 2014 • Open/closed CAPs report, 5 pages, 3/27/14 • Database with detail about all open and closed CAPs, 11 pages for open CAPs, 26 pages for closed CAPs, 3/27/14 • Completed CAPs forms and documents for 15 open CAPs • Completed CAPs forms and documents for a sample of 6 closed CAPs • Data regarding CAPs (in QA reports) <u>Interviews and Meetings Held</u>: o Erna Matthews, Quality Assurance Director o Priscilla Munoz, Settlement Agreement Coordinator o Olga Arciniega, Facility Director o Regarding QAD-SAC 1:1 meetings, Priscilla Munoz, Erna Matthews, Deb Woodruff, Adrian Marquaz, following the monitoring exit, 3/28/14 <u>Observations Conducted</u>: o QAD-SAC 1:1 meeting, section F, 3/27/14 o QA staff meeting, 3/25/14 o Medication variance committee meeting, 3/25/14 o QAQI Council meeting, 3/26/14 o Parents advisory council, 3/26/14
	Facility Self-Assessment The self-assessment was much improved from the last review in that it contained many more activities and these activities lined up more with the monitoring team's report than ever before. Given that this report has alpha-numerically labeled the metrics, this should provide further guidance to the QA director for her next self-assessment. That is, the QA director could use these metrics in her own self-assessment. If so, however, she should be sure to read all of the detail provided within the report for each metric because there is important supplemental information provided. The facility self-rated itself as being in noncompliance with sections E1 and E2. The monitoring team agreed. The facility self-rated E3, E4, and E5 to be in substantial compliance. The monitoring team agreed with E3 and E4, but found E5 to be in noncompliance.

	Summary of Monitor's Assessment: The QA program at EPSSLC continued to make progress. Systems continued to evolve and improve. The QA director and her staff were very responsive to the comments and suggestions from the previous monitoring visit and monitoring report. Even so, some aspects of the program remained with little change. Most of the QA program's description was in the QA narrative, which was designated as a facility-specific policy in the past, but was not designated as a facility policy at this time. The QA director needs to determine if additional facility policies are needed to guide implementation of the QA program at EPSSLC. Of the 14 data inventories, 14 (100%) included data that could be used to identify trends as required in the wording of section E1; 7 (50%) included a wide range of data; 14 (100%) included what appeared to be key indicators; 4 (29%) described the data being collected; and 11 (79%) included a self-monitoring tool (or indicated that a self-monitoring tool was not used, with a rationale). None of the items were notated to be a process or an outcome indicator. Some of the inventories did not include all of the data being collected by the department, such as E, F, S, and T. There were other data sets at EPSSLC (which was good to see), however, it was unclear how these were included in the inventories. EPSSLC had a QA plan matrix. It was almost identical to the matrix submitted for the previous report. The items in the QA matrix should line up with the data list inventory, content of the QAD-SAC 1:1 meetings, content of the QA reports, and presentation at QAQI Council. The QA director and SAC continued to hold, and improve, the QAD-SAC 1:1 meetings. They were not, however, accomplishing their primary goal: to review data items and data, review and analyze data, and review and create CAPs. Instead, they served as a forum for the department leader to provide an update on a variety of topics related to the Settlement Agreement. Although these were not unimportant topics, the purpose of these meetings was to improve quality by reviewing data and making changes based upon the data. An area for improvement is to show data and trends across the variables listed in E1 (or indicate clearly a rationale for not doing so). There should be an analysis of the causes of the problem, not just a description of their occurrence. Continued work was done to improve the CAPs system, including the creation, management, and reporting of CAPs. In October 2013, the QA director appointed one of the QA staff, Cynthia Martinez, to take the lead in managing the CAPs program. This was a good idea that had good outcome for the CAPs program. Substantial compliance was maintained for E3 and achieved, for the first time, for E4. Of the 21 CAPs reviewed by the monitoring team, 21 (100%) appeared to appropriately address the

	specific problem for which they were created. There was, however, no criterion to judge when/if the overall CAP was being met. The facility should ensure that each CAP includes a plan to ultimately assess the problem originally identified. There was an adequate system for tracking the status of CAPs. The facility QA director did maintain summary information/data regarding CAPs and their status (regarding open or closed, and status of action steps) that was updated within the month prior to the onsite review.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The QA program at EPSSLC continued to make progress. Systems continued to evolve and improve (as one would expect to see in any QA program). The QA director, Erna Matthews, was present and actively participated in a variety of meetings at the facility. She worked closely with the Settlement Agreement Coordinator, Priscilla Munoz. The QA director collaborated with some of the other SSLCs, too. All of the members of the QA department remained the same. A QA staff meeting was held from time to time. <u>Policies</u> a. 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, #003.1: Quality Assurance, updated 5/22/13. The monitoring team's comments on the state policy are in previous monitoring reports and are not repeated here. b. There were not facility policies that adequately supported the state policy for quality assurance. The one facility policy, called Quality Assurance Local Policy, was a re-statement of the state policy. This is not necessary to do. Most of the QA program's description was in the QA narrative, which was designated as a facility-specific policy in the past, but was not designated as a facility policy at this time. The QA director needs to determine if additional facility policies are needed to guide implementation of the QA program at EPSSLC. <u>Quality Assurance Data List/Inventory</u> c. There was not yet a complete and adequate data list inventory at the facility. The data list inventory was 22 pages long, contained 21 topic areas (seven were not Settlement Agreement related). Sections O and P were combined in one topic, sections C and K were combined in one topic, sections F, S, and I were combined in one topic, and section S was split across two topics. 18 of the 20 provisions of the Settlement Agreement (100%) were included (all except for G and H). Section I, although included, was given scant attention. Of the 14 inventories (O-P-R were combined, C-K were combined, and F-S-I and ATC	Noncompliance

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		were reviewed as one), 14 (100%) included data that could be used to identify trends as required in the wording of section E1; 7 (50%) included a wide range of data; 14 (100%) included what appeared to be key indicators; 4 (29%) described the data being collected; and 11 (79%) included a self-monitoring tool (or indicated that a self-monitoring tool was not used, with a rationale). None of the items were notated to be a process or an outcome indicator. The facility needs to demonstrate that each data listing is complete, that is, that (a) it includes all relevant data items (and that no important data items are missing), (b) each data item is indeed being collected by the section leader, (c) each is available for presentation if requested, and (d) data are being used as per the wording of this Settlement Agreement provision. As discussed during the onsite review, this information might be included in the data listing inventory database or perhaps within the SAC-QAD 1:1 meeting minutes. d. The data list inventory was not current. ___ of the 14 lists (--%) were updated within the past six months. An overall date for the entire inventory was on the cover page, but each inventory should have its own date of update. The monitoring team has a number of comments and suggestions for the QA director to help her make the data list inventory a more functional and useful tool for the facility: • The nine columns on each page were confusing, and mostly blank. This should be reviewed and corrected. Likely, the first two columns can be combined into one because everything that goes into the QA report is also presented to QAQI Council. It also may be that the third and fourth columns can be combined because it may be that all data that are reviewed by the QA department are also reviewed at the QAD-SAC 1:1 meetings. The updated date and date of review columns might better be used for the entire page, rather than as columns. The columns labeled collection method, Settlement Agreement section, and frequency might not be necessary and, if so, could be deleted. • The QA director reduced the number of items in the QA inventory, as recommended in the previous report. She reduced the list from 67 items to 19 items. The items that remain on this list should be o (a) those that do not easily fit into one of the other departments (e.g., census, satisfaction surveys), and o (b) items regarding the performance of the QA department's activities, such as QAD-SAC 1:1 meetings, CAPs, etc. In the current inventory, it appeared that 3 of the 19 were measuring QA activities: POI (#4) , monitoring tools (#14), and corrective action plans (#15). • Consider having one data list inventory for each Settlement Agreement	

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		provision, or if more than one provision is included in a single list inventory, separate the contents by provision, if possible. • Some of the inventories did not include all of the data being collected by the department, such as E, F, S, and T. • The QAD, SAC, and department head need to thoroughly review the F, S, I, and active treatment coordinator inventories to look for overlap, duplications, and errors. • There were a variety of other data sets at EPSSLC (which was good to see), however, it was unclear how these were included in the inventories. o The residential inventory contained many items that related to aspects of the Settlement Agreement. It was not clear if the section leaders were taking advantage of these data items. o The facility designated some items as key performance indicators (monthly or quarterly). It would be helpful if the list of key performance indicators noted to which inventory it belonged. o The facility had many databases, mostly managed by the data analyst. A listing of these would be good to attach to the inventory. The listing should indicate in which inventory each database was located. o There were four work groups at EPSSLC (FST, MIT, UTI, weights). Their data collection (if any) should somehow be tied into the inventory. • There should be periodic reviews by senior management of each inventory. <u>Quality Assurance Plan Narrative</u> e. The QA plan narrative was current, complete, and adequate. <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; most (but not necessary all) of these data are then included in the QA reports and presented to the QAQI Council. • EPSSLC had a QA plan matrix. It was almost identical to the matrix submitted for the previous report. The only differences were some items were removed from the section M list and the key performance indicator section was updated. The items in the QA matrix should line up with the data list inventory, content of the QAD-SAC 1:1 meetings, content of the QA reports, and presentation at QAQI Council. • These aspects of the QA program at EPSSLC did not line up. Evaluating this correspondence was not being done, but should be. Overall, the facility was not using the QA matrix as it was intended, that is, to be a subset of the data listing, such that it correctly showed which data were to be presented during	

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		QAD-SAC 1:1 meetings, in the QA report, and to QAQI Council along with more detail on how the data were to be collected, reviewed, and managed. Because there were no changes or updates, the monitoring team did not (could not) review the status of the QA matrix. Therefore the metrics f-s are merely listed below, with no data, but with some comments. f. There were items in the QA plan matrix for -- of the 20 sections (--%). The items represented a set of key indicators for -- of the 20 (--%). g. Of the 20, both process and outcome indicators were identified for -- of the 20 (--%) in the QA matrix. h. Of the 20, in -- (--%), the indicators provided data that <u>could be</u> used to identify the information specified in E1: "trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports." • The QA director should describe, for each section (perhaps in the QA matrix and/or in the 1:1 meeting minutes) how data <u>were being</u> collected and presented to identify trends across the variables described in the wording of E1. i. The QA matrix did not include all self-monitoring tools/self-monitoring procedures. • It should 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. j. All data that QA staff members collected were listed in the matrix. k. All of the items in the QA matrix did not also appear in the QA data list inventory. <u>QA Plan Implementation</u> Items in the QA plan matrix should be implemented as written, submitted, and reviewed. The monitoring team will select a sample for review as follows: for some sections: 1:1 meeting minutes, data and graphs submitted during the 1:1 meetings for three months, and the QA report for each of these sections for previous six months. For the next review, the QA director, based on her own self-monitoring, should indicate if the items in the QA matrix were: l. Submitted/collected/received by the QA department for the last two reporting	

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		periods for each item (e.g., at least once each quarter). m. Reviewed or analyzed by the QA department and/or the department section leader. This was likely reported to the QA department by the section leader during the 1:1 meetings. The QA director and SAC could easily report on this. n. Conducted and implemented as per the schedule. o. Received QA department assistance in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. This likely occurred during the 1:1 meetings. The QA director and SAC could easily report on this. <u>Self-Monitoring Tools</u> For the next onsite review, the QA director should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at the facility: p. 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. q. 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. r. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. s. QA review: A report or summary showing that there was documentation of QA department review of the results, at least once each quarter, for each of the 20 sections of the Settlement Agreement.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each	Continued progress was seen at EPSSLC regarding the gathering, organization, and analysis of data. In this section (E2,) the monitoring team's findings were based upon the data that were included in the QAD-SAC 1:1 meetings documentation, in QA reports, and in QAQI Council meeting minutes. That is, the determination of whether the data presented by each department were correct (i.e., lined up with what was in the QA matrix) was done in section E1 above and was found to be in need of much improvement. Based upon the QA reports:	Noncompliance

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	action step; the person(s) responsible; and the time frame in which each action step must occur.	a. Data from the QA plan matrix for n/a of the n/a (--%) sections of the Settlement Agreement were summarized, (note that there was not full correspondence between what data were in the QA inventory and the QA matrix with what data were in the QA reports). Therefore, this metric could not be completed by the monitoring team. Based upon the QA reports, however, few sections analyzed data across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals. See more detail in metrics f. to h. below. <u>Monthly QAD-SAC meeting with discipline departments</u> The QA director and SAC continued to develop and improve upon these meetings. They were occurring every month. In addition: • It was good to see that meetings were occurring regularly (although they were discontinued in mid-January 2014, hopefully temporarily). Based upon the meeting observed by the monitoring team for section F, interview with the QAD and SAC, and review of documents and minutes for every meeting, these meetings were not accomplishing their primary goal: to review data items and data, review and analyze data, and review and create CAPs. Instead, they served as a forum for the department leader to provide an update on a variety of topics related to the Settlement Agreement. Although these were not unimportant topics, the purpose of these meetings was to improve quality by reviewing data and making changes based upon the data. o The monitoring team met with the QAD, SAC, SAC clerk, and state office program compliance coordinator to discuss, in detail, the status of these meetings and specific suggestions on how to make them more productive, focused, and ultimately useful and valued by the department heads, QA department, and facility. • The QA director and SAC need to establish a set of metrics to measure each department's performance on a number of QA-related activities (e.g., updating of data list inventory). • The SAC clerk, Adrian Marquaz, staff kept excellent minutes of these meetings. The monitoring team recommends that the page/minutes also include a column that indicates the performance (yes/no/na) for the many metrics of quality assurance performance that the QA director and SAC need to establish. • The lead psychiatrist conducted his own QA meeting with his department staff. This was good to see. The occurrence of a departmental QA meetings should be considered by all departments and might even be one of the items monitored in the 1:1 meetings as part of the facility's data on implementation of the QA program at EPSSLC. • The notion (and perhaps processes) of root cause/intense case analysis were	

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		mentioned a few times during the onsite review, such as for section N regarding ADRs and in a training conducted by the facility director in November 2013. The monitoring team encourages the QAD and SAC to learn more about root cause analysis and intense case analysis procedures. b. Since the last onsite review, a meeting occurred at least twice for 13 of the 13 (100%) sampled sections of the Settlement Agreement (there were 13 regularly occurring meetings, which included all 20 sections of the Settlement Agreement [100%] because some meetings included multiple sections, such as O-P-R), and all five topics below were conducted during 0 of the 73 (0%) meetings that occurred (during the October 2013 to January 2014 meetings). • 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. c. Since the last onsite review, during 0 of the 73 (0%) meetings, data were available to facilitate department/discipline analysis of data. d. Since the last onsite review, during 0 of the 73 (0%) meetings, data were reviewed and analyzed. For the purposes of this metric, the monitoring team rated this as acceptable if there was review and discussion of data. The quality of the "analysis" was not considered. e. Since the last onsite review, during 15 of the 73 (21%) 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. <u>QA Report</u> The EPSSLC QA report was assembled at the end of the month, following the completion of that month's presentations at QAQI Council. The information in the QA report was what was presented at QAQI Council. The format of the report was changed in January 2014; thus 3 of the last 6 were in the new format. f. 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%). g. Of the 20 sections of the Settlement Agreement, 15 (75%) appeared in a QA report at least once each quarter in the last six months.	

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		• There were no presentations of sections D, E, I, or S. Section U was presented one time. • Some of the monthly and quarterly indicators were related to section D, however, there was no overall section D presentation. • Sections F and N were included in the report in November 2013, but no QAQI Council presentation occurred, so the report contents was duplicated in the December 2013 report. In this second month, presentation occurred at the QAQI Council. h. Of the 20 sections of the Settlement Agreement that were presented quarterly, 0 (0%) contained all of the components listed below. • 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 - Six sections reported use of a self-monitoring tool (F, J, M Q, U V). The others did not. - A short rationale (two or three sentences) for the absence of a self-monitoring tool should be included in those sections of the report. • 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 - The content of the QA report did not line up with what was in the data list inventories. - 9 sections presented a variety of other key indicators and important data. - Findings and names of specific providers (e.g., PCPs) should <u>not</u> be presented in these reports. - An area for improvement is to show data and trends across the variables listed in E1 (or indicate clearly a rationale for not doing so). • Narrative analysis - There should be an analysis of the causes of the problem, not just a description of their occurrence. The sections that came closest to doing so were K, M, N, O, P, R, and T. - The QA director and SAC might include a template for the section leader that prompts one paragraph for a summary of the data and a separate paragraph for the analysis of the data. <u>QAQI Council</u>	

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		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 9/30/13 to 3/12/14 (7 months, 7 meetings). i. There was an adequate description of the QAQI Council in the QA plan narrative. j. Since the last onsite review, the QAQI Council did meet at least once each month. k. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. l. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. m. Minutes (and attachments/handouts) from 7 of the QAQI Council meetings since the last review documented that (a) data from QA plan matrix (indicators, self-monitoring) were presented in 7 (100%), (b) the data presented were trended over time in 7 (100%) and (c) comments and interpretation/analysis of data were presented in some, but not all of the presentations (0%). (Though the quality of the interpretation/analysis needed improvement as noted in metric h.) • Some of the graphs presented had dotted lines indicating what were called upper control limits and lower control limits. These were not attended to by the participants, even when one of the graph lines crossed the upper control limit line for three consecutive months. n. Minutes from 0 of the 7 (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. <u>Corrective Actions</u> Continued work was done to improve the CAPs system, including the creation, management, and reporting of CAPs. In October 2013, the QA director appointed one of the QA staff, Cynthia Martinez, to take the lead in managing the CAPs program. This was a good idea that had good outcome for the CAPs program. Ms. Martinez met each month with the staff responsible for each open CAP, and she maintained documentation. CAPs were not closed out until she completed her review and discussed it with the QA director. The monitoring team reviewed a number of CAPs documents. The number and breadth evidenced the efforts put into the CAPs program. • CAPs procedure that included a definition of a CAP, how they were to be identified and how they were to then be handled/managed. This included a	

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		one-page flowchart, which was used during senior management training and presentations. • QAQI Council presentation materials from their February 2014 presentation. General data about CAPs were included. • CAP initiation log • Corrective action report document • Open/closed CAPs report • CAPs detailed database At this time, there were 15 open CAPs for 8 sections. This compared with 41 CAPs for 11 sections at the time of the previous review. The number of CAPs was less than last time because the system was more efficient, that is, CAPs were developed more appropriately and managed better. There were 41 closed CAPs in their database. o. An adequate written description did exist that indicated how CAPs were generated, though more detail should be written regarding the criteria for the development of a CAP. Including examples of actions that would be considered CAPs and examples of actions that would not be considered CAP would help the QA department and senior management in determining when it was appropriate to create a CAP. • The monitoring team observed two CAPs being created/initiated. One was during medication variance committee and one during QAQI Council. • After this initial discussion, Ms. Martinez planned to meet with the responsible staff person to fully develop the CAP and its documentation. • As noted in section L1, the medical external review process generated some sort of set of corrective actions. Although managed by the medical department, they should also be included within the facility's overall QA program. p. When considering the full set of CAPs, 21 of 21 open and closed CAPs were chosen following the written description, policy, or procedure (100%). The monitoring team reviewed all 15 open CAPs and 6 of the 41 closed CAPs and found the overall goal/purpose of the CAP to be clearly stated. The CAP outcome, however, was not worded in a measurable manner that related to the goal/purpose, and the action steps were not written in observable terms with criterion. q. Of the 21 CAPs reviewed by the monitoring team, 21 (100%) appeared to appropriately address the specific problem for which they were created. • There was, however, no criterion to judge when/if the overall CAP was being met. None (0%) had a criterion attached to the overall CAP. The	

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		monitoring team suggests that the QA director consider each CAP to be an objective and, therefore, each would contain an observable/measurable outcome, conditions under which the outcome should occur, and a criterion/criteria. • 16 of the 21 (76%) CAPs looked at assessing outcomes to ensure that the problem originally identified was remedied or reduced (i.e., 5 of the CAPs did not assess the problem for which they were originally created, instead they only assessed whether the action steps were implemented). • The QA director and Ms. Martinez should ensure that each CAP includes a plan to ultimately assess the problem originally identified. Based on these 21 CAPs: r. 21 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. There were from 2 to 12 actions for each CAP. s. 0 (0%) included the anticipated outcome of each action step. • 0 of 21 (0%) included specific criteria to judge if the outcome of each action step was met. Most were not written in a behavioral objective type format with the observable behavior, conditions, and criteria clearly described. t. 15 of the 15 open (newer) CAPs (100%) included the job title and name of the person(s) responsible. u. 21 (100%) included the time frame in which each action step must occur (i.e., a due date).	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the 15 open/new CAPs, which represented 100% of the total: a. n/a (--%) included documentation about how the CAP was disseminated • This needs to be explicitly stated in each CAP, as discussed with the QA department. b. 15 (100%) included documentation of when each CAP was disseminated, and c. 15 (100%) included documentation of to whom it was disseminated, including the names and titles of the specific persons responsible.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are	a. Based on a sample of 3 completed CAPs and 15 in-process (open) CAPs, 16 (89%) were implemented fully and 16 (89%) were implemented in a timely manner.	Substantial Compliance

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	implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	• The CAPs regarding mock emergency drills and SAPs were not implemented fully or in a timely manner (though they were being implemented). The monitoring team made this determination by reading each CAP and the monthly written comments from the QA department. In the future, the QA department's monthly comments should specifically and explicitly indicate whether or not all aspects and actions of the CAP were implemented fully and in a timely manner. b. There was an adequate system for tracking the status of CAPs. Of the 15 open CAPs being tracked by the facility, 15 (100%) indicated the status of the CAP. Monthly QA department notes indicated any action taken if a CAP had not been implemented. The monthly QA notes provided running commentary on the status of the overall CAP was included. This was good to see. c. The facility QA director did maintain summary information/data regarding CAPs and their status (regarding open or closed, and status of action steps) that was updated within the month prior to the onsite review. She had a table that listed the status and she graphed the number of open and the number of closed CAPs. d. The QA director or section leader did present this information to QAQI Council at least quarterly.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The monitoring team will assess these metrics at the next review. a. For n/a out of n/a CAPs (--%), documentation showed review of their effectiveness (i.e., outcomes), and for n/a out of n/a CAPs (--%), documentation showed review of their timely completion. • Data are needed to indicate if the CAP was effective. b. Of the n.a/ CAPs that appeared to need modification, n.a. (--%) were modified. c. Based on a sample of n/a completed CAPs and n/a in process CAPs, n/a (--%) were discussed at QAQI Council. d. For n/a out of n/a (--%) modified CAPs, evidence was present to show timely implementation. e. For n/a out of n/a (--%) modified CAPs, evidence was present to show full implementation.	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 List of all QIDPs and assigned caseload o A list of QIDPs deemed competent in meeting facilitation 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 and date ISP was filed. o Draft ISPs and Assessments for Individual #88 and Individual #188 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #181, Individual #84, Individual #49, Individual #79, Individual #65, Individual #109, Individual #81, Individual #125, Individual #46, Individual #78, Individual #111, and Individual #149. <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 Carmen Molina, Director of Behavioral Services o Martha Davis, Behavioral Specialist o Mario Gutierrez, Incident Management Coordinator o Alice Villalobos, QIDP Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Section F, S, and T Meeting o QIDP staff meeting o Incident Management Review Team Meeting 3/24/17/14, 3/26/14, and 3/27/14 o Morning Unit Meeting 3/24/14, 3/26/14, and 3/27/14 o ISP preparation meeting for Individual #88 and Individual #188 o Annual IDT Meeting for Individual #67 and Individual #157 o ISPA for Individual #161 regarding restraints

	Facility Self-Assessment: The self-assessment had been updated on 3/4/14 with recent activities and assessment outcomes. For each provision, the facility had identified: (1) activities engaged in to conduct the self-assessment, (2) the results of the self-assessment, and (3) a self-rating. The QIDP Coordinator was responsible for the section F self-assessment. The current self-assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and provided a self-rating for each provision item. EPSSLC used the statewide section F monitoring tool to assess compliance with section F. Additionally, the facility continued observing ISP meetings, 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. Findings for provisions that were audited by the facility were similar to findings of the monitoring team. For example, the monitoring team and the facility each found problems with meeting attendance, timely submission of assessments, and ensuring that action plans were developed to address assessment recommendations. The monitoring team agreed with the overall assessment of noncompliance for each provision item.
	Summary of Monitor's Assessment The facility had made little progress in developing an adequate IDT process for developing, monitoring, and revising treatments, services, and supports for each individual. Recent turnover in the QIDP department had impacted progress made during previous visits. The facility had replaced five of eight QIDPs in the past six months. Two annual ISP meetings were observed during the monitoring visit. Both IDTs were struggling with the statewide ISP planning process and what the resulting outcome should be. Both meetings observed were lengthy and did not result in a plan that would ensure meaningful programming and supports. There was little discussion at either meeting regarding how the individual spent a majority of his or her day or how the team would ensure that they were involved in meaningful activities. The IDTs did not develop outcomes that would build on what the individuals were currently doing to offer new experiences or opportunities to learn new skills based on identified preferences. It was not clear that supports developed by the IDT were either meaningful or functional for the individual. The facility did not have an adequate system in place to ensure that plans were implemented and supports were monitored for efficacy. At ISP meetings observed, the IDT was unable to determine whether or not progress had been made towards outcomes or whether supports were effective. Some data were presented regarding supports in place, however, team members were not sure what the data represented or specifically what progress had been made. Consequently, few changes were made to supports and services even when progress was not evident.

	The facility needs to request additional training from the state office to move forward with developing and implementing comprehensive ISPs. IDTs need additional training on how to develop integrated action plans based on assessment recommendations that incorporate the individual's preferences. IDTs need guidance on setting priorities for training and developing measurable objectives with clear directions for staff designated to implement plans. 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 are available to all team members for review. • The facility needs to continue to track submission of assessment by discipline prior to the annual ISP meeting and address any trends of late submission with the specific department responsible for submission. • 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.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings and two pre-ISP meetings. The ISP facilitator facilitated the annual IDT meetings. The assignment of having ISP facilitators lead the discussion was a new process for the IDTs. 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, the CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, QIDP monthly reviews, the individual's daily schedule, and ISP Preparation	Noncompliance

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		Meeting documentation, as available. A sample was requested of the most recently developed ISPs from each residence on campus, and 10 were submitted for review. Eight of the 10 were developed in the six months prior to the monitoring team's visit. A variety of QIDPs and interdisciplinary teams (IDTs) responsible for the development of the plans were sampled. The QIDP Coordinator confirmed that QIDPs facilitated the teams, including team meetings. Observations of team meetings and reviews of ISPs also illustrated that the QIDP/ISP Facilitator was the team leader and responsible for ensuring team participation. A QIDP Coordinator oversaw the QIDP Department. The facility had seven QIDPs. Two had recently been designated as ISP facilitators. These facilitators were responsible for facilitating the annual IDT meetings. The facility planned to use the Q Construction Assessment Tool to assess QIDPs for competency in facilitation skills beginning in April 2014. None of the QIDPs had been deemed competent in facilitation skills. The ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the ISP facilitators in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the ISP facilitators used this template to draft portions of the ISP prior to the meeting. The facilitators 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. Based on observations of meetings held the week of the onsite review and review of related documentation, facilitation of team meetings was continuing to improve. However, there were still a number of barriers to ensuring that the team developed a comprehensive ISP that integrated all needed services and supports. Barriers included, but were not limited to: • Assessments were still not consistently completed and available to IDT members prior to annual IDT meetings. • It was not evident that all team members were either present at meetings, or, if not physically present, had the opportunity to provide adequate input prior to the meeting. • Implementation and monitoring of supports was inconsistent. Team members were unable to determine that status of outcomes implemented the previous year.	

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		• It was not evident that data were consistently gathered and analyzed, and then used to revise or develop new supports. 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 that the QIDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. At both ISP meetings observed, it was noted that outcomes developed the previous year had not been implemented. There was no evidence that the QDIP was monitoring services and taking action when supports were not in place or action steps developed by the team had not been implemented. There was not an adequate monthly review process in place. As a result, it was unclear whether progress had been made on outcomes or if current supports were effective. In some cases, data were presented regarding outcomes implemented the previous year, however, team members were not sure what the data represented or specifically what progress had been made by the individual. Consequently, IDTs made very few changes in supports and services for the upcoming year. 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 or when outcomes had been completed. To move forward, the facility needs to focus on ensuring that ISP facilitators and QIDPs are competent in meeting facilitation skills. Then, ensure that QIDPs are 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 lack of implementation, change in status, or a lack of progress.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other	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.	Noncompliance

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	persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The QIDP Coordinator was tracking attendance by relevant IDT members monthly. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings for August 2013-December 2013. Attendance remained low for some disciplines, notably so for the psychiatrist, PCP, active treatment, and vocational staff. For the 13 ISP meetings held during the review period, only four individuals (31%) attended their own meeting.	

Team member	
Individual	31%
LAR	78%
Family/Advocate	100%
DSP	83%
QIDP	100%
Psychologist/BA	86%
RN	100%
Occupational Therapist	100%
Physical Therapist	100%
Speech Therapist	100%
Dietician	100%
Primary Care Provider	67%
Psychiatrist	67%
Dental Services	82%
Pharmacy	100%
Vocational Services	60%
Active Treatment Staff	36%
Home Manager	100%
LA Designated	86%
Contract LA	86%

Additional data provided by the psychiatry department revealed that the psychiatrist attended 19 of a total of 26 ISP meetings (73%) between 9/13/13 and 2/28/14. This was a marked improvement from the prior monitoring period, where per interviews with staff, it was noted 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 at that time that they 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, and during the current period, improvement was noted.

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		Review of a sample of ISP attendance sheets confirmed that there were key staff missing who were identified as relevant participants in four of six (67%) of the annual meetings in the sample (i.e., full attendance by relevant participants occurred in 12% of the ISPs). The sample was Individual #84, Individual #65, Individual #49, Individual #109, Individual #81, and Individual #125. Individual #81's and Individual #125's ISPs were developed by an appropriately constituted IDT. Regarding those that were not: • At the annual ISP meeting for Individual #84, relevant team members identified at the pre-ISP meeting that did not attend the meeting included Individual #84, his family, his psychiatrist, and dental staff. • Key team members not in attendance at Individual #65's annual ISP meeting included his LAR, vocational, active treatment, and dental staff. • Active treatment staff and the designated LA were not in attendance at Individual #49's annual ISP meeting. • Key team members not in attendance at Individual #109's annual ISP meeting included his psychologist and psychiatrist. In zero of six ISPs (0%), for any team members not physically present at the IDT meeting, was there evidence of their participation in the development of the ISP. At both pre-ISP meetings observed, for Individual #88 and Individual #188, the QIDP indicated that the individual was not invited to attend the meeting. Individual #67 did not attend her annual ISP meeting. Individual #157 attended her annual ISP meeting and was encouraged to express her preferences. Additional effort needs to be made to ensure that each individual is a part of the planning process. The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process. Relevant team members should be identified at the pre-ISP meeting; then the facility should use that information to track actual attendance by relevant team members at the ISP meeting. When team members cannot attend the meeting, the ISP should note efforts to get input from those team members prior to the annual meeting.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	DADS Policy #004.1 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. Annual ISP preparation meetings were held approximately 90 days prior to the annual ISP meetings. At the ISP preparation meeting, the IDT was to identify the assessments that were required for the annual ISP meeting. The state policy required that these assessments be completed and placed in the share drive for IDT review no later than 10	Noncompliance

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		working days before the annual ISP meeting for review by all IDT members. The assessments were to be used by the QIDP to develop an ISP Guide prior to the ISP annual meeting. Two ISP Preparation meetings were observed. The IDT completed a checklist at both meetings indicating what assessments would need to be completed prior to the annual ISP meeting. The facility was gathering data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of discipline specific assessments for August 2013 through January 2014 indicated that there had been improvements in the number of assessments submitted prior to ISP planning meetings. The chart below shows assessment submission rates for that time period. Discipline Clinical 31% CLOIP 90% Dental 100% Food Services 98% Habilitation Therapies 88% Nursing 87% Pharmacy 98% Program Development 75% Psychiatry 92% Psychology 88% Recreation 85% 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. The pre-ISP determination of assessments needed prior to the annual IDT meeting list was compared to assessments submitted. The sample was Individual #125, Individual #109, Individual #81, Individual #49, Individual #65, and Individual #184. • Individual #125 did not have an updated vocational assessment. • Individual #109 medical assessment was submitted late. • Individual #81's medical assessment was not submitted 10 days prior to his annual ISP date for review by other team members. His dental assessment was completed after the meeting. • Individual #49's medical, nursing, psychological, nutritional, and audiological assessments were determined to be necessary for ISP development, but were not submitted to the monitor team for review. • Individual #65's dental assessment was completed late. His vocational assessment was not updated. • Individual #184's medical assessment was not completed at least 10 days prior	

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		to his ISP for review by team members. In six of six (100%), the team considered what assessments the individual needed and would be relevant to the planning process. The team defined the assessments that were needed for the annual meeting during the ISP Preparation meeting. In zero of six (0%), the team obtained the needed relevant assessments. None of the individuals in the sample had <u>all</u> assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. The facility had begun reviewing a sample of assessments from three disciplines (habilitation therapies, behavioral services, and nursing) to determine if the assessments identified the individual's prioritized needs, preferences, and strengths. The summary of that review indicated that 67% included prioritized needs, 33% included the individual's preferences, and 67% included the individual's strengths. Assessments from various disciplines were reviewed to determine if the assessments were submitted and if they included recommendations that were adequate for planning. Assessment should provide information/recommendations that would guide the IDT to support the individual and develop a comprehensive plan to help the person learn or develop a skill, achieve an outcome, or address a medical or behavioral issue. Findings were: <u>Behavioral Health Services</u> Functional assessments were completed and timely for individuals with PBSPs. The quality of those assessments, however, was not consistently adequate (see examples in K5). Additionally preference assessments (PSIs) were completed for all individuals at EPSSLC, however there were no data that they were timely, and they frequently were not used to develop SAPs (see S2). <u>OT/PT/Communication</u> 100% of the assessments reviewed for OT, PT and speech identified preferences and needs. A number of the assessments provided SAPs for implementation by therapies, though only three individuals were listed as receiving direct OT or PT. Most suggested SAPs for implementation by the DSPs as integrated throughout the day or during routine activities based on current skill levels and potential for learning new ones. There were communication strategies outlined for every individual to expand or enhance their level of communication and social interaction. <u>Nursing</u> Since the last review, the Nursing Department made changes to their Nursing	

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		Assessment format. The changes included adding a new section entitled Recommendations, but the Nurses had not been sufficiently trained or had enough time to gain experience when completing the Annual Comprehensive Assessments to develop adequate recommendations. Comprehensive Nursing Assessments did not consistently identify the individual's strengths, preferences, or needs. For example: • Individual #181's preferences did not include how he participated in his own health care related to his cardiac condition. • Individual #157's nursing assessments did not identify the weight changes that occurred within her IBW nor provide recommendations that would guide the IDT to address the weight changes. 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 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.	
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 always done in time for IDT members to review each other's assessments prior to the ISP meeting. QIDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and then information from assessments is used to develop plans that integrate all supports and services needed by the individual. In zero of two (0%) ISP meetings observed, recommendations from assessments were used to develop plans that would provide a broader range of experiences and lead to the development of new skills. It was not clear in either meeting how the IDT established priorities for training. Outcomes were based on activities that the individuals already had an opportunity to participate in without consideration of potential opportunities for growth. For example, at Individual #157's meeting, • The team acknowledged that work was an important part of her day. Her vocational assessment indicated that she had many positive work skills and needed little assistance at her current job. The assessment included a recommendation to continue working at the workshop. The IDT did not consider vocational outcomes that would offer her further opportunities to develop new work skills.	Noncompliance

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		Individual #67's assessments identified her support needs and preferences, however, the IDT failed to use the information to develop meaningful supports and programming. For example, • The team agreed to continue her outcome to attend the workshop and stay on task for 10 minutes each day shredding paper. Her vocational assessment indicated that she was already able to complete this task. • Her IDT agreed to continue her outcome related to community outings without planning for additional opportunities to try new things. • Additionally, the team agreed to implement an outcome related to self-administration of her medications. There was no indication that this was a preference or priority for her. The adequacy of integration of recommendations into the ISP for specific disciplines is discussed in detail in other sections of this report and some comments are below. Recommendations from assessments were consistently used to develop PBSPs plans for individuals (see examples in K9). For example functional assessments were consistently used to develop PBSPs to address behavioral issues (K5, K9). On the other hand, as described in S2, only 11% of SAPs were based on clear needs identified in assessments. The majority of recent nursing assessments reviewed did not contain statements that were used to develop appropriate protections, services, and/or supports for individuals. For example, Individual # 162, who had experienced emergency room visits related to reoccurring infections requiring isolation, and surgical interventions for clogged Gastrostomy/jejunostomy tube (feeding tube,) the recommendation section stated, "None at this time." A PNMP was developed for each individual to address identified PNM-related risks such as falls or choking. When assessments were completed after the annual IDT meeting, it was not always evident that the IDT met to review the assessment and incorporate recommendations into the ISP. For example, • Individual #125's ISP included an outcome to have an MBSS by 12/31/13. The QIDP monthly review dated 1/20/14 indicated that the status of the outcome was unknown because information had not been provided by the SLP. The facility was not yet in compliance with this provision. To move forward, QIDPs will need to ensure that assessments are completed prior to the annual ISP meeting and all	

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		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).	In the new ISP format, discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with a consensus opinion by team members from various disciplines. Any barriers to community placement were to be addressed in the ISP. See section T regarding the quality of discipline specific determinations. None (0%) of the individuals in the sample were offered a range of opportunities to participate in meaningful activities in the community. None (0%) of the individuals in the sample had adequate access to the use of community services and community supports (e.g., hair salons, gyms, banks, churches, pharmacies). None (0%) of the ISPs in the sample indicated that the individual was adequately integrated into the community (regularly participated in activities in the community and engaged with others in the community, had memberships, hobbies, and interests, works/volunteers, or contributed to the community in some way). The facility continued to provide some day programming opportunities in the community. ISPs included minimal formal training to be implemented in the community. General outcomes were written to attend activities at community sites without describing what training would occur while there. At both IDT meetings observed, the IDT engaged in good discussion regarding community living options. The IDTs developed outcomes for further exposure to living options through attendance at provider fairs (Individual #58) and visits to community group homes (Individual #157), however, the IDT did not consider other outcomes that would encourage community integration for further exposure to new things in the community. It was positive to see that the transition specialists were very involved in the discussion regarding community living options at both ISP meetings. They brought information to the meeting to distribute to team members and were able to address any concerns regarding community living options. The facility had developed a database to document individual's responses to community visits. This information was also shared at the IDT meeting. Seven ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #125, Individual #109, Individual #79, Individual #65, Individual #78,	Noncompliance

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		Individual #49, and Individual #111. None (0%) of the ISPs included meaningful training opportunities in the community. Community based outcomes for all 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 #511 had community based outcomes to "participate in one of the activities offered at Hilos de Plata." • Individual #149 had one community based outcome to "participate in community recreation events once every three months." There was no focus on providing supported employment or volunteer opportunities in the community for individuals at the facility. None (0%) 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 a discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting and attempted to develop plans to include the individual's preferences. Teams were not adept at using preferences to build on new training opportunities for individuals. Preferences were typically based on a limited range of activities that the individual had the opportunity to participate in at the facility. Outcomes related to	Noncompliance

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		preferences were often general statements that ensured that the individual would have opportunities to continue to participate in those same activities with little discussion on how those preferences could be expanded or used to develop new skills. Lists of preferences in the ISPs in the sample were individual specific. 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. Preferences were used to develop outcomes for participation in preferred activities, but training was not based on prioritized preferences in the ISPs. 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 specific interests, or exploring volunteer or work opportunities. For example, • Individual #49's ISP included a community awareness and integration SAP that stated that she would use her gait trainer or wheelchair to travel outside her dorm to feel the fresh air. The team agreed that she enjoyed being outside and needed a walking program. These activities could have been integrated into a training goal in the community would encourage her to gain new skills while participating in an integrated activity in the community. In a review of seven recent ISPs, none (0%) offered specific training to be provided in the community. While the community was occasionally 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 none were focused on gaining specific skills. To move in the direction of substantial compliance, the monitoring team recommends that the facility focus 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	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. As noted in F1e, none of the ISPs reviewed included measurable outcomes to address barriers to community placement. The monitoring team found that many outcomes were not written in a way that staff could measure progress towards completion and/or that plans did not provide enough information to ensure consistent	Noncompliance

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	to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	implementation. None (0%) of the plans in the sample included a full array of measurable outcomes. For example, • Individual #49 had an action step in her IHCP to address her risk for weight issues. The action step stated "weekly weight monitoring." The action step did not include a weight range for guiding staff to identify when she might be at risk. • Individual #181 had an action step to "make punch using a carbonator machine." The strategy/method indicated that the DSP will help him to make punch using a carbonator machine. There was not enough information to guide staff on implementation of the outcome. Another action step stated that he would engage in the activity of his choice. The strategy/method stated that the DSP would hand him the activity of choice. There were no further instructions to ensure consistent implementation or data collection. • Individual #111 had an action step in her ISP that stated "will make contact or participate in one of the activities offered at Hilos de Plata for at least three minutes." The action step did not offer staff clear guidance on what would constitute a successful attempt by the individual. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Sections M and I also address the writing of measurable strategies to address health care risks. It was not always evident that appropriate supports were developed when IDT members identified needs or barriers to achieving outcomes. For example, behavioral health services indicated that they had developed plans to address refusal with routine dental procedures (S1), however dentistry suggested that they had not provided necessary supports. Individualized measurable treatment strategies based on identified needs were developed, in some cases. Examples include functional assessments (K5) and PBSPs (K9). As previously noted, only 11% of SAPs were based on clear need identified in assessments (S2). The monitoring team found that PNMPs were modified numerous times throughout the year based on need and changes in status. There were measurable goals outlined for all direct interventions, outcomes related to PNM-risk areas associated with interventions outlined in the PNMP, and measurable goals suggested for SAPs recommended based on skill levels and identified needs. Although the Comprehensive/Quarterly Nursing Assessments and their associated Integrated Health Care Plans contained goals, more often the goals were not	

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		realistic/holistic, or did not include sufficient interventions to meet their identified health care needs. For example, Individual #21's Comprehensive Annual Nursing Assessment recommendations dated 4/4/13 did not include nursing interventions for addressing medical diagnosis of dysmenorrhea (painful menses), given the statement on the Annual Nursing Assessment that "The amount of pain will be minimized to help her gain weight." Even though the Annual Nursing Assessment documented the dysmenorrhea, it also placed her at risk for aggressive behavior. The current IRRF/IHCP did not address supports to assess and monitor pain and behavior associated with her painful menses. 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. As noted in F1e, ISPs did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. The facility was not in compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	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 meetings. As noted in F1d, the facility did not have an adequate system in place for ensuring that assessment information was integrated into the ISP. The development of action plans that integrated all services and supports was still an area with which the facility struggled. Action plans to address outcomes in both the IHCP and SAPs typically included reference to ancillary plans (i.e., PNMP, communication plans, PBSP), however, strategies from those plans were not integrated into supports with strategies specific to achieving the outcome. SAPs in the sample reviewed listed recommendations cut and pasted from communication and behavioral assessments, however, strategies were rarely specific to the outcome being implemented. For example, Individual #79's skill acquisition plans included instructions to "reference my BSP if you have questions regarding my behavior and intervention" and "reference my communication dictionary for specifics of how I communicate." It was not evident that SAPs included steps that the team had identified through the assessment process that would be needed to accomplish the outcome. The revised ISP meeting guide prompted the teams to discuss, revise, and approve plans	Noncompliance

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		that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and IHCP. For the most part, these continued to be stand alone plans. 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. Observation at annual ISP meetings and pre-ISP meetings indicated IDTs were making little progress towards integrating protections, services, and supports into one comprehensive plan. Each discipline continued to report independently on each particular assessment/plan related to their own discipline. Minimal discussion occurred to attempt to integrate supports among disciplines. It is expected that progress will continue to be made in developing comprehensive plans as IDTs become more adept at developing both functional and 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, some action steps in the sample of ISPs reviewed did not include clear methodology for implementation. Without clear instructions for staff, it would be difficult to ensure consistent implementation and determine when progress or regression occurred. Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. Each action step should be measurable action the individual will perform, include the frequency, method of documentation and reporting requirements, and designate the assigned person for implementing and reviewing progress. A review of ISP outcomes and action steps for • Individual #79 (four outcomes/nine action steps) • Individual #111 (eight outcomes/13 action steps) • Individual #65 (six outcomes/22 action steps) For four of 18 (22%) outcomes reviewed, action plans were specific and relevant to assisting the individual in achieving his/her outcome, including steps the team had identified through assessment that will be needed to accomplish the outcome. An example that did not include specific action steps relevant to achieving the outcome included: • Individual #111 had an outcome that stated "will have a closer relationship with	Noncompliance

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		her mother by email cards and pictures." There was one associated action step that stated "QIDP will mail it." As noted in F2a2, few action steps were written in terms of measurable action that the individual would perform to complete the objective. IHCP action steps were generally brief statements of action to address the risk or references to additional plans (i.e., PNMT, PBSP). Most did not include methodology or criteria for monitoring effectiveness of intervention. As previously noted, each discipline will need to ensure that assessments are completed prior to the annual ISP meeting to ensure training strategies are developed using current recommendations from each discipline. <u>Time frame for completion</u> A sample of ISPs was reviewed to verify that action steps included a time frame for completion. 42 of 44(95%) included projected completion dates. Exceptions were: • Individual #111 had two action steps for decorating her room that did not include a projected completion date. In most cases, the date was an annual date rather than a date based on the individual's expected rate of learning or projected need for specific supports. <u>Staff responsible</u> Outcomes in the sample included designation of which staff /discipline would be responsible for implementation of the outcome and which staff would monitor the plan. In some cases, however, the ISP did not accurately identify the person who would be responsible for implementation. Individual #111's ISP listed PD/QIDP as the person responsible for implementing all action steps, however, some action steps assigned responsibility to the DSP. For example, she had an action step that stated the DSP or nurse would let her know when it was time for her medication. The person responsible was listed as PD/QIDP. The facility was not in compliance with the requirement for identifying methods for implementation, staff assigned to implement the outcome, and time frames for completion.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for	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.	Noncompliance

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	services and supports and are practical and functional at the Facility and in community settings; and	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 in key areas of their lives. For example, outcomes did not address increasing independence in routine household activities, such as laundry, yard work, and meal preparation. As noted in F2a3, recommendations of each discipline were not effectively integrated into the outcomes, action plans, and teaching strategies. Teaching and support strategies were not sufficient to ensure consistent implementation of outcomes. None (0%) 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. Vocational outcomes were not found that would develop vocational skills needed for community employment. Vocational skills were general in nature and did not address barriers to working in 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. <u>Data to be collected</u> The type of data to be collected and the frequency of implementation were to be in 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. Zero of 44 action steps included clear direction for documenting implementation and progress. The facility continued to use very broad terms for when and how to document progress (i.e., progress note, monthly review).	Noncompliance

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		<u>Frequency of data collection</u> For the sample described in F2a4, 37 of 44 (84%) action steps included the frequency of implementation. Most action steps indicated how often the action step should be implemented in terms of weekly, monthly, quarterly, or annually. In seven instances, frequency included terms, such as "as scheduled." Program developers should list frequency in concrete terms, even specifying the day of the week and time for training when feasible to ensure consistent implementation. <u>Person responsible for collecting and reviewing data</u> As noted in F2a4, outcomes in the sample included designation of which staff /discipline would be responsible for implementation of the outcome and which staff would monitor the plan. In some cases, however, the ISP did not accurately identify the person who would be responsible for implementation.	
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.	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. 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.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A small sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in all (100%) of records reviewed. Data reviewed for ISP submission between 8/1/13 and 12/31/13, however, indicated that only 51% of the ISPs developed within that timeframe were filed in the active record within 30 days of development. As noted in other sections of this report, the monitoring team found that outcomes were rarely written in measurable terms, so that those monitoring the plan could determine when progress was made or if the outcome was completed. Additionally, teaching and support strategies were not comprehensive enough to ensure that staff knew how to implement the outcome and provide appropriate supports based on assessment recommendations. 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. 2. Teaching and support strategies should provide a meaningful guide to staff	Noncompliance

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		responsible for plan implementation. 3. ISPs should be accessible to staff within 30 days of the development of the plan.	
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 modify the ISP, as appropriate.	QIDPs were assigned overall responsibility for monitoring services and supports in the ISP. The facility had a monthly review process in place to review all supports. A review of QIDP monthly reviews indicated that none of the reviews (0%) in the sample adequately reflected the status of all outcomes and services included in the ISP. For example, • The January 2014 QIDP monthly review for Individual #109 indicated that no data were available for six of six action steps in his ISP. The monthly review did not include a review of the action steps included in his IHCP. His November 2013 and December 2013 QIDP monthly reviews indicated 0% compliance percentage in the column designated for a summary of progress for three of six of his action steps with no explanation for the lack of progress or participation. One outcome indicated no data were provided for both months and the compliance percentage was identical for the remaining two action steps for both months. • The QIDP monthly reviews for Individual #49 for September 2013 through October 2013 did not adequately reflect the status of outcomes. For example, the October 2013 monthly review indicated that no data were available for her outcome for exposure to the community. No explanation or indication of follow up by the QIDP was noted regarding the lack of available data. She had an action step to "develop a SAP to put on her sweater." The QIDP noted 100% in September 2013 and "SAP completed" in October 2013. It was not clear if the QIDP comments related to development of the SAP or progress made on the SAP developed. For a number of outcomes each month, the QIDP noted that she would continue the outcome without describing implementation attempts or progress towards the outcome. • Data were identical for each outcome reviewed for Individual #81's QIDP monthly reviews for August 2013, September 2013, and October 2013. For example, each monthly review indicated that he had met his outcome to identify a stop sign 63% of the trials, his leisure outcome 60% of the trials, and his outcome to participate in groups 27% of the trials. A sample of QIDP monthly reviews were reviewed to determine if the IDT convened as needed when there was a change in the individual's status or support needs, evidence that the ISP was not being implemented, or a lack of progress towards outcomes that might require revision of the ISP. The monitoring team found that the monthly review process was not adequate for ensuring that ISPs were modified, when appropriate. For example,	Noncompliance

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		• Individual #109's monthly reviews from October 2013 through January 2014 indicated that he refused to participate in his vocational program. There was no indication that the team met to discuss his refusals or modified his plan. His other outcomes indicated that either data were not collected or no progress was made for the four months reviewed. Again, there was no evidence that the team met to discuss lack of implementation or progress. • Individual #49's monthly review for November 2013 indicated that she was placed on emesis protocol on "a few separate occasions" during the month. There was no evidence that the IDT discussed this issue or that adequate follow up occurred even though she was at risk for aspiration and gastrointestinal issues. • Individual #84's QIDP monthly reviews for September 2013, October 2013, November 2013, and December 2013 indicated that he was not provided with the opportunity to visit community living providers quarterly as stated in his ISP. There was no explanation for lack of implementation or no indication that the QIDP followed up on the lack of implementation. The monitoring team found little evidence that individual team members were following up on their responsibility to monitor services and supports and document specific progress or regression. Additionally, supports were not always modified when the individual experienced a change of status, regression occurred, and/or outcomes were not achieved. The monitoring of behavioral services and supports, however, had improved. For example, monthly PBSP progress notes were completed and indicated that action consistently occurred when the individual outcomes were not achieved (see K4). Nursing services and supports were not consistently monitored and specific progress or regression was documented. For example, Individual #21 was assessed and treated for her urinary tract infections, along with a new event of a new infectious organism. This also required the implementation of contact isolation precautions due to the nature of the spread of transmission of the type of organism. An Acute Care Plan for infections was in place, including staff training. The current Annual ISP, or IHCP requested by the monitoring team was not present in the record. A current IRRF dated 3/5/14 was provided in the record request, of which the Infection Risk continued to be determined as low, even though the individual's Annual Comprehensive Nursing assessment documented frequent urinary tract infections. Comprehensive Annual Nursing assessments or nursing assessments for problems identified did not consistently provide statements to assess or evaluate their progress or	

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		lack of progress. For example, Individual #179 had a history of Metabolic Syndrome Risk. His weight showed below the minimum IBW in November 2013 and over the maximum IBW in March 2014. Even though February 2014's weight was between the minimum and maximum, the record did not sufficiently include the efficacy of the related interventions related to the weight gain. The record did not contain information that the IDT met to re-evaluate the weights in relation to the associated history of his Metabolic Syndrome Risk. On the other hand, there were consistent reviews of status when there was a change related to health. For example, post hospitalization assessments were consistently conducted. A habilitation therapy representative attended all morning meetings to identify situations that would require review by the clinicians. The clinicians were required to read the report of events that happened overnight and the minutes of the morning meeting, which resulted in frequent review of related supports to determine if changes had to be made. Documentation by the habilitation therapy department indicated that the PNMP was monitored consistently based on the recommended frequency suggested by the therapist and outlined in the assessment. By report, these were approved by the IDT, but this was not always included in the ISP itself. Effectiveness monitoring was conducted frequently for various aspects of the PNMP, but it could not be determined if this occurred for the entire PNMP on a routine basis. The QIDP Coordinator acknowledged that there was not yet an adequate monthly review process in place. The monitoring team found that the current IDT process is not adequate for implementing, assessing, and monitoring of services for individuals. To move forward towards compliance, 1. QIDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues or consider revising supports. 2. Plans should be updated and modified as individuals gain skills or experience regression in any area.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall	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 planned to begin utilizing the Q Construction Assessment Tool to assess QIDPs for competency in facilitation skills. Zero of seven (0%) QIDPs had been deemed competent in facilitation skills.	Noncompliance

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	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	During the week of the monitoring visit, two annual IDT meetings were observed. At the two meetings observed, • Meetings were lengthy, yet very few revisions were made to current supports. IDTs were unable to determine the status of current supports due to a lack of documentation and consistent monitoring of services. Consequently, both IDTs either continued the outcome with little changes in supports or discontinued the outcome without considering more appropriate action steps to teach the identified skill. • There was still minimal integrated discussion among team members. Each discipline reported on discipline specific areas and suggested supports and action plans relevant to his/her own assessment. The IDTs will need additional training on developing integrated action plans based on information from assessments. • Outcomes and action steps were not necessarily developed based on priorities established for the individual. • Teams were still struggling with using strengths and preferences to provide new training opportunities with a focus on developing new skills. • IDTs were still struggling with developing measurable objectives to track progress or regression. QIDPs were still learning to use the new statewide ISP format to develop the ISP. As noted throughout section F, adequate plans had not yet been developed for a majority of the individuals at EPSSLC. It would be beneficial for the facility to seek additional outside training and consultation from the state office on developing person-centered ISPs. All new employees were required to complete Supporting Vision, the statewide training on the ISP process. Data collected by the training department for new employees during February 2014 showed 100% of all new employees completed training on the ISP process. The facility implemented a new process for providing individual specific training to staff on implementing ISPs for each individual supported in February 2014. Residential Coordinators were assigned to attend ISP meetings and train DSPs on the resulting plans. Staff instructions were provided to DSPs as a guide to implementing supports. Staff instructions, however, for many plans did not offer enough information to ensure consistent implementation or did not include recommended support strategies from assessments. 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.	

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F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	A small sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current ISPs were available in all records reviewed. This was good to see, however, it will be necessary to ensure that plans are revised when warranted to gain substantial compliance with this provision. IDTs were still not ensuring that plans were monitored for efficacy and revised when outcomes were met or when there was regression or lack of progress towards outcomes. The facility self–assessment indicated that 100% of all new admissions between 8/1/13 and 1/31/14 had an ISP meeting within 30 days of admission. During the same time period, 46 of 47 annual ISP meetings were held within 365 days of the previous annual ISP meeting. The monitoring team reviewed data in regards to ISPs held August 2013 through December 2013. A list of ISP dates with the date the ISP was due and the date the ISP was filed (document V.10). 22 of 43 (51%) of the ISPs were filed within 30 days of development. To address this provision, • Scheduling of ISPs was monitored by the QIDP Coordinator. • Tracking information regarding ISP Preparation Meetings, annual ISP meetings, and distribution of completed ISPs was being entered into a log for data collection. The facility reported a decrease in the timely filing of newly developed ISPs over the six month review period due changes in the QIDP department related to the appointment of two new ISP facilitators and turnover among the QIDP staff. An adequate review process will need to be in place to ensure that supports are revised as needed. As previously noted, at both ISP meetings observed, the IDT acknowledged that little progress had been made on most outcomes and some outcomes were not implemented for the previous year. The IDT should have met prior to the annual meeting and revised outcomes and supports when it was noted that outcomes were not implemented or lack of progress was noted. The facility needs to continue to focus on ensuring that an adequate review process is developed and that plans are revised when outcomes are met, individuals experience a change of status, there is a lack of progress towards the accomplishment of outcomes, or when regression is noted.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	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 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 Katherine Hill, Clinical Services Director o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Polypharmacy Committee Meeting o Medication Variance Committee Meeting o Dental Clinic o Psychiatry Clinics o Patient Care Meetings o Daily Clinical 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
	Summary of Monitor's Assessment: The clinical services director served as the lead for this provision. She had only been in the position for four months prior to the compliance review and had many areas that required attention. Provision G had, therefore, not been the primary area of focus. She contacted all departments, not just the clinical departments, to discuss how each integrated with other areas. For each department, a list of activities, which demonstrated integration of clinical services, was created. The monitoring team observed many of these activities throughout the week of the compliance review.

	During the conduct of this review, the monitoring team found that many disciplines were not effectively collaborating to deliver services in and integrated manner. This was having an untoward impact on outcomes for the individuals. The monitoring team attended an ISPA in which the medical and psychiatry providers clearly were not working collaboratively in the best interest of the individual and there was evidence that the behavioral health services were not collaborating with the dental department. Integration of clinical services was not a priority at the facility and there were no major integration initiatives directed at achieving improvement in this area. EPSSLC had yet to develop a policy to assist the facility in moving towards substantial compliance with this provision. Delivering services in a seamless and integrated manner should be an important focus of the facility. EPSSLC will need to give this area more attention in the future.
	Summary of Monitor's Assessment: The clinical services director served as the lead for this provision. She had only been in the position for four months prior to the compliance review and had many areas that required attention. Provision G had, therefore, not been the primary area of focus. She contacted all departments, not just the clinical departments, to discuss how each integrated with other areas. For each department, a list of activities, which demonstrated integration of clinical services, was created. The monitoring team observed many of these activities throughout the week of the compliance review. During the conduct of this review, the monitoring team found that many disciplines were not effectively collaborating to deliver services in and integrated manner. This was having an untoward impact on outcomes for the individuals. The monitoring team attended an ISPA in which the medical and psychiatry providers clearly were not working collaboratively in the best interest of the individual and there was evidence that the behavioral health services were not collaborating with the dental department. Integration of clinical services was not a priority at the facility and there were no major integration initiatives directed at achieving improvement in this area. EPSSLC had yet to develop a policy to assist the facility in moving towards substantial compliance with this provision. Delivering services in a seamless and integrated manner should be an important focus of the facility. EPSSLC will need to give this area more attention in the future.

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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,	To determine compliance with this provision, the monitoring team reviewed state procedures, conducted interviews, completed observations of activities, and reviewed records and data. Examples of integration of clinical services were observed throughout the week of the onsite review. There were also several instances in which integration needed to occur, but did not. The following are examples of integration that were observed by the monitoring team:	Noncompliance

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	psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	• 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. • In the weeks just prior to the compliance review, the dental department and habilitation services began collaborating on a number of issues related to observation and training of DSPs in in the homes. • The nursing department collaborated with habilitation services to ensure that PNMPs included special instruction for medication administration. • Nursing provided training to the DSPs and IDTs regarding infection control practices when individuals required enhanced infection control/isolation. • Generally, the IDT inclusive of psychology, nursing, pharmacy, and habilitation services, was present when quarterly psychiatry clinics or other psychiatric clinical consultations occurred. • The behavioral health services department demonstrated functional integration with the psychiatry department. Efforts to achieve integration of clinical services were noted in a number of committee meetings observed by the monitoring team. The following multidisciplinary committees are discussed throughout the various sections of this report: • Medication Variance Committee • Weight Management Committee • Polypharmacy Oversight Committee • Infection Control Committee • Skin Integrity Committee There were several areas in which the monitoring team noticed that the collaborative work between the clinical areas required improvement: • 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. The facility reported that they were going to make efforts to improve upon this. • The dental department and behavioral health services did not collaborate to develop strategies to help individuals overcome barriers to dental treatment. SAPs were written by program developers, but there was no integration with the behavioral health services department. The monitoring team had observed at	

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		other SSLCs that collaboration between the dental clinic and behavioral health services, through sometimes very simple measures, have improved the likelihood of completing dental treatment. • There was a demonstrable need for behavioral health services to improve integration with the dental clinic, habilitation services, and the QIDPs. • There were numerous accounts of issues related to support of the infection control program. Inadequate medical support was linked to a lack of a pneumonia review process and issues related to infection control. <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 center's lead should address the concerns outlined in the comments above. 2. The facility will need to develop metrics to assist with measuring the level of integration. 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 September 2013 and included in the active records of the record sample were reviewed: • 0 of 50 (0%) consultations documented in the IPN included the requirements of explaining the significance of the consult findings (summary), agreement/disagreement, and a decision regarding IDT referral. The providers sometimes included a brief summary of the consult of one to two lines. More often than not, the IPN documentation simply stated that the consult was reviewed and the provider agreed or disagreed with the recommendations. The notations did not specify the date of the consultation, thereby, making it difficult to determine which appointment the note was addressing because some individuals had multiple consultations from a single provider. In addition to problems with IPN documentation, the reason for the consultations was not always stated and adequate information was frequently not provided. In fact, during the daily clinical services meeting conducted on the Thursday of the compliance review, the lead physician provided follow-up on one consult in which the urology consultant indicated that he did not know why the individual was referred for evaluation. Instructions were provided for the individual to return with additional information including the explanation for the consultation. The Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations and whether to refer the	Noncompliance

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		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. The requirements relative to consultation referrals were reviewed during the week of the compliance review with the clinical services director who reported that a new stamp was implemented that added check boxes for agreement/disagreement and referral to the IDT. This stamp was placed on the actual consultation form. It was apparent that the requirements for IPN documentation were not understood even though the requirements were detailed in the previous monitoring team report. Given that this requirement was not implemented, a lack of progress in this area was not an unexpected finding. The following are a few examples of the IPN entries related to consultation referrals: • Individual #32, IPN, 3/4/14: "Podiatry consult reviewed. Concur with reccs." • Individual #8, IPN 3/5/14" "GI consult reviewed. Prep for colo. Will schedule. Concur with recs. • Individual #23, IPN, 3/18/14: "Ophth consult reviewed. Concur with rec." • Individual #134, IPN 3/19/14: "Derm consult reviewed. Concur with reccs. Will write orders." 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 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., Cardiology Consult, 1/1/14). 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 Neuropsychiatry clinic o Daily medical meeting/Medical clinic
	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 provide 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 and the most appropriate metrics to measure progress. 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. It might also be helpful to review the list of metrics provided in the draft guidelines provided by state office. The facility found itself in substantial compliance with provisions H1, H2, H5, H6, and H7. The facility found itself in noncompliance with provisions H3 and H4. The monitoring team found the facility in substantial compliance with provision H2. Provisions H1, H3, H4, H5, H6, and H7 remained in noncompliance.

