United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of On-Site Review: January 11-15, 2010s

Date of Report: March 17, 2010

Submitted By:	Alan Harchik, Ph.D., BCBA-D Monitor
Monitoring Team:	Carly Crawford, M.S., OTR/L Karen Green McGowan, RN, CDDN Gary Pace, Ph.D., BCBA-D Teri Towe Pamela Wright-Etter, M.D.

Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the ICF/MR component of Rio Grande State Center. In adT1b (on to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three (3) Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him/her every six (6) months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of the El Paso State Supported Living Center.

In order to conduct reviews of each of the areas of the Settlement Agreement and Healthcare Guidelines, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary responsibility. For this baseline review of El Paso SSLC, the following Monitoring Team members had primary

responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, as well as quality assurance, and integrated protections, services, treatments and supports; Pamela Wright-Etter reviewed psychiatric care and services, and medical care; Karen Green McGowan reviewed nursing care, dental services, and pharmacy services and safe medication practices; Gary Pace reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, consent, and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 SA.

II. **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 January 11-15, 2010, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes,

community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

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

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

III. **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 and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility,

this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the facility has with regard to compliance with the particular section;

(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;

(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the facility undertook to assess compliance and the results thereof. The facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the facility self-assessments for reviews beginning in July 2010;

(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. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. It is in the State's discretion, however, to adopt a recommendation or use other mechanisms to implement and achieve compliance with the terms of the SA.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual as Individual #1, Individual #2, and so on. The Monitors are using this

methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

First, the monitoring team wishes to acknowledge the outstanding cooperation, communication, and responsiveness of staff at all levels at EPSSLC during the full week of the on-site tour. Team members were welcomed by the facility director, Tony Ochoa. Tony set an expectation for his staff to be open, forthcoming, and non-defensive. He told them to answer our questions and to not hesitate to share information with us about their work, the facility, and the individuals. Staff responded in just that manner. This was also right in line with the tone set early on by DADS and DOJ, that is, for the monitoring process to be one of information gathering and collaboration.

As a result, a great deal of information was obtained during this tour. Team members visited and observed in every home and on-campus site that provided day programming and activities multiple times and across all three staffing shifts, and records of almost every individual were reviewed to some degree. In fact, in this report, 125 different individuals are named (almost 90% of the total population of the facility). This shows the breadth of information from which the conclusions and recommendations were drawn. The reader is directed to all of the sections of this report and to each of the section's details. Solely relying upon the information presented in this executive summary will leave the reader with only a superficial understanding of the many accomplishments and challenges at EPSSLC. (Please note that pseudonyms are used when referring to specific individuals throughout this report.)

Second, the monitoring team found staff at all levels to be eager to learn from the team members. Although it is difficult to provide much technical assistance during a baseline tour, team members found opportunities to share ideas and make suggestions. Their comments were well received. The team hopes to continue to provide suggestions and recommendations and has done so throughout this report.

Third, although team members found numerous problems in the systems of care and service delivery across the facility (as detailed in this report), they also found that staff members really cared about the individuals who lived at EPSSLC. Many examples of pleasant and positive interactions were observed. One example was particularly noteworthy. Two direct care staff members, Joanne and Veronica, were observed helping Individual #107 with his wake-up and showering routine one morning. He lived in one of the dorms and needed full assistance, including the use of a wheelchair and mechanical lift. These two staff members assisted him in the type of respectful, caring manner that anyone would want for himself, herself, or a loved one.

Fourth, two important members of the senior management team at EPSSLC will be retiring in the next year or so (the medical director and the director of admissions, placement, and family relations). EPSSLC management should be doing everything possible to find other talented professionals to step into these important roles.

Finally, below are some general comments about many of the provisions of the Settlement Agreement monitored during this on-site tour.

Policies

- New policies had been developed at the state level. Some had been distributed to EPSSLC; others were in development and will be distributed over the next few months. EPSSLC was working hard to implement these new policies and had made some good first steps, especially in regards to restraint usage and investigation management. More work will be needed as the facility continues to adapt to these new policies.