	Summary of Monitor's Assessment: There was no progress noted in this area. The monitoring team met with the clinical services director, who served as the center's lead, to discuss this provision. She had worked at the facility for four months at the time of the compliance review. As the clinical services director, the breadth of her responsibilities was expansive and section H was not the priority. She reported that she learned several important issues about the provision just days before the compliance review. Over the past four years, several staff have served in the lead role for section H. Although this provision addresses the fundamental concern of how the facility monitors the delivery of clinical services to ensure that assessments and treatments are timely and appropriate, EPSSLC has never sufficiently addressed the areas covered by this provision. EPSSLC has never developed an overarching strategy to move towards substantial compliance nor has the facility developed a local policy to provide guidance and assistance to staff for the work that needs to be done in this area. Further progress in this provision will require a great deal of guidance from state office to ensure that the expectations and requirements for the provision are clearly understood. Development of a local policy will likely play a vital role in this process.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	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 self-assessment included information related to the following: • A review of the AMAs to determine if the evaluations reflected the needs of the individuals • A review of the Annual Dental Assessments to determine if the evaluations met the needs of individuals and were completed in a timely manner • The percentage of individuals with psychiatry referrals due to worsening or increased behaviors • The number of individuals with Quarterly Medical Summaries where the active problem lists and medications were reviewed according to new developments and changes in health status • The percentage of risk rating forms that detected the needs of individuals. Aggregate data for the other scheduled assessments was not provided in this provision, however, aggregate data for annual assessments was found in provision H5. This data showed 30% compliance for timely submission of Annual Medical Assessments. Compliance with submission of dental assessments was reported as 100%. This differed from the 55% compliance reported by the dental clinic. The data submitted for provision	Noncompliance

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		H5 were the data tracked by the QA department. There was no information submitted on the quality of the scheduled assessments or interval assessments. Overall, the facility did not address all of the requirements of this provision item. The facility lead presented information on medical and dental assessments. The clinical services director reported that she used information submitted by physicians related to the adequacy of assessments. However, the facility had not developed audit tools that assessed the quality of medical assessments. Similarly, there were no tools that assessed the quality of the dental assessments and the facility did not have the capability to provide an objective analysis of the quality of the annual dental assessments because there was only one dentist. Moreover, there were no data presented for this provision with regards to the timeliness and quality of the scheduled clinical assessments for areas, such as psychology, nursing, and habilitation services. There were also a number of interval assessments, such as post-hospital and post-restraint assessments, that were not addressed. 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. For the sample of 15 AMAs submitted by the facility, 86% of the AMAs were submitted in a timely manner. The overall compliance rate for timely submission, for all AMAs completed over the past year was 77%. • The medical staff was completing Quarterly Medical Summaries. For the record sample reviewed in section L, 30% included a current QMS. • Compliance with timely completion of Annual Dental Assessments for the six-month review period was 55%. There were significant concerns related to the quality of dental documentation. Further discussion is found in section Q2. • Habilitation therapists conducted annual assessments for all individuals as all were provided at least a PNMP. Additionally, post-hospitalization assessments were conducted by the clinicians on a routine basis. • Comprehensive psychiatric evaluations were completed for all individuals who were enrolled in psychiatry clinic. • The sample of six records showed improvement with regards to the timely submission of the most recent Comprehensive Nursing/Quarterly Nursing assessments. Notwithstanding this improvement, the assessments did not always convey information from the previous assessments. Plans of care from the assessments, the IHCP and applicable ACP, more often than not, did not	

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		include goals that were realistic or individualized. For example, the Annual Nursing Assessment for Individual #157 did not address weight gain. • There was improvement in the area of psychological assessments with 83% of individuals having full psychological assessments, 100% of individuals having annual psychological assessments, and 100% of individuals with a PBSP having a current functional assessment, • All individuals had preference assessments (PSIs), FSAs, and vocational assessments Based on the facility reported data and document reviews, the monitoring team found that the facility did not adequately complete all clinical assessments in a timely manner and had significant issues related to the content and quality of some assessments. Furthermore, EPSSLC did not submit any evidence to support that systems were implemented to adequately monitor the timeliness and quality of scheduled and interval assessments. <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 facility must monitor all three elements that this provision item addresses: (1) the timeliness 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. <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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H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The facility's assessment of this provision was determined by reviewing the completion of annual and quarterly medical summaries. This was the same type of self-assessment completed for the September 2013 compliance review. The monitoring team provided specific feedback on a number of ways in which the metrics for this provision could be improved based on the state office draft guidelines. The facility's lead indicated that she became aware of the draft guidelines only days before the compliance review. As noted in the September 2013 monitoring team's report, the section H draft guidelines indicated that facility staff would utilize the clinical pathways, guidelines, and protocols to govern treatments and interventions as appropriate. Additionally, the guidelines stated 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 and constipation. Medical, nursing physical therapy, and dietary all contribute to the planning and treatment for individuals diagnosed with these conditions. EPSSLC lacked a mechanism for <u>adequately assessing the effectiveness</u> of the care that was provided. The medical management audits provided some opportunities to assess the effectiveness of care, however, EPSSLC skipped several rounds of the external medical management audits. 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 initiation of quality audits discussed in section L2 resulted in a start of the development of indicators and audit tools. The monitoring teams findings for compliance with the standards of care in diabetes mellitus and other medical conditions is discussed in section L1. <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.	Noncompliance

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H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The facility did not make much progress in this area. Quality indicator audit tools were developed for diabetes, constipation, and hypertension. The proposed state guidelines specified 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 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. The determination of the appropriateness and efficacy of medical care must be made by a physician through the development of audit tools. Other process indicators, such as completion of diagnostic testing, may be assessed by a non-physician. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance.	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 state office proposed guidelines indicated that 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 focused on the QA assessment tracking report for annual assessments. As reported in the self-assessment, compliance with most assessments was greater than 85%. The exceptions were medical (30.6%) and habilitation services (55.5%). As previously noted, there were discrepancies in the compliance rates reported for the Annual Dental Assessments. Consideration was not given to any other mechanisms for monitoring health status. As noted in previous reports. 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 acute changes and chronic long-term disease. The monitoring team noted several components that would contribute to monitoring health status: • Risk assessment • Periodic assessments (medical, nursing, therapies, psychiatry, and pharmacy),	Noncompliance

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		• 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. With appropriate execution of these systems, an individual's care and monitoring could be assessed across this continuum of activities. However, the monitoring team observed issues similar to those identified in previous reviews: • 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. • The facility did not have an adequate 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 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 process for inclusion of the medical providers in the ISP process should be addressed. 2. A medical quality program should be developed that includes a mix of process, outcome, and structural indicators.	
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	The facility <u>must identify clinical indicators that will be used to determine when therapeutic outcomes are reached</u>. 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 clinical meetings, unit meetings, ISPAs, and other meetings discussed above.	Noncompliance

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	clinical indicators.	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 disagrees with the facility's self-rating of substantial 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, which the center's lead should carefully review. The facility had not developed any local policies. <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, 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: ○ DADS Policy #006.1: At Risk Individuals dated 12/29/10 ○ DADS SSLC Risk Guidelines dated 4/17/12 ○ List of individuals seen in the ER in the past year ○ List of individuals hospitalized in the past year ○ List of individuals with serious injuries in the past year ○ List of individual at risk for aspiration ○ List of individuals with pneumonia incidents in the past 12 months ○ List of individuals at risk for respiratory issues ○ List of individuals with contractures ○ List of individuals with GERD ○ List of individuals at risk for choking ○ Individuals with a diagnosis of dysphagia ○ List of individuals at risk for falls ○ List of individuals at risk for weight issues ○ List of individuals at risk for skin breakdown ○ List of individuals at risk for constipation ○ List of individuals with a pica diagnosis ○ List of individuals at risk for seizures ○ List of individuals at risk for osteoporosis ○ List of individuals at risk for dehydration ○ List of individuals who are non-ambulatory ○ List of individual who need mealtime assistance ○ List of individuals at risk for dental issues ○ List of individuals who received enteral feeding ○ List of individuals with chronic and acute pain ○ List of individuals with challenging behaviors ○ List of individuals with metabolic syndrome ○ List of individuals who were missing and/or absent without leave ○ List of individuals required to have one-to-one staffing levels ○ List of 10 individuals with the most injuries since the last review ○ List of 10 individuals causing the most injuries to peers for the past six months ○ Data reports regarding the submission of assessments for IDT review prior to annual ISP meetings ○ A list of all individuals at the facility with the most recent ISP meeting date and date ISP was filed. ○ Draft ISPs and Assessments for Individual #1888 and Individual #88, ○ ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly

	Reviews (for a subsample): • Individual #181, Individual #84, Individual #49, Individual #79, Individual #65, Individual #109, Individual #81, Individual #125, Individual #46, Individual #78, Individual #111, and Individual #149. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Carmen Molina, Director of Behavioral Services o Martha Davis, Behavioral Specialist o Mario Gutierrez, Incident Management Coordinator o Alice Villalobos, QIDP Coordinator Observations Conducted: o Observations at residences and day programs o Section F, S, and T Meeting o QIDP staff meeting o Incident Management Review Team Meeting 3/24/17/14, 3/26/14, and 3/27/14 o Morning Unit Meeting 3/24/14, 3/26/14, and 3/27/14 o ISP preparation meeting for Individual #67 and Individual #157 o Annual IDT Meeting for Individual #88 and Individual #188 o ISPA for Individual #161 regarding restraints
	Facility Self-Assessment: EPSSLC submitted its self-assessment updated 3/4/14. 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 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. To assess compliance, the facility: • Reviewed a sample of 10 IRRFs developed between August 2013 and January 2014 • Reviewed a sample of 10 IHCPs for individuals rated at medium or high risk • Observed a sample of 10 annual ISP meetings • Reviewed facility policies related to the risk process • Reviewed training rosters to ensure all staff completed the Individual Support Plan Process training.

	The facility self-assessment focused on the presence of documentation, but failed to comment on the quality of documentation and processes in place. Each provision included a general statement reflecting an acknowledgement that more work needed to be done for each provision before compliance was met. It was not evident that the facility had an adequate self-assessment process in place to review the risk process. The facility self-rated each of the three provision items in section I in noncompliance. While the monitoring team agreed with the facility's findings for noncompliance, it will be necessary for the facility to develop an adequate assessment process to identify areas for focus in order to move forward.
	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. The facility was in the process of retraining QIDPs and IDTs on completing the risk identification process. A large turnover in the QIDP department had necessitated new training on the risk process. The facility continued to train DSPs on identified risks for individuals and how to implement supports to address those risks. The parties agreed that the monitoring team would conduct reduced monitoring for I2 and I3 because the facility had made little progress. The facility was not in compliance with the three provisions in section I. The monitoring team observed the risk identification process at two ISP meetings and noted progress made with the risk identification process. Notably, each discipline presented relevant information during the risk determination process that was essential for determining risk in each area identified by the IRRF. Both teams engaged in integrated discussion regarding the identification of risks. Integration was less evident, however, in the development of supports to address risks. The facility continued to struggle with ensuring that all assessments were completed and available for review prior to annual ISP meetings. Without up-to-date assessment information, it was unlikely that accurate risk ratings could be assigned during annual IDT meetings. As noted in section F, the facility did not have an adequate system in place to monitor supports. Teams were not consistently documenting the completion of assessments and resulting recommendations and supports were not monitored to ensure consistent implementation. 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. Provision I3 requires evidence that plans were implemented in a timely manner once risks were identified. The facility reported that due to the turnover in the QIDP department, ISPs were often not filed and available for implementation within 30 days of development. The QIDP Coordinator indicated that this was a focus area for the QIDP department.

	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. • 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. • Plans should be implemented immediately when individuals are at risk for harm, and then monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should meet immediately and action plans should be revised.

#	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 to be completed annually and updated as needed. The monitoring team observed two annual ISP meetings. 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). At the IDT meetings observed, each discipline presented relevant information during the risk determination process. Both teams engaged in integrated discussion regarding the identification of risks. Integration was less evident, however, in the development of supports to address 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. The facility was tracking submission of assessments by discipline. The submission of assessments was a barrier to accurately identifying risks and support needs for individuals. Data submitted by the facility indicated that all disciplines were not routinely completing IRRF assessments prior to annual ISP meetings. The table below shows the percentage of assessments submitted 10 days prior to the risk discussion by discipline for August 2013 through January 2014. Discipline Clinical 31% CLOIP 90% Dental 100% Food Services 98% Habilitation Therapies 88%	Noncompliance

#	Provision	Assessment of Status	Compliance

Nursing	87%
Pharmacy	98%
Program Development	75%
Psychiatry	92%
Psychology	88%
Recreation	85%

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. The sample was Individual #125, Individual #109, Individual #81, Individual #49, Individual #65, and Individual #184. Zero (0%) of six individuals had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. Without current assessment data available, IDTs cannot accurately assess risks.

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. Data submitted by the facility indicated that only 31% of clinical assessments were submitted for review prior to the annual IDT meeting. Thus, in most cases, IDTs did not have updated clinical data to drive the risk discussion.

It will be imperative that relevant assessments are submitted prior to the annual IDT meeting and that all recommendations are integrated into the IHCP.

Though there had been some improvements in using assessment results to assign risk ratings, it was not yet evident that all individuals had accurate risk ratings determined by assessment results. For example,

- Individual #79's ISP indicated that risk ratings were provided on the attached IRRF. Her IRRF was not completed.
- Individual #65's IRRF indicated that he was at medium risk for gastrointestinal issues. Given his history of gastrointestinal related issues, he should have been considered high risk. His history included GERD, constipation, polyps, diverticulitis, hemorrhoids, esophagitis, gastritis, and duodenitis. He was taking medication for GERD and constipation.

In order to mitigate risk prior to a significant event or change in status, IDTs should carefully consider all risk indicators and conservatively assign risk ratings with the intent of implementing supports to minimize risks before an adverse outcome or change in status occurs.

#	Provision	Assessment of Status	Compliance
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 parties agreed the monitoring team would conduct reduced monitoring for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. 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. As noted in section F, data were often not consistently reviewed. This raised the question of whether 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. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended following a change of status. Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization, the monitoring team was unable to determine what additional assessments were needed and/or conducted in response to the change of status. The QIDP monthly review process did not document implementation of action steps included in the IHCP. 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 #125's ISP dated 9/17/13 included an action step to obtain a new swallow study. The SLP was assigned to schedule the assessment and report findings to the IDT. The QIDP's monthly review dated 2/19/14 noted that information regarding the swallow study had not been provided by the SLP. There was no evidence that the SLP had obtained the assessment. The monitoring team reviewed a sample of assessments from various disciplines 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> Five of six (83%) records reviewed included a completed Admission/Annual Comprehensive Nursing Assessment and accompanying Nursing Physical Assessment. Four of six (66%) included sufficient Admission/Annual Nursing Assessments to assist the team in developing appropriate plans sufficient to address the individual's health care needs. <u>Medical</u> See section L and N regarding the identification of medical risk factors.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Psychology Based on a review of 10 individual records for whom assessments had been completed to address the individual's at risk conditions, (80%) included an adequate behavioral assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included Individual #81 and Individual #63. The following provides an example of an assessment that was not comprehensive: Individual # 81's functional assessment did not include a direct observation of his physical aggression or SIB. OT/PT Based on a review of 15 individual records for whom assessments had been completed to address the individuals' at risk conditions, 14 (93%) included an adequate OTPT assessment to assist the team in developing an appropriate plan. The record that did not contain documentation of this requirement was Individual #75. Although progress was noted, the facility did not yet have an adequate system in place to ensure that all recommended assessments were completed in a timely manner.	
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 parties agreed the monitoring team would conduct reduced monitoring for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. 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, plans were in place to address risks for all individuals designated as high or medium risk in specific areas. The facility reported, however, that for annual ISP meetings held between 8/1/13 and 1/31/14, only 22 of 43 (51%) of the ISPs were filed within 30 days of development. Thus, support plans to address risks identified at the annual ISP meeting were not available to staff designated to implement the plan. IDTs were not tracking the completion of assessments and documenting resulting recommendations. Documentation of plan implementation was not consistent. Thus, it was not always possible to determine if IDTs implemented all recommendations from assessments within 14 days. For the QIDP monthly reviews, the QIDPs were not documenting implementation of action steps or reviewing status of IHCP outcomes in most cases.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The state 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. 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., monitor weights weekly, 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: 1. Develop action plans with measurable criteria for assessing outcomes. 2. Document the implementation of action plans. 3. Document that clinical data is gathered and reviewed at least monthly. 4. 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 desensitization/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 in-service 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

	○ Spreadsheet of all individuals (both new admissions and existing residents) who had a REISS screen completed in the previous 12 months. ○ For two 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 ○ A list of families/LARs who refused to authorize psychiatric treatments and/or medication recommendations ○ 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 ○ A list and copy of all forms used by the psychiatrists ○ All policies, protocols, procedures, and guidance that related to the role of psychiatrists ○ Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility ○ Schedule of consulting neurologist ○ A list of individuals participating in psychiatry clinic who had a diagnosis of seizure disorder ○ For the past six months, minutes from the committee that addressed polypharmacy ○ Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy ○ Facility-wide data regarding polypharmacy, including intra-class polypharmacy ○ For the last 10 <u>newly prescribed</u> psychotropic medications: Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; PBSP; HRC documentation ○ 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) ○ 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 ○ A list of individuals requiring chemical restraint and/or protective supports in the last six months ○ Section J presentation book <u>Documents Requested Onsite:</u> ○ Most recent facility psychiatric services policy

	○ Copy of psychiatry peer review and document review based on ○ 10 examples of consultation form for pre-treatment sedation ○ Data regarding the number of ISP meetings attended by psychiatry vs. the number held. ○ Data regarding the number of PBSP and BTC meetings attended by psychiatry ○ 10 examples of info submitted for IIRF- and data regarding timeliness of submission for last 6 months ○ Documentation from ISP 3/25/14 regarding Individual #67 ○ Documentation from emergency psychiatry clinic and ISP 3/26/14 regarding Individual #161 ○ All data presented, doctor's notes and orders from Neuro-Psychiatry clinic 3/25/14 regarding Individual #179 and Individual #8. ○ All data presented, doctor's notes and orders from psychiatry clinic 3/26/13 regarding Individual #35 and Individual #127. ○ 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 #9, Individual #73, Individual #75, Individual #32, Individual #79, Individual #83, Individual #188. <u>Interviews and Meetings Held:</u> ○ Eugenio Chavez-Rice M.D. lead psychiatrist with Eustolia Garcia, L.V.N. and Rosina Bueno ○ Mary Ann Clark, R.N., Chief Nursing Executive ○ Giovanna Villagran, Pharm.D., Director of Pharmacy ○ Carmen Molina, LPC, BCBA, Director of Behavioral Health Services with Martha Davis, MA, incoming interim Behavioral Health Services Director ○ Jennifer Pacheco, R.D.H., with Katherine Hill, clinical services director and Olga Arciniega, facility director ○ Katherine Hill, MSW, LCDL, Clinic Services Director

	Observations Conducted: o Observation of two psychiatry clinics o Observation of ISP meeting for Individual #161. o Observation of ISP meeting for Individual #67. o Observation of Neuro-Psych clinic o Observation of individuals in facility homes. o Observation of Pharmacy & Therapeutics meeting and Polypharmacy committee meeting o Behavior Therapy Committee and Behavioral Health Peer Review o Morning Medical Meeting
	Facility Self-Assessment EPSSLC continued to use the self-assessment format it developed for the last review. There were some additions made to the self-assessment, and the psychiatric clinic had developed a monitoring tool, which they implemented during this monitoring period. Review of this monitoring tool indicated that facility staff had reviewed the monitoring report and were performing a review similar to that performed by the monitoring team. There were, however, items that should be added to the tool in order for the facility to improve the self-assessment. The facility self-rated itself as being in substantial compliance with all provision items. The monitoring team agreed with 9 of these: J1, J2, J3, J5, J6, J7, J8, J9, and J10. The monitoring team did not agree with the facility self-assessment regarding J4 because further effort must be made with respect to the integrated 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. There were concerns because although the facility had noted a reduction in pretreatment sedation overall, this was, in part, due to the increased use of TIVA for dental procedures. Currently, all dental procedures were being conducted with TIVA, decreasing the overall pretreatment sedation use. Use of TIVA does not alleviate the need for consideration for desensitization and strategies to reduce the need for 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 J11. Although there had been an overall reduction in the number of individual's prescribed regimens that met criteria for polypharmacy, and there had been some improvement with regard to the justification for regimens, over half of the individuals meeting criteria for polypharmacy had not undergone a facility level review, . 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 J12. Per the facility self-assessment, only 5% of the Comprehensive Annual Psychiatric Medication Reviews had documentation of a discussion of the MOSES/ DISCUS scores by the IDT. Although the facility self-assessment rated this

	provision in substantial compliance, compliance ratings documented did not support this. In addition, given the data provided, it was not possible to determine timeliness of the assessments and there was a lack of tracking/comparing of assessment scores over time. This was a change in the compliance rating from the previous monitoring period. The monitoring team did not agree with the facility self-assessment regarding J13. Per the facility self-assessment, only 5% of the randomly selected comprehensive annual psychiatric medication reviews had documentation of data driven medication decision or changes. Only 5% of quarterly psychiatric medication reviews had documentation of data driven medication decision or changes. Only 5% of quarterly psychiatric medication reviews documented a well developed case formulation and a psychiatric diagnosis. 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. The monitoring team did not agree with the facility self-assessment regarding J15. Although the facility self-assessment assigned a substantial compliance rating for this provision, a compliance percentage of 50% reported by the self-assessment and a continued lack of appropriate data for this provision, where the dates of the most recent Neuro-Psychiatry clinical encounter were not included for 21% of the individuals participating, resulted in the monitoring team assigning a noncompliance rating for this provision. This was a change in the compliance rating from the previous monitoring period.
	Summary of Monitor's Assessment: Psychiatry services at EPSSLC made progress towards substantial compliance in some provisions, while others did not progress. In some cases, substantial compliance was not maintained. Half of the individuals received psychopharmacologic intervention (56 of 113, 49%). The facility had one FTE of psychiatric services. The quarterly psychiatric assessment document had been revised to include 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, and there were improvements in the graphing, presentation, and analysis of data allowing for improved data decision making. The monitoring team observed two psychiatric clinics, and one Neuro-Psychiatry clinic. Per interviews with the psychiatrist and behavioral health 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, behavioral health, nursing, QIDP, direct care staff, and the individual). A review of psychiatric documentation revealed issues with regard to data documenting timeliness of quarterly psychiatric medication reviews. Given the manner in which data were provided, it was not possible to assess timeliness. 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 PSP or "Individual Mental Health/Behavior Plan" had been described via policy and procedure. In J6, where the facility had previously noncompliance, there were improvements. All individuals participating in psychiatry clinic had comprehensive psychiatric assessments completed via Appendix B. In addition, peer review indicated scores above the required 80 points. There were several areas where the facility was able to achieve substantial compliance ratings (J1, J2, J3, J5, J6, J7, J8, J9, and J10), 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.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications</u> The current full time psychiatrist providing services at the facility, who had been designated as the lead psychiatrist, was board certified in adult psychiatry by the American Board of Psychiatry and Neurology and in forensic psychiatry by the American Board of Forensic Examiners. Based on the qualifications of this physician, this item was rated as being in substantial compliance. Psychiatry staffing, administrative support, and the determination of required full time equivalents (FTEs) are addressed below in section J5. <u>Experience</u> The lead psychiatrist practiced for approximately three months at the El Paso State Center in 1997-1998 and, as such, he was new to the practice of psychiatry in the SSLC environment. At the time of this monitoring report, he had approximately 40 additional months of experience, having started his current job 11/1/10. <u>Monitoring Team's Compliance Rating</u> Based on the qualifications of the psychiatrist at EPSSLC, this item was rated as being in substantial compliance.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated At EPSSLC, 56 of the 113 individuals (49%) received psychopharmacologic intervention at the time of this onsite review. All individuals currently participating in psychiatry clinic had a completed initial evaluation per Appendix B. Concerns noted in previous monitoring visits with regard to the timeliness of quarterly psychiatric clinical reviews continued during this review period, however, this seemed to be a data management problem rather than a problem with the timeliness of quarterly clinics. Per the data provided, there were 16 individuals who had not been seen in psychiatry clinic in the previous three months. Of these, data indicated that Individual #57, Individual #60, Individual #99, Individual #75, Individual #35, Individual #38, Individual #78, Individual #81, Individual #82, Individual #89, Individual #90, Individual #127, and Individual #148 were last seen in 2012. The monitoring team has been present in clinical encounters for several of these individuals more recently than 2012, so it was apparent that these data were incorrect. Regardless, given the data, it was not possible to determine if individuals had been seen for quarterly psychiatry clinic on a quarterly basis as required. Per the facility self-assessment, however, 100% of quarterly psychiatric reviews had been completed within the three month time frame. Further, the records reviewed by the monitoring team all showed the occurrence of quarterly psychiatry clinics. 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. Both the use of diagnostic criteria and the collaborative process with other disciplines were improved. 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 equal to the number of diagnosis changes reported during the previous monitoring period. A review of 10 individual's records revealed improvements with regard to consistency of diagnoses among disciplines with all records noting consistency. Per the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		facility self-assessment, 100% of 10 documents reviewed revealed diagnostic concordance. Monitoring Team's Compliance Rating Based on the use of the "Quarterly Psychiatric Medication Review" that allowed for documentation of all necessary information, and appropriate diagnostic concordance between disciplines, this provision was rated in substantial compliance in agreement with the facility self-assessment. There were concerns regarding the timeliness of quarterly reviews, however, this may have been an error in the provided data. In order to maintain substantial compliance with this provision item, data provided for the next monitoring review must include the dates of all reviews so that timeliness can be assessed.	
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 addition, in the intervening period since the last monitoring visit, the facility had implemented the psychiatric support plan. This instrument was, in many cases, utilized in lieu of the PBSP and allowed for better identification of specific symptoms for monitoring in order to determine the efficacy of psychotropic medications. The monitoring team reviewed the active positive behavior support plan (PBSP), sometimes referred to as a behavior support plan (BSP) and/or the psychiatric support plan (PSP) in the sample of 10 records reviewed. In all records reviewed, with the exception of two individuals newly admitted, there was a current (within the past year) BSP and/or PSP 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 PSP, also referred to as "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 during this monitoring visit that the psychiatrist remained an active participant in the development of the PBSP and the PSP or "Individual Mental	Substantial Compliance

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		Health/Behavior Plan." Note, however, that the monitoring team had concerns about PSPs replacing PBSPs for individuals who should have continued to have a PBSP (see section K). 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. Overall, there was a reduction in the percentage of individuals participating in psychiatry clinic who met criteria for polypharmacy. In the previous monitoring report, 58% of individuals participating in psychiatry clinic met criteria for polypharmacy. During this visit, this had been reduced to 51%. 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, the psychiatric physician had improved documentation of the justification for these changes. Also, as noted in J9 below, psychiatric documentation was noted to include recommendations for non-pharmacological interventions outside of the PBSP. For example, documents identified activities that a specific individual enjoyed, musical preferences, and food preferences. This is important because 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. There was 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 behavioral health 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 behavioral health 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. Per this document, 12% of 60 randomly selected quarterly and Comprehensive Annual Psychiatric Medication Reviews documented	

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		strategies to minimize the use of emergency psychotropic medications. While this must improve, there were a no chemical restraints utilized in the intervening period since the last monitoring review. Individual #161 did require chemical restraints immediately prior to this monitoring visit and during the visit, however, these data will be included in the upcoming monitoring review. 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. As noted above, there were no chemical restraints utilized during this monitoring period. For 10 individuals who required pretreatment sedation, nine received one agent. Individual #74 received two agents (a benzodiazepine and an antihistamine) via oral administration. <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 PSP or "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, single agents were utilized in all but one instance. Given these sustained improvements, this provision will remain in substantial compliance, in agreement with the facility self-assessment. In order to maintain this rating, psychiatric documentation reviewed via the facility self-assessment must improve with regard to documentation of strategies to minimize the use of emergency psychotropic medications.	
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	<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 46 instances of pretreatment sedation. Of these, there were 31 individuals who received TIVA, and 10 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 46 instances, 25 (54%) were identified as enrolled in psychiatry clinic. The	Noncompliance

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	minimize or eliminate the need for pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	data indicated that, for pretreatment sedation for medical procedures, there were nine sedations utilizing one medication, and one utilizing two medications. It was notable that the majority of the 10 instances of pretreatment sedation for medical procedures included individuals participating in psychiatry clinic (80%). As stated in previous monitoring reports, the facility must review its use of multiple medications during pretreatment sedation. Staff indicated that the use of multiple medications for pretreatment sedation had been discontinued. Data revealed that the last episode where two or more medications were utilized occurred in October 2013, prior to that, the most recent episode was May 2013. <u>Interdisciplinary Coordination</u> Interviews with the dental department staff, behavioral health, 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. Overall, there was a reduction in the incidence of pretreatment sedation. This was attributed to the initiation of TIVA at this facility. As general anesthesia was being utilized for dental clinic, there was no need for pretreatment sedation in these individuals. <u>Desensitization Protocols and Other Strategies</u> Given the reductions in the use of pretreatments sedation due to the advent of TIVA, there was a reduction in the focus on the development of strategies/desensitization. Per interviews with facility staff, this reduction in pretreatment sedation was seen as positive, but the utilization of TIVA was not considered. Further issues with assessments for desensitization/strategies/skills acquisition needs were noted. Specifically, this process had disintegrated. Specifically, behavioral health staff were no longer participating in this process. This was curious, as behavioral health staff is most familiar with the individuals with regard to supports/strategies that may be effective.	

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		13 desensitization plans were received for review, five for dental, eight for medical. All 13 of these plans were skill acquisition plans. 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 and/or TIVA. That is, formal desensitization programs may not be necessary for all individuals (though certainly will be necessary for some individuals). <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. For further information, 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 integration in 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, 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 this section of the Agreement.	<u>Psychiatry Staffing</u> Approximately 49% of the census (a total of 56 individuals) received psychopharmacologic intervention requiring psychiatric services at EPSSLC as of 3/24/14. At the time of this monitoring review, there was one FTE board certified psychiatrist, designated as the lead psychiatrist. This FTE level allowed for a total of 40 hours of clinical resources weekly. In addition, the facility lead psychiatrist was available after hours via telephone consultation. <u>Administrative Support</u> Psychiatry clinic staff included a 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 scarce psychiatry resources.	Substantial Compliance

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		Determination of Required FTEs Per the facility self-assessment, the current facility census with a total of 56 individuals requiring psychiatric treatment, a ratio of 60 individuals for one full time psychiatrist, sufficient resources existed. 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 experienced a decrease in the number of individuals requiring psychiatric treatment, this provision was rated in substantial compliance, in agreement with the facility self-assessment. In the absence of further population reductions, 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 individuals participating in psychiatry clinic. There were two Appendix B evaluations performed during this monitoring period, both of which were for individuals who were new facility admissions. Records of the two individuals most recently admitted to the facility were reviewed. These were Individual #179 and Individual #181. Both of these records included an evaluation per Appendix B that included a comprehensive case formulation. There were sustained improvements in the collaborative case formulation. The psychiatric peer review process had continued, and there had been one review of EPSSLC psychiatric documentation during this monitoring period. This review, dated 2/12/14 revealed a score of 85%. The documentation provided to the peer reviewer was presented to the monitoring team. 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. In the future, it would be beneficial to have more than one peer review result in order to ensure consistency of services.	Substantial Compliance

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		Monitoring Team's Compliance Rating There improvements with regard to the utilization of the Appendix B format for new admissions. Peer review documents revealed improved scores, with a rating of 85%, above the necessary cutoff. Per the facility self-assessment, 100% of the Quarterly Psychiatric Medication Reviews documented a well developed case formulation and psychiatric diagnosis. There was confusion with regard to other data included in the self-assessment. This document indicated that there had been four admissions to the facility in the previous six months, however, data provided to the monitoring team indicated there had been two. Regardless, given the improvements noted, this provision was in substantial compliance in agreement with the facility self-assessment.	
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. Reiss Screen Upon Admission The facility had two new admissions for the previous six months (Individual #179 and Individual #181) both were administered a Reiss screen within 30 days of admission (based on information provided to the monitoring team). Data indicated that these individuals were referred to, and followed by, psychiatry clinic. Reiss Screen for Each Individual (excluding those with current psychiatric assessment) Per previous monitoring reviews, all individuals residing at the facility who were not currently receiving treatment via psychiatry clinic had received baseline Reiss screens. As all individuals admitted to the facility received a screen at admission, the facility had fulfilled this requirement. In addition, there was one individual (Individual #37) who received a Reiss screen 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 are necessary. A review of the data provided did not include information regarding which screens were positive and required additional evaluation. Referral for Psychiatric Evaluation Following Reiss Screen Data did not reveal that any individuals screened were referred to psychiatry clinic as a result of a positive screen other than the two individuals who where new facility admissions. Per the facility policy entitled "Psychiatry Services" dated 3/5/14, 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	Substantial Compliance

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		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.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	<u>Policy and Procedure</u> Per the "Psychiatry Services Procedure Manual" dated 5/23/13, "each state center will develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation…annual and quarterly reviews will be conducted with participation of the IDT and the individual (if the individual is able to participate)." The policy then defined the roles of IDT members including nursing, psychology, QIDP, DSP, dietary, habilitation therapy, and workshop representatives outlining a system to integrate pharmacological treatment with behavioral and other interventions. The facility had a facility specific policy and procedure regarding psychiatry in effect dated 3/5/14 and this document required the implementation of a system to integrate pharmacological treatments with behavioral and other interventions, however, it did not delineate a procedure. <u>Interdisciplinary Collaboration Efforts</u> The monitoring team observed one psychiatry clinic, and one Neuro-Psychiatry clinic. Per interviews with psychiatry and behavioral health 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, behavioral health, nursing, QIDP, direct care staff, and the individual). There were improvements noted with the receipt of information from behavioral health 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, behavioral health 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	Substantial Compliance

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		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 10 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 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 behavioral health 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 behavioral leadership to improve and integrate treatment efforts. Integration efforts between psychiatry and behavioral health included the attempts by psychiatry to attend ISP meetings, the psychiatrist attending BTC and behavioral health peer review, and opportunities for interaction during psychiatry clinic with the behavioral health staff and other disciplines. <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	

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		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. <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 the use of data to drive medication regimen adjustments, this provision was rated in substantial compliance in agreement with the facility self-assessment. The self-assessment, while indicating substantial compliance, reported low compliance percentages that were not reflected in the document review performed for this monitoring review. For example, the self-assessment reported that only 5% of the documents reviewed included documentation of non-pharmacological interventions or documented a well developed case formulation.	
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	<u>Psychiatry Participation in BSP and other IDT activities</u> Per interviews with the psychiatry staff, it was reported and 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. 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" or a psychiatric support plan either in lieu of, or in addition to, the BSP. Data provided revealed that the psychiatrist attended 19 of a total of 26 ISP meetings (73%) between the dates of 9/13/13 and 2/28/14. This was a marked improvement from	Substantial Compliance

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	psychotropic medication to the degree possible.	the prior monitoring period, where per interviews with staff it was noted 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 at that time that they 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, and during the current period, improvement was noted. <u>Treatment via Behavioral, Pharmacology, or Other Interventions</u> The review of 10 records did not reveal pervasive 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. There was one record reviewed where multiple medication changes had occurred: • Individual #9 had a history of treatment with medications including Zyprexa, Effexor XR, Trazodone, and Vyvanse. In June 2013, Zyprexa was discontinued and Thorazine was trialed. In September 2013, it was documented that Thorazine and Vyvanse were not effective, and Vyvanse was ultimately discontinued in October 2013. Thorazine was cross tapered with Risperdal. Nadolol was started in February 2013. Then in March 2014, Clobazam was started for seizure disorder. At that time, Risperdol was tapered and Vyvanse was reinstituted. This case was illustrative of multiple medication changes over the course of a brief period of time. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> 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. A review of psychiatric documentation revealed that non-pharmacological interventions, in addition to the PBSP, were included. 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 previous monitoring reviews was the psychiatrist's continued requests for additional data. With improvements in data graphing and the behavioral health staff providing data analysis, this had reduced. The psychiatrist was able to utilize the data provided in decision making.	

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		Monitoring Team's Compliance Rating To meet the requirements of this provision item, there needs to be an indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. 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. The self-assessment noted that in 100% of five records reviewed, that the quarterly psychiatric medication reviews included documentation regarding non-pharmacological interventions to reduce the use of psychotropic medications. There was documentation that the psychiatrist was attending ISP meetings. Given the improvements outlined above, this provision will remain in substantial compliance in agreement with the facility self-assessment. The psychiatry clinical staff must remain vigilant with regard to reducing frequent medication regimen changes.	
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 5/1/13, noted that state center responsibilities included that the psychiatrist in collaboration with the IDT members 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." Facility specific policy and procedure dated 3/5/14 indicated, "assessment of the risk versus benefit of continued psychotropic medication therapy as well as the appropriateness of drug selection, effectiveness, dosage, and presence or absence of side effects must be reviewed on a quarterly basis by the psychiatrist in conjunction with the IDT and documented in the record." Quality of Risk-Benefit Analysis A review of the records of 10 individuals who were prescribed various psychotropic medications revealed sustained 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 #73, the "Quarterly Psychiatric Medication Review" form dated 11/1/13 reviewed the risks associated with medications including Clonazepam, Paxil,	Substantial Compliance

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		Seroquel, and Trazodone. The document also outlined specific benefits associated with each of the medications. The IDT discussion was documented, "while she had problems with constipation, it could be aggravated by Paxil, but…anticholinergic burden is moderate and not high. The problems of constipation…occurred even before she was on Paxil and thus we believe it has had minimal involvement in her constipation." The document then went on to discuss positive behavioral changes associated with medications. Furthermore, the document reviewed the risk of decompensation associated with a reduction in medications, "she would present a danger to herself and to others based on her prior behaviors," and specific non-pharmacological interventions that were recommended in addition to the PBSP including, "familiar staff, uncrowded living space…outings…viewing tv…Mexican food." There were, however, examples where increased information would be beneficial. For example, in the case of Individual #179, who had a documented history of a movement disorder related to treatment with antipsychotic medications, the risk discussion included in the psychiatric documentation did not address the risk of movement disorders and or further sequelae of same with regard to ongoing treatment with atypical antipsychotic medication. As discussed with facility staff, the risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician, however, the success of this process will require a collaborative approach from the treatment team inclusive of the psychiatrist, primary care physician, and nurse. Given the improvement in staff attendance at psychiatry clinic, as well as the increased amount of time allotted for each clinical consultation, the development of the risk/benefit analysis could and was 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	

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		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 #23 presented to HRC Committee 12/17/13 demonstrated improved documentation, individualized information, and the need for continued improvement: • Haldol 10 mg daily was presented. • While the specific symptoms necessitating the medication were not expressly stated, the document did indicate increased agitation as evidenced by knocking down furniture, throwing items, yelling, making grunting sounds, and "his breathing becomes elevated as if he is very angry." • It was noted that this individual was previously treated with Haldol, the medication was tapered and discontinued two months prior with an increase in symptoms per objective data. • Specific side effects of the proposed medication were not included . • Non-pharmacological interventions were not included except to state that this individual had a MHBP and a psychiatric support plan. • The plan to monitor this individual's response to the medication was documented. <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	

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		dangerous than the medications." This rating was confusing because the results of the self-assessment were that only 5% of the records reviewed included documentation of strategies to minimize the use of psychotropic medications, had documentation of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of the psychotropic medication, and whether reasonable alterative strategies are likely to be less effective or potential more dangerous than the medications. In the monitoring team's review of 10 individual records, the documentation required for this provision was located in all records. However, as stated above, there were examples where improvements were necessary. 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 evidenced deficits with relation to the inclusion of specific medication side effects and non-pharmacological interventions considered or implemented outside of a MHBP and psychiatric support plan. As discussed in J14 below, the facility must obtain standardized medication side effect profiles from pharmacy staff to ensure completeness. For now, this provision will remain in substantial compliance even though the facility self-assessment indicated only 5% compliance. This was apparently an error in documentation. In order to maintain this rating, improvements in the documentation of the risk/benefit analysis are necessary.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not	<u>Facility-Level Review System</u> The facility had in place a review system for polypharmacy that was centered in the pharmacy department. Since November 2010, the facility had instituted a monthly polypharmacy committee meeting. <u>Review of Polypharmacy Data</u> Documentation presented during the polypharmacy oversight committee meeting 3/26/14 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 34 individuals in August 2013 to 29 individuals in March 2014. • The total number of individuals who met criteria for antipsychotic polypharmacy had decreased from two individuals in August 2013 to one individual in March 2014. • The average number of psychoactive medications prescribed for any individual who received psychotropic medication and met criteria for polypharmacy had remained about the same from 3.52 in August 2013 to 3.5 in March 2014.	Noncompliance

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	clinically justified are eliminated.	A review of the active psychoactive medication list by drug class listing for March 2014 revealed that there was one individual meeting criteria for intraclass polypharmacy for antipsychotic medications, one individual with intraclass polypharmacy for antidepressant medications, three individuals with intraclass polypharmacy for benzodiazepines, two individuals with intraclass polypharmacy for sedative medication (including Trazodone and Melatonin), and three individuals with intraclass polypharmacy under miscellaneous (Benztropine, Lithium, Guanfacine, Propranolol, Guanfacine). This was a total of 10 individuals. In the previous monitoring report, this number totaled 13 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. During all clinic encounters observed during this monitoring visit, a pharmacy intern was present and provided information to the physician(s). 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 29 individuals who met criteria for psychotropic medication polypharmacy. It is notable that as there were a total of 56 individuals in psychiatry clinic, 52% 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 24 individuals prescribed antipsychotic medications at the facility (a decrease from 35 individuals during the previous monitoring review). Of these: • One individual was prescribed two antipsychotics (decreased from two during the previous monitoring review). • None were prescribed three antipsychotics. There were 36 individuals prescribed anxiolytic medications (a decrease from 43 individuals during the previous monitoring period). • Of these, three were prescribed two anxiolytic medications (unchanged from the previous monitoring period). There were 20 individuals prescribed antidepressant medications (a decrease from 26 individuals during the previous monitoring period). • Of these, one was prescribed two antidepressant medications (a decrease from three individuals during the previous monitoring period).	

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		Of the 56 individuals prescribed psychotropic/seizure medication of any class: • A total of 49 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. 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. Furthermore, it was noted that at each monthly review, one individual case was presented. Data provided indicated that of the total of 49 individuals meeting criteria for polypharmacy, 29 would require review during polypharmacy committee due to intraclass polypharmacy or prescription of two or more medications. Other individuals met criteria for polypharmacy only due to the prescription of two seizure medications. Of these 29 individuals, only 15 had been presented to the polypharmacy committee (48%). At the current pace, it would require an additional 15 months to complete a facility level review for all individuals prescribed psychotropic polypharmacy. Review of Polypharmacy Justifications Documentation regarding polypharmacy dated 11/1/13 for Individual #73 provided information pertaining to the use of specific medications. "Paxil…to increase the levels of serotonin in the limbic system and prefrontal cortex…to decrease agitation, aggression and depression. Seroquel…decreases the level of dopamine, thus decreasing the aggressive outbursts…Tegretol…appears to control aggressive behavior in the limbic system…Trazodone…an SSRI…being used as a sleep aid…as soon as we started her on Tegretol, her behavior increased exponentially and she is presently at her best behavior wise and doing extraordinarily well…maybe we could taper another medication, but we know that when we have tried to taper Paxil, her crying spells seem to come back and that when we attempted Seroquel she also had a decompensation, but with Tegretol she has done greatly."	

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		While this justification is detailed with regard to each individual medication, the limiting factor is that it does not consider specific medication interactions. For example, Tegretol is known to cause clinically relevant drug-drug interactions, due to its ability to induce the cytochrome P450 enzymes and, therefore, decreases the concentration of other medications metabolized via this particular enzyme system. In this case, that would include Seroquel. Additionally, Trazodone is not technically an SSRI, although it does have activity at the serotonin receptor. Monitoring Team's Compliance Rating The overall gradual reduction in the utilization of pharmacological agents and in polypharmacy is laudable. Given the results of the facility self-assessment and the fact that over half of the individuals meeting criteria for polypharmacy had not undergone a facility level review, this provision will remain in noncompliance. As per the examples above, review of the medical records revealed some improvement with regard to justification for polypharmacy, but additional considerations regarding drug-drug interactions were necessary. 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.	Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) 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., baseline, 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. 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 2/21/14 to 14 nursing staff members. Per an interview with nursing administration, all facility nursing case managers were current with regard to 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 all examples provided, the psychiatrist documented,	Noncompliance

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		"will present at his next quarterly psychiatric med review." A review of the psychiatric documentation provided for each of the 10 examples of MOSES and DISCUS assessments (five of each assessment) revealed no documentation of such review. During psychiatry clinics observed during this and previous monitoring reviews, the psychiatrist was presented with MOSES and DISCUS examinations (among other data) for review. This indicated that when the individuals were seen in clinic, the examination results were reviewed and utilized, although documentation provided with these examples did not support this. Furthermore, there remained cause for concern because there was no documentation indicating that previous scores were compared to current scores. A review of records for 10 individuals revealed that in nine records, MOSES and DISCUS results were included. In reviewing "Quarterly Psychiatric Medication Review" documents in the eight records, the current and immediate past MOSES/DISCUS scores were included along with a discussion of the results, however, as stated above, this was not included in the specific sample provided for this provision. With regard to the timeliness of assessments, there was cause for concern with regard to Individual #179. This individual was admitted to the facility 11/6/13. At that time, it was documented that this individual had a history of developing tardive dyskinesia in 2009, "severe movements…and since then, was wheelchair bound…also at that time, severe dysphagic problems with high risk of aspiration." Given this individual's history of a movement disorder related to psychotropic medications and the serious sequelae he experienced related to this diagnosis, MOSES and DISCUS assessments should have been performed immediately, but per a review of the record, the assessments were performed in mid-December. There was no documentation included in the record indicating that these results had been reviewed with the IDT. Per the psychiatrist's documentation, "will present at his next quarterly psychiatric med review." In addition, the medication regimen that he is prescribed at the facility included an atypical antipsychotic, Abilify. Data provided for the previous monitoring period indicated that three individuals had a diagnosis of tardive dyskinesia (TD). Data provided for this monitoring period revealed that there were two individuals with a diagnosis of TD. There were concerns regarding these data, both individuals had different TD diagnoses on different dates. For example, Individual #161 was diagnosed with withdrawal TD on 12/9/13 and persistent TD on 1/18/14. Individual #13 was diagnosed with masked TD on 11/15/13 and with withdrawal TD on 12/30/13. Furthermore, 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, as such, 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.,	

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		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. At the time of this monitoring review, no individual was prescribed metoclopramide. <u>Implementation of Avatar</u> The facility had implemented the Avatar system. This was an electronic database where information, including MOSES and DISCUS, results can be stored. It was reported that previous technical issues with the Avatar system had been resolved, and the psychiatrist could now both document the clinical correlation and sign MOSES/DISCUS assessments electronically. The facility had not implemented this final step in the Avatar process, and continued with both electronic and paper documentation. <u>Monitoring Team's Compliance Rating</u> Per the facility self-assessment, only 5% of the Comprehensive Annual Psychiatric Medication Reviews had documentation of a discussion of the MOSES/ DISCUS scores by the IDT. Although the facility self-assessment rated this provision in substantial compliance, compliance ratings documented did not support this. In addition, given the issues outlined above regarding the provided examples including the inability to determine timeliness of the assessments, a lack of psychiatric documentation regarding review of the assessments and a lack of tracking/comparing of assessment scores over time, this provision will be placed in noncompliance.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric	<u>Policy and Procedure</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," dated 5/1/13, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." The facility specific policy entitled "Psychiatry Services" dated 3/5/14 outlined procedures for the completion of specific psychiatry related tasks, and now included more information regarding the process for psychiatry clinic. 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 changes, case formulation, medical/psychiatric drug interactions, strategies to decrease psychotropics, restraints/hospitalizations, pretreatment sedation	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.	strategies/medications/occurrences and outcome, assessment, and plan). <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 10 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) had been added to 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 psychiatrist staffed the facility during this monitoring period, the schedule did not allow for consistent attendance or participation in the ISP process. Data revealed that psychiatry had attended approximately 73% of the ISP meetings during this monitoring period. In an effort to utilize staff resources most effectively, the facility could create 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 three individuals) was observed. In two instances, the individual was present for clinic. Individual #161 was seen as an "emergency clinic patient." Given the exacerbation of symptoms this individual was experiencing, selected members of the treatment team went to her home to observe. This was done in numbers of one or two staff in an effort to reduce the stimuli. 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. Behavioral health staff were noted to make efforts to analyze or explain specific data points and their interpretation of what the data meant in the context of behavioral health care for the individual. This was a step forward with regard to the	

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		implementation of an evidence-based approach in evaluating medication efficacy. Although it was reported that 90-day reviews of psychotropic medication were timely, data presented were not sufficient to determine this. Given the advent of the PSP, there were improvements with regard to 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 10 records revealed varying quality in documentation for the psychiatric reviews. Although the facility self-assessment indicated a rating of substantial compliance, there were issues apparent in the results of the document review performed. For example, only 5% of the randomly selected comprehensive annual psychiatric medication reviews had documentation of data driven medication decision or changes. Only 5% of quarterly psychiatric medication reviews had documentation of data driven medication decision or changes. Only 5% of quarterly psychiatric medication reviews documented a well developed case formulation and a psychiatric diagnosis. Given the noted 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	<u>Policy and Procedure</u> Per DADS policy and procedure "Psychiatry Services" dated 5/1/13, "before prescribing psychotropic medications…the state center must provide information about the psychotropic medications to individuals, their families, and/or their legally authorized representatives…must address characteristics of the medication, including expected benefits, potential adverse or side effects, dosage, and standard alternative treatments; legal rights; and any questions the individual, the family, and/or LAR have." In addition, DADS was reportedly in the process of developing a statewide policy regarding informed consent. This policy was pending at the time of this monitoring visit. 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	Noncompliance

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	medications or restrictive procedures and shall identify associated risks.	"Psychiatric Services" dated 3/5/14. With the latest revisions, this policy and procedure outlined the process via which informed consent for treatment with psychotropic medications must be obtained. Current Practices Informed consent documents in the records available for review revealed that these forms were a signed document that included the medication, dosage, brief listing of side effects, justification, plan, and notation regarding family notification; and a signed checklist to ensure that specific information was addressed via the informed consent process. In addition, psychiatry clinic staff had created a "flip chart" for medications frequently prescribed including medication side effects. This chart was utilized during psychiatry clinic as a visual aid and an outline for the informed consent process. A review of revised informed consent documentation revealed that in addition to the side effect review performed during clinic, the consenter was provided with a medication side effects profile for newly prescribed psychotropic medications. This document was not included in the examples provided for review. Ten examples of informed consent documentation for psychotropic medication were requested for review. Examples for nine individuals were provided (a total of 10 new psychotropic medications). These documents revealed that the facility remained 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 examples provided, six utilized the newly implemented form. In the four examples where the newly designed form was not included, it was documented that nursing staff had obtained informed consent. These examples were dated as late as December 2013. For example, Individual #161 was prescribed the atypical antipsychotic medication Fanapt with consent documented 12/23/13. Per the consent document, the "person giving explanation" with regard to the informed consent was the nursing case manager. Per interviews with facility staff, the responsibility for informed consent had shifted to psychiatry clinic as of 6/1/13. The current facility practice, where it was documented that nursing case managers were obtaining informed consent, was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual (or guardian) the risks, benefits, side effects, alternatives to treatment, and potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the record. Additional issues were noted with regard to the use of the newly designed "Consent for use of Psychoactive Medication for Behavior Support" form. Although in the previous	

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		monitoring review, this document had been revised to include the signature of the physician providing the information during the informed consent process, the six examples provided for review did not include this required element. Another weakness noted in the informed consent process was the lack of documentation of alternatives to medication treatment and the rationale for not implementing these rather than prescribing mediation. It may be beneficial to revise the psychotropic medication consent form to include this information. In previous monitoring reviews, 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 the previous review, of the 10 new medications prescribed, three were antipsychotic medications. For this review, of the 10 most recently prescribed psychotropic medications, five were antipsychotic medications. Medication prescribing trends should be continuously monitored and reviewed by the facility. <u>Monitoring Team's Compliance Rating</u> 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 <u>standardized</u> information regarding specific psychotropic medications, providing this information to the individual or their LAR. In addition, based on recommendations provided during previous monitoring reviews, the "Consent for use of Psychoactive Medication for Behavior Support" form had been updated, however, 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). This form, once updated, should be utilized for all informed consent (e.g., newly prescribed medications, annual psychotropic medication consent) 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 effect information from their facility pharmacy. In order to improve the data review for this provision, the facility could consider keeping a log of all psychotropic medication consents performed by the facility psychiatrist (both new medication prescriptions and annual medication consent reviews) along with the date these were performed. This would allow the facility to note when annual reviews were due.	

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J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Policy and Procedure Per DADS policy, Psychiatry Services dated 5/1/13, "when medications are prescribed to treat both seizures and a mental health disorder, the neurologist and psychiatrist must coordinate the use of medications through the IDT process." Facility policy and procedure dated 3/5/14 required "Integrated Care…the neurologist and psychiatrist must coordinate the use of medications, through the IDT process during the Neuropsychiatric Clinic, when the medication is prescribed to treat both seizures and a mental health disorder." The policy also outlined the necessary monitoring for anti-epileptic medications when used as a psychotropic medication Individuals with Seizure Disorder Enrolled in Psychiatry Clinic A list of individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder included 43 individuals. At the time of the previous review, there were 44 individuals listed that required neuropsychiatric intervention to coordinate the use of medications prescribed to treat both seizures and a mental health disorder. Per interviews with the facility psychiatrist, 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 30 months. Records revealed that of the 43 individuals identified above, 34 were seen in Neuro-Psychiatry clinic in the previous six months. There were nine individuals where there were no data provided regarding Neuro-Psychiatry clinic attendance. This number was increased over the previous monitoring period, where no data were provided for six individuals. This was discussed in the previous monitoring report where it was noted that although this may be 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 two examples reviewed. Additionally, the monitoring team observed the clinic. During the observation, two 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. Also worthy of comment was that behavioral data presented during clinic were up to date and graphed appropriately. One issue noted during this and other clinic encounters were errors in weight measurements. Per a review of the data during clinic, it was documented that per weight measurement taken 3/6/14, Individual #179 had gained a substantial amount of weight	Noncompliance

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		(approximately 20 pounds) in a period of 30 days. This clinic observation occurred approximately 20 days following the weight measurement, and was not noted prior to clinic or by clinic staff until the monitoring team pointed out the discrepancy. <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 43 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. Following a review of the Neuro-Psychiatry clinic data, it was not possible to determine that all individuals requiring consultation were seen at a minimum of 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. 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. Facility self-assessment data regarding this provision were confusing. Data indicated that five records of individuals participating in Neuro-Psychiatry clinic were reviewed to assess integration of treatment. Then, a second data point indicated that a total of 10 records were reviewed, and only 50% of these "showed integration of coordination [sic] on the use of medications, through the Interdisciplinary Team process, when they are prescribed to treat both seizures and a mental health disorder." Although the facility self-assessment assigned a substantial compliance rating for this provision, a compliance percentage of 50% reported by the self-assessment and a continued lack of appropriate data for this provision, where the dates of the most recent Neuro-Psychiatry clinical encounter were not included for 21% of the individuals participating, resulted in the monitoring team assigning a non-compliance rating for this provision. In order to achieve a substantial compliance rating in upcoming monitoring visits, data must be presented accurately, indicating that each individual requiring Neuro-Psychiatry clinical consultation received it within the calendar year. In addition, integration efforts must be documented, with the self-assessment review indicating appropriate documentation in 90% or more records reviewed.	

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Functional Assessments for: • Individual #9 (9/11/13), Individual #81 (9/5/13), Individual #13 (9/30/13), Individual #63 (11/20/13), Individual #109 (3/21/14), Individual #104 (9/3/13), Individual #78 (9 /9/13), Individual #90 (1/10/13), 11 (9/25/14), 112 (12/10/13) o Positive Behavior Support Plans (PBSPs) for: • Individual #9 (3/26/14), Individual #81 (10/7/13), Individual #13 (11/21/13), Individual #109 (1/22/14), Individual #18 (1/27/13), Individual #126 (2/14/14), Individual #32 (1 /22/14), Individual #7 (12/9/13), Individual #51 (12/9/13), Individual #63 (11/21/13), Individual #11 (12/18/13), Individual #112 (12/10/13) o Six months of progress notes for: • Individual #9, Individual #81, Individual #13, Individual #109, Individual #18, Individual #126, Individual #32, Individual #7, Individual #51, Individual #39 o Annual psychological updates for: • Individual #184 (2/13/14, Individual #19 (2/13/14), Individual #21 (2/13/14), Individual #107 (1/29/14), Individual #71 (2/4/14), Individual #172 (2/7/14), Individual #24 (2/5/14), Individual #147 (12/23/13), Individual #10 (1/29/14), Individual #123 (3/24/14), Individual #16 (3/24/14), Individual #179 (2/26/14), Individual #181 (1/4/14) o Full psychological assessments for: • Individual #44 (2/4/14), Individual #32 (1/31/14), Individual #88 (1/31/14), Individual #37 (2/2/14), Individual #126 (2/3/14), Individual #7 (2/4/14), Individual #9 (2/4/14), Individual #89 (2/4/14), Individual #184 (2/5/14), Individual #39 (2/5/14) o Individual Support Plan (ISPs) for: • Individual #127 Individual #83, Individual #11, Individual #23, Individual #32, Individual #79, Individual #120, Individual #25, Individual #18, Individual #8 o Psychological treatment plans and progress notes for: • Individual #13, Individual #161, Individual #149, Individual #179, Individual #10, Individual #37, Individual #120 o Behavioral, Skills Acquisition, and Service Programs, 12/16/13 o How to fill out a data card, 10/7/13 o Treatment Integrity Monitoring Policy, 10/7/13 o Data taking guidelines, 2/9/14 o Section K QA/QI power point presentations, 3/26/14 o Section K self-assessment, 3/4/14 o Section K action plan, 3/4/14

	○ Behavioral Health Services peer review minutes, 9/13-2/14 ○ Flesh Kincaid reading levels for a sample of 10 individuals, 3/27/14 ○ A list of all training conducted on PBSPs, undated ○ A list of behavioral health services staff and BCBA status, undated ○ Percentages of PBSPs monitored at least once per month, 8/13-1/14 ○ List of most recent dates of annual psychological assessments, PBSPs, functional assessments, and consents for all individuals, undated ○ A list of all individuals with a PBSP, including dates of last plan revision, undated <u>Interviews and Meetings Held</u>: ○ Carmen Molina, Director of Behavioral Health Services ○ Martha Davis, Behavioral Health Specialist ○ Angelin Clarke, Behavioral Health Specialist ○ Carmen Molina, Director of Behavioral Health Services; Angelin Clarke, Behavioral Health Specialist; Martha Davis, Behavioral Health Specialist; Mario Rodriquez, Behavioral Health Specialist; Marisela Franco, Behavioral Health Specialist; Maricela Giner, Behavioral Health Specialist <u>Observations Conducted</u>: ○ Peer Review Meeting • Individuals presented: Individual #109, Individual #9 ○ Neurology/Psychiatry Clinic • Individuals presented: Individual #179, Individual #8 ○ Psychiatric Clinic • Individual presented: Individual #35 ○ Observed treatment integrity session • Individual's plan: Individual #49 ○ Section K QA/QI meeting ○ 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: 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. EPSSLC's self-assessment included many relevant activities in the "activities engaged in" sections, however, some provision items in this self-assessment did not include activities that were identical to those found in monitoring teams report. For example, K4 's self-assessment included an audit of progress notes, and a review of data collection timeliness and 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., graphing of target and replacement behaviors, evidence that data are used to make treatment decisions, demonstration that goal frequencies and levels of data collection timeliness and IOA are achieved, and the flexibility of the data

	system) that are identified in this report as necessary to achieve substantial compliance with K4. The monitoring team suggests that the behavioral health services department review, for each provision item, the activities engaged in by the monitoring team (based on this 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 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. Finally, it is suggested that the department review the criterion for compliance in the monitoring team's report, and ensure that the self-assessment use the same criterion for their self-rating. 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 suggests 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: EPSSLC did not achieve substantial compliance for any additional items since the last review. The facility, however, maintained substantial compliance on the six items (K2, K3, K4, K7, K10, and K11) that were in substantial compliance prior to this review, and demonstrated improvements in several additional items. These improvements since the last review included: • Continued development of behavioral systems to ensure that PBSP data are recorded in a timely fashion, are reliable, and PBSPs are implemented as written (K4, K10) • Initiation of full psychological assessments (K5) • Increase in the percentage of individuals with a PBSP having a functional assessment (K5) • Increase in the percentage of individuals with a current full psychological assessment (K6) • Documentation that PBSPs were consistently implemented within 14 days of receiving necessary consent (K9) • Development of a data base that will track all staff that have been trained to implement each individual's PBSP to ensure that every staff assigned to work with an individual has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter (K12)

	The areas that the monitoring team suggests that EPSSLC work on for the next onsite review are: • Ensure that all graphs are correctly labeled (K4, K10) • Ensure that all individuals have a full psychological assessment (K5) • Ensure that all functional assessments contain all of the components discussed below (K5) • Ensure that counseling services treatment plans/progress notes are consistently complete (K8) • Ensure that each individual that exhibits behaviors that constitute a risk to themselves or others has a PBSP (K9) • Ensure that all PBSPs contain all the necessary elements and are complete (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 have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all of the staff at EPSSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as board certified behavior analysts (BCBAs). Six of the six staff that wrote PBSPs (100%) either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. This was similar the last review when 100% of the facility's behavioral health specialists that wrote PBSPs were enrolled in or completed BCBA coursework. The facility maintained one BCBA that wrote PBSPs (the department director). The department director provided supervision of associate psychologists enrolled in the BCBA program. The facility developed a spreadsheet to track each behavioral health specialist's BCBA training and credentials. EPSSLC and DADS are to be commended for their efforts to recruit and train staff to meet the requirements of this provision item.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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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. The internal peer review meetings provided an opportunity for staff to present new cases or those that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #109 and Individual #9's functional assessment and PBSP. The peer review meeting included active participation from all of the department's behavioral health specialists, and appeared to result in some additional strategies to address both individuals' target behaviors. Review of minutes from internal peer review meetings indicated that the majority of staff that wrote PBSPs regularly attended peer review meetings. Additionally, meeting minutes from the last six months indicated that internal peer review meetings occurred in 22 of the last 25 weeks (88%), and that once in each of the last six months, 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. 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 occurs during at least 80% of the weeks reviewed, external peer review occurs during at least 80% of the months reviewed, and there is evidence of follow-up/implementation of recommendations made in peer review.	Substantial Compliance
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	EPSSLC continued to be in substantial compliance with this provision item. EPSSLC used data cards to collect target and replacement behaviors for all individuals with a PBSP. 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. Additionally, EPSSLC's data collection system was flexible because it had 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	Substantial Compliance

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	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.	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. The facility was assessing data collection timeliness to ensure that data were recorded soon after the behavior occurred. These timeliness data consisted of reviewing data cards mid-shift and noting if a "yes" or "no" was recorded up to the previous interval. The 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. EPSSLC established goal frequency (i.e., how often it is measured) and levels (i.e., what are acceptable scores) for data timeliness. They determined each individual with a PBSP would have at least one data timeliness measure per month. Additionally, the facility established that data timeliness measures would initially be at or above 70%. Data provided to the monitoring team indicated that data timeliness frequency and levels established were achieved. Data timeliness observations occurred at least once a month for 99% of individuals with a PBSP from August 2013 to January 2014, and data collection reliability levels averaged 91% for individuals with a PBSP from August 2013 to January 2014. The monitoring team assessed data timeliness 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 seven of nine data cards reviewed (78%) were completed within the previous 60 minutes. This level was below that observed during the last review (94%) and that reported by the facility (91%), however, it did exceed EPSSLC's goal level (70%). Additionally, all seven of the data cards reviewed by the monitoring team had timely target behavior. However, two had replacement behaviors completed more than 60 minutes prior to the observation time. EPSSLC continued to collect interobserver agreement scores (IOA) for every individual with a PBSP. While timeliness measures assess 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 once a month for every individual with a PBSP and the level would be at or above 70%. Data provided to the monitoring team indicated that IOA frequency and levels established were achieved. IOA occurred at least once a month for 99% of individuals with a PBSP from August 2013 to January 2014, and IOA levels averaged 96% for individuals with a PBSP from August 2013 to January 2014. This is similar to the last review when IOA averaged 91%. Finally, the monitoring team observed the collection of data timeliness and IOA, and	

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		found the tool and procedures to be appropriate. Since data timeliness and IOA were consistently above 70%, it is suggested that the EPSSLC increase the minimal acceptable level for the next six months. 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 X (horizontal) axis of some graphs reviewed, however, were labeled as frequency rather then intervals (e.g., Individual #112, Individual #51). EPSSLC should ensure that all graphs are correctly labeled. The routine use of data to make treatment decisions also continued to improve. During the onsite review, 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 medications or interventions. Six months of progress notes were reviewed for 10 of individuals with PBSPs. Six (Individual #81, Individual #18, Individual #51, Individual #126, Individual #32, and Individual #7) of the 10 progress notes reviewed (60%) indicated improvement, or stable and low levels, of severe target behavior, such as aggression or self-injurious behavior. This represented an improvement from the last review when 50% of the PBSP data reviewed indicated decreases or low stable levels of severe target behaviors. Additionally, as found in the last review, for every individual for whom progress was not occurring, there was evidence of action to address the lack of progress (e.g., modification of the PBSP, retraining of staff). Additionally, there was evidence that actions recommended to address the absence of progress had occurred. EPSSLC staff are to be commended for their continuing 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. Additionally, the facility needs to ensure that that goal frequencies and levels of data collection reliability and IOA are achieved for at least 85% of Individuals with a PBSP, and there is evidence that data were used to make treatment decisions in interdisciplinary meetings. Finally, 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.	
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	There were improvements in this item, however, it was rated as being in noncompliance due to the absence of full psychological assessments for each individual, and the functional assessments reviewed were not consistently comprehensive.	Noncompliance

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	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.	Psychological Assessments The facility recently began conducting full psychological assessments and a spreadsheet of full psychological assessments indicated that 94 of the 113 (83%) individuals at EPSSLC had a full psychological assessment. All individuals at EPSSLC should have a full psychological assessment. The spreadsheet indicated that 33 psychological assessments were completed in the last six months, and 10 (30%) were reviewed to evaluate their comprehensiveness. All 10 (100%) full psychological assessments reviewed were complete and included 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. Functional Assessments A spreadsheet provided to the monitoring team indicated that 23 of the 23 individuals with PBSPs (100%) had a functional assessment. This represented an improvement from the last review when 93% of the individuals with a PBSP had a functional assessment. Additionally, all of the functional assessments were current (i.e., written or revised in the last 12 months). The spreadsheet indicated that 12 functional assessments were completed in the last six months. Ten of these (83%) were reviewed to assess compliance with this provision item. 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/administrating questionnaires, interviews, or rating scales. As found in the last report, all of the functional assessments reviewed included acceptable indirect assessment procedures. Eight of the 10 functional assessments reviewed (80%) utilized direct assessment procedures that were rated as complete. This is a decrease from the last review when 92% of the functional assessments reviewed included a comprehensive direct assessment. Individual #63's functional assessment did not include a direct observation. Individual #81's functional assessment included a discussion of a direct observation of his elopement from the home, but not of his self-injurious behavior or his aggressive behaviors. All functional assessments should 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	

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		the target behavior. As found in the last review, 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. All of the 10 functional assessments reviewed (100%) included a clear summary statement. This represented a dramatic improvement from the last review when only 69% of the functional assessments reviewed had a clear summary statement. Overall, eight (i.e., Individual #9, Individual #13, Individual #104, Individual #78, Individual #109, Individual #112, Individual #90, and Individual #11) of the 10 functional assessments reviewed (80%) were evaluated to be comprehensive and clear. This represented an improvement from the last review when 69% of the functional assessments reviewed were judged to be complete. In order to achieve substantial compliance with this provision item, EPSSLC needs to ensure that at least 90% of all individuals have a full psychological assessment. Additionally, at least 85% of the full psychological assessments need to be judged as complete. Finally, EPSSLC needs to ensure at least 90% of all functional assessments are current (i.e., revised at least every 12 months) and that at least 85% of all functional assessments are complete.	
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.	Although improving, EPSSLC's full psychological assessments were not consistently current, therefore, this provision item was rated as being in noncompliance. EPSSLC recently began conducting full psychological assessments. A spreadsheet of all individuals with psychological assessments indicated that 38 of 94 individuals with a full psychological assessment (40%) were current (i.e., conducted in the last five years). This represented a dramatic improvement from the last review when none of the individuals had current full psychological assessment (0%). 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.	This provision continued to be rated in substantial compliance. In addition to the full psychological assessment, EPSSLC completed annual psychological updates. A spreadsheet provided to 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. This is consistent with the last review when 100% of individuals had current annual psychological updates. A spreadsheet indicated that 52 annual psychological updates were completed in the last six months, and 13 (25%) of these were reviewed by monitoring team to assess their comprehensiveness. All 10 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. This the same as the last review when 100% of the annual assessments reviewed were rated as comprehensive. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that two of the two individuals admitted to the facility in the last six months (100%) had psychological updates 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. The monitoring team did not find this item to be in substantial compliance because the treatment plans for psychological services other than PBSPs did not consistently include all of the components listed below, and the progress notes were not consistently related to the measurable objectives in the treatment plan. At the time of this onsite review, eight individuals participated in counseling and/or psychotherapy. This represented an increase from the last review when five individuals received psychological services other than PBSPs. Treatment plans and progress notes for seven of these individuals (88%) were reviewed to determine progress with this provision item. Improvements since the last review included the inclusion of generalization plans and the initiation of a counseling monitoring form.	Noncompliance

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		Although all treatment plans reviewed contained generalization plans, some (e.g., Individual #161, Individual #149) did not clearly provide a plan to generalize skills from the counseling environment to other practical settings (e.g., living, working, etc.). Additionally, the fail criterion was not clear for several individuals (e.g., Individual #161). Finally, some progress notes did not specifically address all of the measurable objectives in the treatment plan (e.g., completion of lessons I-IV of the Circles Curriculum for Individual #10. Overall, three of the seven treatment plans/progress notes reviewed (43%) did not include all of the component listed below. This was comparable to the last review when 40% of the treatment plans/progress notes were judged to be incomplete. 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 on specific objectives • 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	EPSSLC's self-assessment indicated that they believed that this provision item was in substantial compliance, however this item was rated as being in noncompliance because the PBSPs reviewed did not consistently contain adequate use of all of the components necessary for an effective plan. A list of individuals with PBSPs indicated that 23 individuals at EPSSLC had PBSPs. In the last review, the facility had 27 PBSPs. Since the last review, EPSSLC discontinued several PBSPs and replaced them with psychiatric support plans (PSPs). This provision item will focus exclusively on PBSPs. During this review, the monitoring team did encounter several examples of individuals	Noncompliance

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	resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	who had a PSP, but for whom a PBSP appeared to be more appropriate (e.g., Individual #181, Individual #161). Based on K9 of the Settlement Agreement, however, individuals who engage in dangerous/disruptive behaviors that constitute a risk to their, or others, health or safety should have a PBSP. PSPs, on the other hand, focus on individuals who require psychotropic medication for mental health symptoms, and do not engage in serious behavior problems. EPSSLC and DADS have committed to clarify the distinction between PBSPs and PSPs, and review all individuals with PSPs at EPSSLC to ensure that their target behaviors do not require a PBSP. The monitoring team will continue to review the distinctions between PBSPs and PSPs in future reviews. A list of all PBSPs and the date of last revision indicated that all 23 (100%) were current (i.e., revised in the last 12 months) and had all the necessary consents (as described in the 11/5/13 DADS Behavioral Health Services policy). This is consistent with the last review when all PBSPs had the necessary consents. Additionally, EPSSLC was tracking the time from receiving consent to the implementation of the PBSP. All 23 PBSPs (100%) were implemented within 14 days of receiving consent. This represented an improvement from the last review when 70% of PBSPs were implemented within 14 days of receiving necessary consents. Fifteen PBSPs were completed since the last review, and 12 (80%) of these were reviewed to evaluate compliance with this provision item. As found in the last two reviews, all 12 PBSPs reviewed (100%) included descriptions of target and replacement behaviors that were operational. Eleven of the 12 PBSPs reviewed (92%) described antecedent and consequent interventions to weaken target behaviors that appeared to be consistent with the hypothesized function of the behavior and, therefore, were likely to be useful for weakening undesired behavior. This represented a slight improvement from the last review when 86% of the PBSPs reviewed were judged to be consistent with the stated function. The consequent intervention potentially incompatible with the hypothesized function was: • Individual #32's PBSP hypothesized that his physical aggression was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). The interventions in Individual #32's PBSP included removing him from the environment following an episode of physical aggression. If avoiding undesired situations were reinforcing for Individual #32 (as hypothesized in the PBSP), then this intervention would potentially increase the likelihood of his disruptive behavior. Encouraging (and allowing) him to indicate that he wanted to leave the area BEFORE he engaged in physical aggression would represent an effective antecedent intervention. After the targeted behavior occurred, however,	

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		Individual #32 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of his aggression 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 aggressive behavior was to gain others' attention and attain desired items. Antecedent interventions included providing her with staff attention for the absence of target behaviors, and encouraging/reinforcing her for engaging in her replacement behavior (i.e., communicating what she wants (and providing what she requests when possible/practical), before she was aggressive. Individual #9's intervention following aggression included ensuring safety, but minimizing attention (no talking) by blocking the target behaviors. 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. Replacement behaviors were found to be functional (when possible) for 10 of the 12 (Individual #51 and Individual #32 were the exceptions) PBSPs reviewed (83%). This represented a decrease from the last report, when 100% of all replacement behaviors that could be functional were functional. The replacement behaviors that were not judged as functional are discussed below: • Both Individual #51's and Individual 32's PBSP hypothesized that their target behaviors (i.e., disrobing for Individual #51 and aggression for Individual #32) were maintained by escaping/avoiding undesired activities (negative reinforcement). Their replacement behavior were expressive communication. This replacement behavior would be functional if it clearly offered an alternative to the target behaviors for escaping/avoiding undesired activities. The instructions, however, for expressive communication only included examples of gaining access to preferred items, and did not specially instruct the DSPs on how to teach/reinforce requests to escape or avoid undesired activities. Examples of a functional replacement behavior should include teaching and reinforcing,	

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		alternative ways to avoid undesired activities (e.g., requesting a break, or requesting more time, etc.) 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 the skill acquisition plan (SAP) format. In past reviews between the functional assessments and the PBSP, all of the elements of treatment plan were included. During the current review, however, the monitoring team noted two functional assessments/PBSPs (e.g., Individual #109, Individual #81) that were missing one or more of the elements listed below: • rationale/purpose of the plan • description of potential function(s) of behavior • history of prior intervention strategies and outcomes • consideration of medical, psychiatric, and healthcare issues • operational definitions of target behaviors • operational definitions of functional replacement behavior • behavioral objectives for one or more target behaviors • behavioral objectives for one or more replacement behaviors • strategies/SAPs to promote the acquisition or occurrence of replacement or alternative behavior • baseline data for one or more target behavior • antecedent-based or preventative strategies • consequence-based strategies (what to do when behavior occurred) • the use of positive reinforcement • descriptions of data collection procedures Individual #13's and Individual #9's functional assessments/PBSPs contained all of the above elements and, therefore, it is suggested that those functional assessments/PBSPs serve as a model format for future plans. Overall, eight (Individual #9, Individual #13, Individual #18, Individual #126, Individual #7, Individual #112, Individual #11, and Individual #63) of the 12 PBSPs reviewed (67%) represented examples of comprehensive plans that contained all of the above elements. This represented a decrease from the last review when 86% of the PBSPs reviewed were judged to be acceptable. In order to achieve substantial compliance with this provision item, the facility needs to	

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		document that PBSPs are consistently implemented within 14 days of receiving consent, and ensure that at least 85% of the PBSPs reviewed are complete.	
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.	EPSSLC continued to be in substantial compliance with this provision item. As discussed in K4, IOA of target and replacement behaviors was collected for each individual with a PBSP, and the facility had established and achieved minimal frequencies of IOA collections and levels. In order to ensure that PBSPs were implemented as written, EPSSLC also collected treatment integrity data. The facility established that treatment integrity would be collected at least once a month for every individual with a PBSP and the minimal acceptable level would be 70%. Data provided to the monitoring team indicated that treatment integrity frequency and levels established were achieved. Treatment integrity observations occurred at least once a month for 99% of individuals with a PBSP from August 2013 to January 2014, and data collection reliability levels averaged 88% for individuals with a PBSP from August 2013 to January 2014. It is suggested that the facility increase the minimal goal level of treatment integrity. 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. Some graphs, however, appeared to have the X axis incorrectly labeled (see K4). 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 at least 90% of 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 for at least 85% of individuals with a PBSP.	Substantial Compliance
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	All of the PBSPs reviewed appeared simple, clear, and allowed for staff understanding. Additionally, all DSPs interviewed, indicated that they understood the PBSPs. Therefore, this provision item continued to be rated as being in substantial compliance. EPSSLC utilized a brief positive behavior support plan (i.e., working plan) that was	Substantial Compliance

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	be understood and implemented by direct care staff.	located in the individual books, and was written so that DSPs could understand them. The monitoring team reviewed 12 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 were consistently brief and concise, contained a minimal number of target behaviors (the monitoring team's sample averaged 2.2 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 10 PBSPs. The average reading grade level was 8.5. 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.	
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. Behavioral health specialists 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 were found to be thorough and included a review of the PBSP by a member of the behavioral health services department, an opportunity for DSPs to ask questions covering varying aspects of the PBSP, and written questions pertinent to each individual's PBSP. The facility reported that they maintained inservice logs on all staff training. They also reported, however, that they did not have documentation that float/relief staff were trained in the implementation of PBSPs for all individuals they were assigned. At the time of the onsite review, however, the EPSSLC was developing a data base of all staff trained to ensure that when a float/relief staff was assigned to an individual with a PBSP that that staff had been trained in the implementation of that individual's PBSP. 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.	Noncompliance

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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 113 individuals and employed six staff responsible for writing PBSPs. Additionally, the facility employed two psychology assistants and two psychology technicians. One of these staff 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 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 21 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 #157 Individual # 23 Individual #117, Individual # 4, Individual #162, Individual # 9, Individual #113, Individual #109 o Annual Medical Assessments the following individuals: • Individual #44, Individual #32, Individual # 8, Individual #127, Individual #25, Individual #100, Individual #60, Individual #56, Individual # 6, Individual #59, Individual #73, Individual #109, Individual #17, Individual #172, Individual #179, Individual #146 o Neurology Notes for the following individuals: • Individual #60, Individual #172 Individual #152, Individual #38, Individual #162,

	Individual #71, Individual #128, Individual #25, Individual#127, Individual #59 Interviews and Meetings Held: o Katherine Hill, Clinical Services Director o Pamela Richter, DO, Lead Physician 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 Daily Medical Provider Meetings o Weight Committee Meeting o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting o QA Meeting o Neurology-Psychiatry Clinic for Individual #179 o ISPA for Individual #161
	Facility Self-Assessment: EPSSLC submitted three documents in support of its assessment: the Self-Assessment, Provision Action Information, and Action Plan. The self-assessment listed a series of audits that were completed to determine compliance with the settlement agreement. Most of the areas reviewed related to documentation of care. However, the activities were not valid assessments. For example, the self assessment stated that 100% of the AMAs reviewed adequately addressed each individual's health care needs consistent with generally accepted professional standards of care. A physician needed to review the AMAs to make this determination, but that was not how the self-rating was conducted. The monitoring team also found that this finding was inconsistent with the findings of this review. Another item stated that 100% of the APLS were available, current, and had the most updated and accurate diagnoses consistent with current generally accepted professional standards of care. This comment did not have much meaning because there is no professional standard for APLs. 103 of 114 individuals had an eye exam consistent with the standards of care. The terminology used in the self-assessment was incorrect. Mammograms were referred to as preventive. This is the incorrect medical terminology. The self-assessment should be completed by someone with the appropriate medical knowledge. The self-assessment needs to be overhauled. First, a self-assessment related to medical care needs to be completed by someone who is able to select the metrics that are appropriate to measure compliance with

	the Settlement Agreement. For section L, an intimate knowledge of healthcare is needed to best achieve this. Many of the areas that must be reviewed will require data from physician review. A non-physician cannot provide commentary on the adequacy of the care of a physician (peer review). The facility must pay particular attention to this issue. The determination that a professional standard is met is a peer review decision. 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 substantial compliance with all four-provision items. This was largely due to the flawed nature of the self-assessment. The monitoring team disagreed with these self-ratings and found the facility in noncompliance with all four provisions.
	Summary of Monitor's Assessment: The medical department continued to face a number of challenges. A new clinical services director was hired in November 2013. She had the vast responsibility of administrative oversight of the medical, pharmacy, and dental departments. She also served as the lead for section G and section H. Since November 2013, she had had three supervisors and it was very evident during the week of the compliance review that she needed greater direction from the state medical services coordinator in executing her job duties relative to section L if she is to be effective in her role. There were also changes in the primary medical staff. At the time of the review, there was one lead primary care physician and one part-time contract physician. This staffing may have been adequate when considering the caseload of 113 alone; however, having one physician present at the facility most days of the week was not adequate for meeting the needs of the facility. The primary care physicians did not participate in the annual ISPs and this was a barrier to integration of clinical services. Just as important, throughout the week of the review, the monitoring team noticed that collaboration between medical and other clinical services was problematic. In fact, other disciplines reported this as a barrier to integration of clinical services. For the most part, individuals received basic medical services, such as vision and hearing screenings, hepatitis, and pneumococcal and influenza vaccinations. They also received the appropriate cancer screenings. The management of specific medical conditions was more problematic. Diabetes care required improvement to ensure that care was timely. Individuals with pneumonia needed to be assessed to ensure that supports and assessments were appropriate. There was also some evidence that the facility needed to address antimicrobial stewardship within the facility. This was a concern of the facility staff because of the frequent use of antibiotics. The facility did not have an infection control nurse at the time of the review. The active records had evidence that there

	were some issues with infection control practices and possible over use of antibiotics. The use of one drug was also problematic. Pseudoephedrine was prescribed to individuals with a history of behavioral issues and orders were written to use for up to 30 days. This prescribing pattern should be reviewed. During meetings, physicians often cited the lab matrix as the reason for completing or not completing diagnostic studies, such as EKGs and lab studies. The lab matrix does not, and should not, replace best practices and the appropriate standards of care. The monitoring team has commented in the past that the lab matrix is not always consistent with best practices. The facility completed medical audits, however, the sample size was not adequate. Additionally, the most recent internal audits were conducted by the prescriber who provided the care. Another physician should have been used. Chart audits were completed and presented as evidence of a medical quality program. It was good to see that some effort was made in this area, however, the audit tools were relatively weak and overall much more work was needed to have a comprehensive medical quality program. The facility submitted several policies and procedures. Generally, the medical department did not have adequate policies and procedures and had no system to effectively manage the development, revision, and tracking of policies and procedures. Some guidelines included in the preventive care matrix were not consistent with state policy nor were they consistent with generally acceptable standards of care. Ensuring that the practice standards align with the appropriate standards of care is one function of a facility medical director. This role cannot be delegated to administrative staff. Obtaining information for this review was challenging. The lead physician was the sole primary care provider on campus during the first three days of the compliance review. On the fourth day of the compliance review, she was available until noon. While she was available for interviews, there was no other practitioner to provide primary care services the first three days of the week. The monitoring team had to consider the minimal medical coverage in order to minimize the interruption of care for the individuals. The clinical services director was available, however, she was an administrator who did not have any background or training in health care services. As such, she could not speak to many of the issues related to this review. The monitoring team was at many times referred to other individuals. In one particular instance, the monitor was instructed to contact the infection control nurse for additional information. It was discovered that the facility did not have an infection control nurse. One of the former nurses provided volunteer services, but was not available for interviews. Similarly, the lead physician was not present for the discussion of mortality management. This was a standard part of all previous compliance reviews and the monitoring team made a request for the meeting during the early part of the week. EPSSLC should have a plan for medical coverage for future compliance reviews so that medical staff participation in compliance review interviews does not disrupt medical care provided to the individuals. Overall, the findings of this review demonstrated minimal progress in the provision of medical services. The progress observed was primarily in the area of preventive care with increased compliance in cancer screenings.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical staff was comprised of one full time lead physician and one part-time contract physician. The lead physician worked all day Monday through Wednesday and half a day on Thursday and Friday. The contract physician worked on Thursdays and Fridays. A full time clinical services director was hired in November 2013. This position replaced that of the medical director and the facility was no longer seeking to recruit a full time medical director. The clinic nurse hired in March 2012 continued in that position. The lead physician reported that her primary responsibility was clinical care. She supervised the respiratory therapist, but did not supervise any other physicians, such as the contract primary provider or the psychiatrist. She also was not responsible for activities related to the Settlement Agreement. The job description for the lead physician was extensive and appeared to be far more consistent with that of a medical director than that of a lead physician. It included supervision of other physicians and many activities related to medical quality. This was not, however, the role described by the lead physician to the monitoring team. Observations throughout the week indicated that the leadership of a medical director was needed. Based on the current census of 113, the requirements for medical participation in the various meetings, the requirement to provide medical coverage 24 hours a day inclusive of weekends, and the physicians' responsibilities for duties such as employee injuries, it was apparent that EPSSLC required a full time physician and additional full time primary care provider. **Physician Participation In Team Process** <u>Daily Clinical Services Meeting</u> EPSSLC continued the daily clinical services meeting. The monitoring team observed a number of these meetings, which were facilitated by the lead physician. The meetings	Noncompliance

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		followed the guidelines issued by state office with regards to the mandatory topics for discussion and were relatively brief. Meetings attended by the monitoring team lasted approximately 15-25 minutes. 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. It was reported that the meetings were used to discuss the results of the medical quality audits. While the daily meeting provided opportunities for many clinical discussions, the nature of medical quality discussions requires a different forum and audience. Thus, this was an example of an inappropriate use of the meeting time. <u>ISP Meetings</u> There was no improvement in the participation of the medical staff in the annual ISPs. The facility submitted the following data for ISP attendance:	

Medical Staff ISP Attendance 2013 - 2014		
	ISPs	Meetings Attended (%)
Aug	11	0
Sep	9	0
Oct	6	0
Nov	6	0
Dec	11	0
Jan	7	0

As noted in the table, the primary providers did not attend any of the ISP meetings conducted. The clinical services director and lead physician reported that the lead physician provided input prior to meetings, however, there was no documentary evidence to support their statements. The PCP was present for the ISPA held for Individual #161 the week of the compliance review.

EPSSLC will need to develop strategies to improve physician participation in the required meetings. Consideration should be given to re-structuring the medical discussion of annual ISPs in order to improve physician participation and hiring a full time non-physician primary care provider.

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

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		neurology-psychiatry clinic Acute care services were provided at University Medical Center and Sierra Medical Center. Labs were also completed at University Medical Center and could be reviewed online. Roentgenograms were also being done at the facility. A mobile unit was able to complete basic studies and provide digital images to the medical staff within one hour. During the attendance of the ISP for Individual #161, the IDT made a decision to transfer the individual for hospital evaluation. The team was unclear on how to accomplish this other than referral to the ED. The EPSSLC medical staff apparently had not established relationships with the medical staff at the local facilities. It was reported that the individuals were admitted to the on-call physicians. The lack of any informal agreement with the local providers resulted in a lack of continuity of care for individuals who required hospitalization. The staff at EPSSLC should determine how to improve relationships with the staff at local acute care facilities in order to provide more seamless transitions in care. It may be beneficial to discuss this with other SSLCs that have been able to form strong partnerships with the facilities that provide acute care services. There were several areas of concern noted during the conduct of this review. Staff reported questionable use of antibiotics at the facility and the records documented the frequent use of antimicrobials. The justification at times seemed questionable. The monitoring team was also concerned that some issues related to infection control did not seem to attract the appropriate level of attention. Infections that required contact isolation did not appear to immediately trigger this response. The AMAs for individuals did not emphasize the need to monitor the individuals for signs and symptoms of tuberculosis and did not list the latent infection in the active problem list. While latent, the condition required active monitoring, particularly when the individual lived in a group setting with the ability for rapid spread should an active infection develop. Another prescribing pattern that caused concern was the use of pseudoephedrine. It was prescribed frequently to individuals with behavioral issues. The side effect profile of this medication should result in careful selection of individuals for use. Moreover, pseudoephedrine should not be prescribed for 30-day intervals as noted in some records. Follow-up of acute conditions continued to present challenges. In several cases, follow-up documentation was not identified in the records. The IPN entries of the original problem often lacked documentation of the fundamental signs and symptoms of the disease/problem. Post- hospital follow-up documentation improved, but did not occur on weekends. The requirement to complete a post-hospital evaluation within 24 hours	

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		is not suspended on weekends. The facility must provide access to physician medical care 24 hours a day. Overall, there was evidence that most individuals received the basic medical services, such as screenings, immunizations, and some elements of preventive care. The medical management of conditions became more problematic for those individuals with more complicated problems who required additional follow-up. **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: • 10 of 10 (100%) AMAs were current • 7 of 10 (70%) AMAs included comments on family history • 3 of 10 (30%) AMAs stated "family history not available" • 9 of 10 (90%) AMAs included information about smoking history • 9 of 10 (90%) 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: • 13 of 15 (86%) AMAs were completed within 365 days of previous assessment • 2 of 15 (13%) AMAs stated "family history not available" • 15 of 15 (100%) AMAs included information about smoking history • 15 of 15 (100%) AMAs included information regarding the potential to transition The facility also submitted a list of Annual Medical Assessments for the past year. The list included 112 names: • 87 of 112 (77%) were completed in a timely manner	

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		The evaluations were considered timely if completed within 365 days of the prior assessment. There was no improvement in the quality of the AMAs. The state template was implemented, which resulted in assessments that were often lengthy, but not particularly informative. In spite of providing a long list of data elements, the assessments did not assimilate the information in a cogent manner to provide an adequate pictorial of the health status of the individual. Many assessments listed several pages of information on family involvement, labs, x-rays, etc. before actually providing an indication of the active medical problems of the individuals which was found in the section entitled current status, active medical problems. It is not effective to discuss laboratory and x-ray data prior to the presentation of the core information, such as the current medical problems. Moreover, in many instances, the list of active medical problems was incomplete and several of the assessments cited "continue current care" as the plan of care. Unfortunately, in many cases, the AMAs never included information regarding the treatment. The presentation of consultation data and the interval history continued to be disjointed and ineffective in creating a concise and comprehensible summary of the prior year. 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. <u>Quarterly Medical Summaries</u> Quarterly Medical Summaries were being completed by the part-time physician. 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. All of the records had a QMS completed within the past five months, but only 3 of 10 (30%) of records had a QMS that was current. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL	

#	Provision	Assessment of Status	Compliance
		• 9 of 10 (90%) APLs were signed/dated The Health Care Guidelines specify that the APL be updated as problems arise and resolve. There was improvement noted in this area, however, several records included APLs that were not updated with active problems: <u>Integrated Progress Notes</u> Physicians documented in the IPN in SOAP format. The notes were usually signed and dated. However, documentation frequently did not include the pertinent positive and negative findings that would be expected. Moreover, follow-up documentation appeared to be frequently lacking. For example, the assessment of abdominal pain lacked documentation of subjective complaints, the actual abdominal examination, and follow-up (see case examples for details). Post hospital documentation appeared to improve. However, there was no documentation if the individuals returned on a weekend even though the facility was required to provide 24-hour physician availability. The need to correct this immediately was discussed with the lead physician and clinical services director during the compliance review. <u>Physician Orders</u> Physician orders were generally signed, timed, and dated. Incomplete orders were sometimes 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. <u>Consultation Referrals</u> A total of 50 consults completed after September 2013 and included in the active records of the record sample were reviewed: • 0 of 50 (0%) consultations documented in the IPN included the requirements of explaining the significance of the consult findings (summary), agreement/disagreement, and a decision regarding IDT referral. The providers sometimes included a brief summary of the consult of one to two lines. More often than not, the IPN documentation simply stated that the consult was reviewed and the provider agreed or disagreed with the recommendations. The notations did not consistently specify which consult (date) was being addressed. For individuals who had multiple appointments, such as a series of weekly neurology appointments, it was difficult to determine which appointment the note was addressing. These findings were noted in the previous compliance review and no improvement was observed.	

#	Provision	Assessment of Status	Compliance
		In addition to problems with IPN documentation, the reason for the consultations was not always stated and adequate information was frequently not provided. In fact, during the daily clinical services meeting conducted on the Thursday of the compliance review, the lead physician reported one consult in which the urology consultant indicated that he did not know why the individual was referred for evaluation. Instructions were provided for the individual to return with additional information, including the explanation for the consultation. 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. The requirements relative to consultation referrals were reviewed during the week of the compliance review with the clinical services director who reported that a new stamp was implemented that added check boxes for agreement/disagreement and referral and referral to IDT. This stamp was placed on the actual consultation form. It was apparent that the requirements for IPN documentation were not understood, even though the requirements were detailed in the previous monitoring report. Given that this requirement was not implemented, it was not unexpected to see no improvement in this area. 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. Consultation referrals, including examples of documentation, are discussed further in section G2. **Routine and Preventive Care** Routine and preventive services were available to all individuals supported by the facility. Vision and hearing screenings were provided with high rates of compliance. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. Databases 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 clerk. The data indicated that the provision of preventive care, such as cancer screenings was a strength for EPSSLC. Individuals at risk for osteoporosis were also routinely screened. Data from the 10 records included in the record sample listed above and the facility's preventive care reports are summarized below:	

#	Provision	Assessment of Status	Compliance
		Preventive Care Flow Sheets For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 6 of 10 (60%) forms were updated, signed, and dated Immunizations • 9 of 10 (90%) individuals had documentation of receipt of administration of the influenza, hepatitis B, and pneumococcal vaccinations. The status of immunity against varicella, zoster, and some other immunizations could not be determined for many individuals. The PCFSs continued to list "no history" for several immunizations. This was noted in previous reviews. The facility reported that 20 out of 20 individuals for whom zoster vaccines were appropriate did receive the vaccine. There was no documentation in the database for varicella status for Individual #77, Individual #52, Individual #8, and Individual #32. Individual #38 and Individual #134 were reported to have a history of illness, as children, but the database did not document anything more than this. The immunization document reported that all immunizations were complete. The monitoring team commented in the previous monitoring report that this statement did not appear accurate. The monitoring team continues to find that the statement regarding all immunizations being complete is problematic and likely inaccurate. The facility must take the measures to ensure that all individuals have the appropriate immunizations as recommended by the Centers for Disease Control. Screenings • 9 of 10 (90%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing Prostate Cancer Screening • 2 of 7 males met criteria for PSA testing • 2 of 2 (100%) males had appropriate PSA testing A list of males greater than age 50 was provided. The list included 29 males: • 29 of 29 (100%) males had current PSA results Breast Cancer Screening • 1 of 3 females met criteria for breast cancer screening • 1 of 1 (100%) females had current breast cancer screenings	

#	Provision	Assessment of Status	Compliance
		A list of females age 40 and older was provided. The list included the names of 34 females, the date of the last mammogram, and explanations for any lack of testing: • 29 of 34 (85%) females completed breast cancer screening within the past 12 months • <u>Cervical Cancer Screening</u> • 3 of 3 females met criteria for cervical cancer screening • 3 of 3 (100%) females completed cervical cancer screening within past three years A list of females age 21 and older was provided. The list included the names of 39 females, the date of the last pap smear, and explanations for lack of testing: • 36 of 39 (92%) females completed gyn evaluations within the past three years <u>Colorectal Cancer Screening</u> • 4 of 10 individuals met criteria for colorectal cancer screening • 4 of 4 (100%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 51 and older was provided. The list contained 48 individuals: • 48 of 48 (100%) individuals had completed colonoscopies **Disease Management** State office issued numerous multidisciplinary clinical guidelines. The monitoring team recalled reviewing local guidelines for urinary tract infections and upper respiratory tract infections during the September 2013 review. The current staff was not aware of any local clinical guidelines. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below. <u>Diabetes Mellitus</u> The records of 10 individuals were reviewed for adherence to the standards of care in in five areas set forth by the American Diabetes Association. Data are presented below: • 8 of 10 (80%) individuals had adequate glycemic control (HbA1c <7) • 10 of 10 (100%) individuals had assessment for renal proteinuria • 10 of 10 (100%) individuals had annual eye examinations • 6 of 10 (60%) individuals received ACE/ARB for renal protection • 10 of 10 (100%) individuals received the pneumococcal and influenza	

#	Provision	Assessment of Status	Compliance
		vaccinations The active records for individuals with diabetes mellitus included diabetes care flow sheets, but it was not clear who updated the documents. Record reviews indicated the documents were not being updated. While compliance scores were good in many areas, some of the requirements were not completed in a timely manner and the current compliance rates were the result of recent completion of corrective actions. Two individuals had poorly controlled diabetes based on the elevated HbA1c levels. The PCP should ensure that all appropriate measures have been taken including endocrine consultation if indicated. The PCP should also ensure that the guidelines for use of ARBs/ACE are being appropriately applied in accordance with ADA criteria. EPSSLC should conduct quality audits of all individuals with diabetes audits to ensure that care is appropriate. <u>Pneumonia</u> The facility submitted information related to pneumonia. The total number of cases each month is summarized in the table below.	

Pneumonia 2013 – 2014						
	Aug	Sep	Oct	Nov	Dec	Jan
Bacterial	0	1	2	0	1	2
Aspiration	1	1	0	1	5	0
Total	1	2	2	1	6	2

The monitoring team discussed the pneumonia review process with the lead physician and the clinical services director and was informed that there was no pneumonia review committee or formal process for pneumonia review. The monitoring team was directed to discuss pneumonia with the infection control nurse. EPSSLC did not have an infection control nurse at the time of the compliance review. A prior infection control nurse provided some services on a volunteer basis and was not available for this discussion.

Documentation submitted as part of the infection control nursing data indicated that a telephone conference occurred on 11/6/13 with facility staff and state office staff related to pneumonia management. The facility participants were not specified. The information was informative, but it was not clear if the medical staff were participants in this conference. Emails were provided that were subsequently sent to the medical staff related to medical management of one particular individual who was not identified.

Having a process to ensure that each case of pneumonia is reviewed and correctly categorized is of paramount importance in ensuring that the proper supports are

#	Provision	Assessment of Status	Compliance
		implemented. For example, Individual #115 was diagnosed with bacterial pneumonia on 9/10/13 and was diagnosed with aspiration pneumonia on 9/28/13. Aspiration pneumonia occurred again on 12/3/13. This individual had a gastrostomy tube. It would be important for this individual with recurrent aspiration who had a gastric enteral tube to have the appropriate evaluation for recurrent pneumonia. As a pneumonia tracking tool, the AVATAR database should have included information on the medical workup of this individual. It was impossible for the monitoring team to determine, using AVATAR, if individuals with pneumonia had the appropriate management. The facility provided no other information, such as pneumonia checklists to assist with this determination. **Case Examples** Individual #134 • This individual was diagnosed with impetigo, but the IPN entry did not discuss the contact precautions that are required when a contagious diagnosis is made. • The individual had latent tuberculosis infection (LTBI). This was not listed in the APL and it should be. There are very specific signs and symptoms, which should be monitored, and none were mentioned in the AMA. • The physician order cited the "lab matrix" as the indication for the TSH. The lab matrix should never be and indication for an order. Screening due to the diagnosis of Down syndrome would have been a more acceptable indication. • This individual was seen on 10/18/13 for a human bite. The IPN entry documented that the human bite protocol would be followed. There was no documentation of medical follow-up of the injury or lab results. • The APL was not updated with the new diagnosis of hypothyroidism. • The AMA did not list any specific plan of care for the active problems. Plans were stated as "continue current plan." Individual #181 • There was only one QDRR in the record, which was dated March 2014. This was several months after admission. • The individual was seen on 1/19/14 for evaluation of "colicky like" abdominal pain. The IPN documented positive bowel sounds, but there was no documentation of any other abdominal or rectal examination. There was also no documentation of the presence or absence of symptoms, such as nausea, vomiting, or diarrhea. The assessment was "most likely gastritis" attributed to the recent start of ibuprofen. Ibuprofen was discontinued and Pepcid was started. There was no documentation of follow-up assessment. • On 2/11/14, the IPN documented complaints of dizziness with no falls or injuries. The PCP noted that new meds were added 2/4/14, but did not specify.	

#	Provision	Assessment of Status	Compliance
		The exam indicated that the lungs were coarse with rhonchi. The assessment was bronchitis. The plan was to check a chest x-ray, and prescribe robitussin, Zithromax, and nebulizer treatments. The assessment did not provide any documentation of subjective findings, such as cough, shortness of breath, fever, sputum production, etc. Yet the individual was prescribed antibiotics for bronchitis. There was no documentation of the CXR findings or follow-up evaluations. • This individual also was diagnosed with hypertension at a very young age. This diagnosis was not included in the APL. A cardiology referral was made. There was no discussion of the cause of HTN in this young individual • The plan in the AMA for bipolar disorder was "psychotropic meds." Individual #8 • This diabetic individual was started on Diamox for transitory edema. The individual was already receiving Topamax. The neurologist discontinued the Diamox the following day. It is not clear why the psychiatrist was managing a general medical problem, such as edema. It was also not clear why the individual was stated on Diamox for management of edema. Diamox would not be the most appropriate agent for management of edema and since it is a carbonic anhydrase inhibitor, it should not be used with topiramate, which also has carbonic anhydrase inhibitor activity. • The AMA did not list a plan for the active problems, but stated "continue current plans." • The diabetes flow sheet was incomplete. The urine microalbumin was ordered in March 2013 for corrective action plan. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 75 individuals. The following data regarding AED use were summarized from the list provided: • 8 of 75 (10%) individuals received 0 AEDs • 25 of 75 (33%) individuals received 1 AED • 22 of 75 (29%) individuals received 2 AEDs • 14 of 75 (18%) individuals received 3 AEDs • 3 of 75 (4%) individuals received 4 AEDs • 3 of 75 (4%) individuals received 5 AEDs • 13 of 75 (17%) individuals received older AEDS, such as Pb, Mysoline, and dilantin	

#	Provision	Assessment of Status	Compliance
		For the 75 individuals diagnosed with seizure disorder: • 0 of 75 (0%) individuals experienced status epilepticus • 0 of 75 (0%) individuals required transport to an acute care facility due to prolonged seizure activity • 8 of 75 (10%) individuals had VNS implantation • 23 of 75 (30%) 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 - 2014 Aug: 28 Sep: 27 Oct: 30 Nov: 22 Dec: 18 Jan: 30 The total number of appointments was reasonable given the number of individuals with the diagnosis of seizure disorder who actually received medications. On average, 25.8 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: • 10 of 10 (100%) individuals were seen at least twice over the past 12 months • 10 of 10 (100%) individuals had documentation of the seizure description • 10 of 10 (100%) individuals had documentation of current medications for seizures and dosages • 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.	

#	Provision	Assessment of Status	Compliance
		The consults continued to be handwritten and difficult to read. As noted during earlier compliance reviews, the MOSES and DISCUS dates were listed on the consults, but there was no other reference made to the side effect data provided. These evaluations often included information related to drowsiness, drooling, tremors, abnormal movements, constipation, and other problems that may have been related to medications and impacted the quality of life of the individuals. It is important that the PCPs and the neurologist review this information. The neurology notes for the IDT format should include information, such as primary diagnosis, epilepsy classification, seizure control, previous AED trials and side effects, comorbidities, other medications, allergies, and vital signs. The clinic notes reviewed indicated that labs were sometimes not done or available as necessary. Follow-up was sometimes delayed by a few months and individuals with refractory seizure disorder were not referred for evaluation by an epileptologist. Some individuals, such as Individual #38 had been seizure free for greater than five years, but the rationale for not having a discussion of weaning of medications was not documented. The monitoring team attended the neurology-psychiatry clinic for Individual #157. The IDT, the individual, and the family attended the clinic. The PCP did not attend. The clinic was not efficient, and was interrupted by the need to obtain information from the home that should have been known. Overall, having an onsite neurology clinic was a good service for the facility. Additional work is still needed to improve integration of neurology, psychiatry, and medical services. **Access To Specialists** As in the previous compliance review, the monitoring team requested a list of all "outside consultations." The facility submitted a list of all campus and off-campus appointments. There was no specific data related to compliance with clinic appointments and what percentage of appointments was met within the required timeframes. The facility will need to address the requirement to provide access to specialists as part of the provision of healthcare services. Monitoring of clinic appointments must track the timely completion of appointments based on the determined need and prioritization of the appointment. Moreover, the facility must have a procedure in place to ensure that follow-up of failed appointments occurs in a timely manner. The facility must be able to accurately track the needs of the individuals and the response of the facility to those needs in terms of providing access to health care services.	

#	Provision	Assessment of Status	Compliance
		Infection Control The facility did not have an infection control nurse at the time of the compliance review. Throughout the week of the compliance review, the monitoring team heard comments from various staff related to the infection control program at EPSSLC. There was concern about the lack of medical support and input for the facility's IC program. There was also concern about antimicrobial stewardship of the facility and the perceived overuse of antibiotics. The medical staff did not appear to believe these were areas of concern. However, P&T committee minutes indicated that one physician collaborated with the pharmacy intern to complete an inservice on the role of antibiotic use in the development of resistance. There was evidence that this was a concern for the facility. EPSSLC must (1) address the need to have an antimicrobial stewardship program to control antimicrobial overuse and resistance, (2) re-instate a robust infection control program, (3) evaluate the composition of the infection control committee to ensure that membership is appropriate, and (4) ensure that the facility has access to a physician with training and interest in epidemiology and infection prevention. **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. The facility submitted a statement explaining the rationale for the DNR. This paragraph appeared to have been extracted from the annual ISP document. The IPN on 8/14/13 included a statement by the PCP that the DNR was reviewed by the mother. However, there was no documentation by the PCP of the medical reasons for the DNR. There was no indication that this was reviewed by the facility's ethics committee. <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 director must address the staffing issues. There is a continued need for a medical director, the role of which is distinctly different from that of a lead physician. The facility also needs an additional full time provider such as a primary care nurse practitioner to assist with on-call coverage, weekend coverage, and to provide relief for physician vacations, etc. 2. Physician participation in the ISP process must be addressed as discussed above The recommendations throughout this report should be addressed.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td>
<u>Medical Reviews - External</u>
An external medical reviewer conducted Round 9 of the medical audits 2/27/14 to 2/28/14. State guidelines required that a sample of records be examined for compliance with 46 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, all essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. A total of six records were reviewed for the general medical audit. The facility submitted data for the external audits. Those data are summarized in the table below:
<table>
<tr><th colspan="2">Round 9 General Medical Audits
% Compliance</th></tr>
<tr><td>Essential</td><td>Non-Essential</td></tr>
<tr><td>100</td><td>95</td></tr>
</table>
Compliance scores were less than 80% for the following questions:

Q #33 –Are responses to significant lab values documented in the IPN?
Q #9 –Has the MMR immunization been given?
Q#18 – Have the appropriate preventive screenings for pap smears been provided?
Q#35 – Are significant abnormal diagnostic test results addressed by the provider with appropriate and timely follow-up documented in the IPN?

In addition to the general medical audits, medical management audits were also completed. Six charts, three for diabetes, two for osteoporosis and one for pneumonia, were reviewed. The results are presented in the table below.
<table>
<tr><th colspan="3">Round 9 Medical Management Audits
% Compliance</th></tr>
<tr><td>Diabetes</td><td>Osteoporosis</td><td>Pneumonia</td></tr>
<tr><td>93</td><td>83</td><td>100</td></tr>
</table>
A total of 10 action plans were developed for the general medical audits. Three action plans were developed for the medical management audits.
<table>
<tr><th colspan="6">Round 9 - Corrective Action Plans</th></tr>
<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>General Medical</td><td>10</td><td>9</td><td>1</td><td>10</td><td>0</td></tr>
<tr><td>Medical Management</td><td>3</td><td>3</td><td>0</td><td>3</td><td>0</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Ten action plans were completed, however, none were reported to be reviewed by QA. The facility completed the external review within the required timeframe and implemented corrective actions for identified deficiencies. Notwithstanding the timely completion of the audit, the monitoring team had several concerns: • The findings of the monitoring team were significantly different from that of the external reviewer. While the record sample was not the same, the monitoring team was surprised that none of the problems related to legibility of IPN entries, lack of follow-up, and lack of assessment following acute care evaluations/treatment was documented by the external reviewer. • The quality of the IPN documentation was also not addressed in the external audit. It was very provider specific, but the lack of pertinent positive and negative findings was a significant concern that was not commented on in the exit. Examples were provided in section L1. • There were problems with the content and comments of the audit tool. Guidance was provided to the auditor for each question. There were several questions in which the guidance provided conflicted with state preventive care guidelines, particularly with regards to the recommendations for mammography and osteoporosis screening. The summary for state policy states "attempt annual screening mammography for women age 40 -70 years." The guidance in the tool is not consistent with this statement. The monitoring team found that the guidance provided for other questions, such as Question #45 related to consultation recommendations, was also misleading. It is recommended that the validity of this tool and the guidance for the questions be re-evaluated. This has been noted in other reports. This review uses only <u>one source</u> of information to assess medical care, the active record. The sample size will need to be sufficient to make a reasonable determination with regards to the quality of care provided. Twelve records were reviewed with six of the records having a focus on only one specific medical issue. General medical care was assessed for six individuals. The sample size for review of general medical care may not be sufficient and should be increased to reflect the requirement for 10% sample. <u>Mortality Management at EPSSLC</u> There was one death in 2013 and no deaths occurred since the last compliance review. The monitoring team met with the facility director, clinical services director, CNE, QA director, and QA nurse, to discuss mortality management at the facility. The lead physician was not present. However, the part-time contract physician attended the meeting.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>It was reported that there were no outstanding corrective action plans. The nursing department conducted monthly meetings to review CAPs. The process for review of CAPs relate to medical issues was less clear.

While there were no outstanding issues, the monitoring team encourages the facility staff to improve the mortality review process by taking a number of actions:
• Ensure that adequate information is reviewed (no less than one year of the records, and two if possible)
• Ensure that all hospital information is obtained for review.
• A physician, preferably one not associated with the facility, should conduct a comprehensive and objective review of the medical care. The findings and recommendations from the review should be summarized in a written report and presented during the clinical death review.

<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 medical audits must be completed in accordance with state guidelines.
2. The sample size of the audits must be adequate to ensure power sufficient to assess the quality of care.
3. The external/internal medical audits should include greater assessment of clinical outcomes.
4. Future mortality reviews should include a comprehensive and objective review of the medical care 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</td><td><u>Internal Medical Reviews</u>
The facility presented a series of data elements for internal audits. Round 8 internal audits were conducted in August 2013. The facility presented data for Round 8 internal audits conducted January 2014

<table><tr><th colspan="2">Round 9 General Medical Audits
% Compliance</th></tr><tr><td>Essential</td><td>Non-Essential</td></tr><tr><td>68.5</td><td>88</td></tr></table>
Round 9 Medical Management audits were conducted on 3/5/14.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	remedies are achieved.		

Round 9 Medical Management Audits % Compliance		
Diabetes	Osteoporosis	Pneumonia
82	69	70

Again, the facility presented conflicting data. A second submission showing interrater reliability for Round 9 showed the results of internal and external audits. It correctly represented the external scores, but reported internal scores of 93%, 75%, and 64% for diabetes, osteoporosis, and pneumonia, respectively. There were no data for corrective action plans.

The results for the internal round 9 audits may have been helpful to the provider in assessing care. However, completion of the internal audits did not fulfill the requirement to complete the internal audits. Generally, physicians cannot credibly complete audits related to the care that they provide.

Medical Quality Program

The facility rated itself in substantial compliance based on the implementation of a quality indicator audit that was implemented in January 2014. Audit tools were developed for ER/hospital visits, diabetes mellitus, constipation, Down syndrome, and hypertension. The tools included several good questions related to care of these conditions, but overall lacked the power to accurately assess the quality of care because many key metrics were not included. For example, the diabetes audit failed to include key metrics, such as the use of ACE/ARBs for renal protection. The Agency for Healthcare Research and Quality clearly states that process and outcome measures should be considered together to assess diabetes care quality. EPSSLC's tool did not meet those criteria.

Discussions with staff indicated that this program appeared to be developed without any medical involvement. There was no policy, procedure, or guidelines that outlined the process. The facility's data analyst reported that two audits were conducted. Many staff reported during meetings that they were not aware of the process or the findings. The clinical services director reported that the results were reported to staff. However, this occurred within the context of the daily morning meeting, which the monitoring team observed to be a very short meeting lasting only 15-20 minutes. This would not be an appropriate forum to discuss the results of a quality process. Moreover, the monitoring team was uncertain of what data elements would have ben presented. The facility provided the monitoring team with a series of audit tools that were completed by the compliance nurse. However, no data were extracted from the findings of the audits.

#	Provision	Assessment of Status	Compliance
		While it was good to see that the facility made some effort to assess quality, this exercise appeared to function as another chart audit and did not have the fundamental components of a medical quality program. The quality program must consist of a number of elements inclusive of process, outcome, and structural indicators. The first step in this process is determining the set of metrics to be measured. The facility had chosen five conditions to be reviewed. Determination of medical quality will require expanding the conditions that are reviewed. It will also require adding additional metrics, such as preventive care compliance, the ability to provide specialty services in a timely manner, and other aspects of care deemed appropriate by the facility. It may be helpful for EPSSLC to seek further guidance from the state medical services coordinator who has knowledge of other SSLCs that have made progress in this area. <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. EPSSLC must complete the internal medical audits in accordance with state guidelines. 2. The sample size of the audits must be adequate to ensure power sufficient to assess the quality of care. 3. The facility should proceed with the development of the medical quality program. The monitoring team recommends that state office provide further guidance to the clinical services director. Physician involvement is needed in the development of this program.	

L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The monitoring team requested a copy of the complete medical policy and procedure manual including any other facility policies that were related to medical care. Copies of <u>all clinical guidelines</u> were also requested. The facility submitted seven policies and procedures:
		• EPSSLC Policy and Procedures:
		  ○ Prospective Review of New Medication Orders, 7/12, rev 6/13
		  ○ Communication With Hospitals and Other Acute Care Facilities, 8/09
		  ○ Oxygen Therapy/ Supplemental Therapy 6/27/13
		  ○ Medical Emergency Response, 2/11
		  ○ Medical Care, 6/11
		• State Supported Living Center Policy and Procedures:
		  ○ Policy No. 44: Medical Emergency Response, 7/10
		  ○ Policy No 9.2: Medical Care, 5/13
			Noncompliance

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		The development of policies, procedures, and guidelines was discussed at length with the clinical services director. The monitoring team inquired about other local policies, which were reviewed during previous compliance reviews, such as the local anticoagulation policy and the local bowel management policy. The clinical services director was not aware of these policies. This lack of information is one of the essential reasons that a well-defined process for developing, tracking, and revising policies was needed. The clinical services director had administrative responsibility for the department, but was unaware of the status of the policies, procedures, and guidelines that were necessary to provide guidance related to clinical care. In order for the medical staff to be accountable for the requirements of the department, they must have adequate information of the expectations as outlined in the policies, procedures and guidelines of the facility. The facility's medical care policy, written in 2011, did not include a description of the basic medical staff requirements and job duties, such as caseload responsibilities, completion of clinical rounds, on-call coverage responsibility, and weekend coverage. The local policy was also not updated to reflect changes in the state medical care policy, which was revised in May 2013. The medical department needs a comprehensive medical manual that includes the relevant information related to operations of the department and provision of health care services. This would include, but not be limited to information on staffing and caseloads, the role of the PCP in the IDT process, requirements for participation in ISPs and ISPAs, and participation of primary providers in various meetings. Procedures related to delivery systems should be provided, such as how consults are ordered, the process for obtaining labs, ordering x-rays and the various tracking systems. The requirements for the actual provision of care should also be included and cover acute care, preventive care requirements, and the expectations for the use of the various clinical guidelines and protocols. Another component of the manual would be the policies and procedures that describe the oversight processes, such as the internal and external medical reviews, the medical quality program, the mortality review process, and the facility's QA system. Other relevant policies, procedures, and guidelines, such as those related to the use of psychotropics, pharmacy services, and other integrated services should also be included. These official documents must include the issue/implementation date and be signed and dated by the appointing authority. The facility must also have a procedure in place to ensure that all policies and procedures undergo an annual review and are updated and revised as deemed appropriate.	

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		The facility provided some documentation related to medical staff training and in-services. <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. In addition to the guidelines issued by state office, the facility should have additional guidelines for other common medical conditions, such as hypertension, hyperlipidemia, and other identified conditions. 2. Local policies should be developed based on state issued guidelines. 3. Each member of the medical staff should have a medical department policy and procedure manual that includes all relevant policies and procedures and guidelines. 4. The medical department should maintain written documentation of all training and in-services that are provided 5. The department should establish a system for annual review of all medical policies and procedures. 6. The recommendations above should be addressed.	

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: 3/4/14 o EPSSLC Section M Action Plan update: 3/4/14 o EPSSLC Section M Presentation Book/Case Stud 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 Nursing Corrective Action Plans (CAPS) 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 Medication Variance Committee Meetings and associated documents, 2/25/14, 3/25/14 o EPSSLC last five months, Weight Committee Meeting Minutes and associated documents o EPSSLC Medication Room Audits, February 2014 o Last six months, number of medication error, type, discipline, homes, shift, unit, individual, category of severity and error mode o EPSSLC list of medication administration times o EPSSLC Medication Variance Committee minutes, dated: 3/25/14 o EPSSLC Pharmacy and Therapeutics Committee Agenda/ Meeting Minutes and associated documents, 3/26/14 o EPSSLC Morning Medical, IMRT, and Unit meeting minutes, and associated documents, 3/24/13 - 3/28/14 o EPSSLC Skin Integrity Committee Meeting Minutes dated, 12/6/13 o EPSSLC Weight Committee Team Member Responsibilities o EPSSLC Weight Committee Referral Criteria Guidelines o EPSSLC Critical Weight Protocol o EPSSLC Weight Tracking Tool o EPSSLC RN Case Manager Meetings, 10/24/13, 11/7/14, 1/10/14 o EPSSLC Nurse Management Meeting Agendas, 10/16/13, 11/6/13, 12/11/13 o EPSSLC Acute Care Plan (ACP) Meeting Agendas, 11/27/13, 1/31/14 o EPSSLC Medical Emergency Response Policy and Procedure #0442, dated: 10/3/11 o EPSSLC Emergency Drill Check List #044A, dated: September 2011 o EPPSLC Emergency Mock Drill –Drill Instructor Check- Off, not dated o EPSSLC Emergency Oxygen Tank and Suction Machine(s) Checklist #044B, dated: September 2011 o EPSSLC AED and Emergency Bag Check Off #044B, dated: September 2011 o EPSSLC Emergency Check Lists for Automatic External Defibrillator (AED), Emergency Bag, Oxygen

	and Suction Machine, 3/1/14 through 3/28/14 ○ EPSSLC location Listing for Emergency Equipment ○ EPPSLC Training Compliance Report, dated 2/28/14 ○ EPSSLC Environmental/Safety Committee Minutes, dated 10/29/13 and 1/28/14 ○ EPSSLC Last ten individual's medication variances and plan of correction ○ EPSSLC Medication Variance Systemic Findings Cap, initiated: 3/22/14 ○ EPSSLC last six months Medication Variance Trend Report ○ EPSSLC last six months Medication Room Audits, Medication Record Audits ○ EPSSLC Medication Variance Reporting In-service Training Records dated: 3/19/14, 3/21/14, 3/25/14 ○ EPSSLC Medication Administration Observation Guidelines Refresher for Nursing Auditors In-service Training Records, dated: 3/17/14, 3/19/14, 3/21/14 ○ EPSSLC Quality Assurance Nursing Committee Meeting Minutes, dated 2/11/14 and 3/21/14 ○ EPSSLC Refrigerator Temperature Logs, February 2014 ○ EPSSLC Blood Glucose Monitoring, associated MAR, and Diabetic Records ○ EPSSLC Telephone Conference Call Minutes on "How to do Root Cause Analysis of Pneumonias" ○ EPSSLC Infection Control Minutes, dated: 11/26/13, 2/25/14 ○ EPSSLC Antibiogram Report, June through December 2013 ○ EPSSLC Containment and Prevention of MRSA Infections dated: 4/8/13 ○ EPSSLC Containment of Conjunctivitis, dated 10/11/13 ○ EPSSLC Terminal Cleaning and Enhanced Cleaning, revised 11/25/13 ○ EPSSLC last six months agenda for New Staff Orientation (NEO), and revised curricula ○ EPSSLC list of individuals with current ISP dates, including dates of Annual and Quarterly Nursing Assessments, Integrated Health Care Plans, and as applicable MOSES and DISCUS ○ EPSSLC Last 12 months Facility Data for Annual/Quarterly Nursing Assessment's ○ SSLC Individual Support Plan Process, (new) 11/21/13 ○ SSLC Most Integrated Settings Practices #018.2, revised: 10/18/13 ○ SSLC Nursing Education Handbook, updated 8/13 ○ SSLC Standardized Nursing Abbreviations List, not dated ○ SSLC Protocol Cards ○ SSLC Vagal Nerve Stimulator, dated February 2011 ○ SSLC Nursing Quality Assurance Audit Process, dated 3/21/13 ○ SSLC Nursing Policy: Nursing Services #010.3, effective 6/17/13 ○ SSLC Nursing Guidelines/Protocols/Procedures Revised: • Comprehensive Nursing/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised: 1/14 • Care Plan Development, revised: 12/13 • Seizure Management Guidelines, revised: 12/13 ○ SSLC Nursing Protocols: • Enteral Medication Administration, revised: 12/13 • Enteral Nutrition, revised: 12/13 • DIASTAT AcuDial, revised: 12/13

	• Blood Glucose Monitoring, revised: 12/13 • Pre-treatment and Post-Sedation Monitoring, revised: 12/13 o SSLC Nursing Procedures: • Nurse Competency Based Training Curriculum: revised 12/13 • Management of Acute Illness and Injury, revised: 12/13 • Management of the Foley or Supra-pubic Catheter, revised: 12/13 • Neurological Assessment, revised: 12/13 • Medication Administration Observation Guidelines, revised: 12/13 • Medication Administration Guidelines, revised: 1/14 • Self-Administration of Medication Skills Assessment, revised: 12/13 • Gastrostomy Tube: Insertion by a Nurse, revised: 12/13 • Enteral Nutrition, revised: 1/14 o SSLC Blank Nursing Forms • Enteral Feeding Record, revised: 11/13 • Medication Observation From, revised: 11/12/13 • Self-Administration of Medication Monthly Data/Progress Note, revised: 12/13 o SSLC Nursing Protocol: Skin Management and Wound Prevention, dated: 5/11 o SSLC Physical Nutritional Management, #012.3, effective: 3/4/13 o SSLC Weight Management Policy, dated: August 2009 o SSLC Infection Control Committee Guidelines, dated: 5/13 o SSLC Infection Control Appendix J Addendums o SSLC Guidelines for Prevention and Monitoring of Clostridium Difficile Infections o SSLC Guidelines for Prevention and Monitoring of Clostridium Difficile Infections, dated: 7/13 o SSLC Infection Control Reference Manual, dated: 1/6/11 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) 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, infections, 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 #7, Individual #8, Individual #10, Individual #16, Individual #18, Individual #21, Individual #23, Individual #25, Individual #27,Individual #32, Individual #33, Individual #34, Individual #43, Individual #46, Individual #49, Individual #50, Individual #51, Individual #52, Individual #54, Individual #58, Individual #59, Individual #60, Individual #66, Individual #72,Individual #74, Individual #77, Individual #78, Individual

	# 81, Individual #96, Individual #99, Individual #100, Individual #105,Individual #111, Individual #113, Individual #114, Individual # 116, Individual #119, Individual #123, Individual #126, Individual #148, Individual #155, Individual #157, Individual # 162, Individual #179, Individual #181, Individual #195, and Individual #200 Interviews and Meetings Held: o Mary Ann Clark, RN, Chief Executive Officer (CNE) o Martha Manriquez, RN, Nurse Operations Officer (NOO) o Margaret Amada, RN, Volunteer Infection Control Preventionist (ICP) o Melinda Blystone, RN Compliance Nurse o Kimberly Golucke, RN, CRRN, Nurse Educator o Dulce Tellez, RN, Nurse Manager o Liz Charcon, RN, Acting Nurse Manager o Phillip D. Bueno, RN, RN Case Manager Lead o Elaine Lichter, RN, Quality Enhancement Nurse o Veronica Gahner, RN, Clinic Nurse o Staff RNs and LVNs o Interviews with CNE, NOO, Nurse Educator, RN Case Manager Lead/Hospital Liaison, 3/24/14 o Meeting with Nursing Administration, Specialty Nurses, Nurse Managers, 3/25/14 o Interviews with Clinic Nurse and Nursing Compliance Nurse, 3/26/14 o Interviews with QA Enhancement Nurse, 3/27/14 Observations Conducted: o Medication Room Inspections various units o Medication Administration Observation Passes on the following Individuals: • Individual #7, Individual #8, Individual #32, Individual #46, Individual #49, Individual #50, Individual #52, Individual #58, Individual #59, Individual #60, Individual #74, Individual #99, Individual #100, Individual #111, Individual # 116, Individual #126,Individual #157,and Individual # 200 o Enteral Administration of Formula/ Water Flushes of: Individual # 10 o Inspections of Emergency Equipment on 50% of the total units o Residential areas at various times of the day and evening o EPSSLC Morning Medical Committee Meetings, 3/25/14, 3/26/14 and 3/27/14 o EPSSLC Incident Management Review Team Meetings (IMRT): 3/24/14, and 3/26/14 o EPSSLC Unit Team Meetings, 3/24/14 and 3/26/14 o EPSSLC Medication Variance (Med Error Committee) Meeting, 3/25/14 o EPSSLC Interdisciplinary Team Meeting for Individual # 157, 3/26/14 o EPSSLC Pharmacy and Therapeutics Committee Meeting, 3/26/14 o EPPSLC Weekly Weight Meeting, 3/27/14

	Facility Self-Assessment: EPSSLC submitted its self-assessment for section M. For each sub-section, EPSSLC had identified activities engaged in to conduct the self-assessment, the results of the assessments, and a self-rating of substantial compliance or noncompliance with a rationale. The assessment provided documentation of its audits to include the monthly percentages and their averages, but did not show the actual number of audits conducted for arriving at the percentages. The facility incurred a lapse when performing inter-rater reliability checks between May 2013 and December 2013 due to re-assignments of the QA Nurse. The inter-rater reliability resumed in January 2014. The facility indicated noncompliance with M1, M2, M3, and M5, and the monitoring team agreed. The facility indicated substantial compliance for M4 and M6. The monitoring team did not agree with their M4 finding, but did agree with substantial compliance for M6. In addition to the self-assessment, the Nursing Department had continued their own quality enhancement efforts through the use of their case study to evaluate the overall effectives of their nursing interventions, and omissions in defining, recognizing, and determining risk.
	Summary of Monitor's Assessment: The facility's staffing changes resulted in several promotions within the nursing department that included the Hospital Liaison Nurse promoted to the Nursing Operations Officer, and the RN Case Manager promoted to the Nursing Compliance Officer. The Nursing Department designated an RN Case Manager as the RN Case Manager Lead. The RN Case Manager Lead was also assigned the functions of the Hospital Liaison. The Nursing Department experienced two vacancies in their Infection Control Preventionist over a three-month period. The previous Infection Control Preventionist, after resigning in November2013, agreed to return to assist the facility as a volunteer Infection Control Preventionist. The number of volunteer hours was not available. The CNE and Infection Control Preventionist consulted with state epidemiologists with regard to their Multi Drug Resistant Organisms, and followed the recommendations for instituting individualized enhanced/isolation precautions to prevent or minimize transmission. The facility reported 100% of the individual's records were reviewed and found 99% were up to date with the Centers for Disease Control (CDC) recommended adult immunizations.