Restraints

- A lot of attention had been paid to restraint usage and restraint reduction at EPSSLC. Over the past few months, the use of mechanical restraint had been eliminated. Further, staff were aware of the issues and requirements surrounding restraint usage, especially regarding the importance of using restraint as a last resort in emergency situations. Four individuals had restraint as part of their program (in a document called a safety plan). Restraint was implemented for other individuals from time to time, too. The facility needs to ensure that safety plans are in place wherever needed. Presence of a safety plan helps ensure that staff are fully trained and prepared for emergency situations that may require restraint. The determination of whether to develop a safety plan that includes restraint is a team decision that is informed by the psychologist and possibly the psychiatrist. At a minimum, consideration of a safety plan should occur during the review required by the Settlement Agreement in the section on restraints, that is, whenever there has been three or more uses of restraint (not including medical restraint) within any rolling 30 day period.

Incident Management

- Incidents were investigated, for the most part, according to policy. The facility's investigator was knowledgeable and organized in the completion of his responsibilities. Staff were very aware of their duty to report and seemed to know what, when, and how to report, if necessary. Management's daily incident management meeting was a good way for there to be daily discussion about incidents. There were, however, numerous unexplained injuries at the facility, and a number of examples of delays in reporting and in follow-up.

Quality Assurance

- EPSSLC was at the initial stages of developing a quality assurance program. Management should ensure that important outcomes are measured and followed by the QA program. The facility's plan of improvement should not be considered its QA program.

Integrated Personal Support Plans, and Habilitation, Training, Education, and Skill Acquisition

- Personal Support Plans were in place, but they were not nearly as individualized, functional, and useful as they could be. They contained goals, objectives, and instructional plans, but almost all of them were not written or implemented in a way that would allow for progress to occur or to be assessed. A lot of work went into these PSPs and teaching plans. EPSSLC, however, was not implementing teaching plans that met a generally accepted standard.

Integrated Services

- Many of the discipline and department heads talked about their desire to see programming and services become more integrated across their disciplines. They wanted more involvement and communication. This was one of the largest challenges facing EPSSLC. The absence of an integrated service delivery system set the occasion for numerous errors, poor programming, and a lack of generalization and maintenance of positive effects. This is discussed throughout the report.

At-Risk Individuals

- A standardized system of assessing and managing risk was in operation at EPSSLC. The facility had begun to implement the new state policy. One problem found during the tour was that risk was not being assigned to individuals across the different risk categories as specified in the new policy. At EPSSLC, individuals were assigned a risk level based upon the amount of treatment provided, rather than upon the risk presented by the individual. This needs to be looked at and corrected.

Psychiatric Care and Services

- Psychiatry services were provided regularly each week by two consulting psychiatrists. Both had been doing so at EPSSLC for more than two years. Their limited availability kept them busy with regular psychiatric clinic hours. As a consequence, psychiatry was very poorly integrated into the service delivery system at the facility, resulting in problems in service, assessment, diagnoses, medication management, and the monitoring of side effects.

Psychological Care and Service

- Psychology services were more integrated than psychiatry. The psychology staff were very motivated to learn more about applied behavior analysis, developing quality positive behavior support plans, conducting functional assessments, and participating in developing instructional teaching plans. Until they can get more training and supervision, however, it will be a challenge for them to do so.

Medical Care

- Medical care services were overly dependent upon the facility's sole physician. He had implemented some good data tracking, but overall, medical services were also not integrated. Further, more review and oversight of preventative care routines for individuals should occur.

Nursing Care

- For nursing services, a similar situation existed. There were many dedicated nursing staff at EPSSLC. Nevertheless, their understaffed department often failed to follow problems to their resolution and failed to pick up on a number of individual medical conditions. In addition, nursing documentation systems were poor, as indicated in this report.

Pharmacy Care and Safe Medication Practices

- The pharmacy dealt with thousands and thousands of medication dosages every month. They did so with an antiquated pharmacy pill counting method that contributed to there being a very high number of medication omission errors. A newer system is needed. Further, the pharmacist was also not an integral part of the service delivery system. Pharmacist input could be very helpful to other members of the interdisciplinary team.

Physical and Nutritional Management, and Physical and Occupational Therapy

- Rehabilitation specialists in occupational, physical, and speech therapy were attending meetings, creating documents, and developing PNMPs and dining plans, and yet there were numerous positioning errors and frequent failures in follow up in speech and communication.