	The RN Case Manager Lead was in the process of developing tracking tools to effectively track all Comprehensive Nursing Assessments/Quarterly Nursing Assessments, IRRFs, and IHCPs, to ensure timely assessments. Also RN Case Manager had begun holding individual reviews with the RN Case Managers to ensure content and quality of the content of the assessments. The Nursing Department had completed 100% of the required training for nurses. The RN Educator developed educational tools to assist nurses in critical thinking and in the development of health care plans. The monitoring team observed 17 individual's medication administrations for 51 medications across six homes for consistently following, in part, resulting in a finding of substantial compliance for provision M6: • acceptable standards of practice for medication administration • individual PNMP plan • infection control practices to include; the individual self-participating or assisted by the DSP with his or her hand hygiene prior to the administration of medications

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The monitoring team conducted its own independent review of the facility's self-assessment, action plans, and information presented in section M. The monitoring team held interviews and meetings with the CNE, NOO, RN Case Manager Lead/Hospital Liaison Nurse, Compliance Officer, Volunteer Infection Control Preventionist, Nurse Educator, Clinic Nurse, Nurse Managers, QA Enhancement RN, direct care RNs and LVNs, and DSPs. The monitoring team also reviewed individual's records, conducted nursing interviews, observed on units, and attended a variety of meetings. During the review, the monitoring team observed 29 individuals at various times of the day and evening across 10 of the homes. The monitoring team observed 17 nurses on the units (LVNs, direct care RNs, Campus RN, Nurse Managers, and RN Case Managers) who were performing assessments, changing dressings, providing enteral nutrition, and administering medications. The monitoring team also met with Nursing Leadership, Nurse Managers, and Specialty Nurses to review the Presentation Book. Each Nurse was empowered by the CNE to present, review, and discuss his or her section. Information addressing assessment and documentation of restraint use is included in section C of this report. <u>Staffing, Structure, and Supervision</u> At the time of the monitoring review, 113 individuals lived at EPSSLC. The CNE continued	Noncompliance

#	Provision	Assessment of Status	Compliance
		to comprehensively track the number of nursing positions, minimum staffing ratios, and document changes in staffing and the rationale for the changes in staffing. The Nursing Department had structured staffing patterns to include an acuity factor, and made written nursing assignments by unit and shift. Nursing supervision by the CNE was provided through face to face meetings, memos, and holding of regularly scheduled nursing meetings. Nurse Managers, and those in Nursing Leadership positions, were empowered by the CNE to schedule themselves on alternating shifts/weekends to assure nursing oversight. In addition, the Nursing Department held regularly scheduled staffing meetings to provide updates in changes in policy/procedure/protocols. The Nursing Operations Officer also worked varied shifts to ensure administrative supervision of nursing services. The CNE took calls for any afterhours facility needs related to nursing or other applicable facility needs. EPSSLC data showed that 90% LVN and 92% RN positions were filled. The CNE was in the process of hiring two RNs and LVN positions. The CNE explained that the overtime for LVNs and RNs showed increases in December 2013 and January 2014 due to the vacancies. The CNE reduced the use of agency nurses in December 2013 and January 2014 by using the facility's nursing staff to fill shifts, thus, agency nurse showed a decrease in the number of contact hours for LVNs. Nursing Administration changes occurring since the last visit included: • Transferring of Hospital Liaison duties to RNCM lead • Transferring the Nursing Compliance duties to the NOO • Establishing RN Case Manager Lead position • Transfer of the Hospital Liaison duties to the RN Case Manager Lead • Promoting RN Case Manager to Compliance Officer • The RN Case Manager Lead maintained a caseload of three individuals, and the Compliance Officer position was to be shared between Nursing and Medical. The NOO position had been vacated from September 2013 through February 2014. The NOO filled the void of the Compliance Nurse by continuing to conduct the Nursing Quality Enhancement Audits. The facility reported inter-rater reliability checks were not done as a result of the QA Assurance Nurse being reassigned. • The monitoring team interviewed the Compliance Nurse who reported that she does not currently have a descriptive job plan, which the CNE also confirmed. The facility should ensure a plan is in place that defines how the activities associated with the position will be shared, and how growth will be managed. • The Nursing Department Infection Control Nurse resigned in November 2013, the position was filled in January 2014, and vacated again in February 2014. The previous Infection Control Preventionist, after resigning in November2013, agreed to return in March 2014 to assist the facility in capacity of a Volunteer Infection	

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		Control Preventionist. The number of volunteer hours she was providing was not available. Overall, the vacancies had a direct impact toward obtaining compliance, or sustaining consistency from month to month with audit scores, which are representative of the documentation of the delivery of care and services. <u>Availability of Pertinent Medical Records</u> • Records were made available onsite readily and without difficulty. • Nursing entries on IPNs, Medication Administration Records, and Nursing Titles were not consistently legible. • Trigger Sheets contained omissions (blanks). • Temperatures did not consistently include the method by which they were obtained. • Oxygen saturations did not consistently indicate if on oxygen or room air. • Nursing Care Plans for acute episodic events that had not been reviewed, revised, or resolved continued to be present in the chart. For example: Individual #162's record contained Acute Care Plans dated 2/22/13. • Nursing IPNs were consistently documented in the SOAP format • Nursing abbreviations were not consistently documented in accordance with the SSLC Standardized Nursing Abbreviations, and when documented were more often than not illegible. For example, Individual #181's record Nursing IPN entry of 3/23/14. <u>Hospitalizations and Hospital Liaison Activities</u> Since the last visit by the monitoring team, the Hospital Liaison activities were transferred from the NOO position to the RN Case Manager Lead. The NOO now served as the backup Hospital Liaison. The RN Case Manager/Hospital Liaison reported that the activities by the RN Case Manager Lead/Hospital Liaison overlapped for: • Attending ISPAs, Unit Meetings, and COS related to hospital admission, discharge, or transfer to emergency room • Attending Morning Medical Meetings • Coordinated Hospital Admissions • Followed up on Emergency Room Visits • Completed Hospital Liaison Reports and submitted to the units • Requested, received, and distributed hospital/emergency room information • Conducted hospital rounds on individuals hospitalized during the week and on weekends	

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		The RN Case Manager Lead/Hospital Liaison reported that the facility did not have remote access to "real time" records from hospitals, but reported he had not had difficulty requesting and obtaining records from the hospital timely. The monitoring team reviewed documents for five of the most recent hospitalization Liaison Nursing Reports. There were 11 associated with the last five hospitalizations for Individual #7, Individual #43, Individual #72, Individual #48, and Individual #162 of which the monitoring team found: • Six of 11 (56%) Hospital Liaison reports contained the Hospital Liaison Nurse signature (Note, because these reports are electronic, the facility may want to consider an electronic signature) • 11 of 11 (100%) had daily visits • 10 of 11 (91%) of the reports contained pertinent information to keep the IDT team and physician informed of the health status of the individual • 11 of 11 (100%) of the report's discharge planning section was completed. Individual #162's report did not include any additional information about the type of tube, placement of tube, and route that he was receiving his medication and nutrition. The monitoring team reviewed recent hospitalization/emergency room visits for Individual #162 and Individual #10 and found: • On 3/19/14, Individual #162 was discharged from the hospital. A Post Hospital/ER/LTAC Nursing Assessment was completed. The Post Hospital/ER/LTAC form had omissions for communication from the facility provider and RN, and information/instruction that the RN communicated to other IDT members about the changes in the individual's condition or health care needs. A Nursing IPN by the RN Case Manager documented that a Post-Operative IDT meeting was held to review the post hospitalization. The record contained an Acute Care Plan for the Post-Hospitalization Jejunostomy Tube, staff instructions, and staff signatures for the completed training. The record was problematic for events pre- and post-hospitalization: • IPN entries were perplexing in regard to discerning the perforation of the G-tube prior to the hospitalization. For example, Nursing entry, on 2/6/14 indicated the G-tube was in place, "flushes well and is perforated." The note also documented that the G-tube was checked for placement only by injecting air, and did not include aspirating stomach contents. The Nursing current procedure for checking for placement/patency included aspirating for stomach contents. • The monitoring team was unable to discern whether or not the individual was receiving his enteral nutrition due to the omission of enteral feeding record.	

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		• The March 2014 MAR indicated the individual was receiving his medication via the G-tube prior to the hospitalization of 3/13/14, even though the ISP, dated 2/11/14, noted the team was in agreement enteral nutrition and medications should be give via the j-tube. The monitoring team did not located information that the team had followed through to include the physician with the agreement. It was also unclear as to the rationale for the change. • In the March 2014 MAR after the post–op orders were written on 3/19/14 and 3/20/14, the medications were initialed as being administered by G-tube on the MAR. The exception was the Lactulose and Carbamazepine, which were initialed as administered via the j-tube. The MAR should have been revised to ensure the correct route for each of the medications in accordance with physician's post-operative orders. The enteral record was not made available in the document request. The enteral record should also be reviewed to ensure the right route (tube) was being used to administer the individual's enteral nutrition. The physician orders did not include an order that address the length of the j-tube. All post-operative orders, and products from those orders, should be carefully reviewed by all clinicians to avoid the application of obsolete orders. • On 3/10/14 at 9:20 pm, Individual's #10's record provided a nursing assessment for a change in his health status that included vital signs assessment, data relevant to the problem, and a plan that included notification to the RN by the LVN. The RN arrived on 3/10/14 at 9:26 pm and conducted his assessment; the physician was notified of the change of status. The physician ordered the individual transferred to the hospital via ambulance. The individual was discharged on 3/11/14 at 12:30 am. A completed Post Hospitalization/ER/LTAC assessment was completed. The individual was seen post-emergency room visit in the clinic and found with negative findings from the hospital testing for his acute event. The Nursing IPNs included nursing assessments that required 72 hour post hospitalization assessments of which the 3/12/14 1:30 am nursing assessment reported an abnormal vital sign. The continuation of the IPN note documented the abnormal vital sign, and documented in the record "attempted to call MD, will call back later." On 3/12/13 at 10:30 am, the nursing IPN documented "clinic was left with a message to give to the doctor." The monitoring team did not find additional documentation to confirm that the physician received the notifications. The monitoring team reminded nurses of their role as a patient advocate, their responsibilities to ensure there was a physician response, and that responses are timely when reporting the health status of an individual. The nursing IPN's (P) plan were problematic. For examples, statements of "continue to monitor" were not specific as to what was to be monitored, and "asked DSP to report any changes physically or mentally immediately" were not specific as to what the DSP was to observe and report. The Nursing IPN note on 3/13/14 was problematic for	

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		legibility, and included conflicting dates. The Nursing Department should ensure: • Hospital Liaison Reports provide sufficient discharge information to ensure continuity of care. • Nurses should receive training to include pathophysiology of the different types of tubes, placement of tubes, and the difference in the type of tubes. • The MAR should be reviewed for any medication variances committed as a result of administering via the wrong route (tube). • Clarify between the Enteral Nutrition Protocol revised January 2014, and Gastrostomy Tube Nursing Procedure dated December 2013, regarding procedures for checking patency, position/placement of tubes • Ensure the Enteral Medication Administration December 2013 is fully operationalized. • Consider a method for promoting safety by identifying the G/J lumens. • Ensure nursing plans of care are formulated to ensure continuity of care between nurse to nurse, and staff instructions include what specific instructions to the DSP as to what they should be observing. The facility should have a process/procedure for how post hospitalization/emergency room orders, medications, treatments, and enteral nutrition are reconciled using a multidisciplinary team approach. <u>Weight Committee Meeting</u> The monitoring team attended the Weight Committee Meeting on 3/21/14, where the committee utilized a weight database, weight trending reports, lab reports, consultations, medications, and IPN notes to track and trend information about their weights. The meeting was chaired by the PNMT nurse in the absence of the NOO, and was attended by Nursing, Medical, Pharmacy, and Habilitation Therapies. The committee held lengthy discussions when reviewing each individual regarding their progress or lack of progress toward their goals. The following issues were raised during the committee meeting for improving upon the facility's practices and procedures specific to weight management. • Wheelchair weights, and their accuracy • Individuals that are within their minimum or maximum IBW, and experience significant weight loss or weight gain • Data sharing of information on assessments conducted for individuals determined at risk for predisposing conditions. For example, metabolic syndrome. The monitoring team will follow-up at the next visit.	

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		Wound and Skin Integrity The Skin Integrity meeting minutes, dated 12/6/13, showed the meeting was chaired by the Infection Control Preventionist, and was attended by Nurse Case Managers and a member of the Dietary Services. The minutes documented the next scheduled meeting was scheduled for 2/24/14. The documents did not include those minutes, if the meeting occurred. No data were included with the minutes, therefore, the monitoring team could not determine progress or lack of progress regarding skin integrity issues. Infection Control (ICP) The monitoring team reviewed the quarterly Infection Control Minutes for the last six months of meetings. The November 2013 minutes had an accompanying agenda, with detailed information about new, as well as ongoing, infections, analysis of clustering, action plans, and outcome analysis. The minutes also included a review of immunization compliance, PPD Screenings, and environmental rounds. The minutes also contained information on two policies, which had been pending since May 2013, for Containment of Conjunctivitis, and updated Immunization Policy. The policies were stated as "pending" approval by the state office. The monitoring team could not discern from the abbreviated February 2014 minutes and conflicting dates to determine if a meeting was actually held. An agenda was not included. The Volunteer ICP provided the monitoring team with several documents, which included an analysis of infections for 11/25/13, specifically addressing Urinary Tract Infections. The monitoring team was unable to discern the effectiveness of infection control measures upon the infection rates without the presence of data for November 2013, December 2013, January 2014 and February 2014. Activities by the ICP included: • Conducted Infection Control Rounds • Prepared the Infection Control Monthly Reports • Held Infection Control Meetings • Conducted Surveillance for Clustering of Infections • Entered data into the Avatar Infection Control Database • Maintained Isolation Tracking Document • Maintained Reportable Disease to Health Department • Tracked Immunizations • Tracked Individuals Hepatitis C Screenings • Tracked and maintained Line Listing of MDROs • Tracking of PPDs/Convertors • Consulted with State Epidemiologist • Conducted Trainings on:	

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		○ Mantoux Tuberculin Skin Test Trainings ○ Active and Latent Tuberculosis –Signs and symptoms ○ West Nile Fever ○ UTI Protocol and Sepsis ○ Athlete's Foot Prevention Transmission Procedures ○ Perianal Care ○ Isolation Procedures ○ Infection Control Prevention and Practices ○ Standard Precautions ○ Hand Hygiene and Glove Use ○ Vaccinations ○ Donning and Removing Personal Protective Equipment for Staff, Visitors and Families of Individuals in Isolation at EPSSLC ○ Enhanced Infection Control Measures ○ Impetigo, Shingles, Herpes Zoster, ESBL E. Coli, MRSA During an interview with Nursing Leadership that included the Volunteer ICP, the monitoring team learned that the Nursing Department had taken great strides to implement infection control practices in the prevention of transmission of infections. The monitoring team observed Individual #21, Individual #52, Individual #54 Individual #125, Individual #129, and Individual #148 who had enhanced standard precautions or contact isolation in response to the type of organism that could be transmitted by contact and found: • Six of six (100%) had information posted noting the type of precaution/isolation • Two of two (100%) as applicable, had an Isolation Cart containing all the personal protective equipment and available soap and water or hand sanitizer available for use by staff, visitors, and families • Six of six (100%) had the applicable Red trash bin and laundry hamper positioned in the individual's room • Six of six (100%) direct observations conducted unannounced on two consecutive days found that the DSPs and Nursing staff were adhering to the proper Standard Precautions and Isolation Precautions Staff, when queried by the monitoring team regarding the enhanced precautions/isolation procedures, responded correctly. The monitoring team selected Individual # 21 who had recent infections and required contact isolation and found: • On 3/14/14 at 5:30 am, the Nursing IPN documented that the DSP reported the individual had four loose stools. The RN assessed the individual, including vital signs, but which had an omission for pulse rate. The IPN nursing note included	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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pertinent information that the individual had started a new antibiotic for a urinary tract infection. The RN instructed staff to follow standard precautions, (i.e., wash hands). The individual was referred to the clinic. The Nursing IPN had omissions for having described the stool as to color, amount, odor, and/or presence of blood. The individual's skin turgor was not assessed for signs and symptoms of dehydration. Nursing instructions to staff did not include monitoring the individual's intake and output.
• On 3/14/14 at 2:00 pm, DSP reported that the individual had a change in skin integrity related to the reported loose stools. A nursing assessment included a physical assessment, vital signs, a review of the individual's allergies, review of his medications, and diet intake. The IPN nursing note documented that the clinic nurse was notified. The record contained documentation of assessing the skin integrity issue for excoriation.
• On 3/14/14 at 2:10 pm, the record contained documentation of physician orders that included discontinuing antibiotic, an ointment for treating the skin integrity issue, and to obtain a stool cultures for the suspected organism C. Difficile. The record had omissions of notification to the ICP, and omissions for instituting contact isolation precautions due to suspect of the organism, which can be spread from person to person through hand carriage contact. The record did not include a corresponding IPN medical note that the individual was examined by the clinic physician. A positive culture report for C. Difficile was documented by medical on 3/17/14 at 4:50 pm. The Medical IPN note documented placing the individual in isolation on 3/17/14. The record contained a Nursing Care Plan, staff instructions, and documentation of staff signatures.

The facility should ensure it is following the intent of the use of contact precautions, (meaning that in addition to Standard Precautions for individuals <u>known or suspected</u> to have a serious illness that is easily transmitted by direct contact or by contact with items in the individual's environment are instituted).

<u>Immunization/Vaccine Data/PPD Testing Status</u>
The Infection Control Preventionist maintained a line item database for tracking the date for each immunization. The facility reported as of 1/31/14, 99% of the individuals were up to date on their immunizations.

<table>
<tr><td>Tdap</td><td>MMR</td><td>Varicella</td><td>Zoster</td><td>Hep B</td><td>Hep A</td><td>Pneumonia</td><td>HPV</td></tr>
<tr><td>100%</td><td>99%</td><td>100%</td><td>100%</td><td>99%</td><td>100%</td><td>100%</td><td>99%</td></tr>
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For percentages less than 100% for MMR, Hep B, and Human Papilloma Virus, there was documentation regarding the guardian refusal consent status for the MMR. The
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		documentation included a scheduled date for the Hep B and Human Papilloma Virus vaccines to be administered. 98% percent of the individuals received their flu vaccine. The facility explained the remaining percentage of 2%. One individual was not immunized due to vaccine allergy, and another individual had not received the flu vaccine. The monitoring team reviewed Individual #181's record, who was delinquent for his Flu and PPD vaccine, and found a physician's order dated 1/10/14 for his administration of his flu vaccine and PPD. The monitoring team was unable to discern the status of the orders from the record. The record should be reviewed by the Nursing Department to assure the orders have been carried out. 35% of the staff at EPSSLC, as of January 2014, were current with their flu vaccine. No additional information was available for any declinations regarding the vaccine. The facility should work with the Medical Department to provide information about the flu, and how the vaccine may prevent or minimize the flu. In addition, the ICP should track declinations and the reasons associated with the declinations. No data were available regarding the percentage of employees who were compliant with their TB skin testing requirements. The ICP's data showed 89% of individuals, as of January 2014, had received their annual PPD. The remaining 11% of individuals were delinquent. The facility did not indicate in their report what the plan was to ensure those individuals received their PPD. The facility reported 100% (24) of individuals who cannot receive annual PPDs, due to previous positive test or apparent allergic reaction, were up to date with their yearly TB symptom questionnaire, and/or chest –ray result negative for TB. The monitoring team reviewed Individual #10's record regarding his positive PPD/convertor status (i.e., the individual had exposure to the tuberculosis bacteria, which resulted in a positive PPD test and classification as a convertor) and found: Annual Nursing Assessment included information about his positive PPD/convertor status, and a negative TB symptoms questionnaire (i.e., the required standardized assessment for observing and reporting respiratory signs and symptoms associated with the bacteria.) The IRRF and IHCP provided information that the individual was high risk for respiratory and medium risk for infections. Neither the IRRF nor IHCP contained information regarding his PPPD/convertor status, nursing interventions for conducting the required annual TB symptom questionnaire, or for how to recognize signs and symptoms of TB.	

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		Emergency Response The monitoring team, with a member of nursing leadership in attendance, conducted unannounced checks of emergency equipment on six of the nine various homes and units where emergency equipment was contained. The monitoring team found all of the equipment to be available in the designated areas, and operational. Nurses proficiently demonstrated how to use the oxygen, operate the suction machine, and responded correctly to questions posed regarding use of the Automatic External Defibrillator (AED). The monitoring team posed question regarding emergency backup equipment and systems, such as emergency power. The NOO reported that the facility had two backup battery powered suction machines, one of which was currently in use supporting an individual with his suction toothbrush. The facility should evaluate, if a power outage were to occur, that there are a sufficient number of battery operated suction machines, and ensure that all staff know how to identify emergency plugs during a power outage. Currently, the Emergency Crash Bags were not secure. During one of the monitoring checks, an individual was reported to be known to go to the bag, and take out the flashlight. She reported, after our inspection, she would return to recheck the bag. The facility should put in place a system to ensure the equipment and supplies located in the Emergency Bag are secured. The monitoring team reviewed various unit's applicable Emergency Oxygen Tank and Suction Machine Checklist and AED and Emergency Check Off Sheets, and found each was compliant with daily checks and contained the nurse's signature. The monitoring team reviewed all of the Emergency Checklist and Check Off Sheet for 3/1/14 through 3/28/14, and found them compliant for daily check off and nursing signatures. No blanks (omissions) were found on any of these records. The monitoring team findings were comparable to the facility's overall level of compliance. The facility should review and revise its current Emergency Response Policy to accurately reflect the location of all emergency medical equipment. The facility provided its raw data for its Mock Drill for 8/1/13 through 1/31/14. The facility's summary data showed an overall compliance of 100%. The summary did not include the number of drills conducted when arriving at the percentage. No data were available for February 2014. The facility did not have a designated emergency response committee. The monitoring team was informed by nursing that any "actual" emergency response would be included as part of the facility's morning medical and unit meetings. The facility training compliance report showed that one of the staff was delinquent. The document indicated that this nursing employee was on extended family leave.	

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		Quality Enhancement Efforts The monitoring team met with the QA Nurse and CNE who reported that Nursing QA meetings, after a seven month omission, resumed in March. A meeting was held on 3/20/14 and attended by the CNE, NOO, Nurse Educator, Nurse Manager and the QA Nurse. The minutes provided a section for Nursing reviewing their QA/QI section M, by audit type. The minutes indicated the inter-rater reliability processes would be established in April 2014. The QA Nurse had recently returned to the QA position, and in December 2013 re-established inter-rater reliability. The monitoring team will follow-up at the next visit as to the status of the meetings and the integrated process between Nursing and QA for conducting nursing audits and inter-rater reliability. Data associated with the minutes, M documented that the QA nurse was performing inter-rater reliability audits on the following: • Infection Control • Real Time Audit for Acute Infections • Skin Integrity • Pain Management The inter-rater reliability did not show agreement between the nursing and QA staff. The data stated a need for ongoing discussion and review of question interpretation. The monitoring team will follow-up at the next visit as to the status of this process. In addition, the Nursing Department reviewed its Presentation book; the group shared its own applications of applying quality assurance through a continuation of their case study for individual #113. It was impressive that the nurses had used the evolving knowledge from the case study as lessons learned that included their own review of problematic areas and areas in need of improvement. Assessment and Documentation of Individuals with Acute Changes in Status The monitoring team attended a number of the daily Medical Morning meetings, Unit meetings, and IMRT meetings, which were held consecutively each day during the week. The meetings overlapped, providing relevant information regarding individual's health/mental health, hospital planned and unplanned admissions, consultations, restraints, incidents, and physician/psychiatrist/psychologist after hours calls. The meeting also included review and discussion related to meals, medication, and health/mental health assessments. The IMRT reviewed incidents over the past 24 hours. Nursing attended and participated in these meetings by providing 24 hour nursing reports and following up on requests from the meetings. Weekly, the ICP or designee provided a report of the status of new or ongoing infections, the response to treatment, and status of implemented infection control measures in response to infections. For example, Individual #21's required infection control measures were discussed. Once the individual had two negative cultures,	

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		the team would re-evaluate. The individual's case status relative to the status of culture report was tracked daily on the Health Concerns Log/Significant Medical Issues section of the medical morning report. The monitoring team was present for the 3/24/14 unit meeting and IMRT meeting where the team reviewed an incident and discussed actions steps, including the circumstances leading up to Individual #181's fall and associated health/mental health/behavioral concerns, and made decisions to address the event that including on educating the nursing staff on the individual's BSP. The monitoring team reviewed Individual #181's and Individual #179's record in regard to the assessment and documentation with acute changes and found: • Nursing IPN, dated 3/23/14 at 2:30 pm, did not follow the Nursing Protocol for fall or suspected fall in assessing vital signs, and performing a neurological assessment. The Nursing IPN did not include instructions to the individual or the individual's DSP. • Nursing IPN dated 3/25/14 at 12:05 am: the DSP reported that the individual was agitated and started hitting his head against the wall (on 3/24/14) at 10:50 pm. The Nursing IPN documented, on 3/24/14 at 11:00 pm, that the individual stated his head was hurting. A nursing assessment included vital signs. The nurse documented "0" new injuries noted at this time and documented the administration of pain medication. A neurological sheet was not included in the record for assessing compliance for nursing assessments for the nursing determination of a "mild" head injury, therefore, compliance for the head injury protocol could not be discerned by the monitoring team. The Pain protocol was not followed. The record had omissions for: assessing the level of the individual's pain using the Wong Baker Scale, and documenting the response to the pain medication. The facility self-rated this provision as noncompliant due to inconsistency of the nursing department to successfully apply documentation principles to practice, thus, assuring adequate responses to all health care issues and change of status is addressed. To move in the direction of substantial compliance, the monitoring team recommends that the Nursing Department: 1. Ensure nurses consistently document health/mental health care problems, pertinent data and perform complete nursing assessments associated with the problem, and provide timely interventions specifically related to the problem. 2. Ensure the quarterly infection reports are complete, and meetings are held in accordance with the facility's state policy.	

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M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	The Nursing Department had allocated a RN Case Manager as the Lead. The CNE had developed written duties for the RN Case Manager. The monitoring team interviewed the RN Case Manager Lead, with the presence of the CNE. The RN Case Manager Lead continued to have a caseload of three individuals, and performed the Hospital Liaison Activities. The RN Case Manager Lead had a full complement of eight RN Case Managers. One RN Case Manager was currently completing her orientation. The RN Case Manager Lead had ensured each individual had a RN assigned RN Case Manager. Caseloads were assigned using an acuity scale. The RN Case Manager had developed workload management tools for: • Tracking RN Case Managers, Comprehensive Nursing Assessments/Quarterly Nursing Assessments, IHCPs, MOSES/DISCUS • Performing individualized reviews with RN Case Manager • Sending reminders to RN Case Managers <u>Revised Nursing Policy</u> • SSLC Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised: January 2014 The monitoring team, from the sample of 11 records, reviewed six of the Admission/Annual Nursing Assessments (two were new admissions) with dates between 11/26/13 and 3/26/14 for Individual #10, Individual #21, Individual #157, Individual #162, Individual, #179 Individual #181 and found: • One of two (50%) admissions nursing assessment had an accompanying Physical Assessment. • One of two (50%) admissions nursing assessments/physical assessments were completed within 30 days of their admission. • One of two (50%) admissions nursing assessments were completed on the most current, applicable SSLC format. • One of two (50%) admissions nursing assessments had omissions of providing an analysis of the assessment data. • One of two (50%) admissions nursing assessments were adequately completed to address the individual's health problems to assist the team in determining health risk and in the development of an IHCP. • One of the two (50%) admissions nursing assessments contained information about the individual's personal preferences, strengths. • One of two (50%) admissions nursing assessment documented the assessment were provided to the QIDP and other relevant IDT members. • Three of four (75%) annual assessments/physical assessments were completed in accordance with facility policy's timelines. • Two of the four (50%) annual assessments were completed on the most current, applicable SSLC format	Noncompliance

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		• Two of four (50%) annual assessments documented the assessment were provided to the QIDP and other relevant IDT members. • Three of four (75%) annual assessments were adequately completed to address the individual's health problems to assist the team in determining health risk and in the development of an IHCP. • Four of four (100%) annual assessments contained an accompanying completed physical assessment. • None of the four (0%) annual assessments were complete for addressing all applicable areas. • None of the two (0%) annual assessments did qualify/quantify for every health/mental health problem/diagnosis, the data by indicating progress or lack of progress toward the stated goal, or the effectiveness of the health care plans. • None of the two (0%) annual assessments contained documentation of individual's participation in his or her own health care. The monitoring team also reviewed five of the Quarterly/Nursing Assessments with dates between 12/19/13 and 2/23/14, for Individual #23, Individual #32, Individual #33, Individual #34, Individual #54 and found: • Five of five (100%) quarterly assessments were completed in accordance with facility policy timelines. • Five of five (100%) quarterly assessment had an accompanying physical assessment. • Four of the five (80%) quarterly assessment were complete for addressing all applicable areas. • None of the five (0%) quarterly assessments documented the individual's participation in his or health care. • None of the five (0%) annual assessments did not qualify/quantify for every health/mental health problem/diagnosis, the data by indicating progress or lack of progress toward the stated goal, or the effectiveness of the health care plans. The monitoring team's findings of an overall average of 81% for all assessments' timeliness were similar to the facility's overall average. The RN Case Managers are in much need of training and feedback on the content quantity and quality of the Admission/Annual and Quarterly nursing assessments. The Nursing Department should also focus on the issues identified.	

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Facility's Self-Assessment Report of Timely Nursing Assessment

August 2013	September	October	November	December	[redacted]	January 2014	Overall Average
100%	78%	100%	58%	91%		100%	85%

Facility's Nursing Comprehensive Audit Results

August 2013	September	October	November	December	December Revised Tool	January 2014	Overall Average
100%	No data	No data	No data	83%	90%	70%	86%

The facility explained that the downward trend was affected by a revision of the audit tool by the state office for the Nursing Comprehensive audit for January 2014. An explanation was not provided for the two different audit scores for December 2013.

The facility rated itself as noncompliant for this provision due to oversight and quality of assessment is in preliminary stages. The monitoring team concurs with their findings.

For the next six months the Nursing Department should:

1. Ensure the SSLC Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment is fully operationalized.
2. Ensure there is consistency in the use of current forms/formats
3. Provide training opportunities for RN Case Managers that emphasis critical thinking when performing and documenting nursing assessments.

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 CNE, for each record selected for review by the monitoring team, had included an explanation of the facility's own findings for a decrease in the number of acute care plans for 2014 for the months of January, February and March 2013. The rationale provided was that "even with the advent of the protocol cards, revised acute care plan template, interventions bank and the December 2013 SSLC Care Plans, questions continued to arise as to when an acute care plan was required." The CNE further reported that, as a result of the findings, the "EPSSLC Acute Care Plan Guidelines" were created to assist the nurses in development of their critical thinking skills when developing ACPs. The Nursing Department reported that the process was monitored through the Nursing Department's Acute Care Plan Workgroup. <u>Revised Policies Procedures:</u> • SSLC Guidelines Care Plan Development, revised October 2013 • SSLC Guidelines: Care Plan Development, revised December 2013 <u>Inservice/Training on Acute Care Plans (ACPs)</u> Inservice training on Acute Care Plans (ACPs) was provided in Nursing Department Meetings with RNs and RN Case Managers held on 11/18/13 and 11/ 20/13. The inservice included an agenda of the items covered, and signature sheets for the attendees. These items included:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Acute Nursing Care Plan: Format • Developing Acute Care Plans, • Acute Care Plan Log • Updating Care Plans, • Examples of sample ACPs • Acute Care Plan Audit Tool • SSLC Procedure: Care Plan Development. Revised: October 2013. <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 who had current infections: Individual #21, Individual #33, Individual #34, Individual #54, Individual #162, and Individual #179. There were 14 Acute Care Plans that were recently developed and implemented. The findings included: • Seven of 14 (50%) contained baseline data that was sufficient to describe the acute care change in health status that led to the need for the health care plan. • Seven of 14 (50%) contained goals sufficiently that described the desired outcomes as a result of the acute care plan interventions. • Seven of 14 (50%) included the signatures of the Home Managers and Direct Support Professionals verifying training on the individual's health care plan. • Seven of 14 (50%) were implemented within 12 hours. • Five of 14 (36%) ACPs reflected active health care problems; the health care problems had been resolved. • Four of 14 (23%) were sufficiently individualized to meet the individual's needs to resolve the acute change in health status. A positive example: Individual #21 revised staff instructions in transmission prevention, dated 3/5/14, incorporated a plan to ensure the individual's personal preferences were addressed. • Two of the 14 (14%) contained statements of interventions on how the individual would participate in his or her healthcare interventions. • Two of two (100%) ACPs sufficiently included items that coincided with the policies for managing the specific type of organism. The facility had not had enough time to demonstrate progress given the recent state changes in policies/procedures, and institution of a new template and bank of interventions. The monitoring team will follow-up on the outcomes of the training exercises for improving upon ACPs at the next visit. <u>Nursing Discharge Summaries</u> The state office Nursing Coordinator issued changes regarding the Nursing Discharge Summaries on 1/23/14. The monitoring team did not find documentation of nursing staff's acknowledgement of these changes. The monitoring team also did not find inservice	

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		training conducted by RN Case Managers to community group home staff as applicable, for nursing interventions that incorporated reviews/trainings on the individual's personal preferences, special instructions, immunization status, MOSES/DISCUS, DSP instructions, IRRF, or IHCP; all of which are essential to ensure continuity of care from the facility to the community. The Nursing Case Summaries for this review due to date of discharge were not subject to the policy change or the new format. The monitoring team reviewed five Nursing Discharge Summaries and the accompanying discharge packets for Individual # 18, Individual #27, Individual #51, Individual #105, and Individual #195, all of whom had transitioned to into community living and found: • Five of five (100%) were completed no more than 45 days prior to the date the individual moved to the community. • Three of four (75%) contained the applicable MOSES/DISCUS. • Five of five (100%) contained documentation of competency exam. • Three of five (60%) contained documentation about the individual's personal preferences. • None of five (0%) included documentation what a health/mental health emergency would look like for the individual. • Five of the five (100%) contained documentation that the community home nurses received training from the RN Case Managers on the individual's, preferences, special instructions, medications, immunizations, MOSES/DISCUS, IRRFs, IHCPs, ACPs, or DSP instructions. It would be helpful if the community provider staff indicated their credential (e.g., RN, LVN). • Five of five (100%) facility's Nursing Audit Tools used by the facility for documenting the completeness of the packet contained in the Discharge Packet did not have omissions (blanks). Two of the individuals had diagnosis of Down's Syndrome. Nursing Discharge Summary documents did not contain information to help staff understand the syndrome, or related health problems that are associated with the individual's intellectual and developmental disability. The facility rated itself as noncompliant due to the oversight and quality of care plan development, implementation and resolution has not met EPSSLC nursing department standards of practice. The monitoring team's findings were in agreement with the facility's self-assessment for noncompliance.	

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		For the next six months the Nursing Department should: 1. Ensure the procedural change for Acute Care Plans Template, use of bank of care plan interventions, and the SSLC Care Plan Development Guidelines are fully operationalized. 2. Continue training efforts toward exercises for critical thinking in the development, implementation, updating/revising, resolving ACPs and monitoring of ACPs. 3. Ensure RN Case Managers are trained on the recent policy format changes/ for completing discharge summaries. 4. Consult with the State Nursing Coordinator to define written roles and responsibilities of RN Case Managers regarding the community discharges.	
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.	<u>Required Competency Based Trainings/In services/Nursing Newsletters by the Nurse Educator</u> • Mosby's Chapter 21, Musculoskeletal (July, August, September 2013), nurses trained 100% • Mosby's Chapter 22 Neurological System, (October, November, December 2013), nurses trained 100% • Mosby's Chapter 10, Heart, and Chapter 14, Head and Neck, (October, November, December 2013), nurses trained 100% • Mosby's Chapter 12, Ear, Nose and Throat (January, February 2014), nurses trained 100% • Poster Board Inservice Sessions September 2013 through March 2014: o Antibiotic Therapy o Constipation o Urinary Tract Infection • Nursing Competencies o MOSES/DISCUS, October 2013 o Skin Management and Wound Prevention, October 2013 o G-tube insertion by a Nurse, Colostomy, Hemoccult November 2013 o Enteral Medication Administration, December 2013 o Medication Side Effects/Adverse Drug Reactions, December 2013 o Medication Variances Training, March 2014 o Skin Assessments o IPNs, March 2014 o Acute Care Plan, March 2014 • Protocol Challenges (new) o UTI, November 2013 • DSP Health Trainings o Peri Care, November 2013, to include new hires • Nursing Newsletters "El Paso Nurse's Notes" published monthly, on various	Noncompliance

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		subjects. For example: Infection Control, Down's Syndrome, and Nursing Audits • NEO Orientation The monitoring team interviewed the Nurse Educator with the presence of the CNE. It was impressive that the documentation the Nurse Educator had put together in the presentation book was organized by month, subject matter, and contained evidence of nursing trainings/inservices and competency by individual nurse. Since the monitoring team's last visit, the Nurse Educator has acquired an educational classroom for conducting training. The monitoring team observed nurses attending the Medication Variance training conducted by the Nurse Educator. The Nurse Educator had completed all of the required training and had moved training focus in making rounds to assist with bedside competencies, nursing documentation, and development of health care plans. The Nurse Educator attended the facility's Care Plan meetings. The following were a number of policies, protocols, and guidelines which the Nurse Educator utilized. <u>Policies, Procedures, Protocols and Guidelines/Forms</u> • Comprehensive Nursing/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised: 1/14 • Care Plan Development, revised: 12/13 • Seizure Management Guidelines, revised: 12/13 • Enteral Medication Administration, revised: 12/13 • Enteral Nutrition, revised: 12/13 • DIASTAT AcuDial, revised: 12/13 • Blood Glucose Monitoring, revised: 12/13 • Pre-treatment and Post-Sedation Monitoring, revised: 12/13 • Nurse Competency Based Training Curriculum: revised 12/13 • Management of Acute Illness and Injury, revised: 12/13 • Management of the Foley or Supra-pubic Catheter, revised: 12/13 • Neurological Assessment, revised: 12/13 • Medication Administration Observation Guidelines, revised: 12/13 • Medication Administration Guidelines, revised: 1/14 • Self-Administration of Medication Skills Assessment, revised: 12/13 • Gastrostomy Tube: Insertion by a Nurse, revised: 12/13 • Enteral Nutrition, revised: 1/14 • Enteral Feeding Record Form, revised: 11/13 • Medication Observation Form, revised: 11/12/13 • Self-Administration of Medication Monthly Data/Progress Note, revised: 12/13	

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		The monitoring team randomly selected five records from the sample of 11 individuals. The monitoring team found the following: • On 1/8/14 at 9:20 am, the DSP reported Individual #34 "was kicked on lower legs, causing her to fall on her buttocks. She was kicked by another individual." The fall, or suspected fall, protocol was not implemented including documenting a full set of vital signs, performing a neurological assessment, and/or completing a head to toe assessment. The individual's pain was assessed for "no facial grimaces of pain." The assessment did not include notification to a RN, given the nature of the fall, her level of risk taken into consideration, for which she was rated as high risk for osteoporosis, and medium risk for falls. A physician was not notified of the fall. The LVN plan included instructions to staff to report changes in her gait or pain. The individual received a pain medication for possible discomfort. The MAR was not available in the record for review if the medication was administered. The next available note was an IPN Medical note on 1/8/14 at 4:10 pm, for a review of a consult document received into the clinic office. On 1/8/14 (omission of time), the Nursing note stated the mother requested a referral for her daughter to the clinic for evaluation of her coccyx, post fall. The IPN note did not include an assessment of vital signs. The individual was to be seen in clinic on 1/9/14. Given the individual's risk and the circumstances of the fall, the individual's physician should have been notified. No documentation was found in the record that the individual was seen in clinic on or after 1/9/14 for the compliant. The record also did not contain information that let the mother know the status of her request. • On 3/24/14 at 8:00 pm, the nurse documented that Individual #33 had a fall at 4:30 pm and indicated the note was a follow-up IPN note. The record did not include a corresponding IPN entry for the body check conducted on 3/24/14 at 4:45 pm. The individual was assessed by the nurse for a "mild head injury." The record documented her skin integrity issues associated with the fall. The fall and associated injuries were not documented as reported to the physician. There was no documentation as to how her wounds from the fall were treated. The next available was a PT IPN, to consult on the root cause of the fall. No other Nursing IPN notes for follow-up were located in the record. An Acute Care Plan was not implemented. Staff instructions were not included in the IPN nursing note. The IRRF documented she was high risk for falls, and medium risk for fractures. The IPN note documented to "continue to monitor individual prn." The Pain Protocol, Fall protocol, and Head Injury Protocol were not followed. • On 3/8/14 3:08 pm, Individual #54's Nursing IPN note documented he was assessed for risk of an infection and referred to the clinic. The nursing plan documented that the individual was referred to the clinic. On 3/8/14 at 10:10 pm, the Nursing IPN note documented that the individual had a skin integrity issue to his abdomen with a discharge. The Nursing IPN included vital signs, an assessment	

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		of pain, and administration of Tylenol. The MAR documented at 8:00 pm Tylenol was administered. Neither the MAR nor the Nursing IPN documented the effectiveness of the pain medication. The individual was not seen in clinic until two days later, and was diagnosed with cellulitis infection. The individual's wound was cultured and he was placed on antibiotics. A discharge was considered an abnormal finding, and the physician should have been notified earlier. The individual's IRRF documented that he was at high risk for infections. The IHCP documented that if his old G-tube site had an infection, he needed to be referred to the clinic. The monitoring team was not in agreement with the IHCP indicating refer to the clinic. The interventions should be understood for any abnormal finding which is suspect for an infection, should be called to the attention of the physician. • On 2/17/14 at 9:05 pm, Individual #157's record documented that, per the ADL workbook, she had not had a bowel movement in three days. The Nursing IHCP nursing interventions included a notification if no BM in two days. The Nursing IPN documented a suppository was administered on 2/17/14 at 7:20 pm that also included the results from the suppository. The Nursing IPN documented "will continue to monitor per protocol." DSP instructions stated to report "any BM." Three days later, the individual was assessed, for having no bowel movement for three days, and was given a "PRN supp" (suppository) at 8 pm with results at 9 pm. The DSP was to report "any abnormal (…illegible)." The monitoring team could not discern the date the DSP was trained on the IHCP. The individual IHCP was not followed for notification of no bowel movement in two days. The record did not contain evidence of a signature by the DSP that document the staff instructions for reporting "any BM." • On 1/31/14 at 3:15 am, the IPN Nursing Note for Individual #21's record documented blisters to upper lip. The individual's vital signs, respiratory status, was assessed. The individual was referred to the clinic the next morning and was seen by Medical at 10:20 am. No specific treatment was indicated and to monitor. There was no additional follow-up by nursing as to the progression of the blisters or healing of the blisters in the record. Nursing assessments identifying problems should be followed to resolution of the problem. Below are the findings from the facility's audits, for which the monitoring team's findings were similar in that the assessments and implementation of the protocols were not consistently implemented over time.	

#	Provision	Assessment of Status	Compliance

Protocol Audit	August 2013	September	October	November	January 2014	February	Overall Average
UTI	79%	70%	80%	75%	63%	No data	76%
Respiratory Distress	86%	78%	80%	57%	100%	No data	83%
Antibiotic Therapy	[redacted]	91%	73%	No hospitalizations	81%	82%	82%
Vomiting	[redacted]	[redacted]	50%	71%	100%	100%	80%
Constipation	[redacted]	67%	67%	80%	87%	82%	77%
Infection Control	78%	94%		92%	100%	94%	94%
Skin Integrity	89%	78%	90%	90%	94%	85%	88%
Pain Management	100%	86%	69%	75%	42%	60%	72%

The facility rated itself in substantial compliance. The monitoring team concluded that training has not transferred into practice sufficiently to address the health status of the individuals. In addition, the Nursing Department had a number of policy/procedure/protocol changes, of which nursing staff need more time to demonstrate competency and gain experience in the consistency of application of nursing assessments, use of the various protocols for which nursing assessments and plans of care are derived from.

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 RN Case Manager Lead, in an interview, reported he and the QIDP were monitoring random ISPs to observe preparation, participation, quality of risk-rating process, and development of integrated interventions in the IHCP. The RN Case Manager Lead reported the QIDP was using a monitoring tool, and had a database for tracking the IHCPs. The state had revised its IHCP tool in December 2013, and the facility had begun implementing the tool in February 2014. No data were available from any of the monitoring tools, as these were new processes. The monitoring team will follow-up at the next visit regarding findings from the audit tools. The RN Case Manager Lead was observed attending the ISP meeting for Individual #157. The monitoring team attended one of the facility's ISP for individual #157 and found: • All of the relevant IDT members were present during the meeting. • Individual #157 was in attendance and supported during the meeting by her DSP. • The QIDP conducting the meeting consistently ensured that Individual #157's personal preferences were included when incorporating suggestions or recommendations from members of the IDT team. The QIDP provided ample time to allow the individual to respond to any questions from the IDT members. • The meeting room was problematic for: o Overcrowding of the space based on the large number of attendees o Distracting for the individual who was visually impaired and relied upon	Noncompliance

#	Provision	Assessment of Status	Compliance
		her sense of hearing to be able to participate, as a result of frequent movements of the attendees, or attendees going in and out of the meeting. • During the meeting, it was positive to see that the RN Case Manager readily had information available to add to the discussion regarding the individual's change in sleep patterns. This included a review of medications, specifically correlating the timeline of the change with when a sleep medication was discontinued. o Nonetheless, it was disappointing that the RN Case Manager did not bring forward in addressing with the team the significance of the weight gain that had occurred within her ideal body weight. • The meeting included ample time to explain community option opportunities by the individuals' invitees, who discussed options and took into consideration her special needs when making determinations of community homes to visit. • The monitoring team was in agreement with all the risk ratings, except weight, of which the team determined as low risk. The monitoring team was not in agreement because the individual had an unplanned weight gain. There was no correlation between the polypharmacy risk determined as medium and weight. Even though the individual's physician documented, in her assessment, that four of the medications she was taking contributed to her weight gain. The monitoring team selected four individuals from the sample of 11 records. Four ISPs, IRRFs, and Risk Action Plans/IHCPs that identified or contained information about the individuals' High Risk for aspiration: Individual #10, Individual # 21, Individual #32, and Individual #162. • Four of four (100%) had comprehensive interdisciplinary assessments. • Four of four (100%) had identified significant changes in health status since the last review. • Three of four (75%) assessments sufficiently provided data to assist in determining risk. • Three of four (75%) Risk Actions for health were sufficiently correlated. The monitoring team reviewed the four records for Aspiration Trigger Sheet and found: • Four of four (100%) of the individuals identified as being at Risk for Aspiration records contained Aspiration Trigger Sheets. Of the four records, there were 13 Aspiration Trigger data sheets for documenting and monitoring the risk. • None of 13 (0%) Aspiration Trigger sheets were individualized. Individual #162's Aspiration Trigger Sheet, for monitoring decline in function, was perplexing as to what specifically was to be observed by the DSP, to report to the nurse. • Ten of 13 (100%) Aspiration Trigger sheets contained omissions (blanks) for documenting the individual's signs and symptoms. For example, Individual #32's and Individual #21's Aspiration Trigger sheets were blank for seven consecutive	

#	Provision	Assessment of Status	Compliance
		days. No explanation was provided. • Seven of 13 (54%) Aspiration Trigger sheet formats were not consistent. • Seven of 13 (54%) of the Aspiration Trigger sheets, as required, were reviewed by the RN Case Manager. • Four of five (80%) had an associated documented Direct Support Professional Instructions with signatures. One of the four contained a date for implementation, the remaining four could not be discerned for a date because there was not an applicable place next to the signature for recording the date. • None of the five (0%) IHCPs were individualized or contained realistic goals for the combined risk factors of choking, aspiration, respiratory, dental, gastrointestinal, constipation, and bowel obstruction. • One of five (20%) IHCP had dates that indicated the IHCP was developed. The same document was not found compliant with the facilities nursing policy and procedures of implementing within fourteen days. The facility's self-assessment self-rated noncompliance due to process to assure quality of risk assessments and integrated interventions are in the preliminary stages. The monitoring team concluded, from independent review, that the facility was not in compliance with this provision because the facility was not proficient in their process to identify risks or change in individuals' risk. For example, most risks were identified after an individual had an actual event as opposed to a process that focused on prevention. The facility for the next six months: 1. Should focus on processes that sufficiently explain the reasons for identifying risks, difference between risk factors and risk indicators, and the rationale for assigning a level of risk. 2. The facility should fully implement its process for tracking and monitoring the effectiveness of the risk process.	
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	The following were improvements instituted by the Nursing Department and were observed and/or reviewed by the monitoring team since the last visit: • Development of a process, by nursing, to investigate the magnitude of medication variances, as recommended by the monitoring team. • Lessons learned from the variances were fed back to nursing staff regarding their medication variances, as recommended by the monitoring team. • Designated a Nurse Manager to review/investigate all nursing potential and actual medication variances. • Observation of compliance with infection control practices by nursing prior to and during administration of medications.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	• Observation of individuals participating and/or being assisted by the DSP in his or her own hand hygiene prior to receiving their medications. • Observation of Medications administration passes were administered in accordance with generally accepted practices, with the exception of a few prompts, that did not negate the overall compliance with essential elements of medication passes. • Observed the implementation of a newly instituted nursing medication safety procedure for administering high alert medications. For example, Individual #58's administration of Insulin, by injection, included a check off by the presence of two nurses, prior to the dose being administered. • Reviewed established processes for tracking timelines for the discovery of medication variances and the actual date the variance occurred. <u>Medication Administration</u> The monitoring team selected and conducted 51 unannounced medication observation passes. Seventeen individuals were observed receiving their medications during various times of the day across six of the 10 homes for Individual #7, Individual #8, Individual #32, Individual #46, Individual #49, Individual #50, Individual #52, Individual #58, Individual #59, Individual # 60, Individual # 74, Individual #99, Individual #100, Individual #111, Individual #116, Individual #127, and Individual #200. The observations included oral, crushed, medications administered with different mediums, such as applesauce, pudding, and thickened liquids, and an injection. The monitoring team observations included applying "the essential items" from the facility's Medication Observation Pass Form and found: • 51 of 51 (100%) of the medications were administered correctly. Although there were two that required prompts during the pass, the prompts did not negate the competency of the medication observation pass. • 51 of 51 (100%) of the individuals were attended by their DSP for the purpose of identification prior to receiving their medication. • 51 of 51 (100%) of the observations, the nurse prior to, during, and after followed infection control practices. • 51 of 51 (100%) of the observations the nurses performed the three quality checks. • 51 of 51 (100%) were administered according to prescription in terms of right drug, right dosage, right time, right form of drug, and right route. • 51 of 51 (100%) of the applicable "essential elements" weighted on the facility's Medication Observation Form were observed as being followed. For example following the individuals PNMP. • 51 of 51 (100%) of the medications administered were correctly documented on the MAR • 17 of 17 individuals (100%) were observed participating or being assisted to	

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		participate in hand hygiene prior to receiving their medications It was also positive to observe: • Interaction between the nurse, the individual and the DSP. For example, the nurses consistently offered additional fluids for those individuals whose plans did not include fluid restrictions. The nurse also encouraged applicable self-help skills, such as holding their own cup. The monitoring team, prior to medication passes, had the opportunity to observe Individual#10 receiving his G-tube feeding. The monitoring team also observed the dressing change for the G-tube associated with the feeding. The nurse followed accepted standards of practices for: • Explaining what she was doing for the individual in his native language • Checking placement prior to administering the feeding • Checking for residual • Administering the enteral nutrition • Infection Control Practices <u>Revised Protocol/Policies/Procedures</u> • Enteral Medication Administration revised December 2013 • Self-Administration of Medications revised December 2013 • Nursing Administration Observation Guidelines revised September 2013 • Medication Administration Guidelines revised September 2013 <u>Documentation</u> The monitoring team reviewed Individual #60, Individual #99, and Individual #127's MARs that had received a PRN, for which there were ten. • Ten of 10 (100%) MARs documented the reason for the PRN medications. • Ten of 10 (100%) MARs documented the medication or medication used in a treatment was effective. • Four of the 10 (40%), which was perplexing to the monitor how it was discerned that the medication had been effective, as the entry date and time and "effective" were all entered at the same time on the same line. <u>Monitoring Team's Oversight and Monitoring of Medication Administration Practices</u> • 100% of nurses selected to perform medication observation passes were trained as evidenced by the Nurse Educator database by individual name and date. • 100% of nurses had received competency based in-service training on Medication Variances evidence by individual, date, and signature sheet. • 100% Medication room inspections were found in compliance using the facility's	

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		tool for Medication Room Audits. The facility had developed a Corrective Action Plan, dated 2/14/14, addressing compliance for completing Medication Administration Observations quarterly. The self-assessment reported, as of 3/4/14, that they were compliant with the exception of three nurses. The CNE explained that these had not exceeded the due dates in March 2014. The monitoring team also reviewed evidence documentation by individual nurse provided by the nurse educator for the stated compliance. For any nurses not found in compliance with their medication pass observations, actions by the Nursing Department included notification to the Nursing Operations officer by the Nurse Educator and performance coaching and retraining. <u>Medication Variance and Pharmacy and Therapeutics Meetings</u> The monitoring team attended both the Medication Variance and Pharmacy and Therapeutics meetings. The CNE chaired the meeting, and the Nurse Manager provided an in-depth review of her investigations and actions taken as a result of those investigations. During the meeting, the CNE and Nurse Managers confirmed, for each of EPSSLC's committed medication variances associated with a transcription error, the facility had chosen to complete a separate medication variance for each of the variances. Thus, one would expect the facility's data to show an increase in the number of medication variances. The CNE also pointed out, during the meeting, that the medication variance data included a new column for tracking the information from the medication variance form for the date the variance was discovered and the actual date the variance occurred. The CNE reviewed, during the meeting, the facility's corrective action plan initiated on 3/22/14. The plan was implemented for "noncompliance/failures of multiple systems resulted in a medication variance(s)" involving both Pharmacy and Nursing." The CNE, from the discussion at the meeting, added additional items to the CAP, for which the monitoring team will review for compliance at the next visit. For more information related to the pharmacy and therapeutics committee and medication variances refer to section N8. The monitoring team reviewed 19 of the most recent medication variances for: Individual #20, Individual #25, Individual # 54, Individual #66, Individual #72, Individual #77, Individual #78, Individual #81, Individual #96, Individual #113, Individual # 114, Individual #119, Individual # 148, Individual #155, and Individual #179 of which four of the Individuals; had two medication variances. • 17 of the 19 (89%) applicable medication variances of the medication variances had a documented severity index, which was perplexing to the monitoring team, if in fact, the facility had a procedure for conducting a review by all its disciplines when determining severity. • 13 of the 19 (68%) variances documented nursing was responsible for the	

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		committed variance. • Six of the 13 (46%) variances were omissions (individual did not receive his or her medication) and five (38%) were nurse administered the wrong dose. Of the remaining two, was a transcription error and a policy issue • 11 of 13 (84%) variances had been completed in all the applicable sections on the form. • 12 of 13 (92%) variances included notification to the physician. • Individual #54 had two medication variances which occurred for the same medication. One was not discovered for 10 days. The individual was being treated for an infection with a 10-day treatment of antibiotics. The physician was notified and three additional days of medication was ordered to complete his antibiotic treatment. The other medication variance was not discovered for two days and was related to a failure to follow a policy regarding the medication and the individual's documented allergy. To continue to maintain substantial compliance the monitoring team recommends that the Nursing Department and facility continue the work described above and also: 1. Ensure there is a sufficient process in place for check and balances for all aspects of medication administration, and that those processes that are sufficiently integrated among all disciplines who have responsible roles in prescribing, dispensing, administering, and monitoring in the promotion of medication safety and prevention or minimizing of actual or potential errors.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.2: Medical Care, o EPSSLC Self Assessment for Section N o EPSSLC Action Plan Provision N o EPSSLC Provision Action Information o EPSSLC Organizational Charts o EPSSLC Pharmacy Policy and Procedures 2014 o EPSSLC Adverse Drug Reactions, Revised 12/18/13 o EPSSLC Prospective Review of New Medication Orders, Revised 6/2013 o EPSSLC Quarterly Drug Regimen Reviews, 10/2011 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 #161, Individual #52, Individual #157, Individual #23, Individual # 38, Individual # 8, Individual # 134, Individual #77, Individual #32, Individual #13, Individual #100, Individual #83, Individual #120, Individual #58, Individual #181 o MOSES and/or DISCUS evaluations for the following individuals: • Individual #161, Individual #52, Individual #157, Individual #23, Individual # 38, Individual # 8, Individual # 134, Individual #77, Individual #32, Individual #13, Individual #100, Individual #83, Individual #120, Individual #58, Individual #149, Individual #56 Individual #73, Individual #126, Individual #74, Individual #39, Individual #148 Individual #72, Individual #162, Individual #44, Individual #188, Individual #12, Individual #24, Individual # 75, Individual #70, Individual #21, Individual #123, Individual #127, Individual #90, Individual #148, Individual #57, Individual #35, Individual #181 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 Katherine Hill, Clinical Services Director o Pam Ritcher, DO, Lead Physician o Ramesh Komaragiri, MD, Contract Primary Provider o Eugenio Chavez-Rice, MD, Psychiatry Director o May Ann Clark, RN, Chief Nurse Executive o Elaine Lichter, RN, QA Nurse 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. The self-assessment was thoroughly done and included many of the same items reviewed by the monitoring team. Although provision N4 was not directly assessed during this review, it is recommended that the self-assessment determine compliance with all recommendations made by the pharmacists. This requires an assessment of the physicians' responses to prospective and retrospective recommendations. The self-assessment did not include any data related to prospective recommendations (those made as part of the clinical interventions and intelligent alerts). Provision N4 is not limited to recommendations made in the QDRRs. Provision N5 addresses the completion of the MOSES and DISCUS evaluations. The self-assessment included a review of a sample to determine if the evaluations were completed. It also included a review of the annual psychiatric evaluation to determine if there was documentation of discussion of the evaluations by the IDT. The self-assessment should also include compliance rates for overall completion in order to determine if the evaluations are being completed in a timely manner. Since the monitoring team considers the use of the evaluations by the primary providers important, the facility should develop a metric to determine compliance with this requirement. 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, N6, and N7. The monitoring team found provision N8 in noncompliance.

	Summary of Monitor's Assessment: The pharmacy department was staffed with a full time pharmacy director, full time clinical pharmacist, and two full time pharmacy technicians. Although staffing had decreased during the past year, the department continued to operate efficiently and staff worked collaboratively with other clinical disciplines. The roles of staff were well defined and the department maintained a comprehensive policy and procedure manual, which it maintained and updated. Overall, the facility continued to make progress in the provision of pharmacy services. Documentation of communication between the pharmacists and prescribers was maintained and the Intelligent Alerts continued to be effectively utilized. Moreover, the pharmacy department used the data generated by these processes to implement corrective actions. These actions appeared to produce a favorable response, such as a decrease in the number of physician orders that required clarification. EPSSLC continued to complete the QDRRs in a timely manner. Polypharmacy, stat drug use, and the anticholinergic burden continued to be addressed in the QDRRs as required. The process for assessing the risk of metabolic syndrome was enhanced and provided guidance that was more specific. However, the actual criteria for metabolic syndrome will need to be reviewed. The MOSES and DISCUS evaluations were completed by nursing staff and reviewed by the psychiatrist. The delays in psychiatry assessments, observed in the September 2013 compliance review, decreased, but documentation submitted by the pharmacy indicated continued problems with timely completion. The facility's tracking data was not sufficient to determine overall compliance with the requirements for completion. The total number of ADRs reported remained relatively low. However, the pharmacy department did a considerable amount of work in this area in terms of educating the medical staff on the importance of ADR reporting. Physician reporting remained low even in the face of clear ADRs. The pharmacy staff conducted record audits and found ADRs that should have been reported, but were not. One such ADR resulted in hospitalization and possibly required further review. The medication variance system made progress in a number of areas, including medication reconciliation, documentation, verification of variances, and improved attendance by the medical staff. There continued to be a lack of reporting of prescribing variances. While the progress made in pharmacy services was noteworthy, the monitoring team remains concerned about the lack of physician leadership. The Pharmacy and Therapeutics Committee minutes documented inconsistent medical participation. Medical leadership is required for almost all aspects of health care services. The Pharmacy and Therapeutics Committee had evolved to include many responsibilities, such as drug use evaluations, adverse drug event monitoring and reporting, approval of guidelines for medication management, antimicrobial stewardship, and formulary management. The overarching goal is ensuring

	safe, appropriate, and cost effective use of pharmaceuticals. Accomplishing this goal requires a multidisciplinary committee that includes, but is not limited to physicians, pharmacists, nurses, administrators, and QA coordinators. Active physician participation is a key factor in the success of the committee. EPSSLC needs to ensure that the physician participation in this important committee is consistent.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The facility continued to complete prospective reviews for all new orders through the WORx software program. The program checked the standard parameters, including therapeutic duplication, drug interactions, and allergies. EPSSLC implemented the use of the WORx system to track clinical interventions and prospective lab monitoring in June 2013. The monitoring team requested copies of all pharmacy interventions documented since the last compliance review and a copy of the log summarizing the types of interventions. The summary data provided are presented in the table below. Pharmacy Intervention Summary 2013 - 2014 June- Aug / Sep-Nov / Dec - Feb Activities -- / -- / 2 Allergy 3 / 8 / 11 Alternate Route -- / -- / 2 Drug Info 1 / -- / -- Duplicate 5 / 3 / 6 Infection Type -- / -- / -- Interaction 8 / 5 / 5 Order clarification 58 / 36 / 34 Patient Care -- / -- / -- Consultation -- / -- / -- Therapeutic Consultation 4 / 26 / 17 Total 79 / 78 / 77 Order clarification accounted for 55% of the total interventions. The category was subdivided in order to achieve better data analysis. Drug changes and incomplete orders were the two most frequent types of clarifications completed. Corrective actions were implemented to address problems noted through this process. The clinical services director provided inservices to the medical staff related to the requirements for complete physician orders. This appeared to have some positive impact on the physician order writing. The monitoring team was concerned about some potential medication variances that were managed as interventions and were not reported as variances. This was discussed with the pharmacy director. Medication variances are discussed in further detail in section N8. Overall, the current process provided adequate documentation of the prospective interventions (communication with prescribers), the actions taken, and the resolution of the issues addressed.	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The facility implemented the Intelligent Alerts module in June 2013. In addition to the required mandatory lab monitoring, EPSSLC prospectively monitored several additional drugs based on the needs of the facility. At the time of the compliance review, the facility conducted prospective lab monitoring for carbamazepine, digoxin, fenofibrate, lactulose, levothyroxine, lithium, oxcarbamazepine, phenobarbital, phenytoin, primidone, statins, terbinafine, topiramate, valproic acid, vitamin D, and warfarin. 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. Data for the Intelligent Alerts are presented in the table below.