Dental Services

- Dental care needed immediate attention. There were plans for creating a clinic on-site, but the project was not moving along and, as a result, individuals were not getting proper dental care beyond cleanings from the two dental hygienists on staff.

Most Integrated Setting Practices

- Few individuals and their guardians were considering options for community placement. EPSSLC was beginning to implement the new state policy #018, Most Integrated Setting Practices. The new policy, however, contained many of the same procedures that had been in place for a number of years. It will take creativity and cooperative work with the local MRA and the central DADS office in order for there to be progress in this area.

Other Areas

- As indicated below in this report, services and programming for the individuals at EPSSLC would more approach the generally accepted standard if other actions were also taken, including (a) improving the community employment options available for individuals, (b) specializing services for individuals with autism, and (c) obtaining some measures of satisfaction from individuals, their LARS, facility staff, and affiliated providers in the community.

Immediate Attention

- Throughout the report to follow, many details and examples are provided that identify positive practices that were occurring at the facility as well as a variety of areas that were in need of attention and improvement. Some of these areas required more immediate attention to ensure that individuals were not at any risk of harm. Some of these areas of service were as follows: ensuring immediate reporting of all incidents, the assignment of risk levels to individuals, medication management and errors of omission, typical medical screenings that are

part of preventive medical care, treatment of bowel disorders, seizure management, provision of dental services, proper positioning during meal times, and presentation of proper food textures, size, and pacing.

The above summary touches upon the details presented in the full report below. Although the challenges presented to EPSSLC to address the provisions in the Settlement Agreement may appear to be overwhelming, the monitoring team was quite encouraged and is quite optimistic about the ability of EPSSLC management and staff to rise to these challenges.

The monitoring team looks forward to continuing to work with DADS, DOJ, and EPSSLC.

Thank you for the opportunity to present this report.

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>:

DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management
DADS Policy #001: Use of Restraint
Health Care Guidelines, dated May 2009
Texas Administrative Code Title 40, Part 1, Subchapter H, Rule Section 5.354 General Provisions, Use of Restraint in Mental Retardation Facilities
EPSSLC Plan of Improvement
Restraint Checklist Form 4012008R
Administration of Chemical Restraint Form
Restraint Documentation Guidelines for State Supported Living Centers – November 2008
Face to Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint Form
List of individual restraints provided to the reviewers (TX.EP-1001-2.7) for the past 6 months
Restraint trend analysis report for FY10/1st Quarter
Restraint Checklist and Face to Face Assessments for the following restraint incidents occurring 8/09-10/09

Individual #117 8/5/09 Chemical
Individual #81 8/20/09 Mechanical
Individual #104 8/25/09 Physical
Individual #7 8/26/09 Physical
Individual #7 8/26/09 Physical
Individual #109 9/2/09 Physical
Individual #13 9/8/09 Physical
Individual #109 9/8/09 Chemical
Individual #13 9/23/09 Physical
Individual #14 9/25/09 Physical
Individual #102 9/28/09 Physical
Individual #13 10/3/09 Physical
Individual #66 10/24/09 Physical
Individual #66 10/25/09 Physical

Safety Plans for:

Individual #78
Individual #14
Individual #18
Individual #13

HRC committee meeting minutes from 10/09-12/09
Morning incident meeting minutes for the following time periods
</td></tr>
</table>

	▪ 8/10/09-8/14/09 ▪ 9/8/09-9/10/09 ▪ 11/2/09-11/6/09 ▪ 12/7/09-12/11/09 o Staff training curriculum: RES0300; RES0200, RES0105; RES0105 o Review of staff training transcripts four residential direct care staff o Sample of PSPs for individuals for whom restraint was in use: ▪ Individual #78 ▪ Individual #104 ▪ Individual #109 ▪ Individual #14 Interviews and Meetings Held: o Staff interviews with four residential direct care staff o Various staff in homes and day programs throughout campus Observations Conducted: o All on-campus sites that provided day programming and activities o All 3 residential dorms o 6 of the 8 cottages (506, 507, 508, 510, 512, 513) o Staff interactions with these individuals ▪ Individual #78, Individual #104, Individual #109, and Individual #14 o 2 Code Yellow and 1 Code Green incidents o One Incident Management meeting held the week of the review
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility eliminated the use of mechanical restraint in September 2009. The facility continued to utilize physical, chemical, and medical restraints. A list of restraints from the past six months indicated that 8, 13, 8, 12, 7 and 6 individuals were restrained each month, respectively. Restraint Checklist and Face-to-Face Assessments were completed for each incident of restraint reviewed, but forms were often completed incorrectly. The initial in-service training that all staff received prior to beginning work with the individuals who lived at EPSSLC included modules on Restraint: Prevention and Rules, Positive Behavior Supports and Prevention and Management of Aggressive Behaviors. Staff interviewed during the review were aware of prohibited restraints and the requirement to use restraint as a last resort intervention.