<table>
<tr><td colspan="8">Intelligent Alert Summary Data 2013-2014</td></tr>
<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td></tr>
<tr><td>No Lab Monitoring</td><td>11</td><td>1</td><td>1</td><td>1</td><td>4</td><td>21</td><td>23</td></tr>
<tr><td>No Lab Order Written, Prescriber Notified</td><td>2</td><td>3</td><td>3</td><td>1</td><td>1</td><td>1</td><td>3</td></tr>
<tr><td>Oder Per Protocol</td><td>18</td><td>18</td><td>30</td><td>17</td><td>16</td><td>17</td><td>8</td></tr>
<tr><td>Total</td><td>31</td><td>28</td><td>40</td><td>27</td><td>40</td><td>41</td><td>34</td></tr>
</table>

The pharmacy department also maintained data related to the number of interventions for each medication monitored. This allowed the pharmacy director to address issues related to laboratory monitoring associated with medication use. For example, Vitamin D was the drug most frequently documented with the IA module. The majority of orders (72%) had the appropriate lab monitoring. Prescribers were notified of individuals who did not have the appropriate monitoring (18.4%) for vitamin D use and corrective actions were implemented.

The Pharmacy and Therapeutics Committee meeting minutes documented the data generated by both processes along with analysis of the data and the corrective actions that were taken to address problems.

<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>N2</td><td>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.</td><td>The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.</td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
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. The monitoring team reviewed QDRRs included in the active records. A sample of QDRRs was also selected based on the use of psychotropic medication use. A total of 15 QDRRs was reviewed. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications was documented in the QDRRs. The QDRRs did not provide information on the effectiveness of the medications or whether the appropriate evaluations had occurred. The use of chemical restraints and emergency medications are discussed further in section J. The facility reported that information regarding whether chemical restraint was clinically justified, any potential medication-related risks, and effectiveness was captured on the Post-Chemical Restraint Clinical Review form. <u>Polypharmacy</u> The QDRR Report form indicated the presence or absence of polypharmacy for all conditions. In many instances when polypharmacy was noted, the clinical pharmacist made comments related to justification of polypharmacy. The QDRRs noted psychotropic polypharmacy, but generally noted that this was discussed in psychiatry reviews and clinics. 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. <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. The clinical pharmacist now included the exact values for the criteria used and this was a significant addition given the importance of monitoring for the risks associated with the use of these agents.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Notwithstanding the improvements in documentation and assessment, monitoring continued to present some challenges for staff. There were two primary issues of concern. First, the facility utilized the ATP III criteria to determine individuals who were at risk for metabolic syndrome. The use of the blood pressure criteria was problematic. The pharmacist interpreted the criteria such that blood pressure was deemed a risk factor if ≥ 130/85. Per ATP III criteria blood pressure was a risk factor if elevated (systolic blood pressure ≥130 mmHg and/or diastolic blood pressure ≥85 mmHg) or there was current use of antihypertensive drugs. The QDRRs reviewed indicated that blood pressure was not considered a risk factor if the individual had well controlled blood pressure while receiving antihypertensive medications. Using ATP III criteria, hypertension managed with medication was a risk factor. Thus, some individuals with two other distinct criteria may have met the threshold for the diagnosis of metabolic syndrome. The second problem noted in the QDRRs was the continued discussion of the risk of metabolic syndrome for individuals with a well-defined diagnosis of diabetes mellitus. The metabolic syndrome can be defined as the co-occurrence of metabolic risk factors for both type 2 diabetes and cardiovascular disease. Metabolic syndrome is an important risk factor for subsequent development of type 2 diabetes and/or cardiovascular disease. Thus, once the individual has a diagnosis of type 2 diabetes, the discussion of risk of metabolic syndrome is no longer the primary issue. Metabolic syndrome increases the risk for diabetes and heart disease and can be considered a condition that precedes diabetes. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of substantial compliance at this time. A continued rating of substantial compliance will require that the facility address several areas: 1. The clinical pharmacist and medical staff should review individuals to ensure that those with metabolic syndrome are accurately diagnosed so that appropriate risk mitigation can be implemented. 2. Staff should have additional training related to metabolic syndrome. Further guidance should be obtained from the state medical services coordinator. 3. Psychotropic polypharmacy must be addressed beyond the current measures that have been implemented.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.		
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.	This provision item addresses the requirement to have, at a minimum, a quarterly evaluation of side effects completed by facility staff. Maintaining substantial compliance requires timely and adequate completion of the evaluation tools. Moreover, the intent of the evaluations is to provide clinically useful information. This provision item does not specifically address the pharmacy department's assessment of compliance with the requirement. 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. It was reported that the facility utilized AVATAR to complete the MOSES and DISCUS evaluations. All of the documents reviewed were manually completed. A sample of the most recent MOSES and DISCUS evaluations submitted by the facility, the most recent evaluations included in the active records of the record sample, and an additional sample for five individuals who received psychotropic medications were reviewed. The findings are summarized below: Twenty five MOSES evaluations were reviewed for timeliness and completion: • 23 of 25 (92%) evaluations were signed and dated by the prescriber • 23 of 25 (92%) evaluations documented no action necessary • 2 of 25 (8%) evaluations documented that the case would be presented at the next psychiatry clinic and had no conclusion Twenty six DISCUS evaluations were reviewed for timelines and completion: • 26 of 26 (100%) evaluations were signed and dated by the prescriber • 22 of 26 (84%) evaluations indicated no TD was present • 3 of 26 (11%) evaluations indicated the presence of TD • 1 of 26 (3%) evaluations had no conclusion All documents reviewed were completed by the psychiatrist at EPSSLC. Delays in the prescriber review were noted, but the number of untimely reviews decreased compared to the September 2013 compliance review.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility submitted a document that provided information on the MOSES and DISCUS evaluations completed during the six months prior to the review. This data did not provide information on the overall compliance with timely completion. The facility needs a data format that allows for easy determination of the status of evaluations. The current report required referring to multiple pages for any one individual. The lack of good data was a concern because emails submitted by the pharmacy department indicated that several evaluations were not being completed in a timely manner. The psychiatrist dated and signed the majority of evaluations reviewed. Several evaluations documented that no action was necessary, but indicated "will present at the next quarterly psychiatric med review." In addition to the findings related to timeliness and completion, there continued to be no evidence that the primary providers reviewed this information. There was also no evidence that the neurologist reviewed this information. The consultation forms included the dates of the evaluations and the numerical scores, but content was not included. QDRRs provide invaluable information on the side effects of medications and often allude to the presence of adverse drug reactions. The primary providers are responsible for the overall medical management of the individuals. It stands to reason that the PCPs have an obligation to review documents that include information regarding medication side effects. The findings relative to the lack of use of the rating tools by the primary providers and neurologist were addressed in the last monitoring report. There was no evidence that this concern was addressed apart from comments in Settlement Agreement pharmacy documents that "recommendations were directed to medical staff." Action plans for section N indicated that the pharmacy completed audits, but there was no specific documentation related to how improvement would be achieved with physician review and use of this information. While the pharmacy is not directly responsible for the completion of the evaluations, there must be a plan to correct the deficiencies other than stating that corrective actions are directed to the medical department. The facility will need to appropriately address these problems. Compliance Rating and Recommendations This provision will remain in substantial compliance for this review, but compliance will only be maintained if the facility ensures that nursing, medical, and psychiatry address the issues: 1. There must be improvement in the timely completion of the evaluations. The prescriber review must be completed in accordance with facility policy and	

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		procedure. This timeline should be no greater than two weeks. 2. The facility should use the current data to determine the percentage of evaluations that are completed in a timely manner. This will be assessed during the next compliance review. 3. Primary providers must review the evaluations and acknowledge this review in the IPNs or quarterly assessments. 4. 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. 5. The neurology consultant should be provided the MOSES and DISCUS evaluations for review as part of the clinic procedure. 6. The facility should maintain a database that tracks data for each individuals. 7. The facility should consider date stamping the evaluations when they are completed to ensure accuracy of timelines.	
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. Staff received training during New Employee Orientation. Ad hoc training was also conducted as needed. Moreover, the medical staff was targeted and received supplemental information through various inservices. At the time of the compliance review, all designated staff had received training on the ADR system. Additional steps were taken to move towards substantial compliance, such as the revision of the ADR operational procedure, which included a modified Hartwig severity scale that set hospital and ER evaluations as one threshold for further review of cases. Even with more aggressive staff training, the facility continued to struggle with the reporting of ADRs. Much of this appeared to be driven by reluctance on the part of the medical staff to report the adverse incidents. Documentation in meeting minutes indicated that the physicians continued to decline reporting legitimate ADRs. This was discussed with the pharmacy director and medical staff. Physician comments included concern about documentation of ADRs resulting in prohibition of future drug use when a side effect was reported. Documentation submitted by the pharmacy clearly indicated that the medical staff required further clarification on the definition of ADRs. Meeting minutes and other documentation reviewed noted that the medical staff often disagreed with the opinion of the pharmacists regarding the issue of ADRs. This resulted in the decision to decline the recommendations of the pharmacists. Variation of the interpretation of the definition of the term adverse drug reaction resulted in a continuation of a relatively low incidence of reporting for suspected ADRs. Nineteen ADRs were reported in 2013, eight of which occurred from September 2013 to December 2013. One ADR was reported in 2014.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The monitoring team encountered examples of ADRs that should have been reported, but were not. For example, the record (neurology consult) of Individual #157 documented that the individual developed a tremor that was thought to be associated with the use of pseudoephedrine. The medication was discontinued due to this reaction. Documentation submitted by the pharmacy department indicated that the neurologist reported that tremors often occurred with the use of pseudoephedrine and, therefore, declined to complete the ADR reporting form even though the reaction resulted in discontinuation of the drug. The World Health Organization defines an ADR as "Any response to a drug which is noxious and unintended, and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function." The facility's definition of an ADR was "any noxious, unintended, undesirable, or unexpected response to a drug that occurs at doses used in humans for prophylaxis, diagnosis, or treatment of disease. This definition is understood to include any response that would result in a change in patient management and therapy." The reaction to the pseudoephedrine met the definition of an ADR by either standard. Moreover, tremors are clearly documented in the literature as an "adverse reaction" to pseudoephedrine. Recognizing a relatively low number of reported ADRs, the pharmacy department implemented audits of records and daily morning meeting minutes and found five potentially reportable ADRs including: • Hyponatremia, secondary to carbamazepine, resulting in hospitalization • Aggression associated with Keppra • Megaloblastic anemia associated with VPA use • Excessive weight gain attributed to olanzapine use • Emesis and loss of appetite secondary to ferrous sulfate The pharmacy department completed further analysis (documented as a root cause analysis) to determine the lack of reporting. The pharmacy director explained that four of the five ADRs were treated by outside consulting physicians. As a result of the audits and subsequent analysis, the facility was beginning to use the consultation reviews discussed in the daily clinical meetings to screen for ADRs. A series of processes to improve the reporting of ADRs was implemented by EPSSLC. It should be noted that the fact that treatment occurs by an outside the facility/provider has no bearing on the decision to report ADRs. The individual with hyponatremia reported above developed the condition because of medication received at the facility. The need for hospitalization to treat this condition resulted in the ADR being classified as severe. Per facility policy, "for reported ADRs that are classified as severe using a	

#	Provision	Assessment of Status	Compliance
		modified Hartwig Severity Assessment Scale or are fatal, an intense case analysis must be performed." The monitoring team did not find evidence that an intense case analysis was conducted. The P&T recommendation was to conduct a chart review. The monitoring team provided additional information to the facility regarding the typical process for an ICA following the September 2013 compliance review. Record reviews provided examples of ADRs similar to those detected through the recently completed audits that were not reported. It is recommended that the state medical services coordinator provide additional guidance to all medical staff on the requirements for reporting of adverse drug reactions. Some staff appeared concern about reporting ADRs for the purpose of "increasing numbers." The primary focus is not the absolute number of ADRs reported. There is no predictable rate of incidence of ADRs. This varies and is dependent upon the characteristics of the facility. Health care professionals have a professional obligation to report suspected ADRs. The benefits of an adequate ADR system include: • An ongoing ADR system provides a measure of the quality of pharmaceutical care through identification of preventable ADRs and surveillance for high-risk drugs and individuals. Thus, ADR systems should focus on the identification of problems that contribute to ADRs. • The ADR system complements the risk-management and quality activities through mechanisms that monitor, report, and identify problems in order to implement positive changes. • ADR systems are important in assessing the safety of recently approved drugs. • ADR systems assist in establishing the rates of ADR incidence, increase the awareness of health care professionals about drug safety, and provide a screening process for the DUE system It was good to see that the pharmacy department used well-known examples to provide information to staff on the historical importance and value of reporting ADRs. This provision addresses the need to have a system that is sufficient to (1) monitor and detect, (2) investigate and report, and (3) implement corrective actions and conduct follow-up for adverse drug reactions. EPSSLC currently had such a system, but reporting of ADRs identified by the pharmacy staff has been hampered due to the reluctance of the medical staff to report ADRs. This finding also served as another example of the need for a medical director who can foster collaboration and appropriately resolve clinical issues. With the development of systems to monitor, detect, and report ADRs, this provision is now in substantial compliance. Compliance Rating and Recommendations	

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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 monitoring team agrees with the facility's self-rating of substantial compliance.

In order to maintain substantial compliance, the facility will need to capture the types of variances found in the audits completed and appropriately report them as suspected ADRs. This will require cooperation of all members of the medical staff and may require some additional guidance from the state medical services coordinator. Additionally, the facility will need to continue the practice of analyzing and trending data, documenting the follow-up in the P&T minutes, and completing intense case reviews as warranted.

The facility should also consider providing training to healthcare managers, and others, on quality activities such as the completion of root cause analysis.</td><td></td></tr>
<tr><td>N7</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.</td><td>The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.</td><td>Substantial Compliance</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 facility made considerable progress with its medication variance system. The table below summarizes the medication variance data submitted by the facility.

Medication Variances 2013- 2014
<table><tr><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th></tr><tr><td>Administration</td><td>35</td><td>12</td><td>17</td><td>11</td><td>16</td><td>13</td><td>10</td><td>11</td><td>10</td><td>18</td><td>20</td></tr><tr><td>Dispensing</td><td>0</td><td>0</td><td>0</td><td>2</td><td>3</td><td>3</td><td>2</td><td>1</td><td>4</td><td>2</td><td>1</td></tr><tr><td>Documentation</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td>1</td></tr><tr><td>Prescribing</td><td>6</td><td>4</td><td>2</td><td>4</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Transcribing</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td><td>1</td><td>0</td><td>1</td><td>0</td><td>0</td><td>4</td></tr><tr><td>Other</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td></tr><tr><td>Total</td><td>42</td><td>18</td><td>19</td><td>23</td><td>20</td><td>17</td><td>14</td><td>13</td><td>16</td><td>20</td><td>28</td></tr></table>
As noted in the table above, the total number of variances declined. This was attributed to process changes implemented at EPSSLC, such as improved medication reconciliation</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		by nursing and improved compliance with documentation on MARs. The monitoring team observed several noteworthy improvements related to the medication variance system: • The medication variance committee developed a list of drugs that required additional monitoring and follow-up prior to review at the committee meetings. The list included high-risk medications such as psychotropics, AEDs, cardiac drugs, and insulin. This resulted in better assessment of the variances, which assisted in determining the most appropriate corrective measures. • A QA process was implemented by the committee to ensure the correct categorization of the severity of each variance prior to the committee meetings. • The committee minutes reflected that all of the meetings were attended by the lead physician. • The data were presented in a manner that was more reflective of the magnitude of the actual variances. That is, variances were now weighted based on the length of time that they occurred. A variance that occurred for several days or weeks could now be more easily identified. Having a more definitive understanding of the magnitude of the variances provided assistance in implementing the most appropriate corrective measures. Notwithstanding these significant changes, it was clear through discussion at the committee meeting as well as discussion with various staff that there was a need to improve reporting for prescribing variances. Specific opportunities for improvement in this area were actually noted during the conduct of those discussions. Over a number of years, EPSSLC has shown a great deal of progress in the medication variance system. Much of this has been through the collaborative efforts between the nursing and pharmacy departments. The facility will need to make progress in the reporting of variances for all disciplines, including medical and respiratory, to move towards substantial compliance. <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 should continue to use the more in depth data reporting and analysis to address medication variances. 2. Staff should ensure that all variances are reported as required. There may need to be further discussion to determine when clinical interventions require reporting as medication variances.	

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		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 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 PNM Data Reports/Monthly Reviews o PNM spreadsheets submitted o PNMT Evaluation template o PNMT Assessment Audit tools o PNMT Meeting documentation submitted o Daily Provider Meeting minutes o Weight Committee meeting minutes o Skin Integrity Committee 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 List of individuals with non-foundation skills in PNMPs o PNM spreadsheets o Individuals with PNM Needs o Completed PNMP 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 Annual Refresher curriculum materials related to PNM 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 List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months

	○ Individuals with BMI Less Than 20 ○ Individuals with BMI Greater Than 30 ○ Individuals with Fractures ○ Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months ○ Individuals With Falls Past 6 Months ○ List of Individuals with Chronic Respiratory Infections ○ List of Individuals with Enteral Nutrition ○ Individuals with Chronic Dehydration ○ List of Individuals with Fecal Impaction ○ Individuals Who Require Mealtime Assistance ○ List of Choking Events in the Last 12 Months ○ Documentation related to choking event for Individual #173 ○ Individuals with Pressure Ulcers and Skin Breakdown ○ Individuals with Fractures Past 12 Months ○ Individuals who were non-ambulatory or require assisted ambulation ○ APEN Evaluations for Individual #93, Individual #103, Individual #1, and Individual #92. ○ PNMT Assessments and ISPs submitted for Individual #115 and Individual #118 ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, Individual #92. ○ PNMP section in Individual Notebooks for the following: • Individual #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, Individual #92. ○ Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, Individual #92. <u>Interviews and Meetings Held</u>: ○ Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director ○ Blanca Ibarra, RN ○ Virginia Fairchild, RD, LD ○ Karin De La Fuente, MS, CCC/SLP ○ Jose Vasconelos, OTR ○ Eric Herrera, PT ○ Jessica Cordova, DPT

	○ Susan Acosta, DPT ○ OTAs, PTAs, Hab technicians and PNMPCs ○ Various supervisors and direct support staff <u>Observations Conducted</u>: ○ Living areas ○ Dining rooms ○ Workshop ○ Recreation area ○ PNMT meeting ○ Wheelchair clinic ○ ISP Meeting for Individual #67
	Facility Self-Assessment: The self-assessment completed by Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director continued to improve. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team, though not all of elements were addressed and used to determine compliance. Actions and self-assessment activities correlated extremely well with the recommendations made by the monitoring team and reflected significant efforts on the part of habilitation staff. Findings were 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 Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their goals. Ms. Ambruster and the other therapy staff were on track to ensure that progress will be 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.
	Summary of Monitor's Assessment: Leslie Ambruster demonstrated that she is a tremendous leader and her steady and stabilizing manner and perseverance ensured that Habilitation Therapies built on the existing strong foundation and ensured that great progress was made over the last six months in sections O, P, and R. As in previous reviews, it was evident that a tremendous amount of work had been done in this area. Substantial compliance was maintained for provision O1, and met for the first time for O3, O4, O5, and O6. There was a fully constituted PNMT and the current members were consistent over the last year with the exception of the OTR. Back-ups were designated for each, except the dietitian. A meeting was observed and the monitoring team noted significant improvement in the process and in the documentation of their findings and actions. The new format clearly outlined these, individual health status, and completion of team actions. The PNMT continued to refine their process and documentation. They are encouraged to

	continue to work to reduce the volume of paperwork they produce, but continue to ensure that is thorough and complete. There were several new systems that permitted them to better track health status for individuals to ensure prompt referral and review for individuals that needed PNMT supports and services. Positioning continued to be improved, with few concerns noted, though transfers should be an area of continued focus over the next six months. There were overall improvements related to mealtimes. The mealtime coordinator system had been implemented, but continued monitoring was needed to ensure they actively embraced their role of oversight for staff in the dining areas. The mealtime committee should conduct observations with unit leaders to assist the homes in refining this process. Staff assignment should take into consideration the number of individuals who require one to one physical assistance during meals, as well as, those who require physical and verbal prompts related to rate of eating and bite size, for example. There was a significant failure in the case of Individual #25, where both the Mealtime Coordinator and the DSP did not recognize that most of the elements of the plan were implemented incorrectly. The fact that this happened suggests that continued training, monitoring, and expectation are necessary. Two subsequent observations of this individual, however, showed accurate and excellent implementation of the Dining Plan during those times. Other observations of over 50 other individuals revealed only a few, minor infractions. Despite the concern noted, the monitoring team determined that overall the facility was in substantial compliance with O.4 with a few suggestions for consideration. There had been numerous revisions to the training and monitoring systems based on careful review and analysis of the previous report and outlined in QA documentation. These also ensured significant gains in these areas. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 11 individuals, 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 two individuals who were assessed or reviewed by the PNMT over the last six months. Sample O.3 consisted of individuals at EPSSLC who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

#	Provision	Assessment of Status	Compliance

O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner,	The facility had a comprehensive PNM policy that addressed the scope of PNM issues outlined below, but also through a combination of other facility policies, guidelines, and procedural documents, generally outlined a complete and comprehensive system of Physical Nutritional Management. The PNM policy (3/20/14) included the following elements, though some of these were operationalized into the At Risk Policy, the ISP Policy, and QA Policy. The following elements were addressed:
		• Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP");
		• The annual review process of an individual's PNMP as part of the individual's ISP;
		• 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;
		• The roles and responsibilities of the PNMT;
		• 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;
		• Description of the role and responsibilities of the PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant);
		• The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs;
		• Requirements for continuing education for PNMT members;
		• Referral process and entrance criteria for the PNMT;
		• Discharge criteria from the PNMT;
		• Assessment process;
		• Process for developing and implementing PNMT recommendations with Integrated Health Care Plans;
		• The PNMT consultation process with the IDT;
		• Method for establishing triggers/thresholds;
		• Evaluation process for individuals who are enterally fed;
		• PNMT follow-up;
		• Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia;
		• A comprehensive PNM monitoring process designed to address 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
			Substantial Compliance

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	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.	trending of data, actions required based on findings of monitoring (for individual staff or system-wide), o Identification of monitors and their roles and responsibilities, o 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, o 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 o Frequency of monitoring to be provided to all levels of risk. • A system of effectiveness monitoring; and • Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. <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: • Blanca Ibarra, RN (6/17/13) • Virginia Fairchild, RD, LD (10/1/13) • Karin De La Fuente, MS, CCC/SLP (8/1/11) • Jose Vasconelos, OTR (1/29/14) • Eric Herrera, PT (8/1/11) This team had one new member since the previous review (OTR). Back-ups for each position, except the dietitian had been assigned. For part of this review period there were two dietitians and one served as the back-up for the other. Since 10/1/13, Virginia Fairchild has served as the only dietitian for the facility and the only dietitian serving on the PNM team. <u>Consultation with Medical Providers and IDT Members</u> The current medical staff, Pamela Richter, DO, Maria Famatigan, MD, Ramesh Komaragiri, MD, Eugenio Chaves-Rice, MD (psychiatry), Alfredo Lujan, MD (neurology), and Howard Pray, DDS (dental) were listed as the physician consultants to the team, though none served as a primary team member and they did not typically attend the meetings. • For 2 of 2 individuals for whom evaluations had been completed in the last six months (Individual #115 and Individual #118), evidence was provided of efforts by the PNMT to seek participation by medical staff via consults. Of the seven	

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		consults requested by the team, only two were responded to by the physician. Most of these were to request orders for a recommended intervention, though many posed questions to the physicians that were not addressed. This did not appear to be an effective method to gain physician input and collaboration. There was no evidence that a physician reviewed and signed the PNMT evaluations. While attendance at the meeting was an excellent method to gain the input of the medical staff, alternate methods to ensure their availability to the PNMT should be established. IDT members, such as the RN Case Manager, who could serve as a key link to the physician did not attend PNMT meetings routinely. There was, however, consistent participation by one or more PNMT members in meetings of the pneumonia committee, skin integrity committee, and in the daily medical provider meetings. These meetings addressed both individual-specific issues and systems issues as well. Daily medical provider meetings were held and the PNMT RN was present at 84% of these meetings for which minutes were submitted. The PNMT RD was present at 89% of the meetings and the Habilitation Therapies Director was present at 23% of the meetings. There were only 18 of 116 meetings for which minutes were submitted (8/1/13 through 1/31/14) when only one of these representatives was present and only one occasion when none was in attendance (12/31/13). Medical and IDT staff attended these meetings, as well, serving as an excellent medium to ensure timely communication with other team members related to the individuals served by the PNMT and to identify others who would benefit from these services. • For only 3 of 44 PNMT meetings (7%) held from 8/1/13 to 1/29/14, there was evidence of participation by IDT members. Though IDT members did not routinely attend PNMT meetings, the PNMT consistently reviewed their findings with the IDT upon completion of the assessment and routinely attended IDT meetings related to individuals they reviewed or who were referred to the PNMT, as needed. This provided significant alternate opportunities for collaboration in assessment, planning, implementation of interventions and actions, follow-up, and monitoring. The PNMT did not act outside of the IDT. The initial meeting included the IDT meeting in which risks, rationales, and action plans were discussed, and actions were assigned. The PNMT's function was to provide support to the IDT, which included providing education and knowledge through recommendations, evaluation, and treatment. Action plans were the responsibility of the IDT as well as the PNMT. <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	

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		of Texas, as verified online. • 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. Collectively, the five team members had over 67 years of experience in their respective fields and, together, approximately 10 years with individuals with intellectual disabilities. The four back-up team members had 40 years of experience in their respective fields and approximately 28 years with individuals with intellectual disabilities. <u>Continuing Education</u> • 5 of 5 PNMT staff (100%) had completed continuing education directly related to physical and nutritional supports and transferable to the population served within the past six months. Back-up team members were also listed with related continuing education in the last year. A number of relevant courses were attended by team members: • Blanca Ibarra, RN (20 contact hours in the last year) • Virginia Fairchild, RD, LD (11 contact hours in the last year) • Karin De La Fuente, MS, CCC/SLP (18 contact hours in the last year) • Jose Vasconelos, OTR (10 contact hours in the last year) • Eric Herrera, PT (10 contact hours in the last year) These included the following: • Glimpse into Pediatric Dysphagia Assessment • Ethics and Malpractice in Dysphagia: How Not to Screw UP • Approaches to maximize Nutrition and Oral Intake in Children with Feeding/Swallowing Disorders • Adjunctive Biological Therapies in Wound Care: Maggot Debridement Therapy • Thoracic Outlet Syndrome • Quality: Get Off the Sidelines and Get Into the Game • Kinesiology Taping: Considerations for Vestibular Patients • Therapeutic Adaptive Tricycles • Overuse Injuries of the Wrist • Urinary Incontinence with Orthopedic and Geriatric Populations • Orthopedic Special Tests for Shoulder SLAP Tears • Post-Operative Rehabilitation of the Shoulder • Cross-Friction Massage: Myth or Reality • Productivity Management for Occupational Therapists • Geriatric Diagnostic Testing for OT and PT • Medical Errors Prevention for Occupational Therapists	

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		• Evidence-Based Nutritional Strategies for the Aging Brain • Oral Nutritional Supplements: A Solution for a Recurrent Problem • Inflammation as the Key Interface of the Medical and Nutrition Universes • Protein Needs of Older adults • Celiac Disease, Gluten Sensitivity and the Gluten-Free Diet • Managing Gastrointestinal Intolerance in Tube-Fed Patients • Effective Wound Management 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. The facility is commended for supporting this critical aspect of PNM supports and services. <u>PNMT Meetings</u> • Since the last review, the PNMT met at least once for 25 of 27 weeks (93%) from 8/1/13 to 1/29/14 (meeting minutes submitted for that period). The team met twice a week for most of those weeks for a total of 44 meetings. 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: 41/44 (93%) by core member, 1/44 (2%) by back-up, and 95% overall. o PT: 42/44 (95%) by core member, 0/23 (0%) by back-up, and 95% overall. o OT: 38/44 (86%) by core member, 3/44 (7%) for back-up, 93% overall. o SLP: 41/44 (93%) by core member, 2/44 (5%) for back-up, 98% overall o RD: 41/44 (93%) by core member, 3/44 (7%) for back-up, 100% overall Absences for core team members without a backup were noted on 9/10/13 (RN), 1/15/14 (SLP), 1/6/14 (PT), and 8/1/13, 8/6/13, and 12/12/13 (OT). Attendance was still well above the criterion of 80% for the core team and above the criterion of 90% overall for all disciplines. Since 8/1/13, all PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (d) PNMT actions, (e) follow-up, and (e) outcomes/progress toward established goals and exit criteria were clearly outlined on a consistent basis. The meeting minutes were maintained and included the following elements: • Member attendance • Individual reviewed • Current weight • IBW • Level of PNMT Involvement	

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		• Reason for referral • Recommendations • Due date • Next review date The meeting minute format had been revised during this review period and was less complicated and more user-friendly. The team needs to continue to evaluate their documentation process because there continued to be an excessive amount of documentation in the individual records, adding hundreds of pages to each record, which were not likely used routinely by the IDT. For example, in the individual record for Individual #118, there were meeting minutes that contained the names of numerous other individuals. The streamlined meeting minutes could be summarized for each individual reviewed with an IPN (even if it had to be typed to reduce the length). This was better presented in the IPNs (Individual #115, for example on 11/7/13). The meeting minutes should be maintained to back-up IPN documentation and to allow the PNMT to specifically individual status, track actions, and timeframes. An episode tracker and change of status database was maintained with review of individuals who presented with a change of status and/or presented with health concerns that may trigger a referral. • The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns. This was integrated into the policies and procedures in place and evidenced in the monthly QA reports. There was a system of corrective action plans (CAPs) when system issues were identified. They addressed the following: o Requirements that the QA matrix include key indicators related to PNM 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.	

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		Examples of identified system issues addressed included the following: Mealtime Improvement Team, clarification of the PNMT referral process, third shift PNMP monitoring, maintenance of assistive equipment on the homes, and inter-rater reliability for QA mealtime monitoring. Section O required 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 was to be developed based on input from the IDT, home staff, medical and nursing staff, and the PNMT. These aspects, though outlined in O.1 of the Settlement Agreement, are actually reviewed in O.3 below. The monitoring team determined that the facility continued to be in substantial compliance with this element of section O.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>Identification of PNM risk</u> All individuals at EPSSLC (113) 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. Based on lists of individuals with identified PNM concerns, there were individuals who (a) required physical assistance for positioning associated with swallowing: 29 individuals, (b) were dependent on others to eat: 20 individuals, (c) had difficulty swallowing: 77 individuals, and/or (d) were considered to be at medium or high risk of choking (approximately 96 individuals) or aspiration (approximately 76 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), 100% were listed with a PNMP. Based on the self-assessment, five individuals who had been reported with low weight six months earlier, all had demonstrated a consistent weight gain of more than 10%. Similarly, there was only one individual who incurred a decubitus ulcer in the last six months. These factors suggest that the facility and the PNMT were demonstrating improved assessment and monitoring of these health risk concerns. There was one incidence of choking requiring abdominal thrusts (Heimlich) documented since the previous review (Individual #20). Follow-up documentation was submitted. It did not include any assessment documentation by an SLP, but rather only the Client Injury Report, Incident Report, and IPNs by nursing and DSPs. Per the injury report, this incident had been witnessed by a PT, but documentation by the PT was not submitted with the	Noncompliance

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		follow-up documentation. This event appeared to be an issue of supervision, but there was no evidence that the SLP was aware of the incident and had ruled out a need for further assessment. There was no documentation by the PT listed as a witness. There was also no evidence in the documentation submitted by the PNMT that they had reviewed this incident or that they were even aware of it. <u>PNMT Referral Process</u> Per the EPSSLC Physical Nutritional Management policy, individuals identified by the IDT who were at high risk as defined by the At Risk policy (#006) and were not stable and for whom the IDT needed assistance in the development of a plan, may be referred to the PNMT by the PCP, PNMT, or IDT for assessment and recommendations for interventions and supports. More specific criteria guidelines were outlined, though individual circumstances and risk levels would dictate more or less stringent criteria: • Two episodes choking 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 • Seizures; • New or proposed enteral feeding; • Unresolved vomiting (3 or more episodes in 30 days, not related to viral infections); • Significant/unplanned/verified weight loss or gain defined as 5% 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% in 6 months; • Any Stage III or IV decubitus, or any Stage II with delayed healing; • Fracture of a long bone, spine, hip, or pelvis The wording for the weight loss indicator continued to be an issue. Though this portion ("three or more pounds per month for three consecutive months, or 7.5% of body weight per month for three consecutive months") was the wording in the original state PNMT policy, it did not appear to reflect an appropriate indicator and has been revised by other facilities. This is typically identified as weight loss of 7.5% over three months, rather than per month for three consecutive months. The PNMT is encouraged to review this. There were six individuals listed on the current active caseload for the PNMT (Individual #23, Individual #75, Individual #115, Individual #32, Individual #118, and Individual	

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		#92), though Individual #23, Individual #75 and Individual #32 were not listed as referred. Discharge criteria were established via the assessment and at the time they were met, transition from the PNMT to the IDT was planned, including monitoring and re-referral criteria. Individuals in Sample 0.1 were reviewed for incidence of the concerns identified as requiring PNMT referral since September 2013: • Individuals were generally appropriately referred to the PNMT based on the criteria included in the facility policy, as well as other criteria indicating significant PNM needs. Though not formally referred, numerous other individuals who presented with PNM issues were also identified via the episode tracker and reviewed by the PNMT in a timely manner. • In a number of cases, there was no evidence of an ISPA related to the reason for referral to the PNMT. In some cases, the referrals were self-initiated based on the post-hospitalization assessment by the PNMT RN or issues identified in the episode tracker. There were no individuals who had received enteral tube placements since the previous review, as such, the following metrics were not applicable: • % of individuals who received a feeding tube 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. <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 completed in the last six months included the following: Individual #115 (12/10/13) and Individual #118 (9/28/13). • 1 of 2 PNMT assessments (50%) were initiated at a minimum within five working days of the referral, per the dates identified in the assessment, meeting minutes, and IPN documentation. There was reference to referral of Individual #115 in the PNMT meeting minutes on 10/15/13, but the assessment reported that the referral occurred on 11/7/13. This was consistent with the previous review. • 1 of 2 PNMT assessments (50%) was completed in 30 days or less of the date of referral, per the assessment dates (the signatures were not dated by any clinician). This was an increase from 0% in the previous review.	

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		Based on review of these assessments, the following elements were addressed: • Date of referral by the IDT or self-referral, (2 of 2, 100%). The referral source was not identified. This was consistent with the previous review. • Date the assessment was initiated (1 of 2, 50%). This was a decrease from 100% in the previous review. • Evidence of review and analysis of the individual's medical history (0 of 2, 0%). There was no reference in the PNMT report to a diagnosis of dehydration, hypolkalemia, and hypernatremia reported in the risk assessment for Individual #118. This was a decrease from 100% in the previous review. • Identification of the individual's current risk rating(s), including the current rationale (2 of 2, 100%). This was consistent with the previous review. • Recommended risk ratings based on the PNMT's assessment and analysis of relevant data. (2 of 2, 100%). This was consistent with the previous review. It was implied that the PNMT agreed with the most current risk assessment, but this was not clearly stated. • Discussion of the impact of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition (1 of 2, 50%). This was consistent with the previous review. The only reference to behavior was for Individual #118 as a function of reporting the most current risk assessment by the IDT, it was not clear if this was accurate at the time of the PNMT assessment. There was also reference to mealtime behaviors for Individual #118, but not related to other aspects of PNM. In the case that there were not behaviors that impacted, this should be clearly stated as evidence that the PNMT considered this aspect of assessment of the individual's current status. • Assessment of current physical status (2 of 2, 100%). This was consistent with the previous review. • Information about the individual's current respiratory status based on a physical assessment (2 of 2, 100%). This was consistent with the previous review. • Assessment of musculoskeletal status (2 of 2, 100%). This was limited, however. This was an improvement from 50% in the previous review. • Evaluation of skin integrity (2 of 2, 100%). This was consistent with the previous review. • Evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning (2 of 2, 100%). This was consistent with the previous review. • Positioning that may impact PNM status including during bathing, medication administration, and oral hygiene based on observations of these activities (0 of 2, 0%). This was particularly critical for these individuals related to aspiration and there was no evidence that these were assessed. • Evaluation of motor skills (2 of 2, 100%), though limited. This was consistent	

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		with the previous review. • List of medications with potential side effects listed with individual allergies. This did not include drug/drug or drug/nutrient interactions and/or actual side effects, however (2 of 2, 100%). This was consistent with the previous review. • Evidence of review/analysis of medication history over the last year and current medications, such as dosages, and side effects (2 of 2, 100%). This was an improvement from 50% in the previous review. Administration times were not reported. Medications were addressed twice with slightly different information presented in both. This could be combined to reduce redundancy and promote better integration. • Evidence of review/analysis of lab work (2 of 2, 100%). This was an improvement from 50% in the previous review. A heading "Nutrition Related Laboratory Review" was left blank for Individual #115, though limited laboratory findings were reported elsewhere. • Identified residual thresholds, if enterally nourished (NA). This was also not applicable in the previous review. Though Individual #115 had a gastrostomy tube, it appeared that he primarily maintained oral intake, per the nutrition-related section. There was some apparent discrepancy in the analysis of findings, though, as to whether the tube was used intermittently and with what frequency. • Tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation (2 of 2, 100%). This was consistent with the previous review. This was addressed under the current monitoring results section rather than the assessment section for both individuals. • Evidence of observation of the individual's supports at their home and/or day/work programs (2 of 2, 100%). This was consistent with the previous review. • Nutritional assessment, including, but not limited to, history of weight and height, intake, nutritional needs, and mealtime/feeding schedule (2 of 2, 100%). This was consistent with the previous review. Though dehydration had been an identified concern during the month prior to the assessment, her actual fluid intake was not reported. • Evaluation of current assistive equipment (0 of 2, 100%). This was listed, but not clearly assessed for effectiveness (for example, mealtime equipment). Bathing equipment was not assessed for either individual. This was consistent with the previous review. • Evidence that the PNMT conducted hands-on assessment (2 of 2, 100%). This was consistent with the previous review. • Identified the potential causes of the individual's physical and nutritional management problems (1 of 2, 50%). This was a decrease from 50% in the previous review. There continued to be significant unknowns related to the cause	

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		of aspiration for Individual #115. Recommendations related to bed position were made, but it was not clear how often he received non-oral intake in this position, for example. There was no statement as to whether he was observed for support and alignment during tube feeding. There was no evidence of observation of bathing or oral care to determine if there were any potential links to aspiration during these activities. It appeared that he was to begin use of a suction toothbrush, per one recommendation, but there had been no discussion of this in the assessment. Additional recommendations included monitoring of snacks and medication administration. These should have been assessed by the PNMT. • Identified physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations (2 of 2, 100%). This was consistent with the previous review. • Recommendations for measurable skill acquisition programs, as appropriate (1 of 1, 100%), for Individual #115. This was an improvement from 0% in the previous review. • 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%). This was consistent with the previous review. • Recommendations for monitoring, tracking or follow-up by the PNMT (2 of 2, 100%). This was consistent with the previous review. • Discussion as to whether existing supports were effective or appropriate (2 of 2, 100%). Monitoring data and effectiveness data previously gathered by the IDT was not consistently reported. This was consistent with the previous review. • Measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT (0 of 2, 0%). This was a decrease for 50% in the previous review. There was an assessment heading left blank ("Assessment Data Related to Reason for Referral Including Trigger Sheets") and specific clinical indicators were not clearly stated for Individual #118, for example. There were only outcomes stated related to the need for PNMT re-assessment. In the case of Individual #115, the outcome was not related to specific clinical indicators, but rather only related to no reoccurrence of the aspiration pneumonia or hospitalization in three months. It did not appear that they had drilled down the issues enough to establish the indicators. • Establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status (0 of 2, 0%). This was a decrease from 50% in the previous review. Generally established as triggers in the original risk review by the IDT, but these were not specifically addressed by the PNMT • Signatures of all core team members (or alternate) with dates (0 of 2, 0%). While there were signatures, there were no signature dates. This was consistent with	

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		the previous review. Other findings included: • There were improvements noted across four of the elements. • There were decreases across five areas. • Others remained consistent with the previous review: 17 of 21 of those at 100%. • 100% of the assessments contained 22/30 (73%) of the applicable elements (one item related to residuals was not applicable for either individual). Specific Concerns noted included: • 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 and IRRFs. Key clinical indicators should be identified that alert the IDT that the individual may need an increase in intervention or monitoring and may be as basic as vital signs or meal refusals. An example of a key clinical indicator was noted in the IRRF and the IHCP documented in the annual ISP for Individual #118 (1/17/14): If she drank less that 1000 ccs of fluid daily for two or three consecutive days she should be referred to the medical clinic. These will not likely be the same objectives for re-assessment or discharge from the PNMT. • The analysis was much improved, but in the case of Individual #115, there were a number of issues not adequately addressed. Many recommendations related to further assessment, rather than recommendations for specific interventions and supports. The team needs to strike a balance between completion of the assessments in a timely manner and ensuring that key data are gathered for appropriate analysis and the development of an effective intervention and support plan. • It was recommended that Individual #118's IDT review her risk assessment, but there were no recommendations presented by the PNMT. In addition, it was suggested that the IDT establish a critical weight as well as an objective that the PNMT RD would establish a standard and critical weight. It was not clear why this was not done as a function of the PNMT assessment or documented in an ISPA when the PNMT met to review the assessment findings and recommendations. • It was of concern to the monitoring team that in both cases, the most current risk assessments had been conducted well before the changes in status that prompted the need for referral to the PNMT. A change in status of this nature should trigger a need to conduct a review of the risk assessment by the IDT, even if prompted by the PNMT. It was not clear that this was done.	

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		Overall, the assessment format and content continued to improve. The monitoring team attempted to be very specific related to the strengths and weaknesses of the two assessments reviewed in order to further guide the team in making improvements in the assessments they completed. It continued to be evident that much work was being done, but the documentation did not highlight this effectively. There was a combination of too much information so that key data could not be sorted out, and key information that was omitted. The facility had instituted an assessment audit system. It may be useful for the PNMT to conduct their own audit at times with validation by the Director to ensure that all elements were clearly understood. If these audit elements match the elements reviewed by the monitoring team, this should continue to be effective in shaping the quality of these assessments in the future. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs</u> There were two assessments submitted as completed by the PNMT since the previous review. Individual records for these individuals were requested Plans resulting from PNMT recommendations included the following components: • In 1 of 2 (50%) individual plans reviewed, identified PNM needs as presented in the PNMT assessment were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs. For example, the critical weight for Individual #118 was established at 49 pounds and was included in the IRRF dated 1/17/14, at the time of her annual ISP. There were references to ISPA meetings related to PNMT assessment held in the PNMT IPNs, but there was no evidence of documentation of these by the QIDP. • For 1 of 1 (100%) individuals for whom HOBE assessments were conducted, the recommendations were integrated into the individual plans. • For 2 of 2 (100%) individuals, there were appropriate, functional and measurable objectives outlined to allow the PNMT to measure the individual's progress and efficacy of the IHCP and PNMP. • In 2 of 2 (100%) individual plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In 0 of 2 (0%) individual plans reviewed, the specific clinical indicators of health status to be monitored were included. • 2 of 2 (100%) individual plans defined triggers. • 2 of 5 (100%) individual plans identified the frequency of monitoring. <u>PNMT Follow-up and Problem Resolution</u> Each of the recommendations identified in the PNMT assessment should be clearly and consistently tracked through to completion with timely implementation. This could not be adequately determined due to the extreme volume of documentation that was not specific to the individual in their individual's records. The revised documentation system should result in reduced paper making review by anyone more effective. The PNMT may	

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		want to consider the development of a recommendation log in order to track their own timeliness as has been done by some other PNMTs. • For --% individuals, implementation of individual action plans was within 14 days of development of the plan or sooner as needed for health or safety. • For --% individuals, action plan steps had been generally completed within established timeframes. The format of documentation continued to improve, but continued streamlining was indicated. Intervals of PNMT review were clearly stated, and these appeared to occur on a timely basis, though again this was difficult to track. IPNs were consistently entered by the PNMT, and generally reflected actions taken, outcomes, and dates of completion consistent with the meeting minutes. <u>Individuals Discharged from the PNMT</u> Discharge was noted for Individual #4, Individual #89, Individual #90, Individual #162, and Individual #52. There was no evidence of the following: • There was an ISPA meeting to discuss the discharge of the individual from the PNMT to the IDT for 2 of 5 individual for whom ISPAs were available for review (Individual #4 and Individual #162). • A discharge summary provided objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP for 5 of 5 individuals. • There was evidence of ISPA documentation and/or action plan that included clinical indicators to track health status and criteria for referral back to the PNMT, particularly if they differed from the criteria included in the PNMT policy, for 2 of 5 individuals. As stated in previous reports, an effective PNM program requires that the referral to the PNMT 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 through action steps taken, but written assessments, though completed in a timely manner, did not adequately reflect their findings and actions for ready tracking and review. The facility self-rated this provision in substantial compliance, though the monitoring team did not concur at this time. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority	

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		for the next six months: • Ensure that all recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. • Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly and succinctly. • Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in an ISPA. • Consider a recommendation log to readily track completion of action steps.	
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> As described above, 100% of the individuals at EPSSLC were provided a PNMP. The Settlement Agreement (in O.1, but reviewed here) 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 ISP meeting. Teams are also required to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. Review of the PNMP and Dining Plans are required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT/speech and PNMT should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the PNMT, OT, PT, and/or SLP clinicians. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. For individuals in Sample O.1, ISP attendance and pre-ISP documentation related to required attendance were reviewed. • For 14 of 14 individuals (100%), the appropriate disciplines were present at the ISP meeting to approve and integrate the PNMP into the ISP. There were one or more Habilitation Therapies representatives at each meeting and due to the current team assignments and routine clinical services meetings, when issues and coverage for ISPs were reviewed weekly, this appeared to be an adequate approach. • For 7 of 10 individuals for whom pre-ISP required attendance sheets were submitted (70%), the designated team members were present for the ISP meeting per the sign-in sheet. There was no habilitation therapy representatives designated to attend Individual #75's ISP and no one did. A SLP was designated to attend for Individual #4, but did not attend. Though there was a representative in attendance, the IDT had designated that the dietitian needed to attend, but rather the technician was present.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Regarding PNMP review: • 13 of 14 PNMPs (93%) were reviewed by the individual's IDT in the annual ISP meeting. The reviews documented in the ISPs varied somewhat in specificity and thoroughness and not all clearly identified what changes were required and efficacy of the plan. At least nine had specified the frequency of monitoring needed. This was a significant improvement from the previous review. The consistency of this practice was good evidence that the process used (collaboration across disciplines related to assessment and PNMP development, as well as Habilitation Therapy representation) was effective to ensure adequate and appropriate review during the ISP meeting. • For 14 of 14 individuals in Sample O.1 for whom the IDT identified changes needed to be made to the PNMP, revisions based on the IDT discussion were documented in an ISPA, including rationale, and plan and timeline for implementation, or in the case that a less significant change was indicated, a program changes sheet was completed and signed by IDT members in lieu of an actual meeting. The ISPA discussions were clear and consistently documented for review of changes in status, such as hospitalizations or other changes in health status and there was evidence that the IDT reviewed the PNMP at that time to determine the need to modify these plans. The Program Changes clearly outlined the required change with rationale. Though a clear timeframes for completion were not stated, the changes were made, in most cases, that day or within 48 hours. It was also noted that for 19 additional individuals who required PNMP changes and randomly selected for review by the monitoring team, 100% of these also had either an ISPA or Program Change signifying IDT review prior to the changes made to the plans. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 14 of 14 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 14 of 14 individuals (100%) included a list of PNM risk levels and individual triggers. This was consistent with the previous review. • In 14 of 14 PNMPs (100%), there were large and clear photographs with instructions. These were submitted only for Individual #203, Individual #98, and Individual #180. Some photographs for other individuals were submitted, but these were not current. This was an improvement from 7% in the previous review. • 14 of 14 PNMPs (100%) identified the assistive equipment required by the individual with rationale and purpose. This was consistent with the previous review.	

#	Provision	Assessment of Status	Compliance
		• In 6 of 6 PNMPs (75%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair. • In 14 of 14 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 14 of 14 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was consistent with the previous review. • In 14 of 14 PNMPs (100%), bathing instructions were provided. This was consistent with the previous review. • In 14 of 14 (92%) PNMPs, toileting-related instructions were provided, including check and change. This was consistent with the previous review. No instructions were provided for Individual #38. • In 14 of 14 (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 an improvement from 0% in the previous review. • In 14 of 14 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 14 of 14 individuals' (92%) Dining Plans were current within the last 12 months. This was a decrease from 100% in the previous review. • 3 of 14 individuals had feeding tubes with no oral intake. 3 of 3 PNMPs/dining plans (100%) specifically stated that the individual was to receive nothing by mouth, when indicated. This was an improvement from 75% in the previous review. • In 14 of 14 PNMPs (100%) and 14 of 14 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 14 of 14 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. This was identified as positioning for Individual #134 in his PNMP, dated 10/22/13. This was consistent with the previous review. • In 14 of 14 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. This was consistent with the previous review. • In 14 of 14 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.	

#	Provision	Assessment of Status	Compliance
		• In 14 of 14 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. This was an improvement from 17% in the previous review. • In 14 of 14 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. This was an increase from 92% in the previous review. • 14 of 14 PNMPs (100%) included information related to communication (how individual communicated and how staff should communicate with individual). This was an improvement from 40% in the previous review. The PNMPs continued to be excellent, with continued comprehensive content in all areas. • 100% of the PNMPs reviewed contained all of the essential elements with improvements in each of the three areas that were less than 100% during the last review. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> • For 8 of 8 individuals, or 100% (Sample O.1), ISPA meeting documentation noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. Though present for specific changes in these eight cases, the use of the ISPA appeared to be limited. ISPAs for Individual #20, Individual #1, and Individual #92 did not indicate a need for a change in the PNMP. • For individuals for whom the PNMP was revised, there was supporting documentation that 100% of the revised PNMPs had been implemented. The changes were made, in most cases, that day or within 48 hours. Other non-critical changes were made in less than 30 days. This was routinely documented by a Program Change form that had been signed by the IDT. The monitoring team concurred that the facility was in substantial compliance with this provision. • More consistent use of the ISPA process with clear documentation is encouraged. • Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPAs. • Continue with the existing audit process as this, as well as the training, clearly affected positive changes in the content of the PNMPs.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure	<u>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were generally readily available in the dining areas (except Individual #70's foster grandmother had cleaned it from the table before he was finished) and PNMPs were included in the individual notebook (notebooks not with Individual #52 and Individual	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	#67, but readily accessed). General practice guidelines (foundational training) were taught in NEO and in individual-specific training by the therapists, PNMPCs and residential staff. Based on observations conducted by the monitoring team: • 84% dining plans were implemented as written for over 50 individuals observed (errors noted for Individual #82, Individual #59, Individual #72, Individual #49, Individual #70, Individual #67, Individual #16, and Individual #25). For 7 of these 8 individuals, the errors were minor and did not place the individual at any risk. For 1 of the 8 (Individual #25), there were multiple errors, none of which placed the individual at any significant risk at the time. • 97% of PNMPs for over 60 individuals related to positioning and mobility were implemented as written, or alignment and support were consistent with generally accepted standards (errors noted for Individual #25 and Individual #127). Based on additional observations: • 75% of 12 transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards (errors noted for Individual #92, Individual #72, and Individual #52). None of these errors placed the individual in any danger. Furthermore, habilitation therapy staff had re-trained staff within 24 hours of these observations. • (NA) individuals' bathing plans were implemented appropriately or consistent with generally accepted standards. No bathing was observed during this review, so this metric was not rated. • (NA) individuals' oral hygiene plans were implemented appropriately or consistent with the PNMP. No oral hygiene was observed during this review, so this metric was not rated. • In 51 of 51 (100%) observations of medication administration, the nurse followed procedures in the PNMP. The facility had implemented Mealtime Coordinator (MTC) training consistent with the statewide plan. A Mealtime Coordinator was seen in each of the homes. Standardization of this process is essential to ensure adequate competency of these key staff. Unit directors need to be intimately involved in the implementation and oversight of the program. Errors observed by the monitoring team that went unnoticed by the MTC were evident for Individual #25. The system was well established and the committee who implemented this continued to meet to review and refine their system. 10 of 12 (83%) staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan. These questions pertained to rationale for assistive equipment, areas of risk and triggers, rationale for food textures and liquid consistencies, transfers and positioning. Staff should have an active knowledge of the	

#	Provision	Assessment of Status	Compliance
		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. The monitoring team determined that the facility's was in substantial compliance with this provision at this time. Observations related to bathing and oral hygiene will be conducted during the next review.	
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> EPSSLC had a system of comprehensive competency-based training regarding PNM services. Training provided: • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Based on the schedule submitted, class time included nearly 17 hours over three days. 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 using the practice checklist and with coaching by the trainers, though clearly this would be limited given the timeframe permitted. 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. As stated before by the monitoring team, this biased the actual determination of competency of the new staff. Staff were coached and retrained up to three times until competency was established.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		There was no clearly stated action taken in the case that a new employee was not able to pass the check-offs, though one staff had reportedly been terminated due to the inability to pass the check-offs after taking the classes two times and three trials for CBT check-offs. The Habilitation Therapies Director completed an audit of the dysphagia and lifting sections of this training in the last six months and determined that the classes were interactive and learner-centered. The instructors were well-organized and knowledgeable. By report, they were observed to monitor student responses and re-educate when needed. There were many opportunities for hands-on practice. Continued audits of various aspects of the training were planned. 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 and trained residential staff. Competency check-offs (validation) were conducted for foundational and non-foundational skills for individuals in their assigned home. Return demonstration was required for each skill. A competency check-off form was used to establish participants' abilities for each core area related to PNM. 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. • Over 94% of the 36 staff who were listed as participating in the NEO core PNM competencies for (i.e., foundational skills) passed the performance check-offs since the last review (lifting, PNM and Dysphagia). Others who had recently completed NEO, had not yet completed the check-off at the time of the report. • There was a comprehensive system to establish and maintain competency for staff who provided the training, including the PNMPCs, campus coordinators, and residential coordinators. They were required to complete all NEO and Refresher core competencies as well as validate three newly hired staff with a check-off by a Habilitation Therapist. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs was submitted. Training for technicians also included an extensive learning modules related to teaching adult learners and included the following: o Effective Teaching Strategies o Effective Modeling Strategies o Communicating with Difficult People o Higher Order Thinking	

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		○ In-servicing the PNMP ○ Training the Trainer ○ Validating the Skill ○ Monitoring the Program ○ Auditing the PNMP Each of these modules involved classroom instruction, a written test, demonstration of core skills, and validation. Refresher training had been developed in the area of PNM and was comprehensive, based closely on the NEO training developed. This also included the competency check-offs used in the NEO training described above and written tests and the same system for failed check-offs. • 100% of staff required to take the Annual Refresher class successfully passed the competency check-offs. • There was a system to establish and maintain competency for staff who provided the training. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs. <u>Individual-Specific Competency-Based Training</u> Non-foundational training was provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the NEO/refresher training curriculum. This type of training required competency check-offs in order that staff could implement that element. Pulled staff were required to review all elements of the PNMP and other plans and the system of sister homes ensured that all pulled staff were also trained and checked-off. The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. • Per the system in place, 100% of the staff assigned to individuals were trained related to individualized plans prior to the provision of services. • Per the system described, 100% of the staff assigned to individuals had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. • The facility had a process to validate that staff responsible for training other staff were competent to assess other staff's competency. Examples of documentation of this training was submitted for review and appeared to consistently reflect completion as described. • Further, a database had been developed to track this training (in conjunction with psychology), to permit supervisors to review the training status of staff prior to	

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		assigning them to an individual with specialized supports (non-foundational) in place. An example of the list of staff trained and the data base template was submitted. • Samples of the extensive system used to document this staff training was submitted for review and appeared to consistently reflect completion as described. • Changes to plans that required additional training was consistently documented. A random sample of this training was selected for 19 individuals and documentation was located in the training files maintained by Habilitation Therapies. In 100% of the cases, there was an ISP, ISPA, or program change form, and evidence of staff training conducted for trainers, residential across three shifts, recreation, medical, and workshop. There was also a system of "sister" homes that permitted consistently trained staff to fill in when it was necessary to pull staff to another home. The self-assessment reported that the facility was in substantial compliance for this provision and the monitoring team concurred.	
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> A system of compliance monitoring was established at EPSSLC using the Individual PNMP Monitoring Tool. This and the Home Meal Monitoring forms were revised during the last six months to specifically target mealtime and communication skills. These were facility-developed monitoring tools. The former Individual Meal Monitoring, Communication, and Universal Monitoring forms were discontinued. The passing score for compliance was raised from 80% to 90% to more accurately identify areas of need. • 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 covered all areas that were likely to provoke swallowing difficulties or increase PNM risk. For example, compliance occurring in January 2014 per the schedule submitted was as follows for 39 individuals: • Total: 41 for 39 individuals • Shift: o 1st shift: 16 (39%) o 2nd shift: 19 (46%)	Substantial Compliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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3rd shift: 6 (15%), completed by Campus Coordinators

Focus:

PNMP: 15 (37%)
Individual Mealtime: 4 (10%)
Oral care: 4 (10%), coordinated with Dental hygienists
Medication Administration (by nursing): 5 (12%)
Communication: 5 (12%)
Mobility: 3 (7%)
Transfers: 1 (2%)
Positioning: 2 (5%)
Bathing: 2 (5%)

In addition, mealtimes were also monitored extensively based on an overview of the dining area (Home Meal Monitoring) that targeted all individuals across the meal in a particular home. This monitoring was scheduled for every home at least one time a month and involved a variety of staff facility-wide. This sufficiently addressed mealtime in combination with the individual mealtime monitoring described above. QA monitoring was conducted and included Department Heads and Supervisors with a direct stake in active treatment.
There was an extensive process to review and track findings based on the monitoring conducted. Follow-up was clearly documented on the forms submitted. Further follow-up was based on an analysis of the monitoring forms for errors. These were reported via emails to residential supervisors on a weekly basis. Other issues were also addressed, for example, the wheelchair seat back was torn and there was evidence of a work order completed (Individual #115).
Quality Assurance monitoring was also conducted by the Habilitation Therapists with the PNMPCs on a prescribed schedule as follows:
<table>
<tr><th>Monitoring Frequency</th><th>QA Frequency</th></tr>
<tr><td>Monthly</td><td>Quarterly</td></tr>
<tr><td>Quarterly</td><td>Bi-Annually</td></tr>
<tr><td>Bi-Annually</td><td>Annually</td></tr>
<tr><td>Annually</td><td>Annually</td></tr>
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Equipment should be monitored for availability, condition, and working order with routine general check-offs for how to use the equipment. A Preventative Maintenance form was completed to monitor the working condition of individual and general use equipment on at least a monthly basis.
<u>Monitoring for Individuals in Samples</u>
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		Completed forms for PNM-related compliance monitoring conducted in the last three months were requested for the individuals in Sample O.1 with (11 individuals) and Sample O.2 (3 individuals). Monitoring frequency was listed as follows: • Every six months for Individual #75 and Individual #20 • Every three months for Individual #118, Individual #92, Individual #23, Individual #4, Individual #1, Individual #162, and Individual #100 • Monthly for Individual #115 and Individual #32 • For 13 of 14 individuals (93%) in samples O.1 and O.2, compliance monitoring occurred at the frequency outlined in the assessment and/or ISP/IHCP and in a timely manner. • Concerns were noted for eight individuals in the samples and adequate follow-up was documented for 100% of these concerns as noted on the monitoring form and, when indicated, also included a work order, follow-up with supervisory staff, or a report to the therapist. The system for follow-up was completed on three levels listed below. The concerns were relatively minor and did not require any systems or facility-wide changes or actions to be instituted. o With staff re-education on the spot o Residential supervisors o Follow-up monitoring for all failures under 80% within two weeks or as directed by the Director or Habilitation Therapist. These are repeated until a passing score was achieved. Overall, the monitoring team's own observations of PNMP implementation were similar to the compliance data the facility's monitors reported. The monitoring team agreed with the facility's self-rating of substantial compliance.	
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>Monitoring by the IDT and/or PNMT to Assess individual Progress and Plan Effectiveness</u> • IHCPs generally contained indicators identified to assess the individual's PNM status. • 14 of 14 individuals (100%) were monitored as to the effectiveness of PNMPs. These did not consistently include progress, related health status, and other clinical indicators identified in the therapy assessment, IHCP, and risk action plans, however. • For 6 of 6 individuals receiving direct PNM therapy, there was documentation as to the review of the effectiveness of the intervention plan based on objective clinical data included in the plan (Individual #19, Individual #92, Individual #184, Individual #58, Individual #1, and Individual #148). • In the case of a change of status, there was limited evidence that the IDT met,	Noncompliance

#	Provision	Assessment of Status	Compliance
		reviewed the existing interventions, and made changes in a timely manner. There were limited ISPAs related to post hospitalization, for example (Individual #115 and Individual #118). In other cases, it was not clear that both the IHCP and IRRF were reviewed and it was not evident that the IDT also reviewed the PNMP supports. There should be clear evidence of an ISPA that indicated review of each of these and identified the need or not to revise them. The revised documents should correspond to that process. • For at least nine individuals, there was evidence that the IDT identified the need for, and developed, individualized triggers as indicated. • Trigger sheets for nine individuals (100%) included individualized triggers as indicated. • Trigger sheets for 7 of 9 individuals were generally completed correctly (78%), with very few blanks. • Trigger sheets for 9 of 9 individuals were reviewed at least daily by the nurse, though instructions were for review every shift. Though many were reviewed on multiple shifts, there were numerous blanks in the documentation suggesting that a shift nurse had not reviewed the data. Case Manager review was more consistent for four of these. The monitoring team concurred that the facility was not in 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.** Ensure that ISPAs are held to address changes in status and changes in supports and services. There was extensive use of the Program Change form and facility guidelines had been established for use. While this would be appropriate in the case of simple wording changes and minor changes in the plan, an ISPA should be held in the event that any change could impact other supports and services. **2.** There should be a determination in every ISPA as to whether the PNMP, IRRF, and or IHCP need to be modified based on the identified issues and plans outlined. If no changes were necessary, this should be stated to demonstrate that this was considered. **3.** Ensure use of trigger sheets was consistent with the facility guidelines.	
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	<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 that identified 15 individuals who received enteral nutrition (13% of the current census). Fourteen were listed with gastrostomy tubes and one with a gastrostomy-jejunostomy tube. Ten received continuous feedings and two received bolus feedings, per the list submitted. Twelve were identified as NPO and three were listed with oral intake and the tube was used to	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	supplement meal refusals. Per other documentation Individual #92 had begun to receive pleasure feedings, though this was not included in the list provided. A sample of 10 APENs was requested, as completed since the previous review. Only five were submitted as completed: for Individual #93, Individual #103, Individual #1, and Individual #92. The APEN for Individual #57 was completed but not submitted. The ISPs submitted did not include the IRRF or IHCP for any of these. • At least 5 of 15 individuals (33%) who received enteral nutrition (Sample O. 3) were evaluated at a minimum annually based on the APENs submitted. • 3 of 5 individuals with APENs submitted (60%) had an appropriate evaluation to determine the medical necessity of the tube since the previous review. Most did not appear to present a determination if the feeding schedule was the least restrictive or if there were potential modifications needed in preparation of transition to oral intake. Also, there was not sufficient oral motor review to address potential for any level of oral intake or interventions that may be indicated (Individual #93 and Individual #103). • For 1 of 2 individuals (50%), for whom the IRRF were submitted, there was evidence of adequate discussion by the team related to the medical necessity of the team. The review for Individual #92 identified that pleasure feedings were on hold at the time of the review, but the rationale was not documented in the IRRF. Her progress with this was also not reviewed. The IRRF for Individual #162 was not submitted in his individual record. • --% of individuals who received enteral nourishment and were admitted since the last review (NA) had a review of the medical necessity of the feeding tube within 30 days. No one who received enteral nutrition had been admitted to SSLC since the previous review. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • Three of the individuals who received enteral nutrition (Sample O.3) were adequately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. In the case of Individual #15, a MBSS was recommended, though denied by the physician. There was no documentation related to the rationale for this. • One individual who was identified as potentially benefitting from oral motor treatment and cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process (Individual #92). The IRRF indicated that pleasure feedings were on hold, but without rationale. • 1 of 1 individual's (100%) plans to return to oral eating were based on the results of the IDT's discussion and were integrated in the IHCP and the ISP or ISPA.	