	Restraint incidents were discussed during the next morning incident management meeting following restraint use. Issues from these meetings were referred for follow-up and reviewed during subsequent incident management meetings until the issue was resolved. There was a section in the incident management meeting minutes for the discussion and review of restraint information, but this section was blank in the majority of the minutes for the past three months. There was, however, discussion of restraints in the campus coordinator reports. In addition, Human Rights Committee (HRC) minutes indicated a review of individual restraints. The HRC minutes, however, did not indicate whether or not the restraint procedure was one that had been approved by the committee as a planned procedure as part of treatment plan or safety plan. During the on-site tour, one physical restraint occurred. The monitoring team was not in the building where it occurred at the time, but was able to get there within a few minutes of the initiation of the physical restraint. By that time, the individual was independently walking to the nurse's office to be examined. The psychology staff was already on the scene, and they were actively interviewing the staff that had placed the individual in restraint. By the next morning the psychology staff had determined that there was a better way for the staff to have responded to the individual's aggression, and had trained the staff, and other staff in the area, on an alternative way to manage this individual's aggression in the future. The incident was followed up on at the incident management meeting the next day. It was clear that the staff were well on their way to reducing the use of restraints and other physical restrictions at the facility.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in	Assessment of this item required review of policies and an examination of implementation of those policies. Policies existed to address this provisions of the Settlement Agreement.. The policy was labeled Use of Restraints #001, and dated 8/31/09. It included five addenda guidelines and forms. This was the state policy and was adopted, in whole, by the facility. For the remainder of Section C of this report, any reference to policy, unless otherwise stated, will refer to Policy #001: Use of Restraint The use of prone restraint was prohibited by the policy. In addition, the use of mechanical restraints was discontinued by the facility as of September 2009. There was no evidence that prone or mechanical restraints were in use. Staff who were interviewed were aware of the mandates prohibiting the use of prone and mechanical restraints. Additionally, Interviews with psychology staff and direct care staff revealed that all staff recognized that physical restraints were to be used as a last resort intervention. Policies specific to the use of restraints addressed when restraints may be applied and procedures that must be followed when a restraint is applied. These policies were in line with the contents of this settlement agreement item. The policy disallowed restraint use for punishment or staff convenience. There was no evidence of restraint being used for staff convenience or as punishment in the sample of	

#	Provision	Assessment of Status	Compliance
	the Facilities' policies shall be used.	restraint documentation reviewed. Staff were mandated by policy to complete initial training and were retrained annually on restraints. This was supported by documentation in the staff training transcripts reviewed and by discussions with staff interviewed during the review.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Policy required that restraints be terminated as soon as the individual was no longer a danger to himself, herself, or others. Restraint checklists reviewed indicated that restraints were terminated when the individual was no longer a danger to himself or others.	
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 policy described the types of restraints that were prohibited by the facility (Section C) and it mandated staff training regarding the use of restraints, including intervention and redirection techniques, approved restraint techniques, and supervision of restraints (Section I.B.3). Prevention and Management of Aggressive Behavior (PMAB) was used at all facilities across the state and was the specific training program identified in the state and facility policy. Training transcripts showed that staff had received training on restraint use and competency-based PMAB training upon initial hiring and were retrained at least annually. Informal interviews with staff confirmed a basic knowledge of policies regarding restraint including prohibited restraints and required documentation and follow up. When staff were questioned about what they would do if an individual began engaging in dangerous behavior, direct care staff consistently talked about antecedent approaches or redirection approaches to managing the behavior. Current forms used to document behavioral restraint incidents list mechanical restraints as an option. To avoid confusion on types of restraints that may be used, forms should be updated to remove references to mechanical restraints.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions.	The policy stated that restraints may only be used for crisis intervention or medical reasons. The policy, however, was vague in terms of when Personal Support Teams (PSTs) need to develop plans to reduce or eliminate the use of restraint for an individual. The policy referred to "individuals with high numbers of incidents" but did not define what constituted a high number.	