#	Provision	Assessment of Status	Compliance
		• 0 of 1 individual's plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. The Change of Status IHCP for Individual #180 was dated 7/3/13. This plan indicated that changes to the PNMP and Dining Plan were made, but there was no evidence of these changes until 7/29/13, per the PNMP on that date. The only Dining Plan submitted was dated 10/15/13 and reflected oral and enteral intake. • --% of 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. Pleasure feedings provided only by the SLP. • Individual #92 was monitored as outlined in the plan. • For 0 of 1 individual, the IDT met and interventions in the return to oral intake plans were reviewed and changed, as appropriate, in a timely manner. There was no evidence of this related to the hold on oral intake for Individual #92. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be: • Integrated into the IHCP, ISP, and/or an ISPA. • Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and positioning plan that addressed positioning during enteral intake only, rather than a Dining Plan. The monitoring team concurred with EPSSLC's self-rating of noncompliance. 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, especially related to oral motor evaluation, 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. 3. Establish clear support plans with clinical indicators for individuals with potential to return to oral intake and/or who would benefit from therapeutic intervention to address issues that may be barriers to return to oral intake.	

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o EPSSLC client list o Admissions list o Staff list o Section P Presentation Book and Self-Assessment o Section P QA Reports o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring templates o Completed Effectiveness Monitoring sheets submitted 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 List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months 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 Documentation of competency-based staff training submitted o PNM/Assistive Equipment Maintenance Log o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions

	○ OT/PT Assessment Tracking Log ○ Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to EPSSLC: Individual #179 an Individual #181. ○ OT/PT Assessments, ISPs, and ISPAs, and other documentation related to OT/PT supports and intervention for the following individuals: • Individual #58, Individual #148, Individual #28, Individual #125, Individual #125, Individual #161, Individual #46, Individual #67, Individual #16, Individual #15, and Individual #17. ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, and Individual #92. ○ PNMP section in Individual Notebooks for the following: • Individual #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, and Individual #92. ○ Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, Individual #92. <u>Interviews and Meetings Held</u>: ○ Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director ○ Jessica Cordova, DPT ○ Susan Acosta, DPT ○ OTAs, PTAs, Hab technicians and PNMPCs ○ Various supervisors and direct support staff <u>Observations Conducted</u>: ○ Living areas ○ Dining rooms ○ Workshop ○ Recreation area ○ Wheelchair clinic ○ ISP Meeting for Individual #67

	Facility Self-Assessment: The self-assessment completed by Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director continued to improve. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team, though not all of elements were addressed and used to determine compliance. Actions and self-assessment activities correlated extremely well to the recommendations made by the monitoring team and reflected significant efforts on the part of staff. Findings were 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 Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Ms. Ambruster and the other therapy staff were on track to ensure that progress will be made for the next review. They were very close to achieving substantial compliance, especially in P.3 and P.4, with a need to focus on staff training related to AAC and communication, as well as, consistency and quality of effectiveness monitoring. 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. Though continued work was needed, the monitoring team acknowledges the work that was done since the last review. The facility rated itself in substantial compliance with P.2, P.3, and P.4 and continued compliance with P.1. The monitoring concurred with P.1 and P.3, but while the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team determined that P.2, and P.4 were not yet in substantial compliance.
	Summary of Monitor's Assessment: OT, PT and speech now completed a combined Comprehensive Assessment and Assessment of Current Status. The assessments were exceptional as to content and the issues now were not related to comprehensiveness as they have come full circle since the baseline review. The focus now should be on organizing the content, eliminating redundancy and professional jargon, and striving to be thorough yet concise. These reports were lengthy and clearly required considerable time to put together. Content should be stated clearly and succinctly, in a manner that is user friendly to the entire IDT. On a positive note, the process has resulted in a clear understanding of comprehensive and functional assessment by the clinicians. Individuals who have received an assessment within the last year were thoroughly reviewed and it was clear that every effort was made to determine an individual's potential for expanding existing skills and/or learning new ones. With this achievement, it would now make sense to continue this excellent clinical reasoning process and streamline how it is documented. The other challenge will be to seamlessly integrate the communication assessment content into the existing OT/PT assessment formats (comprehensive and ACSs), without excessive redundancy and reporting of non-essential information. This was reviewed with Leslie Ambruster and she had already identified many of these concerns herself. There were few direct intervention plans in place for individuals with OT/PT needs and those reviewed

	were not well documented with an assessment and discharge summaries. Consistent documentation of direct supports and review of indirect supports was needed, using the guidelines outlined in this report with regard to content. The therapy clinicians are excellent and truly dedicated to the individuals living at EPSSLC. They all appear to work well as a team and as a member of the IDT. Early on in this process, the monitoring team encouraged them to integrate clinical services into the real life, daily routine of every individual and they have fully embraced this. <u>Samples for Section P:</u> • Sample P.1: 11 individuals for whom an individual record and the most current OT/PT/SLP assessment were submitted. • Sample P.2: 2 individuals newly admitted in the last six months for whom a current assessment was submitted. • Sample P.3: 3 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 were appropriately completed per the ISP schedule, change in status, or IDT request. There was a tracking log of assessments completed from 8/27/13 through 2/5/14, but it was not possible to track when the most current comprehensive assessment had been completed and whether the assessments documented were Comprehensive or Assessments of Current Status/Updates. By report, all individuals had received a Comprehensive Assessment. Previously, the OTs and PTs completed a Comprehensive Assessment and/or an Assessment of Current Status/Update with the SLPs adding content related to dysphagia and a very limited overview of communication. The SLPs had also completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status/Update. At the time of this review, some changes had been made to the standard format for these reports (per the state office) and were in use as of 10/1/13. EPSSLC had also chosen to combine the communication assessment into the OT/PT assessments and the formats were blended in an attempt to address all of the required assessment requirements by the state, as well as, the essential elements outlined by the monitoring team. The first combined assessments appeared to have been completed as of 10/29/13 per the tracking log submitted. By report, all individuals newly admitted to EPSSLC were to be provided a comprehensive assessment of communication completed within 30 days of admission. All individuals were to be provided a Comprehensive Assessment every five years, unless related to a	Substantial Compliance

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		significant change in status (defined as a change from medium to high in any PNM-related risk area) or special IDT request. An Assessment of Current Status was to be provided annually in the interim for individuals who received both direct and indirect services in years that a Comprehensive Evaluation was not required. Assessment due dates and timeliness of completion were tracked in the tracking log for individuals with ISPs scheduled from 8/27/13 through 2/5/14. The log data did not clearly match the data reported in the self-assessment. It was reported that delinquencies in November 2013 and December 2013 were related to the gap in service by the OT; one had resigned and it took some time to replace her. Timeliness since 1/1/14 was 82%. The following individuals in Samples P.1 had Comprehensive Evaluations current within the last 12 months (dates listed are the signature dates): 1. Individual #32 (9/30/13) 2. Individual #115 (4/30/13) 3. Individual #75 (6/27/13) 4. Individual #20 (8/27/13) 5. Individual #23 (8/27/13) 6. Individual #4 (6/14/13) 7. Individual #1 (10/2/13) (Her individual record documents were not submitted as requested, but the assessment and ISP were contained in another request.) The Assessment of Current Status was not considered a stand-alone evaluation, but rather served as an addendum or update to the previous Comprehensive Evaluation. Both should be contained in the individual record. The following individuals had Updates/Assessments of Current Status completed within the last 12 months and each had an associated Comprehensive Evaluation submitted and/or contained in his or her individual record: 1. Individual #162 (1/27/14) 2. Individual #92 (11/22/13) 3. Individual #100 (10/26/13) 4. Individual #118 (12/24/13) <u>Timeliness of Assessments</u> Two individuals were admitted to EPSSLC since the last review. A Comprehensive Evaluation was submitted for both of these as requested (Individual #179 and Individual #181). • 2 of 2 individuals in Sample P.2 (100%) received an OT/PT assessment within 30 days of admission based on the signature dates of the assessments submitted for review. The following metric was not applied because EPSSLC did not use an OT/PT screening for	

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		individuals newly admitted to the facility, so no screenings were submitted for 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. There were 11 current OT/PT evaluations submitted. Also, ISPs were submitted for all individuals in these samples and were current within the last 12 months. Timeliness of the current OT/PT assessments was as follows: • 9 of 11 individuals' OT/PT assessments or updates (82%) were dated as completed at least 10 working days prior to the annual ISP. This was an improvement from 50% in the previous review. Individual #92 was listed with a due date of 11/22/13 and the assessment was turned in on that date. It was not clear if this due date was modified based on the Thanksgiving holiday. The facility due dates must be based on actual working days and should not count holidays, with the assessment turned in by the 10-day due date before the ISP. Based on signature dates, and actual working days, the following assessments were not completed 10 working days <u>prior</u> to the ISP: Individual #23 and Individual #20. • 11 of 11 assessments (100%) were current within 12 months for individuals in Sample P.1 who were provided PNM supports and services. This was consistent with the previous review. <u>OT/PT Assessment</u> Only current Comprehensive Evaluations included in Sample P.1 were included in the following analysis (7). 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. It should be noted that 100% of the assessments reviewed contained 100% of the essential elements outlined by the monitoring team. The analysis for comprehensiveness of the OT/PT/SLP assessments was as follows: • 7 of 7 assessments (100%) were signed and dated by both OT and PT clinicians upon completion of the written report. This was an improvement from 92% in the previous review. • 7 of 7 assessments (100%) included medical diagnoses. This was consistent with the previous review. • 7 of 7 assessments (100%) included medical history. This was consistent with the previous review. • 7 of 7 assessments (100%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. This was consistent with the previous review.	

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		• 7 of 7 assessments (100%) addressed health status over the last year. This was an improvement from 89% in the previous review. • 7 of 7 assessments (100%) included comparative analysis that clearly analyzed health status compared with previous years or assessments. This was consistent with the previous review. • 7 of 7 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This was consistent with the previous review. • 7 of 7 assessments (100%) listed medications and potential side effects relevant to functional status. This was consistent with the previous review. • 7 of 7 assessments (100%) included individual preferences, strengths, and needs. This was consistent with the previous review. • 7 of 7 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. • 7 of 7 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. • 3 individuals required a wheelchair for mobility. 3 of 3 assessments (100%) included a description of the current seating system with a rationale for each component and need for changes to the system were outlined as indicated, also with sufficient rationale. This was consistent with the previous review. • 7 of 7 assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. This was consistent with the previous review. • 7 of 7 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. • 7 of 7 assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP that address the individual's PNM risk levels. This was consistent with the previous review. • 7 of 7 assessments (100%) included discussion of the individual's potential to develop new functional skills. This was consistent with the previous review. • 7 of 7 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. • 7 of 7 assessments (100%) included a monitoring schedule. This was an improvement from 75% in the previous review. • 7 of 7 assessments (100%) included a re-assessment schedule. This was an	

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		improvement from 92% in the previous review. • 7 of 7 assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was consistent with the previous review. • 7 of 7 assessments (100%) detailed the supports and services needed for successful community living. This was consistent with the previous review and was a significant strength of all of the assessments. • 7 of 7 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This was consistent with the previous review. The Assessment of Current Status was considered an update to the previous Comprehensive Assessment. In that case, the existing Comprehensive Assessment should be available in the individual record along with each subsequent Assessment of Current Status, until such time that the comprehensive was repeated (i.e., in three years, or other established interval per policy or assessment recommendation). At that time, each would be purged and replaced by the new Comprehensive Assessment and the cycle would be repeated. There were new assessment formats recently developed by the state and distributed. These contained standardized main headings were to be used by all disciplines. The facility had implemented these changes. There was some inconsistency, however, where specific information was included and it is recommended that this be reviewed. Further findings revealed continued improvements related to OT/PT assessments as follows: • 7of 7 assessments (100%) contained 100% of the 23 elements listed above. This was an improvement from the previous review when only 33% of the assessments contained 100% of the essential elements. • There were improvements in three of the elements. • There was no regression for any element. • 20 were consistent with the previous review at 100%. There were four individuals in Sample P.1 for whom individual records were submitted with current Updates/Assessments of Current Status, but only two had associated Comprehensive Assessments submitted and/or contained in the individual records (Individual #92 and Individual #162). • For 4 of 4 individuals for whom Updates/Assessments of Current Status were completed (100%), 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	

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		previous year, as well as monitoring data from the previous year and monitoring and re-assessment schedules. There was continued overall improvement in the quality of OT/PT assessments for this review period, though timeliness had slipped slightly. Though there was a reported improvement of on-time assessments submitted at or near 100% submitted on or prior to the due date of 10 days prior to the ISP, this could not be validated by the monitoring team based on review of the sample and the assessment log. The assessments were exceptional as to content, but they were lengthy (averaging over 34 pages for comprehensives), with some duplication of information and information that was likely non-essential. On a positive note, the process has resulted in a clear understanding of comprehensive and functional assessment by the clinicians. Individuals who have received an assessment within the last year were thoroughly reviewed and it was clear that every effort was made to determine an individual's potential for expanding existing skills and/or learning new ones. With this achievement, it would now make sense to continue this excellent clinical reasoning process, but to also streamline how it is documented. There was an audit system in place involving review by the Director on a monthly basis for a sample of assessments. This continued to be an appropriate approach as all clinicians were reported to have demonstrated competency with the elements identified above. The other challenge will be to seamlessly integrate the communication assessment content into the existing OT/PT assessment formats (comprehensive and ACSs), without excessive redundancy and reporting of non-essential information. This was reviewed with Leslie Ambruster and she had already identified many of these concerns herself. The monitoring team looks forward to watching this process and has great confidence that EPSSLC will arrive at an excellent solution. EPSSLC maintained substantial compliance with provision P.1. The facility continued to demonstrate improved compliance with the quality of OT/PT assessments. Ensure that assessments are completed by the due dates (10 working days prior to the ISP). 1. Ensure that the audit system promotes improvements in the content of OT/PT assessments at or near 90% which is the standard held by the monitoring team. 2. Review and analyze the existing assessments and formats to reduce redundancy and streamline how information is presented. 3. Clarify the function and format of the Assessment of Current Status. The current format has essential information, but it is difficult to read and important information becomes buried in the text (see Section R). This makes it difficult for the IDT to use it as a reference and to identify key elements that should be included in the ISP. The ACS should address essential findings from the last year,	

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		but should not be equivalent to a full comprehensive assessment. This will permit these to be completed in less time and permit more opportunities for direct supports and interventions.	
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 3 individuals listed as participating in direct OT and/or PT and each was included for review in Sample P.3 (Individual #58, Individual #1, and Individual #148). • For 1 of 3 individuals (33%), an OT/PT assessment or consult identified the need for OT/PT intervention with rationale (Individual #1). a. In the case of Individual #58, it was reported that she did not have any identified needs requiring direct skilled therapy at that time (7/31/13). An IPN dated 12/18/13, documented a treatment intervention related to sitting, neck range of motion, and trunk rotation. A SAP Strategy Plan (December 2013) identified an objective for her to look up for two minutes and to improve her hip and knee range of motion by five degrees. IPNs related to PT were submitted from 8/4/13 through 8/7/13 and 12/18/13 through 3/14/14. There was no evidence of documentation of assessment to establish the need for this intervention and there was no follow-up related to the need for an increase in Baclofen dosage. An IPN related to PT intervention was dated 2/3/14. It was identified as a monthly summary. It was not stated how often therapy had been provided, but that it should continue two to three times per week for the next month. There was no evidence of further review of this intervention. b. An assessment for Individual #148 had been completed on 3/27/13 by OT at the request of the IDT (referral on 3/7/13). There were no recommendations for direct OT at that time, but rather Environmental Awareness SAPs related blind guide assistance and use of a handrail. There was no evidence that these were implemented at that time. As of 6/20/13, there was no indication that a SAP had been implemented per the ISPA on that date. On 10/2/13, a SAP Strategy Plan was developed by OT, with re-assessment in eight weeks. Progress notes were written to reflect OT intervention through 3/7/14 with ongoing progress reported. There were no further IPNs until 3/18/14, when it was reported that Individual #148 had fallen and required hospitalization. On that date, it was stated that OT intervention would continue. • 1 of 3 individuals had direct intervention plans (33%) implemented within 30 days of creation or sooner as indicated by the individual's health and safety (Individual #1). • For 1 of 3 individuals (33%), there were objectives related to functional individual outcomes included in the ISP or ISPA (Individual #148). A Program	Noncompliance

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		Change form was completed on 10/29/13 to initiate PT intervention, in the case of Individual #1. Intervention had been recommended in the Comprehensive OT/PT assessment (10/2/13), but was not discussed at the ISP on 10/17/13. Less than two weeks later, the Program Change was initiated. This should have been discussed and integrated at the time of the annual ISP. The facility should be cautioned in the use of the Program Change forms to conduct business that should require the IDT to meet and discuss the individual's status. This ensures improved integration and collaboration by all team members. • For 1 of 3 individuals (33%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Direct PT intervention for Individual #1 continued through 3/6/14, when it was determined that she had reached a plateau and that further PT was not indicated. There was no evidence that this had been reviewed by the IDT. The system for documentation was somewhat inconsistent for each of the individuals reviewed. There was a combination of session IPNs and monthly progress reports. Further, there was little evidence that actual therapy had been provided for Individual #58. Progress notes/IPNs: • 2 of 3 individuals receiving direct OT/PT Services (33%) 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. <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 PNMP and Dining Plans were required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT	

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		should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the OT and/or PT clinicians. As described above, the ISPs or ISPAs for individuals in the sample who participated in direct OT or PT services did not consistently establish the need to begin or terminate therapy. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. Pre-ISP documentation and ISPs were requested for individuals included in Sample P1 and P.3. Review of the ISPs submitted was as follows (attendance by the SLP was reported in Section R below): • 100% (13 of 13) of the ISPs submitted were current within the last 12 months. • 100% (13 of 13) of the current ISPs had attached signature sheets. • 8% (1 of 13) of the current ISPs with signature pages submitted were attended by both the OT and PT (Individual #118). • 15% (2 of 13) were attended by PT only. • 46% (6 of 13) was attended by OT only. • 31% (4 of 13) of the current ISPs had no representation by an OT or PT (Individual #92, Individual #20, Individual #1, and Individual #4), even though at least three individuals had PNM needs (Individual #1, Individual #92 and Individual #4). The SLP was designated by the IDTs to attend the meetings for each of these individuals. Of the 12 individuals for whom pre-ISP required attendance sheets and ISP signature sheets were submitted (no pre-ISP for Individual #148), six designated required attendance by OT and/or PT. Each of these was attended as designated by the IDT (100%). The facility needs to clearly establish a rationale for attendance by all team members and, once established, attendance should be consistent with this rationale. Clinicians may find the need to negotiate their attendance based on actual services and supports provided and/or proposed to be provided. This element was self-rated to be in substantial compliance, but the monitoring team did not concur at this time due to inconsistencies in documentation for direct interventions. Very few individuals received these services. 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. Representation by OT and/or PT should be reconciled with the IDT during the pre-ISP process and should be consistent with the designation by the team. 3. Ensure that there is an assessment or consult that clearly establishes the need for	

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		OT/PT interventions and that states the goals and objectives. 4. Ensure that there is consistency across clinicians with regard to the manner in which services are documented. Audits for this may need to be established. 5. Ensure that there is a clear discharge summary (in the IPNs). 6. 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. Review the use of Program Change forms as they should not routinely substitute for an ISPA meeting.	
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.	<u>Competency-Based Training</u> 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 with a finding of substantial compliance. Substantial compliance with O.5 is the standard for compliance with this element.	Substantial Compliance
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 had a current OT/PT policy. Though it did not include all of the following elements, most of these were addressed in the PNM policy dated 3/20/14 and generally in practice with additional written guidelines as needed: • 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 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	Noncompliance

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		• Requirements for documentation for individuals receiving direct services. There was no evidence of guidelines for this aspect and this was reflected in section P.3 above. <u>Monitoring System</u> The facility implemented a system for the adequate monitoring of PNMPs conducted by the PNMPCs. This included staff compliance for implementation of PNMPs and the condition and availability of adaptive equipment. The standardized system for compliance monitoring consisted of a determination of frequency by the IDT during the annual ISP meeting. The Habilitation Therapy Director reviewed the compliance results with the therapists on a monthly basis and determined targets for each month's schedule. These are scheduled to ensure that monitoring was conducted across all three shifts and tracks the activities to ensure that all areas of the PNMP were addressed. The forms were revised recently to more specifically also target mealtime and communication on the Individual PNMP Monitoring form. The passing score was raised from 80% to 90% to more accurately identify areas that needed attention and follow-up. Follow-up was completed on three levels. Upon completion of the monitoring, the monitor reviewed the results with the staff and re-educated them as needed. The Director tracked all failed monitoring on a weekly basis and reported the results to the Residential Supervisors for immediate follow-up. Follow-up monitoring was then assigned within two weeks and reviewed for all failures under "80%" (this was thought to be an error in the self-assessment as it was also reported that compliance had been established at 90% rather than 80%). Additional follow-ups were scheduled until a passing score was achieved. QA monitoring was conducted by licensed therapists on a specific schedule to ensure that the PNMPCs demonstrated continued competency. • The tools included adequate indicators to determine whether staff demonstrated competency to safely and appropriately implement the PNMP, though there did not appear to be an indicator related to medication administration. • There were sufficient instructional guidelines for those using the forms to monitor. • Monitors (PNMPCs) were competent to monitor the PNMP elements based on the training submitted. Though much work had been done to modify the existing system since the last review as outlined above and in section O.6, it did not appear that all areas of the PNMP had been monitored based on the established schedule. Per the documentation submitted frequency for the individuals in Sample P.1 was as follows: • Every month: Individual #115 and Individual #32 • Every three months: Individual #162, Individual #100, Individual #92, Individual	

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		#23, Individual #4, Individual #1, and Individual #118 • Every six months: Individual #20 and Individual #75 The forms submitted were reviewed to determine if monitoring was completed as per the established schedule and if all areas of the PNMP had been reviewed, across all shifts within that time frame. Findings were as follows: • Monitoring appeared to be conducted at the established frequency described above, though this could not be verified for Individual #75. Individual #162 was listed with monitoring every three months, though he had been monitored every month from October 2013 through February 2014. • While collectively monitoring occurred across all three shifts, this was not the case for individuals. • Medication administration was not monitored for any individual in the sample and did not appear on the very complex monitoring form. • Individual #115: Oral care was monitored only once out of three months per the forms submitted. Positioning was monitored two of the three months and bathing was monitored only once. • Individual #162: There was no monitoring of bathing or mealtime (he was asleep), though mealtime compliance was scored at 100%. • Individual #100: All areas were monitored, but only on first shift. • Individual #20: No evidence of compliance monitoring during the previous three months. As listed above she was to be monitored every six months. • Individual #75: There was no evidence of mealtime monitoring or oral care. • Individual #32: There was no evidence of monitoring for bathing. It was reported that though staff required corrections for transfer techniques, yet was scored as "yes" for compliance. • Individual #92: All areas except bathing appeared to be monitored. • Individual #23: He was monitored during a snack, but there was no PNMP or Dining Plan available because it was left in the home. One element was scored "yes" that the Dining Plan and PNMP matched and another was marked "yes" that the PNMP was in the individual book. The element related to availability of the plan(s) was marked "no." Despite this serious error, compliance was 91%. • Individual #4: There was no evidence that transfers, bathing, oral care or alternate positioning were monitored. • Individual #1: There was no evidence that transfers, oral care, positioning, or bathing were monitored. • Individual #118: There was no evidence that transfers, oral care, or bathing were monitored. Only positioning in her wheelchair was monitored.	

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		• It was noted, however, that the PNM monitoring process did not adequately balance all areas that were likely to provoke swallowing difficulties, or increase other PNM risk, including: o Meals o Bed positioning o Wheelchair positioning o Medication administration o Oral care o Bathing o Transfers As described in section O above, there were continued issues related to staff performance of transfers, re-positioning, and mealtime assistance, though still improved from the last review. There was also a system established for effectiveness monitoring by the therapists, though this was not clear based on the documentation submitted. The frequency of this was established by the therapists. Effectiveness monitoring guidelines indicated that it should occur as follows: • Monitor upon initiating a program • Monitor upon modifying a program • Monitor following identified issues or concerns based on daily review of nightly reports • Monitor following identified issues or concerns based on daily unit meetings • Monitor following identified issues or concerns based on weekly Habilitation Therapist meeting • Monitor following identified issues or concerns based on compliance monitoring • Monitor based on the same frequency as IDT directed compliance monitoring • Monitoring of direct intervention is based on every direct therapy session with "periodic" review of progress to determine effectiveness. Based on the sample of individuals selected for P.1, evidence of effectiveness monitoring for each was requested for six months. There was no form and no specific guidelines as to content for the IPNs completed. There were numerous entries by clinicians addressing a number of areas across the PNMP. A system to track if all were addressed in a timeframe of no less than quarterly, or more often as indicated for individuals at higher risk or identified need was not clearly established. By report, these were focused on compliance for implementation as well as a review of plans and equipment to determine if they were effective. Compliance monitoring forms were not submitted and this was not consistently addressed in each of the IPNs related to effectiveness monitoring. A consultant who	

#	Provision	Assessment of Status	Compliance
		reviewed this system identified similar concerns and these should be addressed over the next six months. • Based on the monitoring team's direct observation of over 30 individuals, over 90% of positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. • Based on review of the maintenance log, individuals for whom adaptive equipment was noted to be in disrepair or needing replacement, equipment was repaired or replaced within 30 days, or unless the issue impacted the individual's health or safety, then action was taken within 48 hours. All equipment was checked at least quarterly for presence and condition in addition to the compliance and effectiveness monitoring systems. This element was self-rated to be in substantial compliance. While there was an established system of effectiveness monitoring, clinician compliance with this was not clear and documentation was inconsistent. There were no forms and no specific guidelines as to content for the IPNs completed. There were numerous entries by clinicians addressing a number of areas across the PNMP, but there was no clear method to track whether all were completed within the established timeframes. The results of compliance monitoring were not consistently addressed in each of the IPNs related to effectiveness monitoring. A consultant who reviewed this system identified similar concerns and these should be addressed 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. Establish benchmarks and a tracking system and schedule for effectiveness monitoring by OTs and PTs. It appeared that monitoring was done with significant frequency, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. The guidelines outlined above tended to focus on events that already may suggest that a support was not effective. While this trigger system promotes that the therapist look at supports when there is a change in status of some kind that may suggest that changes to the plan is indicated, that is not the entire picture. It is also critical to respond proactively in a routine manner before there is a risk-related event. Consider the development of a form to guide this process or at least provide documentation guidelines. Effectiveness monitoring should be tied to the occurrence or lack of occurrence of health risk issues. For example, if a support, such as a gait belt is in place to reduce falling during transfers, it is critical to determine if the belt fits properly and is applied correctly. It must be in good condition and be readily available. It must be used appropriately and effectively aide in the process of the transfer. Further to be effective, evidence that there has been an impact on the	

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		incidence of falls since the previous monitoring must also be reported. This should be addressed for all aspects of the PNMP and other supports provided. 2. Conduct audits and staff training as to the process expected for effectiveness monitoring. 3. Consider simplification of the compliance monitoring tool. The PNMPCs document a lot of information in a very small space, making analysis of the content time consuming and complicated. The facility is on the right track, though continued fine tuning of the system is needed.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o EPSSLC Organizational Charts o EPSSLC Self -Assessment Section Q o EPSSLC Action Plan Section Q o EPSSLC Provision Action Plan o EPSSLC Facility Operational Dental Services Policy, Suction Toothbrush/Biotene 8/22/12, 2/14/14 o EPSSLC Facility Operational Dental Services Policy, Suction Toothbrush/Chlorhexidine 8/22/12, rev 2/14/14 o EPSSLC Facility Operational Dental Services Policy, Chlorhexidine Use Definition 8/22/12, 2/14/14 o EPSSLC Facility Operational Dental Services Policy, Equipment Maintenance 8/22/12, 2/14/14 o SSLC Nursing Protocol: Post Anesthesia Care, June 2010 o SSLC Nursing Protocol: Pre-treatment and Post sedation Monitoring, 12/12 o Presentation Book, Section Q o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams 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 Complete Dental Records for the following individuals: • Individual #59, Individual #27, Individual #162, Individual #19, Individual 100, Individual #104, Individual #78, Individual #105, Individual #63, Individual, #99, Individual #179 o Annual Dental Summaries for the following individuals: • Individual 147, Individual #17, Individual #188, Individual #56, Individual #172, Interviews and Meetings Held: o Raquel Rodriquez, RDH o Jennifer Pacheco, RDH o Katherine Hill, Clinical Services Director o Olga Arciniega, Facility Director Observations Conducted: o Dental Department o Daily Medical Provider Meetings o QA Meeting

	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. The self-assessment cited that the facility's dental director was the center's lead, however, EPPSLC did not have an onsite dental director and the contract dentist retired on 3/14/14. The self-assessment utilized the state standardized template. The accuracy of the data for many items was suspect and needs to be reviewed. Moving forward, the facility's lead should review the comments and recommendations of this report and make any appropriate changes to the self-assessment. The facility rated itself in noncompliance for both provisions. The monitoring team concurs with the facility's self-ratings.
	Summary of Monitor's Assessment: EPSSLC made no progress in the provision of dental services. In fact, there was evidence that dental services deteriorated since the last compliance review. During that review, a number of serious issues surfaced and the facility did not appear to make any serious attempts to correct the issues in a timely manner. It could not be determined if individuals received adequate dental care because the documentation was inadequate and there was no evidence during this review that the deficiencies were corrected. The facility did not have a dentist at the time of the compliance review. It was reported that the contract dentist retired on 3/14/14. The dental hygienist reported that he would "help" in clinic until a new dentist was hired, but the exact terms of this were not defined. Therefore, the monitoring team had no indication of the ability of the facility to provide dental services in the future. The retired contract dentist was not present at the facility during the week of the compliance review. Data accuracy made determination of provision of services difficult. The total number of clinic appointments submitted in documents was not correct. There was an interruption of general anesthesia services during the months of November 2013, December 2013, and February 2014. This was reported to be due to budget constraints. When it did occur, there continued to be a lack of specific policies and procedures to guide the selection of individuals and post-anesthesia monitoring. The facility documented that during the reporting period, 55% of annual dental assessments were completed in a timely manner. This poor compliance score did not result in any particular corrective action plan. Oral hygiene continued to be tracked, but data showed that good hygiene ratings decreased and fair ratings increased. In February 2014, habilitation services and the dental department began collaborating to

	conduct monitoring in the homes related to positioning, equipment use, oral care, and education of the direct support professionals. The facility combined document requests submitting the same sample to fulfill multiple requests such as complete dental records, comprehensive examinations, and general anesthesia records. Thus, all of the records in the sample of 10 complete dental records were recent (January 2014) general anesthesia cases. The data submitted by EPSSLC were not reliable and this has been a cause for concern over a period of years. The reason for this is not clear. However, this report points out that the facility was currently not capable of providing accurate data related to the provision of dental services. This was evident with the data related to general anesthesia that required correction, the inaccurate failed appointments data, and the total clinic data that was obviously incorrect. It is of paramount importance that the use of general anesthesia at EPSSLC be clarified. At the time of the compliance review, based on data and interviews, it appeared that few options were available to individuals. Individuals either fully cooperated to have procedures done or general anesthesia (the most restrictive and invasive alternative) was utilized. While minimal sedation may not be appropriate for some individuals, it appeared that EPPSLC had taken the approach that it was not used. In fact, during the September 2013 compliance review, this was explicitly stated by the dentist and was supported by the data. The complete lack of use of minimal sedation may also not be the most prudent approach. Such findings during the September 2013 review resulted in the recommendation that further review be conducted by state office. Based on the findings of this review, there was no evidence that any reviews were conducted, any practices altered, or that individuals were receiving the treatment needed. As noted clearly during the exit comments, assessing the provision of dental care requires the appropriate documentation in the records in support of that care. This review revealed that record documentation was insufficient, facility data were unreliable, and individuals may be at risk for poor oral health.

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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	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with the members of the clinic staff and facility director. <u>Staffing</u> The part-time contract dentist who worked 10 days a month retired on 3/14/14. At the time of the compliance review, the dental clinic was staffed with two full time dental hygienists. A community dental anesthesiologist came to EPSSLC two days a month for general anesthesia clinic. This service was suspended in November 2013, December 2013, and February 2014 due to budget issues. At the time of the compliance review, the facility did not have a dentist. It was reported that the former contract dentist would provide some services, but the number of hours was not specified.	Noncompliance

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	American Dental Association for persons with developmental disabilities shall satisfy these standards.	Annual Assessment The monitoring team requested a list of annual assessments completed in the last six months, listed by month. The facility submitted a list of assessments completed each month. Assessments were completed within 365 days of the previous assessment. The data from the documents submitted are presented in the table below.	

Annual Assessment Compliance 2013						
	Aug	Sep	Oct	Nov	Dec	Jan
No. Of Exams Completed	9	13	5	15	2	--
% Timely Completion	77	100	0	100	100	--

The dental department did not submit complete data in the document request. The data ended with the month of December 2013. Only two appointments were listed for that month. The table reflects the data submitted.

The self-assessment documented that from 8/1/13 to 1/31/14, 33 of 60 (55%) of annual assessments were completed within 365 days. The annual dental examination is the fundamental dental assessment that is required to be completed on a yearly basis. The facility failed to complete this exam in a timely manner for 45% of individuals, yet no corrective action plan was implemented. The facility, however, reported that new forms and document tracking processes were being put into place.

The Annual Dental Examinations included in the complete dental records for 10 individuals were reviewed. 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. These records indicated that EPSSLC continued to have serious problems related to the documentation of dental care. Most individuals had a simple IPN entry for documentation of the annual examination. Very often, the note indicated that the individual was seen in the cottage for the annual examination and a four-line note was written. The assessment, which included the examination findings usually just stated "exam" and the plan, was for general anesthesia. As noted in the September 2013 review, the IPN documentation of the annual exams did not provide the IDTs with any information regarding the condition of the individual's oral health. Starting in October 2013, the newly revised Annual Dental Summary was used to document the annual dental examination for a few individuals. However, this was also not the correct form for the annual examination. As noted in previous reports, the Annual Dental Summary was intended to be a chart review done in preparation for the ISP. The monitoring team had no way to determine why this practice was allowed to continue at EPPSLC. This type of documentation failed to document significant information, such as intraoral and

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		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, medication use, information on positioning, or provision of oral hygiene instructions. At EPSSLC, even the exams completed under general anesthesia, in many instances, did not provide much of the information that was required in order to meet the requirements of the Settlement Agreement. The content of documentation was not unexpected. During interviews, the dental hygienist informed the monitoring team that changes in documentation were made just prior to the compliance review. Therefore, the records submitted would essentially look no different from that of the previous visit. The dental clinic was under the purview of the clinical services director. However, she was unaware of why the changes in documentation, particularly documentation of the annual assessment, were not implemented sooner. <u>Annual Dental Summaries</u> The revised state Annual Dental Summary was implemented in October 2013. Copies of six Annual Dental Summaries completed in January 2014 were submitted for review. The following summarizes the data included in those documents: • 6 of 6 (100%) had an entry concerning behavioral issues, and the need for sedation/restraint use • 6 of 6 (100%) documented oral hygiene status • 6 of 6 (100%) documented oral cavity tissues • 6 of 6 (100%) included a completed odontogram • 6 of 6 (100%) documented treatment recommendations • 6 of 6 (100%) documented risk ratings specific to periodontal disease and caries • 6 of 6 (100%) included comment on community and living services6 of 6 (7%) included comments on preferences, strengths, and goals. The ADSs were completed as required. In some instances, the forms were not fully completed. The greatest concern was that the form was used to document the annual examination. As previously noted, the ADS was <u>not</u> intended to document the annual dental examination because it did not include the appropriate information. <u>Initial Exams</u> Two individuals were admitted during the reporting period. The initial evaluations for both individuals were completed within 30 days of admission.	

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		Oral Hygiene The facility continued to monitor the oral hygiene ratings of the individuals. Oral hygiene ratings were documented during annual exams. The facility now reported only yearly ratings as noted in the table below:	

Oral Hygiene Ratings (%)			
	Good	Fair	Poor
2012	18	54	27
2013	9	69	22
8/13 -1/14	1	79	20

The percentage of good ratings decreased while the percentage of fair ratings increased. Staff had no explanation for this occurrence. In February 2014, habilitation services and the dental department began collaborating to conduct in-home monitoring of positioning, equipment use, and oral care. This also provided opportunities for additional training to be done with the direct support professionals.

The self-assessment noted that "data" were reviewed and determined that oral hygiene instructions were provided to 80% of individuals. The data reviewed were not specified. The monitoring team reviewed IPN documentation, Annual Dental Summaries, and other assessments. These documents did not consistently indicate that oral hygiene instructions were provided to individuals and/or staff.

Suction Toothbrushing
Thirteen individuals received treatment with suction tooth brushing and Biotene. The treatments were provided two to three times a day to individuals with gastric tubes and a history of aspiration risk. Treatments were administered by nursing and documented on the MARs. Training was conducted by the hygienists, nursing, and respiratory therapists. The plan was to have direct care professionals provide the treatments after all were trained. It was reported that nursing maintained oversight of this program, but the dental department did not have any data to document that treatment occurred as prescribed by the PCPs.

Preventive, Restorative, and Emergency Services
The clinic had one fully equipped and functional operatory and provided basic dental services, including prophylactic treatments, restorative procedures, such as resins and amalgams, extractions of non-restorable teeth, and x-rays. The facility utilized the services of a dental anesthesiologist who provided services two days each month. As already noted, the service was suspended for a number of months.

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		Individuals who required treatment that was more extensive or were medically fragile were referred to a local dentist who completed treatment in the hospital. Data related to the provision of services were tracked in the state issued dental database. The total number of clinic visits and key category visits as submitted by EPSSLC are summarized below. Clinic Appointments 2013 - 2014 Aug / Sep / Oct / Nov / Dec / Jan Preventive: 49 / 61 / 40 / 19 / 31 / 42 Emergency: 2 / 0 / 0 / 1 / 0 / 0 Extractions: 2 / 6 / 1 / 0 / 0 / 3 Restorative: 4 / 2 / 3 / 1 / 0 / 3 Total: 49 / 61 / 40 / 19 / 31 / 42 The data presented by the clinic appeared to be inaccurate because the total number of appointments always equaled the number of preventive care appointments. For the category of preventive care appointments (document XIV.5.f), treatment explanations were provided. The reasons included: • DSP oral hygiene training • Scaling attempt • Restorative attempt • Brushing • Desensitization • Post-hospital appointment • Emergency • Evaluation For the month of August 2013, 12 of 49 (25%) appointments were in-home trainings for the DSPs. While this was very important, the monitoring team could not clearly determine the extent of services provided because of the inaccurate data. Post-hospital appointments and restorations were not preventive appointments. Emergency Care Emergency care was available at EPSSLC during normal business hours when a dentist was present. There was no on-call dental coverage. Dental issues were referred to the PCP who made a decision about referral to the emergency department. As already noted, the monitoring team was not informed about the number of hours that services would be provided by a dentist in the immediate future, pending the hiring of a new dentist.	

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		Radiographs According to the self-assessment, 7 of 61 (12%) of individuals did not have current radiographs. The seven individuals were medically compromised and could not have general anesthesia or were edentulous. There was no dentist present at the facility during the week of the compliance review to discuss the standards that were used for obtaining radiographs. The requirements were not covered in dental policy. Oral Surgery There were no referrals to the oral surgeon for treatment. Sedation/General Anesthesia The facility used no pretreatment sedation. The number of individuals who utilized general anesthesia is summarized in the table below.	

General Anesthesia/Minimal Sedation						
	Aug	Sep	Oct	Nov	Dec	Jan
General Anesthesia	0	10	10	--	--	8
Oral Sedation	0	0	0	0	0	0
Off-Campus	0	1	2	0	0	0
Total	0	11	12	0	0	9

The medical and dental departments did not have a specific policy that outlined the scope of sedation that could be utilized at the facility and the process for determining candidates for these services. Two policies were submitted (1) SSLC Nursing Protocol: Post Anesthesia Care, 6/10, and (2) SSLC Nursing Protocol: Pre-treatment and Post sedation Monitoring, 12/12.

All of the records for the sample of 10 complete dental records were recent (January 2014) general anesthesia cases. For that sample, the monitoring team noted that many records lacked inclusion of the REACT Checklists. Vital sign flow sheets were also not included in most of the records reviewed. Some of the records that lacked vital sign flow sheets also did not include the nursing IPN entries. For the records with IPN entries, the vital signs were sometimes recorded in accordance with policy and at other times, they were not. Overall, the documentation did not provide evidence that EPSSLC provided the appropriate level of post-anesthesia care following the use of general anesthesia. Moreover, the recommendations made in the September 2013 monitoring team report to review (1) the scope of services, (2) indications for use of anesthesia, (3) evaluation of individuals prior to anesthesia, and (4) post anesthesia monitoring of individuals did not appear to have been addressed

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		As part of it's quality efforts, the dental clinic should also track and document adverse events that occur following sedation and TIVA, such as individuals who require transfer to acute care facilities within 72 hours of procedures. <u>Staff Training</u> All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn. Data provided by the facility indicated compliance with the requirements for training. Ninety five percent of direct support professionals completed the refresher through iLearn. <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 makes the following recommendations: 1. The facility director must proceed with hiring a new facility dentist. 2. The new facility dentist will need to work closely with the state dental services director to understand the requirements of the Settlement Agreement. 3. There should be increased clinical oversight of the suction toothbrushing program to ensure that treatments are occurring in a timely manner. 4. The facility should address concerns related to general anesthesia as noted above, including the development of specific policy. 5. The facility must ensure appropriate monitoring during the peri-operative period. 6. The facility must resolve the long term and ongoing problem with the lack of validity and reliability of data in the EPSSLC dental clinic.	
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;	<u>Policies and Procedures</u> The monitoring team requested all facility (local) policies related to the provision of dental care via the document request. The lack of submission of policies and procedures has been documented in previous reviews. The monitoring team requested during interviews a copy of all policies and procedures. Staff indicated that the department currently had four policies and procedures and all were included in the document request. The dental department needs to have a dental department manual that includes all policies, procedures, and guidelines involving the provision of dental services to ensure that all aspects of dental services are covered. That manual should be readily retrievable and available for review by staff. Topics should include, but not be limited to: • General operations of clinic and staffing	Noncompliance

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	use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	• Informed consent • Dental radiographs • Oral hygiene tracking • Dental recall • Dental sedation • Anesthesia - medical clearance, recovery • General anesthesia personnel • Infection control • Training • Dental emergencies • Oral care Some policies may not be under the purview of the dental department, however, policies such as informed consent and the HRC review process should also be included the manual. Local policies should be updated to reflect changes in state dental policies. The department should also ensure that policies are reviewed on an annual basis and updated as required. 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. Dental records are discussed in section Q1 under assessments. Failed Appointments The guidelines issued by state office required reporting of missed/no show 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 number of appointments as identified and reported by EPSSLC are summarized in the table below:	

Failed Clinic Appointments 2013 - 2014						
	Aug	Sep	Oct	Nov	Dec	Jan
Missed/No show	3	1	4	0	0	1
Refused	1	0	1	3	0	1
Failed	0 (4)	0 (1)	0 (5)	0 (3)	1 (0)	0 (2)
% Failed	8	1.6	12.5	15.7	0	4.7
Total Appointments	49	61	40	19	31	42

#	Provision	Assessment of Status	Compliance
		Clinic staff did not use the standard definition for a failed appointment and, therefore, reported that there were no failed clinic appointments other than one in December 2013. The department continued to struggle with basic data management and inconsistencies were seen in several data sets that required correction. The percentage of failed appointments in the table was calculated by the monitoring team and is based on the correct number of failed appointments. Even this number may not reflect clinic attendance because as discussed in section Q1, the total number of actual clinic appointments included a significant number of trainings that occurred in the homes with the direct support professionals. The facility submitted explanations for the missed appointments. Fortunately, there were few missed/no show appointments documented. The clinic-tracking schedule noted that most were rescheduled, but completion was not documented. A few appointments were left as pending. <u>Sedation and Dental Restraints</u> The dental department did not use any sedation or mechanical restraints.	

General Anesthesia/sedation/Restraints 2012 - 2013				
	Facility Reported Sep 2013		Facility Reported Mar 2014	
	2012	2013	2012	2013
General Anesthesia	70 (62.5%)	30 (100%)	60	59
Oral Sedation	42(37.5%)	0	1	none
Restraints	0	0	0	None
Total Appointments	112	30	60	59

The 2012 data reported for this review were significantly different from the data reported from the last review. The fundamental issue is the use of general anesthesia and the concerns regarding overuse. The hygienist reported that they were able to do cleanings without anesthesia. However, for record samples, the facility chose to submit only cases of general anesthesia. Additional data are needed to further explore this area. The facility should document what procedures are done with and without anesthesia to better assess this area.

<u>Strategies to Overcome Barriers to Dental Treatment</u>
EPSSLC continued to report a very low refusal rate with essentially no one refusing treatment. The accuracy of that data is questionable. For example, the Annual Dental Summary for Individual #188 stated that the individual refused treatment and had a support plan in place to address refusals. This individual was not listed on the refusal list.

Almost all dental treatment that was completed required the use of general anesthesia.

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		Moreover, the hygienist reported that nearly 72 written plans addressed barriers to oral health. The facility did not provide any summary data for the various plans and strategies. Rather it submitted a series of SAPs and other documents that addressed the identified issues. The plans were written by program developers who also inserviced the DSPs. The plans did not provide any information on the status of the individuals. The behavioral health services department had no role in this process. It also appeared that the dental clinic had little role in the process because they were not informed on the status of the multiple plans and could provide little information. When asked how this impacted treatment in dental clinic, the hygienist replied that it did not. If individuals required treatment, the consent and HRC processes were implemented and the individuals received treatment with the assistance of general anesthesia. It appeared that very little was done to use intermediate modalities to accomplish treatment. This was understandably so as it would be difficult to do so without the involvement of the behavioral health department. This approach was reflective of the culture seen at EPSSLC in which many of the clinical services areas were not collaborating effectively to deliver services in an integrated manner. This was a particularly pronounced example of departmental siloing. The following information was taken from Annual Dental Summaries reviewed: • As already discussed, Individual, #188 was reported to have a history of refusals, but was not listed on the refusal list. The ADS indicated that a support plan was in place to assist in cooperation with dental clinic. There were no clinic appointments for that purpose noted. All treatment was completed with general anesthesia. • Individual #172 was reported to receive sedation in the past. All treatment was now done with general anesthesia. The reason was not provided. The ADS indicated a desensitization plan was needed. • Individual #56 was reported to do well in clinic, but invasive treatment required general anesthesia. There was no indication what types of treatment, if any, could be achieved with minimal sedation. The ADS documented that a desensitization plan was implemented, but no further information was provided. • Individual #17 was reported to have a desensitization plan implemented in 2013, but no further information was in the ADA. Treatment was completed with general anesthesia. • Individual #147 had a desensitization plan implemented in 2013 and all treatment was completed with general anesthesia. The examples above were taken from a random sample of Annual Dental Summaries submitted by the facility. All of the individuals (100%) in the sample had treatment	

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		accomplished with general anesthesia. Reliability of the data was questionable, but for every record reviewed in which dental procedures, such as extractions, restorations, or scalings, were completed, general anesthesia was utilized. More accurate data are needed to determine what, if any, types of treatments are being provided without the assistance of general anesthesia. The monitoring team has continued concerns about the use of general anesthesia at the facility and the resistance to even consider the potential use of intermediate forms of sedation. <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 address the need to develop a comprehensive dental clinic manual. 2. Issues related to dental records and documentation discussed in section Q1 must be addressed. 3. The continued problems with data management must be addressed. 4. The facility must address the issue of refusals in a collaborative manner recognizing that strategies and interventions may be along a continuum.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Section R QA Reports o Current SLPs, license numbers, ASHA numbers, 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 List of individual with PBSPs o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment 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 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 PNMP Monitoring form template o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o Staff training data submitted o Communication Assessment for individuals recently admitted to EPSSLC: Individual #179 an Individual #181 o Communication Assessments, ISPs, ISPAs, SAPs, intervention plans, IPNs, and other documentation related to communication for the following individuals: Individual #40, Individual #189, Individual #92, Individual #28, Individual #125, Individual #125, Individual #161, Individual #46, Individual #67, Individual #16, Individual #15, and Individual #17. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, and Individual #92. o PNMP section in Individual Notebooks for the following:

	• Individual #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, and Individual #92. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #20, Individual #23, Individual #100, Individual #1, Individual #4, Individual #115, Individual #32, Individual #118, Individual #162, Individual #75, and Individual #92. <u>Interviews and Meetings Held</u>: o Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director o Erika Alcantar, MS, CCC-SLP o Patricia Bush, MS, CCC-SLP o Karin de la Fuente, MS, CCC-SLP o Rebecca Roberts, SLPA o Speech technicians o Habilitation Therapy technicians o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Workshop o Recreation area o ISP for Individual #67
	Facility Self-Assessment: The self-assessment completed by Leslie Ambruster, MS, CCC-SLP, Habilitation Therapies Director continued to improve. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team, though not all of elements were addressed and used to determine compliance. Actions and self-assessment activities correlated extremely well to the recommendations made by the monitoring team and reflected significant efforts on the part of communication staff. Findings were reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating, though the self-rating did not always reflect the Director's intent and these were modified during the interviews (R.4). There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Ms. Ambruster and the other speech staff were on track to ensure that progress will be made for the next

	review. They were very close to achieving substantial compliance, especially in R.3 and R.4, with a need to focus on staff training related to AAC and communication, as well as, consistency and quality of effectiveness monitoring. 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. Though continued work was needed, the monitoring team acknowledges the work that was done since the last review. The facility rated itself in substantial compliance with in R.1, R.2, and R.4. The monitoring concurred with R.1 and R.2, but while the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team determined that R.3 and R.4 were not yet in substantial compliance.
	Summary of Monitor's Assessment: There was continued, steady progress toward substantial compliance in all aspects of provision R. There were currently two full time, very talented, speech clinicians on staff and a SLPA. Observations of these therapists during this and previous reviews demonstrated that they understood what was needed to enhance and expand communication skills in individuals with severe intellectual disabilities. Efforts to improve the content of communication assessments were evident. The integration of communication assessment information into the OT/PT assessment was a relatively new system. The Assessments of Current Status were extremely long and sorting through the information to locate information specific to communication was difficult for the reader. This would likely make it difficult for the IDT to effectively use these documents. The essential information was generally contained in the reports, but interpretation and application by the reader was difficult, particularly related to the items listed above. Conceptually, the monitoring team supports this process, but to be effective, the department has work to do on the format and streamlining the presentation of information. There was significant duplication and non-essential information included. There should be more emphasis on clearly presenting objective data, formulating a thorough and succinct analysis that lays out the rationale for recommendations related to supports and services. These issues were reviewed with the Director who had already identified many of these issues via the system of assessment audits in place. Though improvements were noted, on-time completion of assessments continued to be problematic and loss of staff in one discipline, impacted timeliness of assessments for the other disciplines. While the collaboration between psychology and SLPs was a developing strength, continued effort was indicated to ensure integration of the recommendations in the communication assessment into the PBSP. This was also needed related to the ISPs as well. Consistent documentation of direct supports and review of indirect supports was needed. All of the SLPs worked diligently to complete assessments and identify appropriate communication supports for individuals, including AAC. There were, however, numerous references to the need for cause and effect (or other cognitive skills) as a prerequisite to benefit from AAC. This was a concern to the monitoring team; the clinicians need to continue to further investigate more creative ways in which

	individuals could benefit. Training opportunities in the natural environment continues to be the most effective way to determine this potential, rather than a single observation. In some cases, it appeared that clinicians referred to assessments in a previous year, rather than providing a current assessment of potential or need for communication supports. Activities observed in the groups areas were excellent, with effective modeling by speech clinicians. The DSP staff did not appear to understand the purpose of this: to ensure that they need to integrate meaningful communication, learning, and social interaction into all activities throughout the day (i.e., not only during a special activity conducted one time a week with speech staff). Staff should be encouraged to get together to brainstorm how to do this creatively with existing materials, as well as, to identify new materials and activities that are functional, age-appropriate, and meaningful. Staff participating in these activities demonstrated that they are fully capable of accomplishing this and now it must be reinforced and expected. The following samples were used by the monitoring team: • Sample R.1: 14 individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals admitted since the last compliance review. • Sample R.3: Individuals with AAC systems selected by the monitoring team • Sample R.4: Individuals receiving direct speech services (3)

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Staffing There were two full time SLPs with responsibilities related to communication, but who also shared responsibilities related to mealtime and dysphagia with OT. They were Erika Alcantar, MS, CCC-SLP, and Patricia Bush, MS, CCC-SLP. Karin de la Fuente, MS, CCC-SLP, was the core PNMT member, working part-time with no other caseload responsibilities and was not included in the review of this provision. There was a full time speech assistant to both full-time SLPs, Rebecca Roberts, SLPA. The Habilitation Therapies Director, Leslie Ambruster, MS, CCC-SLP, was also a SLP, available for direction, clinical assistance and oversight, though without consistent clinical responsibilities. The facility document listed budgeted and filled positions. There appeared to be two budgeted positions for speech language pathologists that were listed as filled at the time of this review. The number of other positions budgeted, such as the SLPA and the use of contractors, was not provided. Actual FTEs and ratios were not calculated in this document and included as requested. Based on the list provided for section R related to staffing listed and the reported census of 113, the current ratio was approximately 1:57. This information should be accurately included in the document request section I.	Substantial Compliance

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		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 113): • Erika Alcantar: Her responsibilities included the Systems area (A, B, and C dorms), approximately 39 individuals. • Patricia Bush: Her responsibilities included the Cottage areas (506, 507, 508, 509, 511, 512, and 513), approximately 74 individuals. • Rebecca Roberts: Her responsibilities included assisting in both the Systems and Cottage areas as assigned by the SLPs. Per the self-assessment, ASHA guidelines outlined an average caseload for a SLP as 55 to 60 individuals. Further, the guidelines related to workload versus caseload were applied as per ASHA position papers to account for the fact that EPSSLC was a 24-hour care facility and individuals presented with severe to profound multiple disabilities who in many cases required a more intense level of service. • EPSSLC used a reasonable process to establish appropriate caseloads for SLPs. It included the following: o The Director tracked the current census in conjunction with the number of clinicians available for communication-based services. o The facility employed a formula for determining appropriate caseload ratios (SLP=1.0 units and SLPA=.5 units) o As such, the average ratios ranged from 39 or 40:1 in the Systems area and from 74 to 77:1.5 in the Cottages area since August 2013. The current staffing had remained stable since the previous onsite review. The SLPs provided supervision to the SLPA as well as mentoring and training the Habilitation Therapy technicians to enhance their competency in the implementation of communication supports and services. DADS and the state Regional Service Center have continued to provide consultants to apply research-based methods of AAC for individuals with developmental disabilities at EPSSLC. • EPSSLC provided an adequate number of speech language pathologists with specialized training or experience to provide communication supports and services based on the process established by the facility, though two of the three were contract therapists. This was consistent with the previous review.	

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		Qualifications: • The facility documented appropriate qualifications for licensed SLPs. Licensure was verified on at least a quarterly basis and data were included in the self-assessment as 100% compliance for all clinicians. • 4 of 4 speech staff, with responsibilities related to communication (100%) were currently licensed to practice in Texas as verified online. This was consistent with the previous review. Continuing Education: Based on a review of continuing education completed since the previous review: • 4 of 4 current speech staff, responsible for communication supports and services (100%) had completed continuing education in the last year related to communication in an area that was relevant to the population served. This was consistent with the previous review. Continuing education attended by the clinicians (including the Director) appeared to be relevant to communication and included the following in the last six months: • Augmentative Communication: We Have Ways of Making You Talk! (2 contact hours) • Documentation for Speech-Language Pathologists Providing Services in Long-Term care (.1 CEUs) • Constraint Induced Language Therapy for Aphasia (.1 CEUs) • Treatment Efficacy in Autism Spectrum Disorders (.1 CEUs) • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (11 contact hours) While the SLPA had not attended any continuing education since the previous review, she had attended continuing education courses related to communication within the last year totaling at least 15 contact hours, as reported in the previous review. The intent of ongoing continuing education is to ensure that the clinicians attain and/or expand their 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 or DADS-sponsored courses 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.	

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		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. Each of the following elements was sufficiently addressed in the policy in conjunction with other procedural documents and a well-established procedure was currently in practice: • 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. There appeared to be a sufficient allocation of well-qualified and experienced speech staff resources, based on the current census and identified need. The current staff ratio and caseload size were adequate at the time of this review. Limitation to caseload size is critical to ensure that clinicians are able to complete assessments in a timely manner, provide appropriate direct interventions, provide sufficient training, modeling and coaching for the implementation of communication programs, and to adequately maintain the necessary equipment. There was a reasonable process to determine the number of qualified staff required and there were policies and procedures that outlined the roles and responsibilities of the SLPs as described above. The monitoring team concurred with the self-assessment of substantial compliance with this provision. The monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Continue to aggressively recruit at least two fulltime SLPs (or retain the current contract staff who were highly knowledgeable and skilled).	

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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> Assessments were appropriately completed per the ISP schedule, change in status, or per IDT request. By report, all individuals had been provided a Comprehensive Assessment. There was a tracking log of assessments completed from 8/27/13 through 2/5/14, but it was not possible to track when the most current comprehensive assessment had been completed and whether the assessments documented were Comprehensive or Assessments of Current Status/Updates. Previously, the SLPs at EPSSLC completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status/Update. At the time of this review, some changes had been made to the standard format for these reports per the state office and were in use as of 10/1/13. EPSSLC had also chosen to combine the communication assessment into the OT/PT assessments and the formats were blended in an attempt to address all of the required assessment requirements by the state, as well as, the essential elements outlined by the monitoring team. The first combined assessments appeared to have been completed as of 10/29/13, per the tracking log submitted. All individuals newly admitted to EPSSLC were to be provided a comprehensive assessment of communication completed within 30 days of admission. All individuals were to be provided a Comprehensive Assessment every five years, unless related to a significant change in status (defined as a change from medium to high in any PNM-related risk area) or special IDT request. An Assessment of Current Status was to be provided annually in the interim for individuals who received both direct and indirect services in years that a Comprehensive Evaluation was not required. Assessment due dates and timeliness of completion were tracked in the tracking log for individuals with ISPs scheduled from 8/27/13 through 2/5/14. Overall, per the self-assessment, there were 29 assessments completed for ISPs from 10/1/13 through 1/31/14. Of these, 21 were reported to be on time, 10 days prior to the ISP, 72% overall. Timeliness prior to 1/1/14 was impacted due to the change in format to include communication into the OT/PT assessment and a gap in service by OT. Timeliness since that time was 82% per the assessment log submitted. <u>Assessments Provided</u> Communication assessments for individuals in Samples R.1 (11 individuals) and R.4 (three individuals, though a duplication was noted in both samples for Individual #92) were submitted as requested for the following: Speech-Language Communication Comprehensive Assessment • Individual #118 (1/4/13) • Individual #40 (7/23/13)	Substantial Compliance

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		• Individual #100 (11/12/12) • Individual #162 (1/29/13) • Individual #75 (6/27/13) Speech Language Communication Update • Individual #20 (8/27/13) • Individual #32 (10/21/13) • Individual #189 (5/27/13) • Individual #1 (9/26/13) • Individual #4 (7/12/13) • Individual #23 (8/27/13) • Individual #115 (4/26/13) Habilitation Therapy Assessment of Current Status • Individual #118 (12/24/13) • Individual #92 (11/22/13) • Individual #162 (1/27/14) • Individual #100 (10/26/13) • 13 of 13 individuals (100%) in Samples R.1 and R.4, who received direct and/or indirect communication supports and services, were provided an assessment or update current within the last 12 months. Per facility practice, all individuals were to be provided a communication assessment annually regardless of services. This was consistent with the previous review. • 2 of 2 individuals admitted since the last review (100%) received a communication assessment within 30 days of admission. One of these, Individual #179's assessment was completed after the established due date. The other, for Individual #181, was completed on the due date listed in the tracking log. This was consistent with the previous review. • For 10 of 13 individuals (77%) in Samples R.1 and R.4, assessments or updates were dated as having been completed at least 10 working days prior to the annual ISP. This was an improvement from 45% in the previous review. Individual #92 was listed with a due date of 11/22/13 and the assessment was turned in on that date. It was not clear if this due date was modified based on the Thanksgiving holiday. The facility due dates must be based on actual working days and should not count holidays, with the assessment turned in before the date of the ISP. Based on signature dates, and actual working days, the following assessments were not completed 10 working days prior to the ISP: Individual #4 (completed after the ISP on 6/28/13), Individual #75, and Individual #189.	

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		• The following metric was not applied because EPSSLC did not complete communication screenings at the time of this review. For --% of individuals identified with communication needs through a screening, a comprehensive communication assessment was completed within 30 days of identification. Based on review of the assessments submitted and included in Samples R.1 and R.4, there were only two individuals with comprehensive assessments completed within the last 12 months (Individual #75 and Individual #40) and these were completed in July and August 2013. Neither was in the most current format implemented in October 2013, however, and each was a stand-alone communication assessment rather than the combined OT/PT/SLP assessment format currently in use. As such, these were not included for review. Two alternate comprehensive assessments were requested and included in the analysis below. 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 three comprehensive communication assessments was as follows: • 3 of 3 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was an improvement from 89% in the previous review. • 3 of 3 assessments (100%) included diagnoses and relevance of impact on communication. This was an improvement from 94% in the previous review. • 3 of 3 assessments (100%) included individual preferences and strengths. Ideas for how to integrate preferences into communication opportunities were a notable strength of these assessments. This was an improvement from 94% in the previous review. • 3 of 3 assessments (100%) included medical history and relevance to communication. The medical history reported was extensive with limited analysis of the relevance to communication, though this was clearly stated relative to the current diagnoses listed. This was an improvement from 11% in the previous review. • 3 of 3 assessments (100%) listed medications and discussed side effects relevant to communication. This was an improvement from 94% in the previous review. • 0 of 3 assessments (0%) provided documentation of how the individual's communication abilities impacted his/her risk levels. Risk areas were comprehensively presented with OT and PT but the relationship with communication was not offered. This was a decrease from 28% in the previous review. • 3 of 3 assessments (100%) incorporated a description of verbal and nonverbal	

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		skills with examples of how these skills were utilized in a functional manner throughout the day. This was an improvement from 78% in the previous review. • 3 of 3 assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was an improvement from 67% in the previous review. • Communication assessments (NA%) 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. This was not indicated for any of these individuals. • 3 of 3 individuals' communication assessments (100%) included discussion of the expansion of the individuals' current abilities. This was an improvement decrease from 78% in the previous review. • 3 of 3 individuals' communication assessments (100%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 56% in the previous review. • 3 of 3 assessments (100%) included the effectiveness of current supports, including monitoring findings. This was an improvement from 94% in the previous review. Two of these were for new admissions so effectiveness of recommended strategies will occur in the future. It is recommended that the clinicians review the consistency of monitoring as well as the findings. • 3 of 3 assessments (100%) 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 89% in the previous review. • 3 of 3 assessments (100%) offered a comparative analysis of health and functional status from the previous year. Two of these were for individuals who were newly admitted so this information was limited. This was an improvement from 17% in the previous review. • 3 of 3 assessments (100%) gave a comparative analysis of current communication function with previous assessments. Two of these were for individuals who were newly admitted so this information was limited. This was an improvement from 83% in the previous review. • 3 of 3 assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was a decrease from 78% in the previous review. • 3 of 3assessments (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was an improvement from 89% in the previous review. • 3 of 3 assessments (100%) had a reassessment schedule. This was an improvement from 89% in the previous review.	

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		• 3 of 3 assessments (100%) supplied a monitoring schedule. This was an improvement from 44% in the previous review. • 3 of 3 assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was an improvement from 50% in the previous review. • 3 of 3 assessments (100%) made a recommendation about community referral and transition. This was an improvement from 89% in the previous review. • 3 of 3assessments (100%) included specific recommendations for services and supports in the community. This was an improvement from 83% in the previous review. • 3 of 3 assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was an improvement from 89% in the previous review. Additional findings related to the communication assessments were as follows: • 0 of 3 assessments (0%) contained 100% of the 23 elements listed above. • 3 of 3 assessments (100%) contained 96% of the essential elements listed; only one element was not addressed in each. • There were significant improvements across 96% of the elements since the previous review. To further improve the assessments and better integrate communication into the OT/PT assessment the following is presented for consideration: • Extensive health and medical history over the last year was listed for each individual, but these were not discussed relative to any impact they may have had on communication. This was clearly done for current diagnoses. Health concerns over the last year should also be addressed. If there was no impact, a statement to this effect would suffice. • Documentation of how the individual's communication abilities impacted his/her risk levels was not consistently noted, though the risks were clearly outlined, as well as recommendations for changes in these. Most comments were related to behavior health rather than other risk areas. General statements as to the individual's need for interpretation of meaning by staff were consistently noted but the connection between this and risk concerns were inferred rather than clearly stated. • A comparative analysis of health and functional status from the previous year was scattered throughout the assessment rather than focused in the analysis of findings. While the functional status of communication relative to the previous year was clearly and consistently stated, overall health status and the impact on function was implied rather than clearly defined, when the clinician stated that	

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		the individuals' functional communication remained unchanged over the last year. • Ensure that AAC was considered from a fresh perspective each year. • Ensure that specific changes to the communication dictionary are discussed in each assessment for those who had this support. These should be consistently and specifically outlined. • The need for direct interventions was clearly stated when indicated, as well as, specific SAPs for some individuals. The communication strategies were highly individualized and well outlined for use in existing SAPS to effectively integrate communication into these and other routine activities throughout the day. For individuals who had identified communication deficits, specific statements to this effect would be useful. The integration of communication into the OT/PT assessment was a relatively new system. The Assessments of Current Status were extremely long and sorting through the information to locate information specific to communication was difficult for the reader. This would likely make it difficult for the IDT to effectively use these documents. The essential information was generally contained in the reports, but interpretation and application by the reader was difficult, particularly related to the items listed above. Conceptually, the monitoring team supports this process, but to be effective, the department has work to do on the format and to streamline the presentation of information. There was some duplication and non-essential information included. There should be more emphasis on clearly presenting objective data, formulating a thorough, yet succinct, analysis that laid out the rationale for recommendations related to supports and services. These issues were reviewed with the Director who had already identified many of these issues via the system of assessment audits in place. It was reported that one to two assessments of each type were audited monthly from August 2013 through January 2014, or approximately 10% of the total number completed. These audits were conducted by the Director. The average scores for inclusion of the essential elements ranged for 97% to 100% during that time period. It is recommended that the audits address the inconsistencies highlighted above and result in strategies to streamline the assessments. Updates or Assessments of Current Status (ACS) were submitted for 11 individuals included in Samples R.1 and R.4. • 11 of 11 updates (100%) were completed consistent with the established schedule, the individuals' need, and/or previous recommendations, though the associated comprehensive communication assessment was not consistently contained in the individual record.	

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		The Assessments of Current Status included the following minimum requirements: • The individuals' current status • Description of the interventions that were provided • Effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year • Monitoring data from the previous year and monitoring and re-assessment schedules. <u>SLP and Psychology Collaboration:</u> There were 20 individuals identified with behavioral issues and co-existing severe (nonverbal or limited verbal skills). There were 21 individuals listed with PBSPs who also had replacement behaviors related to communication. One individual in Sample R.1 was listed with a PBSP per the list submitted (in document folder VIII) and it was included in his record. Based on review of the individual record for Individual #32, the following was noted: • For 1 of 1 communication assessment (100%) in Sample R.1 for individuals with identified challenging behaviors there was discussion of the communicative intent of those behaviors in the Behavioral Considerations section. • 1 of 1 communication assessment and PBSP reviewed (100%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. • 1 of 1 communication assessment reviewed (100%) contained evidence of review of the PBSP by the SLP. • For 1 of 1 individual (100%), communication strategies identified in the assessment were included in the PBSP. • For 0 of 1 individual (0%) communication strategies related to behavior identified in the assessment were included in the ISP. Minutes for meetings held to review PBSPs during the last six months were submitted. • Based on review of the PBSP Committee meeting minutes from 9/23/13 through 1/29/14, participation by a SLP or SLPA was noted in 15 of 19 meetings (79%). Though it was reported that the meetings were no longer attended primarily by the SLPA, the meeting minutes reflected that she attended the majority of the meetings for which minutes were submitted. • A monthly meeting between psychology and speech was conducted for team building, to review processes related to the Settlement Agreement under R.2, and to staff on specific individuals. By report, progress had been made in the understanding of each discipline's role and responsibility in collaborating	

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		related to behavioral and communication supports. Concern for progress made is noted by the monitoring team, however, because the current Director of Psychology had resigned during the week of this review. • A case example was submitted related to Individual #161 to demonstrate the collaboration between speech and psychology that included use of AAC concepts, core vocabulary, and the collection of baseline data prior to initiating individual therapy (co-treatment with the SLP and psychologist). As of 2/20/14, the psychologist had indicated that Individual #161 required no further communication supports though the SLP documented that she would follow-up in one to two weeks. There was no evidence of this in the Presentation Book or any of the documentation submitted related to Individual #161. Participation in the review of PBSPs during these meetings was one opportunity to promote collaboration between psychology and the speech staff and collaboration was evident in the minutes in some cases. 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. Continued effort is needed to ensure that there is sufficient coordination of supports, services, and communication methods. There may be other means to accomplish this beyond the PBSP meetings, such as the Pre-ISP planning and during the assessment process. Evidence of this should be documented and evident in the supports and services developed. The facility self-rated this provision in substantial compliance, and the monitoring team concurred based on the findings reported above. Continued review and revision of the existing format is indicated and strategies to ensure continued timeliness are indicated. In the combined assessment, each discipline's timeliness will impact timeliness rated in the others. Further, significant effort will be necessary to make further progress in the collaboration between speech and psychology over the next six months and maintain compliance in this area.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication	<u>Integration of Communication in the ISP:</u> Attendance at the annual ISPs for individuals was reviewed. • For 4 of 5 individuals in Samples R.1 and R.4 (80%), a SLP (or SLPA in the case of Individual #1) was in attendance at the ISP as designated by the pre-ISP. Though the IDT had indicated that a SLP was required to attend, only a PT was present (per the sign-in sheet submitted for Individual #40) who was involved in direct therapy. Pre-ISP required attendance sheets were not submitted for Individual #162. A SLP was in attendance at two other meetings that did not designate a need for speech representation (Individual #32 and Individual #23).	Noncompliance

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	interventions that are functional and adaptable to a variety of settings.	• For 11 of 13 individuals (85%), communication strategies identified in the assessment were included in the ISP. • In 11 of 13 ISPs for individuals with communication supports (85%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, and strategies for staff use) were identified. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for 6 of 13 (46%), as evidenced in the ISP. Some only mentioned the dictionary as a support, but did not reflect IDT review • 11 of 13 ISPs (85%) included a description of how the individual communicated, though some provided very little as to how staff should communicate with them. • 6 of 13 ISPs (46%) contained skill acquisition programs to promote communication. Some identified the need for SAPs, but these were not translated to the ISP action steps. Others did not appear to be meaningful or functional. For example, one goal was to teach Individual #32 to say "yes." It was assumed this was to be implemented because he reportedly often said "no." It was not clear how teaching him to say "yes" would effectively address his identified communication needs. • Information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP was addressed in 3 of 13 ISPs (23%). This element of this provision was greatly improved. Though there was evidence that the IDT discussed communication, some did not clearly outline that the dictionary was reviewed and that modifications were or were not required. Most did a much improved summary of how the individual communicated and how staff should communicate with them. This will not always be sufficiently reflected in the paragraphs selected from the speech assessment, though these issues should be addressed by the team and reflected in the narrative of the ISP. The communication strategies outlined in the communication assessments were generally very good and highly individualized. Consistent integration of these into the ISP would be a useful practice. The facility was in the process of extensive IDT training on the ISP process and documentation requirements. In December 2013, the Habilitation Therapies Director collaborated with the QIDP Coordinator on sample wording for the ISP Guides. In January 2014, sample documents were provided for integration into the training and in February 2014, the Habilitation Therapies Director was present during the training offered. <u>Individual-Specific AAC Systems:</u> Approximately 20 individuals were listed with some type of personal communication system, beyond the communication strategies and dictionaries. These systems were generally portable, functional, and individualized. None, however, were observed in use	

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		during the week of this review. Individualized AAC device instructions were developed in most cases to provide a picture of the device and to clearly outline the purpose with staff instructions for use and care of the device. There were seven individuals listed as participating in direct communication therapy intervention at the time of this review. Ten individuals were listed with environmental control switches. The SLPs had initiated environmental communication strategies and social skills/communication groups in collaboration with Residential and Recreation staff. The community wallboards had been revised to reflect research-based strategies for core vocabulary and motor planning. The Systems SLP had initiated core vocabulary and AAC supports during group activities in the large activity room. The Cottages SLP had initiated co-treatment with recreation to incorporate core vocabulary and AAC supports in classroom activities and in the workshop. These indirect supports provided additional exposure to AAC for all individuals and offered opportunities within the context of the daily routine for SLPs to observe potential for more individualized AAC. Examples of these groups were observed by the monitoring team during this review. There were excellent group and individual interactions that involved the individuals and DSPs, as modeled by the SLPs, SLPA, and speech technician. When the group was complimented on the activity, the staff responded that "speech comes once a week." Clearly staff had missed the point of these activities: to model how to integrate communication, learning, and social interaction into all activities, not merely a special activity once a week. Clearly, more work was needed to ensure that communication was well-integrated into the daily lives of the individuals living at EPSSLC, though these were great strides in the right direction. This will likely be one of the most important supports that the speech clinicians can provide to ensure well- integrated communication opportunities. Staff should be encouraged to get together to brainstorm how to do this creatively with existing materials. They will need significant additional materials and curricula, however, to ensure that activities are interesting and meaningful. The current options were limited with a poverty of age-appropriate and meaningful materials. Specific plans had been outlined for implementation of the group mentoring and should continue. The facility is highly commended for their efforts in this regard with tremendous progress noted in the last six months. Communication dictionaries (CD) were also provided to many 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 should enhance staff understanding of the individual and promote consistent responses, but does not specifically improve the individual's expressive or receptive skills. Changes needed to	

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		the CDs were not always specifically outlined in the ISP. In some cases, changes were stated as needed, but not specifically outlined, even in the communication assessment. The following metric could not be determined: • --% of individuals for whom the IDT directed a revision in the communication dictionary, the communication dictionary was revised within 30 days. Many of the assessments for the individuals in Sample R.1 and R.4 reviewed above 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. In some cases, the assessments reported that a device was tried out with an individual, but when they did not spontaneously use it, the device was dismissed as a viable option. Specific efforts to promote practice and use in the natural environment should be identified for those individuals within the environmental communication efforts outlined above. This has been identified by the monitoring team in the previous reviews, as well. <u>General Use AAC Devices:</u> All of the general use systems noted during this onsite review were operational, and had a clear function within the environment, though none were seen in use. Directions were not necessarily posted or available, though use of these was competency-trained in NEO. These primarily included wall boards and Put 'Em Arounds. AAC Specialists through the Area 19 Education Service Center consulted with EPSSLC in August 2013. The consultation report was included in the Presentation Book and their findings were consistent with that of the monitoring team in previous reports. The consultants identified that, though general use AAC was noted, it was not used in a meaningful way by individuals or staff. Recommendations included that training and modeling be provided to designated staff related to a core communication system implemented during identified times of the day. The intent was to make the systems available to individuals and to determine next steps in the implementation of AAC systems. Picture schedules were also suggested for individuals based on observations for whom this would be most appropriate. <u>Direct Communication Interventions:</u> There were only three individuals listed as participating in direct communication-related interventions provided by the SLP (Individual #40, Individual #189, and Individual #92).	

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		Records related to the provision of direct intervention for these individuals were reviewed (Sample R.4). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow: • For 2 of 3 individuals (67%), a direct intervention plan was implemented within 30 days of the plan's creation, or sooner, as required by the individual's health or safety. For Individual #189, his ISP was dated 6/4/13 with an identified need for direct therapy noted. There was a Program Change documented on 9/26/13 identifying the purpose and measurable objective for a communication SAP, nearly four months later. There were SAP Strategy Plans dated October 2013 and December 2013. There were IPNs documented related to direct therapy prior to October 2013 (September notes documenting services provided in August), but it could not be determined if this was implemented in a timely manner following his ISP. There was no further evidence of program changes or ISPAs related to changes in the intervention plans (performance criteria reduced from 70% to 50% in December). A Program Change dated 2/6/14, indicated that direct therapy was being discontinued due to lack of progress, uncooperativeness and disinterest. • For 3 of 3 individuals (100%), the current SLP assessment identified the need for direct intervention with rationale. • For 3 of 3 individuals (100%), there were measurable objectives related to individual functional communication outcomes included in the ISP. • For 3 of 3 individuals (100%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). This was reported on a per session basis rather than a monthly summary in order to provide a clear comparative analysis of the clinical data reported. • For 3 of 3 individuals (100%), there was a description of the benefit of the device and/or goal to the individual. • For 2 of 3 individuals (67%), consistency of implementation was documented. The last IPN for Individual #189 was dated 12/11/13, though a program change to discontinue therapy was dated 2/6/14. • For 3 of 3 individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. For changes in the plans for Individual #189 and Individual #40, it was not clear that an ISPA had been conducted, but rather Program Change forms had been signed by team members. There was only one plan submitted for Individual #92, though IPNs were submitted for services provided since 8/15/13. Specific changes in the intervention plans could not be determined. There was a change related to use of a portable communication picture book, dated 9/16/13, documented on a program change form only. The	

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		facility should be cautioned in the use of these forms to conduct business that should require the IDT to meet and discuss the individual's status. This ensures improved integration and collaboration by all team members relative to programming and supports. • For 0 of 1 individual for whom direct intervention had been discontinued (0%), termination of the intervention was well justified and clearly documented in a timely manner. There was evidence of direct intervention through 12/11/13 for Individual #189, but there was no justification for an apparent lag in service or termination prior to 2/6/14. It appeared that direct intervention was to continue for Individual #92, but the last IPN submitted was dated 3/14/14, so it appeared that no service had been provided in more than 10 days at the time of this review, though her plan indicated services one to two times weekly. • 3 of 3 (100%) individuals receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the generally accepted 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. IPNs were completed for each session. While these were generally adequate, there was no evidence that specific data was reviewed, summarized and comparatively analyzed to establish whether progress had been made related to the measurable goals and objectives on a month to month basis. Strategies used in the SAP process should be reviewed in order to apply these to the clinicians' documentation. <u>Indirect Communication Supports:</u> Indirect communication supports included PNMPs, communication dictionaries, and general use AAC. AAC supports were identified in the annual assessment and described in the PNMP, including pictures of specific devices as indicated. Other indirect supports were developed in the form of SAPs implemented by DSPs in the home, day program, or work areas. There were a number of SAPs developed for replacement behaviors, though SLP involvement in this process was not clear. SLPs are encouraged to work closely with the program developers on new or existing SAPs (not only those related to communication) to ensure that communication strategies were well integrated into these plans. The challenge moving forward is ensuring that these plans are implemented as intended and this requires real-time modeling and coaching. There was little to no	

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		evidence that these were reviewed by the SLPs via the effectiveness monitoring currently conducted. This may become tied to the environmental communication that is being implemented. Programs for individuals who received indirect communication supports (SAPs) should include the following elements: • Implementation within 30 days of the plan's creation (typically as of the ISP or ISPA), or sooner as required by the individual's health or safety. • The current SLP assessment should clearly identify the need for indirect intervention with rationale. This was consistently noted for the assessments completed and reviewed. • Measurable objectives related to individual functional communication outcomes to be achieved through indirect intervention should be included in the ISP. • Staff instructions provided for individuals' AAC devices, including written step-by-step instructions and pictures. <u>Competency-Based Training and Performance Check-offs:</u> EPSSLC had a system of comprehensive competency-based training regarding communication services. Training provided: • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • 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. Based on the schedule submitted, class time included less than one and a half hours to address deaf awareness and AAC, which was less than the previous two hours reported in the previous review. It would not be possible to adequately address communication issues in this time frame. This was significantly less than the time allowed for other PNM-related issues. It was reported in the self-assessment that communication was addressed as part of the curriculum for dysphagia and eating behaviors. At any rate, only about four hours was allotted for training in these areas. Communication is an issue shared by all individuals and a key element to the successful provision of all supports provided by staff. As such, significant time is needed to provide instruction as to effective strategies. 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 using the practice checklist and	

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		with coaching by the trainers, though clearly this would be limited given the timeframe permitted. 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. As stated before, by the monitoring team, this biased the actual determination of competency of the new staff. 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 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. Return demonstration was required for each skill. A competency check-off form was used to establish participants' abilities to use an adaptive switch, picture communication board or book, Put 'Em Around and talking Photo Album devices. Another competency listed as communication was not clearly outlined. It was not clear if there was a check-off related to basic communication strategies beyond the written test such as communicating effectively, identifying nonverbal communication, using prompts and cues, and offering opportunities for choice-making. The NEO training curriculum had been revised as of 4/17/13. The training materials reviewed addressed 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	

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		• Benefits and use of AAC • Communication on the PNMP Competency tests and check-offs related to communication included the following per the documentation submitted: o General communication strategies o General AAC knowledge o Picture Communication Sheets o Picture Communication Board o Put 'Em Around o Adaptive Switch o Sound Generating Device o Talking Photo album • Over 94% of the 36 staff had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review, based on the participation reports. Others who had recently completed NEO, had not yet completed the check-off at the time of the report. • There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs was submitted. Refresher training had been developed in the area of communication and AAC implemented (revised 4/16/13, but dated 2/12/14). This also included the competency check-offs used in the NEO training described above and written tests. The same system for failed check-offs. The training contained very good content, including the elements described above though the time available for instruction was very limited. • 157/157 (100%) of staff required to take the Annual Refresher class successfully passed the competency check-offs. • There was a system to establish and maintain competency for staff who provided the training. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs. <u>Individual-Specific Competency-Based Training</u> Non-foundational training was provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the	

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		NEO/refresher training curriculum. This type of training required competency check-offs in order that staff could implement that element. Pulled staff were required to review all elements of the PNMP and other plans and the system of sister homes ensured that all pulled staff were also trained and checked-off. The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals (approximately 10 individuals) that were not taught in NEO. • Per the system in place, 100% of the staff assigned to individuals were trained related to individualized communication plans prior to the provision of services. • Per the system described, 100% of the staff assigned to individuals had completed competency check-offs in all specialized components of their communication plans (i.e., non-foundational skills) prior to the provision of services. • The facility had a process to validate that staff responsible for training other staff were competent to assess other staff's competency. • Further a database had been developed to track this training, to permit supervisors to review the training status of staff prior to assigning them to an individual with specialized supports (non-foundational) in place. An example of the list of staff trained and the data base template was submitted. 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. 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 the information in the communication assessment related to the PBSP was well integrated. Ensure that the communication strategies are effectively translated into the PBSP and consistent with the individual's communication function and methods of communication. 2. Ensure that information related to communication was effectively translated to the ISP. 3. Address the consistency and necessary elements of documentation of direct interventions. 4. Track that all staff (NEO) had successfully completed the competencies related to communication. 5. Track that all staff assigned to individuals with non-foundational supports are competent to implement these.	

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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 PNMP Monitoring Tool. This form was revised at least twice since the previous review and addressed the following: • Staff acknowledged training in AAC and described features and use • AAC pictures were appropriate and individualized. • Staff was observed providing meaningful communication with individuals every five to 10 minutes. • Staff were observed modeling AAC within the context of a meaningful activity. • Staff were observed to respond to the individual when they attempted to use AAC. • Staff provided an example of meaningful communication. • Staff demonstrated core signs (want, more, wait, finish and help). Completed forms for communication-related compliance monitoring conducted in the last three months were requested for the individuals in Sample R.1 with communication supports (11 individuals). Monitoring frequency was listed as follows: • Every six months for Individual #75 and Individual #20 • Every three months for Individual #118, Individual #92, Individual #23, Individual #4, Individual #1, Individual #162, and Individual #100 • Monthly for Individual #115 and Individual #32 Compliance reported in January 2014 per the self-assessment was as follows for the sample of 24 individuals audited: • Staff acknowledged training in AAC and described features and use (100%) • AAC pictures were appropriate and individualized (100%). • Staff was observed providing meaningful communication with individuals every five to 10 minutes (78%). • Staff were observed modeling AAC within the context of a meaningful activity (42%). • Staff were observed to respond to the individual when they attempted to use AAC (75%). • Staff provided an example of meaningful communication (96%). • Staff demonstrated core signs (want, more, wait, finish and help) (50%). Upon review of the forms submitted for the individuals in Sample R.1, the following was noted: • NA was frequently marked related to communication rather than yes or no. • In one case 26 total items were marked no for a monitoring for Individual #162 on 1/23/14, yet the compliance score was listed as 92%.	Noncompliance

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		• Staff required training on an item for Individual #115 (1/24/14), yet the item was marked as "yes". • Staff were not consistently modeling use of AAC. Compliance monitoring should be conducted routinely to address implementation of all specific communication plans (including AAC) and communication strategies across implementation of activities. This may be also accomplished as the staff are engaging in other activities on the PNMP or implementing other SAPs. Compliance monitoring appeared to be conducted at the assigned frequency. There was an extensive process to review and track findings based on the monitoring conducted. Follow-up was clearly documented on the forms submitted. Equipment should be monitored for availability, condition, and working order with routine general check-offs for how to use the equipment. A Preventative Maintenance form was completed to monitor the working condition of individual and general user devices on at least a monthly basis. Communication dictionaries should be monitored for availability, effectiveness, and whether staff understand how to use them. This did not appear to be done consistently. <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 of these should be included in the ISP with documentation in the IPNs. These notes should include the following: • 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, consistency of implementation • 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	

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		There was no specific tool used for effectiveness monitoring, though documentation was noted in the IPNs by a number of OT/PT clinicians. Effectiveness monitoring had been conducted on one occasion only for Individual #118 related to communication strategies, but not specifically to the talking photo album listed. There was no evidence of any other monitoring for the other individuals in the sample reviewed. There was a significant lack of consistency related to the completion of these for individuals who were provided communication supports and there was a lack of reference to these findings in the communication assessments reviewed. The facility concluded that they were in compliance with this provision of section R, but the monitoring team did not concur 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. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines to enhance consistency. 2. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment or other established guidelines. Ensure that these findings 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 #127, Individual #83, Individual #11, Individual #23, Individual #32, Individual #120, Individual #Individual #25, Individual #18, Individual #8, Individual #188, Individual #89, Individual #42, Individual #79, Individual #117, Individual #100 o Skill Acquisition Plans (SAPs) for: • Individual #89, Individual #42, Individual #79, Individual #117, Individual #100, Individual #18, Individual #78, Individual #34, Individual #63, Individual #11, Individual #126 o Functional Skills Assessments (FSA) for: • Individual #89, Individual #42, Individual #79, Individual #117, Individual #100 o Preferences & Strengths Inventory (PSI) for: • Individual #89, Individual #42, Individual #79, Individual #117, Individual #100 o Vocational assessments for: • Individual #89, Individual #42, Individual #79, Individual #117, Individual #100 o Behavioral, Skills Acquisition, and Service Programs policy, 12/13/13 o Engagement Spot Check Sheet, undated o Engagement, Dignity, and Respect, Group Management Observation, undated o A list of all training conducted on SAPs, undated o Active Treatment, undated o Revised Stay Back Protocol, 7/25/13 o A list of all individuals with community SAPs, undated o A list of community outings per residence, 8/1/13- 1/30/14 o A list of individuals who are employed on and off-campus, undated o Section S Self-Assessment, 3/4/13 o Section S Action plan, 3/4/14 o List of individuals under age 22 and their status regarding public school o ISPs, IEPs, ISD progress reports, ISPAs for: • Individual #35 Interviews and Meetings Held: o Alice Villalobos, QIDP Coordinator; Guadalupe Azzam, Active Treatment and Day Programs Coordinator; Mindy Partida, Program Developer o Guadalupe Azzam, Active Treatment and Day Programs Coordinator o Rosa Renteria, QIDP, EPISD liaison

	Observations Conducted: o Pre-ISP meeting for: • Individual #188 o SAP implementation for: • Individual #78 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. For example, S1 of the self-assessment reviewed a sample of SAPs to determine if they contained the components described in the monitoring team's report. The monitoring team believes, however, that the self-assessment could better reflect the activities that the monitoring team assesses. For example, S2 of the self-assessment appeared to focus on ensuring that functional skills assessments, vocational assessments, and preference and strengths inventories were completed. This is important, however, the focus of S2 in the monitoring team's report is on determining if assessments were clearly used to select individual skill acquisition plans, and that these assessments were available to team members at least 10 days prior to the ISP. 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) • Improvements in the quality of SAP maintenance and generalization plans (S1) • Improved engagement monitoring tool (S1) • Continued support of public school students' educational programming (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) • Track engagement across all treatment areas, review trends, and establish acceptable levels of engagement in each treatment area (S1) • Document that functional skills assessments, preference and strengths inventories, and vocational assessments are completed and available to team members at least 10 days prior to each individual's ISP (S2) • Consistently document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • Ensure that monthly SAP reviews consistently occur (S3) • Graph monthly SAP outcomes (S3) • Ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are data based (S3) • Initiate SAP integrity measures (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)

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but	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.	Noncompliance

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	not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	<u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at EPSSLC had multiple skill acquisition plans (SAPs). The facility recently reorganized the writing, monitoring, and training of SAPs. The new plan was for SAPs to be written by program developers, and implemented by direct support professionals (DSPs). Additionally, the new plan specifies that DSPs will be trained in SAP implementation by the program developers, and monitored by an interdisciplinary group. 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. Twenty-eight SAPs across 11 individuals were reviewed to determine if they were functional and practical. In 13 of the 28 SAPs reviewed (46%), the rationale appeared to be based on a clear need and/or preference. This was similar to the last review when 44% 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 #100's SAP of learning to shake hands, indicated that he had poor social skills and that improving his social skills, such as shaking hands, would increase the likelihood of him succeeding in the community In the majority of SAPs reviewed (54%), 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 #42's SAP of brushing her teeth stated that she liked to eat so she needs to continue to brush her teeth. There was no indication that she could not brush her teeth, or that it was practical or functional for Individual #42 to learn to brush her teeth. • The rationale for Individual #79's SAP of participating in activities stated that she loved to participate in activities. It was not clear why, then, she needed a SAP to learn to participate in activities. EPSSLC should ensure that the rationale for the selection of each 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.	

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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 of several of these components, however, continued to be poor. Plans for maintenance and generalization, although improved, continued to need work. 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. Twelve of the 28 SAPs reviewed (43%) contained a plan for generalization consistent with the definition above. This represented an improvement from the last review when 17% of generalization plan reviewed were consistent with the above definition. Similarly, 10 of the 28 SAPs reviewed (36%) contained maintenance plans that were consistent with the above definition. This also represented an improvement from the last review when 11% of the SAPs reviewed contained acceptable plans for maintenance. An example of a complete generalization plan was: • The plan for generalization in Individual #100's SAP to wash his stated that he would wash his hair when he goes home for a visit An example of an unacceptable plan for generalization was:	

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		• The plan for generalization for Individual #89's SAP of activating his radio was combined with his maintenance plan and stated that he will be given opportunities to utilize an environmental switch to increase his independence An example of a maintenance plan that was consistent with the above definition was: • The plan for maintenance for Individual #79's vocational SAP of clocking in at the workshop stated that after completing the program, she will be asked to clock in and out of her job on a daily basis An example of an incomplete maintenance plan was: • The plan for maintenance for Individual #79's SAP of identifying exit signs stated, "encourage her to understand and identify the exit signs…". At the time of the onsite review, the facility used various training methodologies, including total task training and forward and backward chaining. Additionally, the quality of several other components listed above were unacceptable. For example: • The behavioral objectives were often not objective (e.g., Individual #89's tooth brushing SAP) • The consequence for an incorrect response often stated to repeat the steps, but did not indicate how many times the DSPs should repeat the step (e.g., Individual #89's SAP to select his shoes). Other SAPs indicated that DSPs should repeat modeling again following an incorrect response, however, the SAPs did not appear to include modeling. • The instructions were often unclear, simply indicating that individuals should be prompted (e.g., Individual #89's toothbrushing SAP), but not indicating the level of prompt (e.g., verbal, gesture, physical, etc.) • Many of task analyses were confusing including a combination of staff behaviors (e.g., DSPs to cut Individual #79's hair) and individual skills. Finally, some training SAPs (e.g., Individual #79's SAP to go shopping twice a week) appeared to actually be a service objectives (i.e., necessary services provided for individuals, such as brushing an individual's teeth). 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, the facility should ensure that operational definitions and training instructions clearly specify the level of assistance required, and that SAPs and service objectives are differentiated.	

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		The monitoring team believe that the new plan for the organization of SAPs at EPSSLC could result in an improvement in the quality of SAPs. To be successful however, it will require the assistance of many staff from various disciplines to assist to ensure that the SAPs are meaningful and practical for each individual, and that they consistently include all of the components necessary for maximizing learning. <u>Compliance and Dental Desensitization plans</u> The department of behavioral health services reported that compliance and desensitization plans designed to teach individuals to tolerate dental procedures were developed by the behavioral health services department. The behavioral health services department determined if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. It is recommended that the facility utilize a system (e.g., spreadsheet, regular interdisciplinary meetings, etc.) to ensure that appropriate action occurs for all individuals who are refusing routine dental exams. Available documents indicated that no formal desensitization plans were completed since the last review. Outcome data (including the use of sedating medications, see section Q) and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail during future onsite visits. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition plans</u> 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. <u>Communication and language skill acquisition</u> 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). <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at EPSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals in the day programs and homes at EPSSLC was measured by the monitoring team in all treatment sites, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals	

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		and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each cottage and day program is listed in the table below. As reported in past reviews, the monitoring team was encouraged by the general positive interaction of staff and individuals at EPSSLC, and continued development of the community day program. The table below documents engagement observed in various settings throughout the facility. The average engagement level across the facility was 52%, which represented a slight decrease from the last review when engagement across the facility was 60%. 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. EPSSLC recently modified their tracking procedures to better standardize the observation time and definition of engagement. No data from this new engagement monitoring tool were available at the time of the onsite review. It is recommended that engagement data be summarized and reviewed to help target areas that require additional support to improve engagement. Additionally, engagement targets for each home and day program should be established, and sites with low engagement be provided plans for improvement. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
B Dorm	5/8	3:8
C Dorm	2/10	2:10
508	2/2	1:2
506	3/5	2:5
511	5/9	3:9
508	2/4	2:4
513	4/7	3:7

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513	5/7	3:7
C Dorm	1/4	1:4
A Dorm	0/4	1:4
Workshop	14/14	4:14
515 (day program)	2/7	2:7
515 (day program)	1/3	1:3
509	2/2	1:2
511	4/8	2:8
508	3/3	2:3
507	1/3	1:3
507	0/2	0:2
Workshop	12/15	4:12

<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.

Only one individual at EPSSLC was under 22 years old and he was the only individual at EPSSLC who received educational services from the El Paso ISD. He was scheduled to graduate in June 2014.

Ms. Renteria reported that his school year was going quite well. His ISP occurred at the time of the last onsite review and his IEP in November 2013. Good communication continued with the public school teacher, and transportation to and from school was no longer a problem.

Planning was underway for him to have an appropriate day and/or employment program upon graduation. That is, he needed to have a daily routine that involved going off campus each day to school or work.

Progress reports were reviewed by the QIDP and the IDT, documented in the ISP monthly reviews.

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		The monitoring team has no further recommendations for the facility for this aspect of section S1.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	EPSSLC conducted annual assessments of preference, strengths, skills, and needs. This item was rated to be in noncompliance, however, because only 11% of SAPs reviewed were clearly based on assessments, and there was no documentation that these assessments were available to team members at least 10 days prior to each individual's team meeting. To assess compliance with this item, the monitoring team reviewed Individual Support Plans (ISPs), Functional Skill Assessments (FSAs), Preference and Strengths Inventories (PSIs), and Vocational Assessments for five individuals. 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. There were no data demonstrating that FSAs, PSIs, and vocational assessments were completed at least 10 days prior to the ISP. As discussed in the last review, the FSA appeared to be an adequate tool for assessing 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 worn, 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. Overall, these five individuals had a total of 22 SAPs, and three of those (11%) had documentation that assessments were used to develop them. This represented a decrease from the last review when 54% of the SAPs reviewed included documentation that assessments were used to develop them. Examples of assessments that were used to develop SAPs included: • Individual #117's ISP documented that he was very sensitive to touch and would not allow professional staff to conduct routine medical and dental exams	Noncompliance

#	Provision	Assessment of Status	Compliance
		without sedation. Therefore, a SAP to teach him to touch others' hands was developed to increase his tolerance to touch, and the likelihood he would comply with routine medical and dental exams without the need for sedation • Individual #117's ISP documented that he did not communicate his desires, but can push a button. Therefore, a SAP was developed to teach him to operate a communication device to request snacks. Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #79 had two vocational SAPs, however, there was nothing in her ISP, FSA, PSI, or vocational assessment that suggested that these were practical SAPs for her, or that they were based on any assessment data • Individual #89 had a SAP to select his shoes each day. There was nothing in his ISP, FSA, or PSI, however, suggesting that this SAP was based on a need or preference for Individual #89 • Individual #42 had a SAP to increase her on-task behavior at the workshop. Her vocational assessment, however, indicated that she completes all of her work tasks. Over the next six months, EPSSLC needs to ensure that all assessments of individuals' preferences, strengths, skills, and needs are completed at least 10 days prior to the ISP. Additionally, the facility should ensure that there is documentation of how assessments were used to select individual skill acquisition plans.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting	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 monthly SAP reviews were not consistently occurring at EPSSLC. Additionally, no SAP data were available for this review. It is recommended that monthly SAP data be graphed so as to increase the likelihood that decisions	Noncompliance

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	consistent with the individual's needs, and	concerning the continuation, discontinuation, or modification of SAPs are data based. As during the last review, the implementation of a SAP was observed by the monitoring team to evaluate if it was implemented as written. The results were similar to those found in the last two reviews, suggesting that SAPs are not consistently implemented as written. 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 ensure that monthly SAP reviews consistently occur. Additionally, the facility should begin to graph SAP monthly data, and ensure that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs. Finally, 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. EPSSLC also provided a list of individuals and their community training objectives, however, there were no data demonstrating how frequently 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 the last review, the community day program appeared to represent an excellent 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 was consistent with the last two reviews 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: ○ Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.2, 10/18/13, and exhibits and forms attachments ○ EPSSLC facility-specific policies regarding most integrated setting practices • El Paso Most Integrated Setting Practices, 2/7/14 (same as state policy) ○ EPSSLC organizational chart, March 2014 ○ EPSSLC policy lists, undated, probably March 2014 ○ List of typical meetings that occurred at EPSSLC (not provided) ○ EPSSLC Self-Assessment, 3/4/13 ○ EPSSLC Action Plans, 3/4/14 ○ EPSSLC Provision Action Information, most recent entries for the most part were 2/2/14 ○ EPSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 3/24/14 ○ Community Placement Report, last six+ months, 9/14/13 through 3/21/14 ○ List of individuals who were placed since last onsite review (5 individuals) ○ List of individuals who were referred for placement since the last review (8 individuals) ○ List of individuals who were referred and placed since the last review (1 individual) ○ List of total active referrals (11 individuals) • Documentation for some of the individuals who were referred for more than 180 days ○ List of individuals who requested placement, but weren't referred (1 individual) • Documentation of activities taken for those who did not have an LAR (1) • Those who requested placement, but not referred due to LAR preference (none) ○ List of individuals who were not referred solely due to LAR preference (49 individuals) ○ List of rescinded referrals (2 individuals) • ISPA notes regarding each rescinding (2 of the 2) • Special Review ISPA Team minutes for each rescinding (none) ○ List of individuals returned to facility after community placement (none) • Related ISPA documentation (n.a.) • Root cause analysis (n.a.) ○ 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 • 1 of 9 individuals who moved since 3/15/13 ○ Completed Potentially Disrupted Community Transition forms (none, none needed) ○ List of individuals who died after moving from the facility to the community since 7/1/09 (0, 0

since the last review)
- List of individuals discharged from SSLC under alternate discharge procedures and related documentation (1 individual)
- FST workgroup minutes 2/13/14, agenda and handouts for meeting 3/24/14
- Monday department head meeting minutes, 10/28/13 to 3/3/14 (8 meetings)
- APC reports
  - APC Department meeting minutes (called the Placement Report), most recent, 3/14/14
  - APC weekly reports, version for state office only, 1/10/14-1/31/14 (4)
- APD monthly calendar, March 2014
- Email to QIDPs with updates about all referrals, 10/8/13, 1/24/14
- APC's colorful spreadsheet of the status of each individual's referral status and reasons for no referral, and six pie chart graphs of some of the data, 3/24/14
- Variety of documents regarding education of individuals, LARs, family, and staff:
  - Provider Fair
  - Community tours
  - Work with local LA
  - Work with local providers
  - Facility-wide staff trainings/activities
  - For individuals
  - For families, including documentation of interactions with individuals' family members
  - Brochures, provider home handouts, posters, and facility newsletters
    - Galleria of homes, March 2014
    - Community placement DVD, March 2014
  - CLOIPs and PPs: a sample
- Description of how the facility assessed an individual for placement
- 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), 2/5/14
- List of individuals who had a CLDP completed since last review (5
- EPSSLC day of move tracking sheets, blank and some completed, and state's new version
- APC's CLDP assessment log
- EPSSLC CLDP pre/post move supports self-checklist
- Example of a good discharge assessment, 4/18/13
- DADS central office written feedback on CLDPs (0)
- QA related activities and documents
  - Blank statewide section T draft self-assessment, October 2013
  - Description of one problem experienced by an individual after moving
  - APC presentation packet to QAQI Council, 3/26/14, including graphs and tables, data through February 2014
- State obstacles report and SSLC addendum, March 2014
- PMM tracking sheet, 3/25/14
- PMM self-assessment checklist

	○ Transition T4 materials for: • Individual #149 ○ ISPs for: • Individual #6, Individual #118, Individual #38, Individual #63, Individual #18, Individual #120, Individual #65, Individual #109, Individual #49, Individual #79, Individual #84 (discipline assessments were utilized from the last five individuals in this list for metric T1b3.a.) ○ Pre-ISP draft used during the pre-ISP meeting: • (none reviewed) ○ Draft ISP used during the ISP meeting: • Individual #67, Individual #157 ○ CLDPs for: • Individual #27, Individual #195, Individual #18, Individual #105, Individual #51 ○ Draft CLDP for: • Individual #38 ○ 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 #27: P, 7, 45, 90 • Individual #195: P, 7, 45, 90 (monitoring team attended the 90-day) • Individual #18: P, 7, 45 • Individual #105: P, 7, 45 • Individual #51: P, 7, 45 ○ A packet of emails showing follow-up activity and correspondence for each of the five above individuals. <u>Interviews and Meetings Held</u>: ○ Antonio Ochoa, Admissions and Placement Coordinator ○ Luz Delgado, Post Move Monitor ○ Gisel Hita, regional director for Draco-El Paso; Irma, day habilitation program manager; Anthony, Letti, and Blanca, staff at group home <u>Observations Conducted</u>: ○ FST cross department meeting, 3/24/14 ○ CLDP meeting for: • Individual #38 ○ ISP and pre-ISP meetings for: • Individual #67, Individual #157 ○ Community day program group home visit for post move monitoring for: • Individual #195 ○ Group home visit for:

	• Individual #27, Individual #124
	Facility Self-Assessment The self-assessment given to the monitoring team was the same self-assessment used in previous reviews, though with updated data inserted. As stated in those previous reports, this self-assessment format was insufficient for adequately conducting a self-assessment of section T because it did not guide the APC to look at the same items, in the same way, as did the monitoring team. This rendered the self-assessment results invalid. The monitoring team was of the understanding that facilities were no longer going to be using this self-assessment format because state office had issued a new self-assessment template. The monitoring team was given a blank version, which was clearly marked as a draft. It was much improved from the previous version. The monitoring team recommends that the self-assessment line up with the set of metrics and protocols that the Monitors submitted to the parties in October 2013 because the new self-assessment, although improved, did not fully line up with these metrics and protocols. For this review, the APC self-rated the following 13 provisions to be in substantial compliance: T1a, T1b, T1b2, T1b3, T1c, T1c1, T1c2, T1c3, T1d, T1e, T1h, T2a, and T2b. The monitoring team agreed with 6 of these: T1c, T1c2, T1c3, T1h, T2a, and T2b. In addition, the monitoring team rated T4 to be in substantial compliance. A comparison of the narrative in the monitoring team's report and the APC's self-assessment shows that although there was agreement in the compliance rating for most of the provisions, the reasons for the agreement were often not the same.
	Summary of Monitor's Assessment The facility made a lot of progress in section T. Seven provisions were found to be in substantial compliance. Many of the other provisions were close to substantial compliance. Below the monitoring team details what needs to be done to put some of these "close" provisions into substantial compliance: • T1a: A plan to increase the capacity of the community providers to provide more readily available supports is needed; involvement of state office. • T1b: Update state policy and create a facility-specific policy or policies. • T1b1: Action plans directly related to the obstacle to referral must be in the ISP. They must be individualized, measurable, and comprehensive. (The corresponding section F provisions also need to be in substantial compliance.) • T1b2: (1) An individualized education plan must be in each ISP. Each one needs to address the specific reasons for the individual not being referred, be measurable, involve the LAR when appropriate, and report on the previous year's plan. (2) More individuals need to attend tours (or indicate why they did not go on a tour).

	• T1b3: (1) Ensure assessments for the annual ISP include the standardized statement that has been disseminated by state office and is required to be in each assessment. (2) Ensure that the final written ISP document states that each professional member of the IDT presented his or her recommendation during the ISP meeting and lists those recommendations. • T1c1 and T1e: The monitoring team listed (and reported on) a number of different categories of activities and supports that need to be included in the CLDP's list of pre and post move supports, or in within section IV of the CLDP. Discharge assessments from every discipline must specifically address/focus on the new community home and day/work settings: there should be recommendations for the community residential and day/work providers, and descriptions of how supports might be provided differently or modified in a community setting. Five individuals were placed in the community since the last onsite review. 11 individuals were on the active referral list. Of the 9 individuals who moved in the past 12 months, 1 had one or more untoward events that occurred within the past six months (11%), but this was a non-serious event that did not threaten the success of the placement. The APC, PMM, and TSs continued to do an outstanding job in working with family members and LARs to fully engage them in the educational, referral, and transition processes. As a result, a number of individuals were newly referred. Post move monitoring continued to be implemented as required and maintained substantial compliance. 12 post move monitorings for 5 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed-up when action was needed.

#	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	<u>Placement Department Staff</u> EPSSLC continued to make good progress across 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 APC and his staff were very responsive to the many suggestions and recommendations made in the previous monitoring report. The APC continued to hold an almost-weekly meeting with his staff to review the status of referrals, each staff person's schedule, upcoming community living related activities, the facility's APD calendar, and any other relevant topics. A weekly Placement Report was issued after each of these meetings. The report was very informative, however, each entry should be dated. In addition, the facility's cross-department FST meeting was	Noncompliance

	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.	recently re-initiated with the goal of addressing the ISP-related components of section T. <u>Transition-Related Numbers</u> Transitions: • The number of individuals placed was at an annual rate of about 9%. 5 individuals had been placed in the community since the last onsite review. This compared with 4, 7, 3, 4, 1, 1, 3, and 1 individuals who had been placed at the time of the previous monitoring reviews. Referrals: • 8 individuals were referred for placement since the last onsite review. This compared with 5, 10, 9, and 6 individuals who were newly referred at the time of the previous reviews. o 1 of the 8 individuals was both referred and placed since the last review. • 11 individuals were on the active referral list. This compared with 12, 12, 12, 8, 9, 10, 4, and 7 individuals at the time of the previous reviews. o 4 of the 11 individuals were referred for more than 180 days. This compared to 7, 2, 3, 1, and 6 at the time of previous reviews. o 3 of these 4 individuals were referred for more than one year. This compared to 2 and 1 at the time of previous reviews. <u>Determinations of professionals</u> Professional members of the IDT are required to state their opinion regarding the most integrated setting for each individual in their annual assessments, during the ISP meeting, and in the written ISP document. Compliance is addressed in T1b3. <u>Placement and referral not opposed</u> a. In reviewing the CLDPs and ISPs for 16 individuals who were on the referral list or who had been placed, 16 (100%) individuals and/or LARs did not oppose transition to the community. <u>Responding to individual requests and rescinded referrals</u> There were 2 rescinded referrals since the last review. This compared to 2, 3, 2, 2, and 2 at the time of the previous reviews. Documentation (ISPA notes, ISPs, or SRT) was provided for 2 of the 2 individuals regarding the reasons for the rescinding. b. Of these 2, the reasons for the rescinding appeared to be reasonable for 2 (100%). • One was rescinded by the individual's LAR/mother. • One was a joint decision between the LAR and the IDT to rescind due to a combination of medical/seizure and behavioral issues. An adequate review to determine if changes in the referral and transition planning	

		processes at the facility was conducted for 2 (100%) of the rescinded referrals. Of these reviews, actions were recommended in 2 (100%) cases. Of these, actions were implemented for 2 (100%). • Discussion regarding the rescinding of Individual #49's referral occurred during the FST 2/13/14 meeting. It was discussed that the IDT determined that they wanted to refer her, but they presented this at the annual ISP meeting, before her family and her mother (who was her LAR) were adequately involved. As a result, although the LAR agreed to the referral, she ultimately became uncomfortable with the community providers' ability to keep her daughter safe. The group discussed always ensuring that the LAR and family were properly informed, educated, and involved. The APC and his staff took action by adding a prompt for this into their ISP training template example in two places, and into their pre-ISP meeting training template example in one place. • Review for the other individual (Individual #50), recently occurred. His referral was rescinded by his LAR, with agreement from the IDT, due to changes in behavior, psychiatric status, and medication. Discussion and review led the APC and his staff to meet with the clinical services coordinator to ensure that, in the future, the APD would be notified of any changes in medications and/or psychiatric status of any individual on the referral list. These discussions should be documented in a clearly identified portion of an existing document, such as within the Placement Progress report document. The APC said he was now going to include a space for this in that report. Even if the topic is discussed in another meeting (e.g., FST meeting, ISPA), it can easily also be included in the Placement Progress report, too. The rescinding of a referral should not be considered a failure and should not deter IDTs from referring individuals. A review for quality improvement purposes, however, should be conducted for all. c. One individual was described as having requested placement, but was not referred. This compared with 5, 3, 4, 3, 2 individuals at the time of the previous reviews. Of the 1 individual who requested placement, but was not referred, 0 individuals had an LAR who made this decision. Of the remaining 1 individual, an appropriate review, appeal, and or lack of consensus review was conducted for 1 (100%). • The individual could not be referred due to legal reasons. This was the same individual noted in previous monitoring team reports. • A second individual had requested referral for a number of years, but his LAR would not agree to referral. In the past month, due in large part to the work of the APC, TSs, and PMM, the LAR allowed for his referral.	

		The list of individuals not being referred solely due to LAR preference contained 49 names. This compared to 49 individuals at the time of the previous reviews. This was an accurate count, based upon the APC's detailed work in reviewing the ISP of every individual at EPSSLC. The resultant data also informed the APC's obstacles report (see T1g) and helped guide the activities of the APD. <u>Systemic issues</u> d. There were systemic issues delaying referrals (at the state and/or facility level). One systemic issue at EPSSLC was that almost 50% of the individuals' LARs preferred placement at EPSSLC. To that end, the APC, TSs, and PMM had devoted a lot of time to working extensively with individual families and providers (see T1b2). Thus, there were actions being taken to resolve this facility-level systemic issue. Of the other individuals who were not referred, 11 were due to the individual's own preference, 25 were not referred due to determination that their behavioral or medical needs could not be met in the community, and another 15 were not referred due to legal status. The lack of additional referrals indicated that the availability of supports in the community to address the needs of individuals with complex medical and/or behavioral needs was severely lacking. e. There were existing and/or potential systemic issues delaying transitions (at the state and/or facility level). • This was the continued need for providers to develop housing that was wheelchair accessible. Although the facility was trying to work locally with the El Paso providers, there was a limit to what they could accomplish without action from the state. f. Funding availability was cited as a barrier to individuals moving to the community. • 15 individuals were reported to have no funding for community placement due to their legal status. • Given the adaptive equipment needs of many of the individuals, the facility was working with providers to address the cost of expensive equipment that was not covered by insurance, Medicaid, or state funds (e.g., special lift and transfer equipment). This had not delayed or prevented any individual from transitioning. This did, however, have the potential to be a barrier in the future. g. Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. • This was done by the APC during presentations at least once per month for the past six months at the weekly department head meetings on Mondays. He also emailed the APD's weekly Placement Progress Report and monthly	

		APD calendar to senior management, department heads, and QIDPs. <u>Pace of transitions</u> h. Transitions were not occurring at a reasonable pace. To make this determination, the monitoring team reviewed CLDPs, ISPs, ISPAs, 180 day meeting notes, the APC's weekly Placement Report, the APC's weekly enrollment report sent to state office, and various emails and meeting minutes. The state's expectation was that once a referral was made, the transition to the community should occur within 180 days. The IDT was required to meet monthly to review and address the obstacle to transition after the 180-day window. The ISPA was then to be sent to state office. • Of the 5 individuals placed since the time of the last onsite review, 2 (40%) were placed within 180 days of their referral (i.e., 3 were not). o 3 of these 3 were placed after more than one year of being referred. o 2 of these 3 had complicated medical, physical and nutritional, adaptive equipment, and accessibility needs. o 1 of these 3 had complicated behavioral support needs. • At the time of the review, 11 individuals had been referred for community transition. 4 of these 11 individuals had exceeded the 180-day timeframe. o One of these 4 was 30 days past 180 days and was scheduled to transition in early April 2014. His CLDP meeting was held during the onsite review. o Of the other 3, all 3 individuals had exceeded one year. o 2 of these 3 had complicated medical, physical and nutritional, adaptive equipment, and accessibility needs. o 1 of these 3 had complicated behavioral and psychiatric needs. • This is more evidence that there were systemic issues delaying transitions. Having complex medical or behavioral needs should not delay transition for over a year. There were not sufficient resources in the community to meet the needs of these groups of individuals. i. Reasonable activity and actions had occurred related to the transition and placement for 16 of the 16 (100%) individuals. IDTs did not meet each month for the individuals who were past 180 days on the referral list. Although this was not a Settlement Agreement requirement, it was part of the state's policy and would improve the facility's documentation of IDT activity regarding these transitions. • Of the 4 individuals referred for more than 180 days: o One was moving in April 2014 into a newly created home. Three other individuals (none of whom were referred for more than 180 days) were also scheduled to move to the same home. o A second individual referred for more than 180 days had completed	

		her CLDP about a month ago and was about to move when a new medical/infection control problem occurred, delaying her transition. ○ A third individual referred for more than 180 days had completed her CLDP and had begun transitioning to a new out-of-town home when it was determined that the placement could not meet her needs. This had occurred right at the time of the last review. The facility, family, and IDT had numerous discussions since then (i.e., over the past six months). Based on this, the goal was to have the facility be highly involved in her placement, even more so than before, including having the APC travel to Ft. Worth to work directly with providers there. Due to the distance to the Ft. Worth area, however, the facility, IDT, and family decided that a plan more likely to be successful was to transfer the individual to the Denton SSLC and have her transition to the community from there. This transition falls under provision T4 and will be monitored at the next onsite review. ○ The fourth individual referred for more than 180 days had many specific home accessibility needs. A provider with an appropriate home and bedroom was not available. The facility continued to hold meetings and do occasional provider visits. • Of the 3 individuals who were placed who had been on the referral list for more than 180 days, reasonable activity and actions were taken for all 3 by the facility, however, the lack of capacity in the community delayed their transitions. ○ For all three individuals, the problem was that an accessible home was not available. The facility took actions, such as directly talking with each possible provider, staying informed of the status of any new homes or openings in any current homes, and meeting regularly with the IDT. This information was found in ISPAs or in section IV of the CLDP. These CLDP paragraphs helped the reader to understand the actions, timeline, and rationale for the individual's longer transition. ▪ This again points to the need for a plan to address the absence of a sufficient number of homes for individuals with these types of needs. ○ In addition, for Individual #51, an accessible home and bedroom became available, but turnover of provider staff in the home gave the IDT and LAR pause, such that they delayed the individual's transition until they were comfortable with the provider's ability to provide the individual's needed supports.	

		j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for 16 of the 16 (100%) individuals. k. Adequate justification was provided for the lengthier transition process for 7 of the 7 (100%) individuals. • The monitoring team had to request additional documentation and narrative from the facility following the onsite review in order to obtain enough information to make this determination. The APC should maintain a better log of the activities for these individuals than what was currently being done. What was included in the weekly Placement Progress report was insufficient for this.	
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:	<u>State policy</u> a. The state policy for most integrated setting practices was recently issued. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spells out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc.	Noncompliance

		• The policy did not mention the Settlement Agreement requirement that action be taken prior to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. • There was no mention of need for IDT to use CLDP to ensure supports are in place. • The policy listed two reviews of CLDPs to be undertaken, one at the facility and one at state office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. • The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences. • The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports. Facility policy b. There were not facility policies that supported the state policy for most integrated setting practices. • There was one facility policy related to most integrated setting practices, but it was merely the state policy with a cover page from EPSSLC. The facility, however, should have policies and procedures that operationalize/define implementation of the parts of the state policy that are not specific. Examples include (but are not limited to) the way in which community tours are managed, how educational activities are presented to individuals, how the admissions and placement department staff ensure that all supports and services are included in CLDPs, how the PMM conducts post move monitoring, and which staff are to review the CLDP prior to its submission to the facility director. Training of facility staff on policies is addressed in T1b2 below. The rating for T1b is based solely on the development of adequate state and facility policies. Sections T1b1 through T1b3 are stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b.	

	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	This section relates to the activities of the IDT, QIDP, and the ISP process. EPSSLC recently again initiated the FST committee. This group should be able to adequately address the metrics in this provision (T1b1) as well as the other ISP-related provisions of section T, which include T1b2 item#1, and all of T1b3. The monitoring team recommends that the APC and QIDP coordinator begin to collect data on these same metrics as does the monitoring team. The FST committee provides an excellent forum to review status, provide training to QIDPs (i.e., invite them to the meeting for training and data review and/or schedule other trainings), and answer questions. <u>Protections, services, and supports</u> a. 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 in section F, substantial compliance was not found for F1d, F2a1, and F2a3. <u>Obstacles to movement</u> Regarding referral at the individual level: b. Of the 11 ISPs reviewed, 8 should have had obstacles <u>to referral</u> defined (the other 3 individuals were referred for transition to the community). Of these 8 ISPs, 8 (100%) included an adequate list of obstacles to referral. • The obstacle to referral for 7 of the 8 was LAR preference. That is, in these 7 cases, the IDT would have referred. For the 8th case, it was a combination of LAR preference and medical-weight issues; the IDT would not have referred this individual. • The reasons for the LAR's preference were also indicated in each ISP. c. Of the 2 annual ISP meetings observed, an adequate list of obstacles <u>to referral</u> was identified for 1 of 1 (100%). • Individual #157 was referred for community placement. A plan to address obstacles at the individual level: d. Of the 8 ISPs, 4 (50%) included an action plan to address/overcome obstacles identified. Of these 4, 3 (75%) were adequate (i.e., were individualized, measurable, and comprehensively addressed the obstacles). • More specifically, 5 of the 8 ISPs did not include plans that addressed the specific obstacles the team had identified, but rather included generic efforts to provide more information to the individual about community options. Recently, TSs were reported to be attending and participating more in ISP meetings to help guide the QIDP and IDT. They were also going to be reviewing the draft of the ISP document before it was finalized. e. Of the 2 annual ISP meetings observed, a plan to address/overcome the identified	Noncompliance

		obstacles was included for 2 (100%). Of these, 2 (100%) were adequate. • Individual #157's LAR expressed concerns regarding the IDT's decision to refer her for community placement. Most of her concerns related to ensuring that an adequate transition process would be put in place. The IDT members acknowledged her concerns and agreed to continue with the referral process with the stipulation that they would meet again in two weeks to develop a written transition plan to submit to the LAR for approval. • The only obstacle for community placement for Individual #58 was the LAR's preference that she remain at EPSSLC. The APC offered additional information to the LAR regarding living options and encouraged the LAR to attend provider fairs and community tours with Individual #58. Regarding transition at the individual level: f. Of the 5 CLDPs and related ISPAs reviewed, 5 should have had obstacles <u>to transition</u> defined. Of these 5 CLDPs and/or ISPAs related to transition, 5 (100%) included an adequate list of obstacles to transition. g. Obstacles to transition were defined for 5 individuals. Of these 5 individuals, 5 (100%) had action plans to address the obstacle <u>to transition</u>. • Individual #27: The need for dental work to be completed at the facility was an obstacle to transition. The facility arranged for him to be able to return to the facility for the dental work after he moved to the community. • Individual #18: There was an increase in self-injurious behavior that became an obstacle to transition after referral. The IDT met, made changes to the PBSP, got the habilitation department SLP involved in changing/improving his communication system and staff prompting of communication (because the SIB was hypothesized to be related to communication), and trained all staff who were working with the individual. His transition was not delayed due to this obstacle. • Individual #195: An obstacle to her transition was finding a provider who had an accessible home. The facility met regularly with providers and continued to have the individual do visits to homes. Eventually, a provider expanded a home's capacity to four (from three). • Individual #105: The obstacle to his transition was finding a home that was accessible and could accommodate his equipment. The facility had documentation showing their ongoing communication with local providers. • Individual #51: He was referred in August 2012 and there was insufficient documentation regarding obstacles to transition. In the past eight months, however, much activity occurred and was documented. There were two obstacles. The first was finding an accessible home. Eventually, one became available at a local provider. Then, during the transition, there was a	

		tremendous amount of turnover in the staff who worked at the home. The IDT and LAR met and decided to delay the transition date so that they could ensure that all new staff were hired, trained, and ready for the individual. This occurred and his transition went well. <u>Preferences of individuals and LARs</u> Preferences of individuals are determined and described: h. Of the 11 ISPs, 11 (100%) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). • 9 of the 11 were unable to clearly provide their preferences. The IDT, however, described ways they tried to determine these individuals' preferences, such as by demeanor and responsiveness to tours. i. Of the 2 annual ISP meetings observed, the individual's preference for where to live was adequately described in 1 (50%), and this preference appeared to have been determined in an adequate manner for 1 (50%). • The IDT for Individual #157 discussed living options in terms of her preferences and assessment recommendations. For example, team members noted that she would need a spacious home with open space for her to move around because she was blind, female roommates, and a structured routine at home. • Individual #58's LAR did not want to discuss living options at the meeting. Preferences of LARs are determined and described: j. Of the 11 ISPs, 11 (100%) included an adequate description of the LAR's preference and how that preference was determined by the IDT. k. Of the 2 annual ISP meetings observed, the LAR's preference for living setting was adequately described in 2 (100%), and this preference appeared to have been determined in an adequate manner for 2 (100%). • Both LARs attended the meeting and were involved in the discussion.	
	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.	<u>1. Individualized plan</u>: a. In reviewing 11 recently completed ISPs, 3 individuals had been referred for placement and were engaged in the CLDP process. For the remaining 8, 8 (100%) had a plan that addressed education about community options. Of these, 2 (25%) were adequate (Individual #6, Individual #118). Regarding the plans for education in this set of 8 ISPs: • 5 of the 8 (63%) had a list of activities that was individualized and specified what will be done over the upcoming year. To meet criteria with this metric, the plan should go beyond a generic provision of information; it should reflect the specific concerns that individuals and families/LARs have raised about the community, as well as reflective of the individual's needs.	Noncompliance

		○ The most challenging area with regard to education of individuals and LARs/families is individualizing this process. Action plans should target specific types of providers for community tours, identify research that the team would do to answer the individual/LAR's specific questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans to address the reasons for the individual, family member, or LAR's reluctance/preference. For example, if an LAR has questions or concerns about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. When teams have questions about availability of supports in community settings, these should be researched. ○ In the 2 ISP meetings observed during the onsite review, IDTs for both individuals developed outcomes for further exposure to living options through attendance at provider fairs (Individual #58) and visits to community group homes (Individual #157). • 4 of the 8 (50%) were in measurable terms and provided for the team's follow-up to determine the individual's reaction to the activities offered. ○ Individual #157's IDT developed outcomes for additional visits to community providers and agreed to collect data regarding her reaction to the visits. • 4 of the 8 (50%) included the LAR, as appropriate, based upon the content of the ISP. This was also evident in the two ISPs observed. • 6 of the 8 (75%) adequately described how/if the previous year's plan was completed. ○ This also occurred during the two ISP meetings observed. Individual #58's IDT acknowledged that her outcomes for the previous year were not adequately implemented. Barriers to implementation were discussed. It may be helpful to: 1. Add some prompts or headers to the ISP shell to help the IDT address each of the above four bullets. 2. Have the transition specialist who attends the ISP meeting ensure that the IDT always adequately addresses these four bulleted items. 3. Train and review these, with data, during the FST committee meetings.	