#	Provision	Assessment of Status	Compliance
	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.	Further, the policy was not specific as to when a Safety Plan addressing restraints should be developed for an individual. At EPSSLC, four individuals had safety plans in place. Restraint trend analysis data indicated that other individuals were at risk for the use of restraints, but they did not have a safety plan in place. It was not evident that the safety plans were reviewed to evaluate the effectiveness of the plan. Plans did not include strategies for phasing out restraint use and did not specify the restraint monitor. The use of medical restraints was addressed in Policy 001, Section M. A specific review of medical restraints was not conducted during this baseline review though it was noted that medical restraints, particularly during dental procedures were approved for a large number of individuals reviewed. The use of medical restraints for individuals was reviewed in the Personal Support Plan under the Rights Assessment section and Human Rights Committee minutes showed a review of the use of medical restraints for individuals. It was also noted that individual Personal Support Plans indicated that individuals requiring restraints for dental procedures were participating in a dental desensitization program. Instructional plans to address individuals' fears and discomfort with medical and dental procedures were in place for all individuals who were receiving pre-treatment sedation. The quality and management of those plans, however, needed more attention to instructional methodology, outcomes, review, and modification. This is discussed further in section Q.2. of this report regarding dental procedures. In the nursing sample reviewed (listed in Section M below), only one of 25 individuals was restrained during medical procedures and nursing documentation for that single episode was inadequate and did not meet the requirements of the Settlement Agreement or Health Care Guidelines. During upcoming monitoring visits, the used of medical restraints and procedures to decrease their use will be reviewed. Policy 001 addressed the use and monitoring of chemical restraints. There were 12 instances of chemical restraints used during the six-month period prior to the review. Chemical restraints will be reviewed further during upcoming reviews.	
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	Policy 001, section F required a face-to-face assessment of individuals within 15 minutes of the application of any restraint. Staff were required to complete a Face-to-Face Assessment, Debriefing, and Review checklist for each incident of restraint applied for crisis intervention. This form was in place for all incidents of restraint reviewed. The form, however, was not	

#	Provision	Assessment of Status	Compliance
	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.	always completed as required. For Individual #66 on 10/24/09 and 10/25/09, an older version of the form was used rather than the recently revised form. See individual comments at section C6 of this report. Documentation indicated that an assessment was conducted of each individual within fifteen minutes from the start of the restraint this included at least an attempt to monitor vital signs and a brief comment on mental status by a nurse with the following exceptions: • The restraint checklists for Individual #13 on 9/8/09 and Individual #14 on 9/25/09 indicated that the individuals refused assessment by the nurse. There was no indication what time the assessment was attempted or if a follow up attempt was made. • The restraint checklist for Individual #109 on 9/2/09 indicated that restraint began at 12:45. Assessment by the nurse did not occur until 2:20. • The checklist for Individual #66 on 10/24/09 and 10/25/09 indicated assessment by a nurse within the time frame, but did not give a summary of the assessment. Policy 001, Section I stated the maximum time in restraint for crisis intervention may not exceed 30 minutes before attempting release. Mandates met this provision of the Settlement Agreement. There were no restraints lasting over 30 minutes in the sample of restraints documented. Policy 001, Section H.2 addressed monitoring of individuals following restraints applied away from the facility with provisions of this agreement. Mandates met this provision of the Settlement Agreement. There were no documented instances of restraints used away from the facility in the review sample.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of	The facility used a Restraint Checklist and Face-to-Face Assessment, Debriefing, and Review checklist for each incident of restraint applied for crisis intervention. This form included a check for restraint related injuries. Samples reviewed were often incomplete or completed incorrectly. Details are provided below: • Individual #117 8/20/09- Description was confusing as to what type of restraint was being used; chemical restraint was noted. • Individual #7 8/26/09 – Type of restraint/Notification/Safety Plan sections were incomplete. • Individual #7 9/8/09 – Type of restraint/Safety Plan/Notification sections were incomplete. Checklist review section was not signed and dated. • Individual #109 9/8/09 – Form indicated range of less restrictive measures were not exhausted prior to restraint. No action recommended. Notification section	