		2. Provider fair: b. The facility did hold a provider fair within the past 12 months (on Saturday 3/15/14 and on Saturday 9/27/13). Data were collected on a variety of variables (e.g., attendance, participation, satisfaction, suggestions). Data from the September 2013 fair were used to make changes to the March 2014 fair. Every provider from El Paso attended the most recent fair. Data from the March 2014 fair were summarized and included plans for further improvements for future fairs. One interesting finding was that the providers reported that they enjoyed learning about each other's services. The facility continued to meet the standard for this item of T1b2. 3. Local MRA/LA: c. The facility did appear to maintain good communication and a working relationship with the LA. The facility 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 (September 2013, January 2014). The APC provided documentation regarding these meetings. The topics were very relevant to most integrated setting practices. CLOIP data were reviewed and summarized by the APC in his referral status spreadsheet. In addition, the transition specialists maintained frequent contact with the local providers to inform them of individuals who were ready for transition. The annual LA inservice was held on the same day as the recent provider fair. This item of T1b2 continued to be met. 4. 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). d. The facility did have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate, identified all individuals and whether or not each went on a tour). • To meet this aspect of T1b2, the facility needs to demonstrate that: o 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). ▪ The APC created a very good spreadsheet that listed each individual, home and QIDP, whether he or she participated in a tour (and if not, why, such as legal reasons or that the LAR or IDT said no), and the date of the tour. ▪ The APC's data showed that of the 113 individuals, a tour was appropriate for 89. Of these 89, 37 had participated in tours (42%, an improvement from previous reviews). ▪ Special tours were set for clinical and DSP staff (see #7). o Places chosen to visit are based on individual's specific preferences, needs, etc.	

		▪ Based upon the monitoring team's discussions with the APC and his staff and with some of the QIDPs, places chosen to visit were based upon individuals' preferences and needs (e.g., wheelchair accessible), however, the number of options within El Paso was somewhat limited due to the small number of providers. All tours included day programs and then homes. o Tours are for individuals or no more than four people. ▪ This was the case for all tours. o Individual's response to the tour is assessed. ▪ Staff completed a short report form. The transition specialist summarized it. She then sent the information summary in a group email to the QIDPs and it was to be included in the next living options discussion at the next annual ISP (or if a living options discussion was held prior to the next annual ISP meeting). e. Based on the facility's own report, of the 89 individuals at the facility for whom a tour was appropriate, 37 (42%) went on a tour appropriate to their needs within the past year. f. Of the 89 individuals in the sample for whom their teams had determined a tour was appropriate, 37 (42%) went on a tour tailored to their needs within the past year. To meet the standard for this item of T1b2, at least 90% of the individuals for whom a tour was appropriate should have attended a tour. <u>5. Visit friends who live in community</u>: g. The facility had a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. • These opportunities were being considered by the APC and his staff as they planned tours and other educational activities. • 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. This item of T1b2 met the standard. <u>6. Education activities at/by facility for individuals</u>: h. Since the last onsite review, other educational activities for individuals did occur during self-advocacy meetings), did not occur during house meetings for individuals (there were no house meetings), did not occur during family association meetings (there was only one meeting scheduled during this period and APD staff did not	

		attend), and did occur during any other appropriate situations or locations. • The APC, TS, and PMM continued to work individually, sensitively, and slowly with many LARs and family members. There continued to be many moving examples of how LARs/family members came to learn more about community living and eventually supported their loved one to be referred and transition (e.g., Individual #38, Individual #18, Individual #120). This continued to be a strength of the facility. Some of this was documented on the facility's Family Education progress note form. • The TSs developed a newsletter called the Home Inquirer. This was for individuals, family members/LARs, and staff. • New brochures were developed. • The excellent TS real estate style postings continued. • New and additional posters regarding community living were made and posted. • Another DVD of homes in the community was created and disseminated. It was called Galleria of Homes, March 2014. • An interview of a former resident was put onto DVD for sharing with individuals, family members/LARs, and staff. This item of T1b2 continued to meet the standard. <u>7. Education activities for direct support professionals (DSPs), clinicians, and managers</u>: i. More than 75% of DSPs were documented to have participated in one or more activities (e.g., inservice, workshop, community tour). j. More than 75% of clinicians were documented to have participated in one or more activities (e.g., inservice, workshop, community tour). k. More than 75% of managers and administrators were documented to have participated in one or more activities (e.g., inservice, workshop, community tour). • All new employees received didactic training from the APC or one of his staff during NEO. A PowerPoint presentation was made. • All staff received training on community living and the most integrated setting practices policy at the facility's series of town hall meetings in March 2014. Multiple sessions were held and almost every staff member was documented to have attended. • The TSs and/or PMM provided a separate training session for each department's clinicians and managers in November 2013. The departments were dental, psychiatry, habilitation, residential and campus coordinators, QIDPs, nursing, dietary, and residential staff. Documentation was provided showing that 129 staff received this training. • "Pro-Tours" were set up for professional staff (e.g., clinicians, managers) to go on special tours of providers. This occurred in October 2013 and	

		December 2013. Fifteen professional staff attended these tours. This was a very good and creative idea by the APD staff. • QIDPs received training on the ISP as it related to section T. The APC created a sample ISP with red highlighted text (including the four parts of item #1 above). This was very recently done (i.e. during the week of the onsite review), thus, any positive effects were not yet apparent. This item of T1b2 met the standard. <u>8. Reluctant individuals/LARs learn about successes</u>: l. Since the last onsite review, information about successful community placements was shared with (a) individuals who were reluctant to consider community placement, and (b) LARs who are reluctant to consider community placement. • These options were made available to families, usually during the individual discussions held with the transition specialists or PMM. • In one example, the sister of Individual #18 now volunteered to talk with other family members about her family's experience. This played a role in the recent referral of upcoming placement of Individual #38. This item of T1b2 met the standard.	
	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.	The monitoring team requested a set of recent ISPs, attachments, and assessments. Eleven were selected for review by the monitoring team (see above under Documents Reviewed). These were from the entire EPSSLC campus, for individuals with differing levels of needed support, and facilitated by seven different QIDPs. The ISPs were from meetings held October 2013 to February 2014. <u>1. Professionals provided recommendation in assessments</u>: a. Assessments were reviewed for 5 of the 11 ISPs. Of the 5 ISPs reviewed, all of the assessments for 0 individuals (0%) included an applicable statement or recommendation from all disciplines. • The ISPs sampled were from some individuals who were referred, not referred, and rescinded. • Assessments were not completed (or perhaps some were completed, but not submitted) for all disciplines. • Statements were most regularly made in the habilitation (OT/PT/ST), recreation, and nutrition. All of the statements were positive about community placement, except for one by medical (for Individual #109). The other medical statement was ambiguous (for Individual #84). • The state office new standardized statement/requirement was not being used by all disciplines all the time, but should be.	Noncompliance

- Below are some data for these 5 ISPs:

Discipline	# assessments	# with a statement	# w/ state statement
Medical	2 of 5	2 of 2	0 of 2
Nursing	4 of 5	3 of 4	1 of 3
Dental	4 of 5	1 of 4	0 of 1
Psychiatry	1 of 5	1 of 1	0 of 1
Psychology	3 of 5	2 of 3	2 of 2
Pharmacy	1 of 5	1 of 1	0 of 1
OT-PT-ST	5 of 5	5 of 5	4 of 5
Nutrition	4 of 5	4 of 4	4 of 4
FSA	2 of 5	2 of 2	2 of 2
Vocational	4 of 5	3 of 4	2 of 3
Recreation	5 of 5	5 of 5	0 of 5
Educational	1 of 5	1 of 1	0 of 1
Social History	3 of 5	0 of 3	0

<u>2. Professional determinations presented/discussed at ISP meeting</u>:

b. In 2 of the 11 (18%) written ISPs reviewed, and during 2 of the 2 (100%) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included.
    - In 6 of the 11, the written ISP only referred to the IDT as a whole.
    - In 3 of the 11, the written ISP mentioned one or two disciplines, not all of them.
    - It may be that this was occurring during the meetings, but was not being included in the finalized ISP document.

<u>3. Thorough discussion of living options at ISP or other IDT meeting</u>:

c. In 11 of the 11 (100%) written ISPs reviewed, and during 2 of the 2 (100%) annual ISP meetings observed, a thorough discussion of living options occurred.
    - Living options discussions at ISPs continued to be done very well at EPSSLC. With the transition to a new set of QIDPs, the monitoring team hopes the facility can maintain this quality.
    - During the two ISP meetings observed by the monitoring team, both IDTs engaged in good discussion regarding living options. APD staff attended both meetings and presented brochures and other information to the teams regarding living options that were currently available in the community.

<u>4. IDT determination in written ISP</u>:

d. In 11 of the 11 (100%) written ISPs reviewed, a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included.

e. In 11 of the 11 (100%) written ISPs reviewed, a statement regarding the overall

		decision of the entire IDT, inclusive of the individual and LAR, was included.	
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 5 CLDPs completed since the last review. This was 100% of the CLDPs completed since the last review. The monitoring team reviewed 5 of the 5 (100%) CLDPs in depth. A sixth CLDP was submitted following the onsite review. It was for the individual who was scheduled to move, but did not due to recent medical/infection issues. Her CLDP was not included in this review. <u>Timeliness of CLDP</u> Initiation of CLDP a. 4 of the 4 (100%) CLDPs were initiated within 14 calendar days of referral (1 of the individuals were referred in 2012 and was not included in this metric). The monitoring team based this finding upon documentation of CLDP-related activity occurring within 14 days of referral including an indication, including the actual 14-day meeting minutes or indication on the CLDP cover/first page. The addition of a date on the cover/first page was done on some, but not all of the CLDPs. The APC should add this to his CLDP template. Ongoing development of CLDP b. 5 of the 5 (100%) CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process. Paragraphs in section IV of the CLDP detailed the activities that occurred for the longer transitions. <u>IDT member participation in placement process</u> c. 5 of the 5 (100%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., 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). <u>Coordination of CLDP with LA</u> d. 5 of the 5 (100%) CLDPs or other transition documentation included documentation to show that the facility worked collaboratively with the LA. This collaboration did not appear to be more than the LA's attendance at the CLDP meeting, the provision of provider lists, and conducting the LA's own pre move site review (separate from the facility's pre move site review). On the other hand, there did not appear to be any activity that the LA was to engage in that he or she did not.	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 provider staff.	The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the LA and community provider. <u>The CLDP specifies actions to be taken by facility</u> a. 0 of the 5 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 of the activities listed below, in the six closed bullets, occurred adequately and thoroughly. However, each of the CLDPs (100%) included some of these six activities. • Training of community provider staff, including staff to be trained and level of training required. Each of the CLDPs included a lot of good detail about the content of training (i.e., what was to be trained), including the content of the IRRF and IHCP. i. who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), 1 of 5 (20%) (Individual #195), ii. 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), 0 of 5 (00%), and iii. a competency demonstration component, when appropriate, 5 of 5 (100%). • Collaboration with community clinicians (e.g., psychologist, behavior health specialist, psychiatrist, PCP, nurse, SLP). This was noted in 0 of the CLDPs (0%). If collaboration with community clinicians was considered by the IDT and perhaps deemed not necessary, the CLDP should indicate this decision. • Assessment of settings by SSLC clinicians (e.g., OT/PT). This was noted in 1 of the 5 CLDPs (20%). The habilitation therapies staff noted that the carpet in Individual #18's new home might make it difficult for his wheelchair. As a result, the provider agreed to change out the carpet for flooring. • Collaboration between provider day and residential staff. This was not evident in any of the CLDPs (0%). • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not evident in any of the CLDPs (0%). If not needed, this should be indicated in the CLDP. • Collaboration between Post-Move Monitor and Local Authority staff. This may likely have been occurring, but was not noted in any of the CLDPs. It may be helpful to: 1. Include these six items within section IV of the CLDP. 2. Add these six items to the APC's CLDP supports checklist.	Noncompliance

		Documentation of day of move activities b. 5 of the 5 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. Documentation for 1 of the 5 (20%) indicated that the activities did indeed occur (for Individual #51). CLDP meeting prior to moving A CLDP meeting occurred for 5 of the 5 individuals (100%). It was described in each of the CLDPs c. During the CLDP meeting observed during the onsite review, an adequate and complete CLDP meeting was conducted for Individual #38. The monitoring team observed the occurrence of the following activities (except for item 3, which could not be determined during the meeting; and items 2 and 4 because the individual did not attend the meeting). • Attendance by all relevant IDT members, community providers, and LA • Individual preparation occurred prior to the CLDP meeting, if appropriate to do so • DSP preparation occurred prior to the CLDP meeting, if appropriate to do so • Individual participation occurred, or was facilitated, if needed • There was active participation by team members • All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved • The post-move monitor actively participated to ensure that supports were adequately defined and required evidence specified.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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. The following review was based on a sample of assessments from 5 of the CLDPs. <u>The assessments selected for completion are appropriate and none are left out</u> a. For 5 of the 5 CLDPs reviewed (100%), all necessary assessments were completed. • There were between 12 and 14 assessments per individual. <u>Assessments done within 45 days of move date</u> b. For 5 of the 5 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. <u>Assessments are available for use by the APC and IDT</u> c. For 5 of the 5 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. <u>Assessments are of adequate quality</u> d. For 0 of the 5 CLDPs reviewed (0%), the assessments were of adequate quality based upon the following four closed bullets: • A summary of relevant facts of the individual's stay at the facility. o The content of the assessments for most of the assessments for all 5 individuals contained relevant facts regarding the individual's stay at the facility. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o Most of the assessments for all 5 individuals were thorough enough to assist teams in developing a list of supports. For example, the assessments provided a lot of information about Individual #18's preferences and how to best interact with him. • 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 assessments for 0 of the 5 individuals specifically focused on the new home or day settings. However, more assessments than ever before contained this focus. • 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 assessments for 0 of the 5 individuals specifically focused upon how the necessary supports might need to be provided in these new settings. However, more assessments than ever before contained	Substantial Compliance

		this focus. ○ For example, nursing assessments for individuals who had nursing care/health management plans at the facility should include recommendations about their continuation and/or any modifications that need to be made to accommodate community settings that might not have nurses available at all times. ○ Similarly, psychology/behavioral assessments should identify differences (e.g., environmental, staffing, training of staff on protective holds) that could impact the implementation of the PBSP in the community, and/or make recommendations about needed modifications. Although the full set of discharge assessments did not meet the standard, some of the assessments were very good. In particular, dental, residential, and recreational discharge assessments for all 5 individuals provided a lot of good information for the community provider. The nursing discharge assessments for some, but not all of the individuals provided good suggestions for the provider regarding interaction style and medication administration. In one example, the nursing staff conducted a two week medication administration study to concentrate on what aspects of medication were most important for the provider to know (for Individual #195). Overall, however, the nursing discharge summaries needed improvement as described in some detail in section M3. Habilitation therapies discharge assessments provided a lot of good information, however, they did not focus on the specific new settings and contexts in which habilitation supports would now be provided. The medical, psychiatry, and behavioral health services/psychology assessments did not focus on the new settings. Overall, based on the progress seen since the last review, this provision remained in substantial compliance. It may be helpful to: 1. Have the APC develop a tool to self-monitor the quality of discharge assessments. It should look at the quality by directly assessing the above four bullets. 2. Number the final recommendations in the CLDP so that the reader can more easily determine if the final recommendations made it into the list of pre and post move supports.	

T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The lists of pre-move and post-move supports were identified in the CLDPs. There was continued improvement in the lists of supports, however, more work was needed. The APC and PMM finally created a self-assessment checklist to help ensure all of the components of this provision were adequately addressed (they should include the items in T1c1 in addition to the items here in T1e)). A blank checklist was given to the monitoring team and the APC reported that it was used for the most recent CLDP, however, no completed checklists were submitted to the monitoring team. <u>Pre- and post-move support lists are adequate</u> a. In 0 of the 5 CLDPs reviewed (0%), a comprehensive set of essential and nonessential supports was identified in measurable/observable terms. This finding was based on the following three numbered bullets. 1) The list is comprehensive and inclusive, demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This applied to 3 of the 5 individuals, and was only demonstrated in 0 of the 3 (0%). Merely saying to continue the PBSP was insufficient. Further, the CLDPs and PBSPs detailed many aspects about interaction style, communication, preferences, clothing, food, music, schedules, and so forth that were critical to each of these individual's success. • The PMM reported on some of what was implemented by the providers (e.g., Individual #18), but even so, the CLDP should clearly indicate these aspects of the PBSP as post move supports. ▪ As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with crises at the facility should be modified in a community setting. None of the CLDPs included an emergency plan. This was especially disappointing to see because the facility had one failed placement (at the time of the last review) and one of the contributing factors was the absence of an emergency crisis plan. o All safety, medical, healthcare, therapeutic, risk, and supervision needs were addressed. ▪ This applied to all 5 individuals and was adequately done for 3 of the 5 (60%). Many support and service needs were addressed in the assessments and in training for staff; some but not all were included as supports to be implemented. For example, important medical conditions were addressed for hemorrhoids (Individual #51) and ground diet and GERD	Noncompliance

		protocols (Individual #105). However, the supports for Individual #18 were insufficient regarding his dining plan, wheelchair supports, safe swallowing, and meal choices. Similarly, they were insufficient for Individual #195 regarding all of her PNM, PT, OT, and dining needs. ▪ Interestingly, even though the CLDP support only referred to training and inservices, the monitored to see if the supports were actually implemented (e.g., Individual #18's diet and food preparation). This should be corrected in future CLDPs to show two separate supports: one for training and one for implementation. o What was important to the individual was captured in the list of pre- and post-move supports. ▪ This applied to all 5 and was adequately addressed for 2 of 5 (40%). Surprisingly, the provision of preferred activities and items were absent in 3 of the 5 CLDPs (though they were included in the staff training content). In the most recent 2 of the 5, however, detailed numerous supports for preferences were included. It appeared the facility had realized this omission and corrected it. o The list of supports thoroughly addressed the individual's need/desire for employment, and/or other meaningful day activities. ▪ Employment or day supports applied to 5 of the 5 individuals and were adequately addressed for 0 (0%). There were no supports related to any day programming, day activities, or employment. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of pre- and post-move supports. ▪ This was not addressed in any of the CLDPs (0%). Positive reinforcement applied to all individuals and probably played a role in their success at the facility. It was mentioned to be considered in Individual #27's CLDP, but never became a support. For Individual #51, the absence of a support was particularly problematic because his CLDP specifically said, "Always always reinforce compliance, communication, and desired behavior." o There were pre-/post-move 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 addressed for all 5 (100%). Four of the individuals had at least two skills that were going to be addressed formally	

		with a SAP. o There were not pre-/post-move supports for the provider's <u>implementation</u> of supports. That is, the components of the PBSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and communication programming that community provider staff would be required to continue were not included. ▪ Many items in training did not appear within the supports list; for instance, there were detailed inservices on oral hygiene techniques and for nutrition needs, but not post move supports to ensure that these dental and nutritional supports were provided to the individual. ▪ As noted immediately above, implementation of supports and implementation of what was trained should be in the list of post move supports. Even so, the PMM often monitored for implementation anyway. o All recommendations from assessments are included; or if not, there is a rationale provided. This occurred for 5 of the 5 CLDPs (100%). ▪ For the most part, recommendations were included. ▪ When they weren't, there was very good narrative describing the IDT's deliberations and discussion. ▪ This was a strength of the 5 CLDPs. 2) The wording of every pre-/post-move support is in measurable, and observable terms. o Many were in measurable terms, however, many continued to include words, such as "continue," "participate," and "provide." 3) Every pre-/post-move support included a description of what the PMM should look for when doing post-move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. o This was much improved and included references to checklists and direct observation. o The PMM should guide the IDT to consider <u>three</u> general categories of evidence: direct observation, staff interview, and documentation (e.g., checklists). She usually looked at these three aspects during her post move monitoring (see T2a and T2b); it would improve the CLDP if these were also included in the CLDP . <u>Essential supports were in place on the day of the move</u> b. For the 5 of 5 (100%) CLDPs reviewed for individuals who were placed, a pre-move site review was conducted by the facility. c. Of these 5, 5 (100%) were done timely and completely. d. Of these 5, 5 (100%) indicated that all of the essential supports were in place prior to	

		the individual's move, or if they were not, identified the issue and showed that action was taken to remedy the situation. • The PMM provided very good detail on the pre move supports, including a good narrative of the home, provider, and supports. e. For___ of __ (%) pre-move site visits observed by the monitoring team (if any), the pre-move site visit was conducted thoroughly (not applicable, none were observed by the monitoring team).	
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.	Policy/Procedure a. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. • The state recently developed and disseminated the beginnings of a section T/most integrated setting practices QA program to each of the facilities. It included three tools, to assess the written completed CLDP document, written completed post move monitoring forms, and the written completed transition document for provision T4 type transitions. It included two sets of instructions (one page each). One was for the conducting of the three tools. The other was regarding the full set of transition-related data and review system. • The content of the three tools lined up better than ever before with the content of the monitoring team's metrics and reports. The state should again review the Monitors' reports for the next revision of these tools. • Tools regarding the important ISP-related components of section T were not addressed (e.g., T1a, T1b1, T1b2, T1b3). • The facility should have its own facility-specific policy/procedure for quality assurance to meet what is required by this provision T1f. Collection of data b. Data/information were not collected (i.e., a complete set of data were not being collected). The data that were being collected were relevant and valid (however, a complete set of data were not being collected). The data were not being collected reliably (however, a CAP was recently initiated to address this, which was good to see). • The monitoring team has, for some time now, recommended the following set of data to contribute to the APC's QA program and to set the occasion for summation, review, and analysis of data. These are simple data to collect and graph. Some of it was already being done. 1. Number of individuals placed each month or monitoring period 2. Number of new referrals each month or six-month period 3. Number of individuals on the active referral list as of the last day of each month	Noncompliance

		4. Number of individuals on the active referral list for more than 180 days, as of the last day of each month ▪ This was presented in a table format. 5. Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers). ▪ This was presented in a table format. 6. Number of individuals who have requested placement, but have not been referred, as of the last day of each month 7. 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 8. Number of individuals not referred solely due to LAR preference as of the last day of each month ▪ This was presented in a pie chart. 9. Number of individuals who had any untoward event happen after community placement each month (including return to the facility or death) and number that had a root cause type review ▪ Cumulative number of each type of untoward event for all placements 10. Number of rescinded referrals each month or each six-month period, and number that had a root cause type review 11. Number of alternative discharges (T4) 12. Number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles (from T1b1) 13. Number of individuals who went on a community provider tour each month and total number/percentage of individuals who went on a tour in the past 12 months (from T1b2) The facility added the following data: 14. Data from the old living options discussion tool 15. Obstacles to referral, percentage for each type of obstacle. ▪ Presented in table format. 16. Obstacles to transition, number for each type of obstacle. ▪ Presented in table format. State office added the following data, but none were being collected or presented by facility: 17. Data from new monitoring tool for CLDPs. 18. Data from new monitoring tool for post move monitoring. 19. Data from new monitoring tool for T4 discharges.	

		20. Self-assessment results. Summarization/analysis of data and actions taken c. Data were not reviewed, summarized, and analyzed. There was no narrative or explanation of the data. Actions were not taken as a result of analysis of the data. The data were included in the facility's QA program, but it was not a full set of relevant data. Re-admissions: There were 0 re-admissions. This compared with 2 re-admissions at the time of the last review, and 0 re-admissions prior to that. Because there were no re-admissions, the following metric was not applicable to this review. d. For ___ of the ___ (%) who returned to the facility after a failed community placement, an adequate review was conducted to determine if changes in the referral and transition planning processes at the facility should be made. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for __ (%). Deaths Following Community Placement: There were no deaths of individuals who had moved to the community. This compared with 0 deaths prior to this review. Because there were no deaths of individuals who had moved to the community, the following metric was not applicable to this review. e. ___ individuals that transitioned to the community passed away since the last onsite review. Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the facility should be made for (%) of the cases. Of these reviews, actions were recommended in ___ cases. Of these cases, actions were implemented for ___ (%). Other Adverse Outcomes: f. Over the past year (12 months), of the 9 individuals placed, 1 (11%) experienced one or more potentially negative outcomes since placement. Of these, there was an adequate review conducted for 1 (100%) of the cases to determine if changes in the referral and transition planning processes at the facility should be made. Of these reviews, actions were recommended in 0 cases. Of these (n.a.) cases, actions were implemented for (n.a.) (%). • The sole instance was the transfer/switching of two individuals between two homes with the same provider. It was arranged between the LARs, the provider, and APC. Although a move from one home to another qualified as a potentially adverse outcome, the change was not due to problems in either individual's transition, placement, or lifestyle, but instead due to a desire for a home that made more sense for both individuals in terms of location and housemates. • The APC added root cause analysis review to his template/agenda for all	

		weekly APD meetings. These were the meetings that produced the weekly Placement Report. Thus, these reviews were now likely to be documented in these weekly reports. • The APC, TSs, and PMM reported that they felt they learned from the failed placement of Individual #37. They said that based on what they learned, they did extra training of provider staff of worst case scenarios, sent a staff member for the first overnight visits and first few days for one individual (Individual #51) and then made arrangements for the behavioral health specialist to be on-call during the first few days (fortunately, although available, she was not needed because the individual did very well).	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	Annual narrative by facility a. The facility did not have an adequate system to collect information about obstacles to transition. • APC kept a very good database spreadsheet with detail about each individual. He created this database by reading the ISP of every individual at the facility. • The data system separated the obstacles to referral from the obstacles to transition (i.e., once an individual was referred). • For obstacles to referral, relevant obstacles were identified for every individual (there were five categories). In this report, at EPSSLC, 60% of the individuals were not referred solely due to LAR preference. • For obstacles to transition, the total was 28. It was unclear if more than one obstacle might have been assigned to one individual. This should be clarified in future reports. • Also, the obstacles to transition chart should have a column added to indicate the number of those obstacles that were successfully resolved (i.e., transition/placement occurred). o This information should also indicate if any "compromises" of the individual's needs, preferences, and/or supports were required in order for the transition to occur. An example of a compromise would be if the individual "settled" for a day habilitation program because the vocational program that the team recommended (or that the individual preferred) was not available in the part of the state in which the individual/guardian wanted to live. Another example would be if the individual moved to an area of the state that was not the original preference because clinical services were not available there. b. The facility did have an annual narrative that showed it had (a) conducted a comprehensive assessment of obstacles, and (b) developed and implemented appropriate actions to address and overcome these obstacles on the local level	Noncompliance

		within the authority of and resources available to the Facility. • The narrative included strategies to address both sets of obstacles (referral and transition). • There was good detail on how they were addressing the obstacle to transition identified by their data as most prevalent: LAR preferences (also noted in T1b2 above). • The narrative described the work the facility was doing with providers to make them aware of the needs of individuals and to ensure them that if they developed homes, there were individuals who would likely be referred to them. Annual narrative by DADS state office c. The State did not present an annual narrative that showed it had (a) conducted an analysis of the Facilities' data, (b) taken 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, and (c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature. DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 6 obstacles to referral categories and 12 obstacles to transition areas used in FY13. • DADS included a list of 14 initiatives it was continuing to support. • The report included attachments with each of the Facilities' annual reports. • The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the monitoring team's reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • <u>Transition obstacles data</u>: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles).	

		○ State office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, state office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The monitoring team believes that this information should be included in the report. • <u>DADS strategies</u>: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. ○ During recent discussion with state office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition). • <u>Assistance</u>: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). ○ The monitoring team was unable to determine this because there was no information in the report addressing it.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall	a. The facility did provide an accurate Community Placement Report for six months ending on the week prior to the onsite review (9/14/13-3/21/14) that included the following information: • Number and names of individuals transitioned to the community	Substantial Compliance

	issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	• Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference (there were 49 names)	
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	EPSSLC maintained substantial compliance with this provision item. Overall, post move monitoring was done thoroughly and competently. Follow-up was tenaciously pursued. Providers responded and individuals were doing very well in the community. The PMM was responsive to comments and recommendations from the last onsite review and monitoring report. Since the last review, 12 post move monitorings for 5 individuals were completed. This compared with 12 post move monitorings for 6 individuals, 22 post move monitorings for 9 individuals, and 10 post move monitorings for 5 individuals at the time of previous onsite reviews.	Substantial Compliance

	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.	The monitoring team reviewed completed documentation for 12 (100%) post move monitorings for 5 different individuals. Of the 12 post move monitorings, 9 were completed by the post move monitor Luz Delgado and 3 by the transition specialist Helen Alvarez. <u>Timeliness of Visits</u> For the 5 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; no individuals attended 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. The PMM used the newest iteration of the form for all of these post move monitorings. 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 7 of the 7 (100%) 45- and 90-day visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 12 of the 12. o The PMM should now provide detail in her report regarding: ▪ Whether she had evidence of all aspects of required training and inservicing, such as who, what, how, and documentation of competency (rather than merely stating training documentation was reviewed). o The PMM looked at each support in great detail. For instance, she found that a suppository was given to an individual <u>on</u> the third day without a bowel movement instead of <u>after</u> the third day. • Each post move monitoring also included a review of all pre move supports (as it should). The yes/no boxes were marked in each post move monitoring report. o For Individual #27's, there was also a statement that the pre move supports were monitored and found to be in place. This statement was	

		good to see and should be included in future post move monitoring reports. • 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 every support. o The narrative in each of the supports was outstanding and detailed, allowing the reader to have a very good understanding of the status of each support, the individual's experience, any challenges experienced by the provider, and any required and any suggested feedback. o Interviews with staff clearly and well described. o The PMM often looked at much more than was required by the CLDP. This was good to see especially because many of the CLDP supports did not adequately describe what the PMM was to look for (i.e., what to observe, what documents to review, who to interview). • LAR/family satisfaction with the placement and the individual's satisfaction were explicitly stated in 12 of 12 (100%). • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements was provided by the PMM in 12 of the 12 (100%). o The PMM tended to put in general comments within the paragraph about the individual's satisfaction. • 12 of 12 reports (100%) indicated the specific name and title of each person interviewed by the PMM. <u>General status of individuals</u> Based upon the monitoring team's review of documents and discussion with the APC and PMM, of the 5 individuals who received post move monitoring, 5 (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 for any individuals whose placements failed or who had the kinds of problems noted in T1a. There were no such events for these 5 individuals. <u>Use of Facility's best efforts when there are problems that can't be solved</u> In 8 of the 12 post move monitorings (75%), additional follow-up, assertive action, and activities were required of the post move monitor. These were for 5 of the 5 individuals (100%). The problems were all of a moderate level, such as documentation and checklists, allowing a mid day nap, appropriate clothing, 3:1 chair repairs, 3:1 chair refusals, BM charts, nose scratch, toothbrushing and SAP documentation, and urinating in bedroom. None of these were extremely serious issues, however, any one of them could have become a serious issue if not for the successful intervention and follow-up by the PMM.	

		The PMM also never hesitated to involve EPSSLC staff and clinicians. For example, the residential coordinator for Individual #27 went to the his day program and home to observe, model, and provide feedback to staff; the APC and habilitation therapy staff went to the provider to repair the 3:1 chair; the IDT was consulted regarding Individual #195's nose scratch; the EPSSLC went to the provider's day program to assess the ongoing need for a 3:1 chair; the EPSSLC behavioral health specialist was consulted for suggestions regarding urinating in the bedroom; and the PMM assisted with one individual's difficulty in going in the van for medical appointments. The suggestions were brought to the provider, implemented, and the problem resolved. Numerous examples of emails between the PMM and provider were shared with the monitoring team. <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 to be held and there were to be minutes/documentation of the meeting following post move monitorings for which an ISPA was appropriate to have been held. An ISPA meeting was not necessary for any of these 12 post move monitorings.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	EPSSLC maintained substantial compliance with this provision. The monitoring team observed one post move monitoring at the day program and home of Individual #195 for the 90-day review. The monitoring team also briefly visited the home of Individual #27 and Individual #124. 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 Draco Services of El Paso. Individual #195 was doing very well at home and at her day habilitation program. She was observed to be alert, somewhat social, and her clothing, grooming, and appearance were very nice. Some of her progress included self propelling her wheelchair much more than before, allowing staff to fully	Substantial Compliance

		complete her toothbrushing, and allowing staff to wash her hair and braid it from the front. The provider developed a 13-item checklist for documenting many of the CLDP supports. This was a very good document and could be used by other provider's, too. The home and bedroom were nicely furnished. The provider installed three specialized grab bars for Individual #195 to use. Individual #195 particularly liked these type of grab bars; the provider put one in her bedroom, in one in the living room, and one on the outdoor patio. Staff were extremely knowledgeable of the individual's need, preferences, and supports. The PMM interviewed one of the staff (Alma). She answered all questions correctly and with great detail. Facility and provider staff were impressed and very happy with Individual #195 's progress and successful transition. Draco El Paso, under the leadership of regional director Gisel Hita, continued to do a consistently good job for individuals who transitioned from EPSSLC.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations	This item does not receive a rating.	
T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the	The parties had agreed that in addition to the categories listed in the Settlement Agreement, other circumstances resulting in an individual moving from a SSLC might fall under the category of "alternate discharges." One of these reasons was an individual transferring to another SSLC.	Substantial Compliance

	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	One individual was listed as being discharged as per section T4. Thus, the discharge was required to meet this provision's discharge and transfer requirements. The individual (Individual #149) transferred from EPSSLC to another SSLC. <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summary completed for Individual #140, it did (100%) contain the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. These include a summary of the individual's developmental, behavioral, social, health, and nutritional statuses. This summary appeared to "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. A review was conducted to determine whether or not the facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: • In 1 out of 1 records reviewed (100%), good cause was identified in the discharge summaries. • The facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies) for 1 out of 1 individuals (100%), reasonable time was given to prepare. • The facility developed a final summary of the individual's developmental, behavioral, social, health and nutritional status, and the information was adequate for 1 out of 1 individuals (100%). • For 1 out of 1 individuals (100%), the facility provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving facility. • Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the report for 1 out of 1 individuals (100%) adequately described the key supports that the individual would need in the new setting.	

SECTION U: Consent	

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands items.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands items.	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) • Documenting in the observation notes procedure, W.2, 2/1/14 • Documenting in the shift home logs, W.10, 2/1/14 • Intellectual disability needs process, 1/9/14 o EPSSLC organizational chart, March 2014 o EPSSLC policy lists, undated, probably March 2014 o List of typical meetings that occurred at EPSSLC (not provided) o EPSSLC Self-Assessment, 3/4/13 o EPSSLC Action Plans, 3/4/14 o EPSSLC Provision Action Information, most recent entries for the most part were 2/2/14 o EPSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 3/24/14 o List of all staff responsible for management of unified records o Description of changes since the last onsite review (there were none) o List of other binders or books used by staff to record data o Description of the shared drive o Tables of contents for the active records 4/5/13, individual notebooks 4/15/13, and master records (4/5/13), no changes o Unified records committee meeting agenda and handouts, 3/15/14 o NEO and refresher recordkeeping practices training signature sheets, August 2013-January 2014 o List of items found missing by the monitoring team and the MRC/URC's response to each o ISP packet audits, August 2013 and November 2013 data o Assessment submissions data, submitted and on-time data, August 2013-January 2014 o Policies listed by Settlement Agreement provision, undated o Another list of policies, undated o A 12-page spreadsheet that listed state and facility-specific policies and also showed various information regarding training (e.g., who, how, data/numbers), undated o Description of the unified record audit process o Blank unified record audit tools, (none) o List of individuals whose unified record was audited by the URC, September 2013-February 2014 o Completed audits for 10 individuals, December 2013 and December 2013 • Original state monitoring tool for recordkeeping, 2 pages each, printouts from their database (for 23 of the 25 audits done September 2013-January 2014)

	• 22 page audit tool for active record, individual notebook, and master record • Additional master record checklists (four) o Graph of documented and undocumented errors (from 22-page audit), August 2012 to March 2014 o Database printouts of errors for each 22-page audit, 4 pages/audit, September 2013-January 2014 o Data regarding inter-rater agreement for old statewide self-monitoring tool o Documents following the audits: • Full set of emails to responsible staff, six months, August 2013-January 2014 • Email follow-up documentation • Corrected errors report, February 2014 and March 2014 o QA report for section V, February 2014 o CAP for health data entries, 2/6/14 o Various documents regarding V4, including a description of criteria for each of the six components, V4 interviews, and graphs o Active records and/or individual notebooks of: • Individual #74, Individual #46, Individual #70, Individual #58, Individual #123, Individual #66, Individual #80, Individual #81, Individual #38, Individual #88, Individual #83, Individual #56, Individual #54, Individual #107, Individual #42 o Master records of: • Individual #30, Individual #13, Individual #84, Individual #179 <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 Unified records committee, 3/24/14
	Facility Self-Assessment The monitoring team reviewed the self-assessment, compared it to the previous self-assessment, and looked at comments made in the previous report. The self-assessment was almost identical to the previous self-assessment, except there was one additional item in V1 (#4). Further, all of the comments regarding problems with the previous self-assessment and suggestions made in the last report regarding the previous self-assessment applied to the new self-assessment. Therefore, the MRC and URC need to look at the last report's comments. Regarding V1, the MRC and URC did not use the full set of data available to them to conduct the self-assessment. They only used data from the old statewide self-monitoring tool and from their own

	assessment database. They did not use the very relevant information from the 22-page quality assurance audit (but they did use those data in the V3 self-assessment, where they did not belong). For V3, the same comment from the last report apply, that is, this should be a self-assessment of the quality assurance audits. The results/data from the quality assurance audits should be used as part of the self-assessment for V1 and V4, not as part of the self-assessment of V3. The facility self-rated itself as being in substantial compliance with V1, and in noncompliance with V2, V3, and V4. The monitoring team found all four provisions to be in noncompliance.
	Summary of Monitor's Assessment: EPSSLC again continued to make good progress on provisions V1 and V3, and limited progress on V2 and V4. Fifteen of 15 (100%) individuals' records reviewed included an active record, individual notebook, and master record. The status of the active records maintained since the last review. The monitoring team's onsite review of active records showed about a dozen errors/missing documents per active record (these called documented errors by EPSSLC), plus there were errors in legibility, signatures, etc. (these were called undocumented errors EPSSLC). This was similar to what was found by the URC in her own audits (see V3). Further, the number of documented errors was self-reported to be increasing in the facility's documented/undocumented graph line (i.e., from 12 documented errors per record to 16 per record, September 2013 to February 2014). It was very good to see EPSSLC tracking and trending their own data on this. The MRC and URC engaged in a number of activities to increase the likelihood of the unified record meeting substantial compliance (e.g., ISP assessment data, 100% audit, ISP packets). Many of these activities had been occurring for a number of years. Each should be evaluated for the purposes of continuous quality improvement. A daily 7-page observation note form was initiated since the last onsite review. Its use should be reviewed by the facility. Most SAPs did not have a data sheet in the individual notebook. If data were supposed to be recorded elsewhere, it should be indicated in the individual notebook. A master record existed for every individual at EPSSLC and all were in a format that was organized, manageable, and described in previous reports. All were converted to the most current format. Overall, the master records were in good shape. Provision V2 was managed by the MRC and QA director. Overall, other than updating some of the spreadsheets, no progress had occurred.

	Five quality assurance reviews (audits) were conducted in each of the previous six months. All of the reviews were done in a consistent manner, using their new 22-page tool (beginning with November 2013 audits), were reported to take about a half day to complete (compared to more than 8 hours per audit noted in the last report), and were neatly and clearly documented. The system of actions following the conduct of the audits remained the same. The overall data system, review of data, and analysis of results needs to be improved in order to meet substantial compliance with this provision. In other words, the facility was obtaining some good data regarding the status of the unified record, changes over time, and corrections of errors. However, the information was not being reviewed adequately by the recordkeeping staff, QA department, in the QA report, or in the presentations to QAQI Council. For provision V4, they did more work on this than at the time of the previous review, however, their proposed activities for each of these six aspects of V4, although a good start, were insufficient.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	EPSSLC again continued to make good progress on provisions V1 and V3, and limited progress on V2 and V4. There was stability in the recordkeeping department staff since the last review. The department consisted of Priscilla Guevara, the medical records coordinator (MRC), Melinda Hall (URC), one recordkeeping clerk (Pearl Crain), and an administrative assistant (Ruben Morales). At EPSSLC there were no home secretaries. Thus, the MRC, URC, and clerk were responsible for a great deal of filing and records management. To conduct this review, the monitoring team examined aspects of the unified record for more than a dozen individuals, reviewed documents and reports, talked with various staff at the homes and day programs, and observed records in use, in the program sites, and during various meetings. State policy remained the same as in previous review. The overall facility-specific recordkeeping policy also remained the same. Two new policies were implemented. One was regarding the new observation notes and the other regarding home shift logs. The table of contents and maintenance guidelines for all three components of the unified record were last updated in April 2013. EPSSLC had made no facility-specific modifications, however, the active record table of contents needed updating given the many changes in documents, sections, and recordkeeping requirements. The MRC should be sure to follow state procedure when doing so. Recordkeeping practices remained a part of new employee orientation and a part of annual refresher training (via the town hall format), taught by the MRC and/or URC.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There was no competency based component. Any additional trainings were now part the responsibility of each facility department. The MRC, however, did not track the occurrence of these trainings, however, she should. The MRC actively participated in the facility's QA program. This included completing a quarterly QA report. The MRC continued to hold a quarterly unified records committee meeting. Attendance was sparse and, therefore, little was accomplished . Fifteen of 15 (100%) individuals' records reviewed included an active record, individual notebook, and master record. <u>Active records</u> The status of the active records maintained since the last review. The monitoring team reviewed active records in four of the cottages and in the dorms record room. Staff observed or briefly questioned by the monitoring team reported that the active records worked fine for them, but that lots of time was spent handling the cumbersomeness of the binders, such as locating items (items were there, just took time to find them due to the size of bulkiness of the binders). Some looked forward to having an electronic record some day. The monitoring team's onsite review of active records showed about a dozen errors/missing documents per active record (these called documented errors by EPSSLC), plus there were errors in legibility, signatures, etc. (these were called undocumented errors EPSSLC). This was similar to what was found by the URC in her own audits (see V3). Further, the number of documented errors was self-reported to be increasing in the facility's documented/undocumented graph line (i.e., from 12 documented errors per record to 16 per record, September 2013 to February 2014). It was very good to see EPSSLC tracking and trending their own data on this. Undocumented errors, on the other hand, showed continuing improvement in this graph, averaging less than two per record (though the data from the old statewide tool, from September 2013 through February 2014 was reported to be about 60% correct; that tool looked at undocumented errors). For the documented/undocumented errors graph, the monitoring team pointed out that an adjustment must be made for any month in which there were not 5 audits done; otherwise, the comparison from month to month is not valid. The monitoring team found a number of missing or questionable documents during the onsite review of the unified record. These were reported to the MRC and URC. Below are some of these items. The MRC and URC immediately looked into these and gave more information to the monitoring team the following day. This information is also below.	

#	Provision	Assessment of Status	Compliance

		• In the table of contents, the "Code/advanced directive" item was not found in any record.
		  o The monitoring team pointed out that the item needed to be there, unless it should be an asterisked (as applicable) item. The MRC and URC were going to look into this.
		• The guardianship section required a copy of the order and most recent update. These were missing from all records for individuals with an appointed guardian.
		  o The URC said that she found the same to be true and that they were going to work on getting copies from the master record.
		• There was a consent for weekly allowance. This was being treated as the trust fund consent, but they are not equal.
		  o The URC and MRC said they were going to fix this.
		• The table of contents and the active records did not have the Psychiatric Support Plan tab.
		  o The URC and MRC said they were going to fix this.
		• There were no water safety assessments. Instead there were bathing assessments. This was a non-asterisked item.
		  o The MRC and URC said that there was guidance available to IDTs, but confusion remained. They were going to attend to this.
		• In the hospitalization tab, there were only IPNs,
		  o The URC and MRC said that they had seen this problem, too. They will work to fix it.
		  o The URC looked into one individual's (Individual #70) other hospital documentation and found that nursing was keeping it in their own file in a file cabinet. She then explored a second client's documentation and found the same thing (Individual #85). The URC and MRC said they were going to work on this with the nursing department.
		• There were no recent ISP reviews in some records (e.g., Individual #46).
		  o The URC said she found recent ISP reviews, but none since July 2013.
		• The active record of Individual #58 needed to be purged of documents that were to have been removed.
		  o The URC looked into this, agreed, and reported that she did do so.
		• The individual notebook for Individual #107 contained many months of clothing inventories, cluttering up an already full individual notebook.
		  o The URC reported that she purged these from his individual notebook and that she then did the same for all of the individual notebooks in that home.
		• The nursing sections of most of the active records needed attention. For example, items were not in the proper order, purging/thinning was needed, and a "care plan" sub-tab was in each record, but not in the table of contents.	

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		• In previous reports, the monitoring team suggested that body inspection forms not be in the IPN section. At this time, they continued to be present in the IPNs, however, they did not clutter the IPNs. Further, the MRC reported that this was discussed with the CNE who felt it important to keep them in there for the flow of the IPN information. This seemed reasonable to the monitoring team. The MRC and URC engaged in a number of activities to increase the likelihood of the unified record meeting substantial compliance. Many of these activities had been occurring for a number of years. Each should be evaluated for the purposes of continuous quality improvement. • There were new policies and procedures for observation notes and shift logs. • ISP-related documents ("ISP Packet") were a focus of activity by the recordkeeping department. • The 100% record audit continued every quarter. • The assessment database was maintained in order to track if ISP annual assessments were turned in, and if they were turned in on time. • An active record check out system was put into place and was working very well. • V3 audits continued (see V3 below). Given these activities, and given that the data from the ISP packet, 100% audit, and assessment database showed very good performance, the monitoring team wondered how that could be when the overall status of the contents of the active record still needed improvement (though the documented errors portion of the V3 audit supported the finding that improvement was still needed). It may be that ISP packet, 100% audit, and assessment database were only capturing part of the active record (albeit important parts). Thus, the MRC and URC should drill down in their V3 audit data to find those areas most in need of improvement and then focus on these, too. That being said, it was likely that if the ISP packet, 100% audit, and assessment database were not being done, even more errors would be occurring. Thus, these should not be abandoned. Similarly, the number of undocumented errors was reported to be less than two per record, yet the old statewide self-monitoring tool (which was still being used) was scored at about 60% correct for each unified record. This too needs to be reconciled. <u>Individual notebooks</u> 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. This was good to see. DSPs Yadia Hernandez and Marta Ortega were briefly interviewed by the monitoring team; they reported that they used the individual notebooks every day, read and wrote in the	

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		observation notes, and checked the PNMP everyday to see if there were any changes. A daily 7-page observation note form was initiated since the last onsite review. Its use should be reviewed by the facility. It seemed to the monitoring team that although it had good prompts so that DSPs would not forget to include relevant information, its size made the individual notebooks extremely cumbersome. Further, the monitoring team's review found that the pre-populated sections were completed, but that the open comments section was blank for almost every individual for everyday. This open comments was not required. In the old observation note, the DSP were required to write more of a brief narrative of the day. Perhaps there is some middle ground that the MRC, URC, and residential director can agree upon. Recent direction from state office was to return to the old way of doing narrative observation notes. The individual notebook table of contents needs to be updated, too. The monitoring team found items/tabs that were not in the table of contents as well as items in the table of contents that were not in the individual notebooks (e.g., components of the ISP, reference to a safety plan, Most SAPs did not have a data sheet in the individual notebook. If data were supposed to be recorded elsewhere, it should be indicated in the individual notebook. <u>Other binders/logs</u>: EPSSLC re-initiated the use of another binder for some data that would typically be in the individual notebook (i.e., the old pink/purple binders). This was now called the Health Data notebook. It included bowel movement, intake/output, and meal refusal data. It was much better organized than the previous pink/purple binders. Having a health data notebook is fine to do. Similarly, the workshop had day program SAP data sheets. The MRC reported that both of these binders/logs were included in the V3 audit. <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. All were converted to the most current format. Overall, the master records were in good shape. The MRC and URC had made further improvements to their system of making notes on the master record cover page to indicate what activities had been done to obtain any of the documents that were not present in the master record (e.g., birth certificate). They did not, however, continue documentation to closure. For example, some cover pages indicated that the LA was contacted. There was either no further information, or an "N/A." The reader could not determine if information was not available, if there was no response from the LA, or if it was still in process. An exception was for Individual #179	

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		who's cover sheet indicated that documents were received from the LA (though it would have been better to indicate which documents were received). <u>Shared drive</u> The shared drive was described to the monitoring team. The recordkeeping department reported that all information in the shared drive also appeared in hard copy in the active record and/or individual notebook. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	This provision was managed by the MRC and QA director. Overall, other than updating some of the spreadsheets, no progress had occurred. For instance, document XVIII.10d stated "A process has not been developed to determine the number of staff who are supposed to receive training on each policy and the number of staff who did receive training on each policy." Three spreadsheets were submitted. One listed each of the Settlement Agreement provisions and the corresponding state ad facility policies. It was 8 pages long. The second spreadsheet listed a variety of other state policies and corresponding facility policies. It seemed to the monitoring team that these two spreadsheets could be combined. A third spreadsheet was yet a third variation of a listing of state and facility policies. This spreadsheet also listed the person responsible for training, the staff required to receive training, and how often training should occur. 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. Somehow combine these three disparate spreadsheets. 2. Include a number of staff who are required to receive training and a number who were trained. In order to do this, include an "as of" date. The facility should establish a criterion, such as these dates being updated every quarter. 3. Include within the "Person responsible for training" column, in addition to the person: o what type/method of training is needed (e.g., classroom training, review of materials, competency demonstration), o type of documentation necessary to confirm that training occurred, and o where this documentation is stored and summarized.	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with	The facility made continued progress in this provision.	Noncompliance

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	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.	Five quality assurance reviews (audits) were conducted in each of the previous six months. Thirty audits were conducted in the previous six months. All of the reviews were done in a consistent manner, using their new 22-page tool (beginning with November 2013 audits), were reported to take about a half day to complete (compared to more than 8 hours per audit noted in the last report), and were neatly and clearly documented. Unified records chosen for audit ensured no repeats of the same individual within a 24-month period. The review consisted of these parts: • The unified record audit tool. It was 22 pages; it required the auditor to score every item on a variety of variables, all related to the table of contents, filing guidelines, and Appendix D of the Settlement Agreement. It also contained a page for summarizing the findings. o The multiple columns, however, were only being used for observation notes and IPNs. That was not the intent of the numerous columns. o Because some of the columns were not applicable to many of the documents, those rows should be pre-populated with n.a. In this way, all of the open boxes on the form would need to be completed. • Detail reading and review of three months of observation notes and IPNs to inform her review and scoring of many items in the statewide self-monitoring tool and in the 22-page tool. • Completion of V4 interviews (for a different set of individuals). • Checking for documentation of medical consultations for the past 12 months. • Checking the ISP to determine what SAPs should be in the active record and individual notebook. Missing SAP data were now being considered to be an error (as suggested in the previous report). The URC still needed to resolve problems when a SAP wasn't found because some were the responsibility of habilitation therapy or of the workshop. Interobserver agreement continued to be 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 <u>all five</u> unified records <u>every</u> month. To repeat from the last report, this was 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 and only do one per month. That being said, the IOA should be with the new 22-page tool, not only on the old statewide self-monitoring form.	

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		The system of actions following the conduct of the audits remained the same. It consisted of the following:
		• Results of the statewide self-monitoring tool were entered into a database.
		• Results of the 22-page documented/undocumented errors were entered into another database.
		• Emails were sent to notify the responsible person of any errors needing correction. A separate email was sent to each person each month with details of what needed to be corrected.
		• Emails of replies from responsible persons were stored. Sometimes no reply or response was received at all, sometimes a correction was done with no email. More importantly, the URC maintained a correction tracking document.
		• A document tracking correction was maintained.
		  o The URC did not go searching for corrections, instead the responsible person brought the document to her office and then she filed it in the unified record.
		• A Corrected Errors report was sent out every Friday to management.
		• Items continued to be tracked with no cut-off date.
		
		The URC summarized and tracked her data in these reports:
		• ISP packet data
		• Assessment data
		• 100% record audit data
		• Four pages for each audit, including table and a graphs
		• QA report, quarterly:
		  o Statewide self-monitoring tool only
		
		The overall data system, review of data, and analysis of results needs to be improved in order to meet substantial compliance with this provision. In other words, the facility was obtaining some good data regarding the status of the unified record, changes over time, and corrections of errors. However, the information was not being reviewed adequately by the recordkeeping staff, QA department, in the QA report, or in the presentations to QAQI Council. Consider that the only data presented in the QA report was the old statewide self-monitoring tool data. The department needs to summarize, present, and analyze data that are directly related to relevant recordkeeping activities and the Settlement Agreement. The monitoring team suggests the MRC and URC review the monitoring team's previous report for El Paso SSLC for V3 as well as the most recent monitoring tem reports for the San Angelo and Lufkin SSLCs.
		
		At a minimum, the MRC and URC should have and present data that include:	

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		• Statewide self-monitoring tool: month to month graphs showing long term performance scores. • 22-item tool: month to month graphs showing long term performance scores; perhaps also separate scores for the three components of the unified record. • Number of documented and undocumented errors: month to month. This graph existed (which was good to see), but was not part of the QA report or QAQI Council presentation. It showed that documented errors were increasing over the past six months. An adequate QA system would have noticed this and implemented corrective actions. o A CAP was developed for entries into the health data log. It was good to see that the recordkeeping staff were taking corrective actions. A more organized system of data review, however, continued to be needed. • Number/percentage of documented errors that were corrected. This also existed (which was good to see), but was not trended. It may be that data only existed for January 2014 and February 2014. • Master records: number of recommendations and the number of these that were for missing social security cards and birth certificates. • Various data related to V4 (once those activities are better defined). To somewhat summarize, the facility was doing a good job in conducting the five quality assurance audits and doing follow-up on needed corrections. The facility was not, however, adequately engaging in actions to address the re-occurrence of these errors.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	There are six types of activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The monitoring team reviewed all six with the MRC and URC. They did more work on this than at the time of the previous review, however, their proposed activities for each of these six aspects of V4, although a good start, were insufficient. Similarly, they wrote in one of their document submissions that: "This process is currently being developed by the Unified Records Coordinator and the Program Auditor as to identify the criteria for each component to ensure the six components are being met." The monitoring team recommends that the MRC and URC collaborate with other SSLCs and with state office. As they move forward, they should consider how to use data from V1 and V3 to assess aspects of V4, how to incorporate some of the data and information needed for V4 into their V3 audits, collecting and summarizing/graphing data for each of the V4 components, and including V4 data and information in their QA activities, QA report, and presentations to QAQI Council. Moreover, they should keep in mind that V4 requires	Noncompliance

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		more than self-assessing, that is, it also requires that facility "utilize such records in making care, medical treatment and training decisions." The facility was in substantial compliance with three of the six items (50%), item #1, item #5, and item #6. 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> An active record check out system was put into place and was working very well. This helped ensure that records were available and accessible to staff. The monitoring team looked at the check out binder and sign out sheets in each home. There were many entries each day. In home 509, the check out log was 100% correct. Seven volumes for two individuals were not on the shelves, but all were signed out. Similarly, in the dorms building record room, two volumes of Individual #16's active record were missing, but both were signed out. Data on the availability of the active records and the accuracy of the check out log is one type of information that could be collected by the facility to monitor this aspect of V4. Another could be the presence/availability of individual notebooks. Record accessibility during meetings is addressed in item #6 below. The monitoring team also observed that: • 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 all individual notebooks. Individual records were available and referenced at ISP Preparation meetings and annual ISP meetings. • Records were accessible to medical staff. • Records were consistently available and accessible to nursing staff. • The monitoring team reviewed Individual #21's record onsite, and located the necessary information in the medical and individual active records related to documentation of recent infections. • Individual notebooks were generally accessible to DSPs. When asked, DSPs reported that the individual notebooks were readily available to them. • Habilitation therapy staff documented profusely related to all supports, services, and interventions in the IPNs. The active records were available to them. The facility met the standard for this aspect of section V.	

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		2. Data are filed in the record timely and accurately 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 could be used to satisfy this aspect of V4, too. The MRC and URC proposed that their ISP assessment database be used for this aspect of V4. The monitoring team agrees with this, however, the ISP documents are but one set of data and documents that must be filed timely and accurately. In addition, they might consider doing an occasional comparison of what is in the electronic shared folder (which probably contains the most recent documents) to see if what is in the active record corresponds to what is in the shared folder. The monitoring team also observed that: • The facility had begun gathering data on the submission of ISPs for the individual records. A list provided by facility reported that only 51% of the ISPs developed between August 2013 and January 2014 were filed within 30 days after the annual ISP was held. • Individual #21's record did not include the current ISP, or IHCP. • Individual #179's record did not include the Admission Nursing Physical Assessment. • Individual #10's record did not include the Bristol Stool Chart for January 2014. • Individual #34's record had blanks (omissions) on the ADL flow sheet. The ADL flow sheet was not individualized. All of the ADL flow sheets included a select category to document a menses cycle whether male or female. o The ADL flow sheet is in much need of a revision. o DSPs should be included in the re-evaluation and use of the flow sheet. • Psychiatry-related data were readily located. • Medical documents were filed in a timely and accurate manner. • Habilitation therapy information was consistently recorded in the IPNs rather than a consult filed in another section of the record, this was good to see. 3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure) The MRC and URC reported that they were "reviewing data sheets for accuracy and timeliness." It was not clear, however, what they were looking at, what were the criteria,	

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		and how often it was assessed. The monitoring team also found that: • Target/replacement behavior were recorded on separate data cards. They were both timely and accurate. • 78% of data cards reviewed by the monitoring team were recorded in a timely manner. • SAP data were recorded in the individual records, but often were not accurate or timely. • Physicians documented in the IPN in SOAP format. The notes were usually signed and dated. • Trigger Sheets for documenting relevant information about the individual's signs and symptoms, related to his or her identified risk, had omissions (blanks) for documenting whether or not the triggers were present or not. For example, Individual #162's record had omissions by both the DSP and the Nurse. • There were improvements with regard to the accuracy of data collection per direct care staff and behavioral health staff. Behavioral health 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. • QIDP monthly reviews indicated that data on progress towards ISP outcomes was often unavailable at the time of review. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> The URC reported that she was reviewing IPNs. The URC looked at three months of IPNs for each of the five monthly quality assurance audits (see V3 above). It was not clear, however, what it was she was planning to include for this aspect of V4. She also noted that she was looking at medical consultations and whether they were being filed in the active record within five days. The MRC and URC were awaiting guidance from state office regarding criteria for IPNs. Once this is received, they should consider creating a process for training and monitoring IPN quality. In addition, the monitoring team observed that: • The Integrated Progress Notes (IPNs) were primarily used to document episodic events related to illness/injury or the use of restraints. The IPNs did not include information that nurses consistently incorporated a review of the individual's history and/or prior illnesses and /or injuries and prior assessments or medications pertinent to the acute illness or injury as part of their evaluation	

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		and/or when they made care, treatment, and training decisions. For example, Individual #32's record documented a fall, the entry had omission for a review of having any recent fall incidents or if it was the individual's first incident. • Habilitation therapy effectiveness monitoring was routinely documented in the IPNs to determine if the supports were addressing the identified need (PNMP). It could not be determined, however, if all aspects of the PNMP were reviewed at the same frequency as established in the assessment because these were not tracked, but rather included as individual progress notes only. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> The URC continued to implement the staff interview following one of the annual ISP meetings each month. Four or five staff were interviewed. She also did a half-page summary. These were very similar from month to month. In addition, the monitoring team observed that: • During a nursing staff meeting, the CNE, Nurse Managers, and Specialty Nurses who had conducted case study provided to the monitoring team on Individual #113. During the discussion, it was evident how this team had used the unified record to look back at historical information when determining how care, treatment, and training decisions should be made. Information from the case study was fed back to nurses through regular scheduled nursing meetings, and in the development of trainings. The facility met the standard for this aspect of section V4. <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 URC was attending the beginning part of ISP meetings to see if the active record was being used. The monitoring team has, in previous reports, suggested that this was not a good use of the URC's time. Instead, this information could easily be obtained from the QIDP or from another observer at the meeting. Of course, this is a decision for the facility to make, however, given the many tasks that the URC needed to complete, the monitoring team suggests that the MRC and URC again consider this.	

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		The monitoring team found the following: • The QIDP facilitator provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #88 and Individual #188. Data from assessments were entered into these two forms, so that team members could reference current assessments when developing necessary supports. The active record was available at the meeting and was used by the team when additional information was needed. • Pre ISP meetings were observed for Individual #67 and Individual #157. The QIDP used information in the active record to update IDT members to determine which assessments were needed prior to the annual meeting and to review progress towards outcomes. • At the CLDP meeting, the QA auditor referred the IDT to look at Volume 1 of the active record for information on SAPs that were being discussed. The group then did look at the record. • The unified record was present during an ISP held for Individual #157. The active record, when referenced by the RN Case Manager, was used in response to a question posed by the IDT team as to the status/findings of a report. • Psychiatry rounds included the use of the active record. • Active records were used before, during, and after the PNMT meetings for review of status and documentation of interventions, supports and recommendations • The monitoring team did not observe any instances during which inaccurate information was presented and not corrected. Further, the monitoring team observed that data and other information from the record was used in meetings rather than relying on impressions. The monitoring team suggests that the Nursing Department should ensure, when assessing individuals, important information is conveyed from the record, such as pertinent history, when presenting health information to other IDT members or allied health professionals in order to sufficiently address the individual's acute and chronic health conditions.	

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
ACB	Anti Cholinergic Burden
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ACS	Assessment of Current Status
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
ADS	Annual Dental Summary
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
CMD	Choking, Modified Barium Swallow Study, and Dysphagia Committee
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
COS	Change of Status
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
DDI	Drug Drug Interaction
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)
EBWR	Estimated Body Weight Range
EC	Enteric Coated
EC	Environmental Control
ECG	Electrocardiogram
ED	Emergency Department
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
H&P	History and Physical
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
JNC	Joint National Committee
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
MCC	Medical Compliance Coordinator
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 Instructions
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
PD	Program Developer

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
PMR	Protective Mechanical Restraint
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
RPN	Risk Priority Number
RPO	Review of Physician Orders
RPO	Rights Protection Officer
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
VP	Ventriculoperitoneal
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
VZV	Varicella Zoster Virus
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