#	Provision	Assessment of Status	Compliance
	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.	was incomplete. • Individual #13 9/8/09 – Type of restraint/Notifications/Physical/Mental Evaluation was incomplete (marked refused). Review not signed and dated. • Individual #13 9/23/09 – Description of interventions incomplete. Notification section incomplete. • Individual #13 9/25/09 – Type of Restraint/Notification section incomplete. Checklist review section not signed and dated. • Individual #66 10/25/09- No description of interventions attempted. Notification section incomplete. Restraint Review not signed and dated. Face-to-Face Assessment not signed and dated. State and facility policy required one-to-one supervision and monitoring of restraint application. During the on-site tour, direct observation of "code green" and "code yellow" incidents revealed immediate response (within one minute) by medical and psychology staff to offer support during behavioral incidents. Residential direct care staff said that, even on the night and early morning shifts, they had immediate support during behavioral crises either by other direct care staff, supervisors or nursing staff.	
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:	Individuals with three or more restraints in any rolling 30-day period had a safety plan written that outlined the use of restraints or protective equipment with that individual. At the time of the on-site review, only four individuals in the facility had a safety plan in place (Individual #78, Individual #14, Individual #13, and Individual #18). The facility compiled restraint data and trended the data in regards to individual, location, staff involved, time of day and day of week. Narrative summaries analyzing trends were uniform from quarter to quarter without any substantial recommendations for reduction in restraint use from the facility's management team. Therefore, it was not clear how, or if, these data was used within the facility. For example, a trend identified by the monitoring team indicated a slight increase in crisis intervention restraint at evening mealtime. Observation of mealtimes in cottages, where some individuals were receiving 1:1 or 2:1 staffing, revealed a tense, crowded, watchful atmosphere at mealtime rather than a time to relax and enjoy dinner. This factor may have contributed to an increase in behavioral incidents. For instance, in cottage 512, there were 7 staff with 9 individuals during mealtime, and in Cottage 506, 7 staff were on duty with 14 individuals, all present in the dining area during mealtime.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For the four individuals identified at risk for restraint usage, the team had met and discussed possible contributing factors and developed a written safety plan for those individuals.	

#	Provision	Assessment of Status	Compliance
		The adequacy of the assessment process for individuals who have been placed in restraint more than three times in any rolling 30-day period will need to be reviewed during upcoming monitoring visits.	
	(b) review possibly contributing environmental conditions;	The adequacy of the assessment process for individuals who have been placed in restraint more than three times in any rolling 30-day period will be reviewed during upcoming monitoring visits.	
	(c) review or perform structural assessments of the behavior provoking restraints;	The adequacy of the assessment process for individuals who have been placed in restraint more than three times in any rolling 30-day period will be reviewed during upcoming monitoring visits.	
	(d) review or perform functional assessments of the behavior provoking restraints;	The adequacy of the assessment process for individuals who have been placed in restraint more than three times in any rolling 30-day period will be reviewed during upcoming monitoring visits.	
	(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;	The four individuals identified as high risk for the use of restraints had a PBSP in place. The adequacy of the PBSP for reducing the use of restraints was not reviewed during this visit. The PBSP for individuals who have been placed in restraint more than three times in any rolling 30-day period will be reviewed during upcoming monitoring visits.	
	(f) ensure that the individual's treatment plan is implemented	The adequacy of assessments and supports for individuals who have been placed in restraint more than three times in any rolling 30-day period will be reviewed during	

#	Provision	Assessment of Status	Compliance
	with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	upcoming monitoring visits.	
	(g) as necessary, assess and revise the PBSP.	The adequacy of the assessment process for individuals who have been placed in restraint more than three times in any rolling 30-day period will be reviewed during upcoming monitoring visits.	
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.	There was evidence that teams met within three business days following each use of restraint to discuss the circumstances. Information was included in PSP updates. It was not clear when PBSPs were updated or modified in efforts to reduce the need for restraint use.	

Recommendations:

1. Policies should state criteria for requiring that an individual has a safety plan in place. Safety plans should include recommendations for decreasing restraint use and be reviewed for effectiveness.

2. In cottages with higher than typical staffing ratios, psychology/behavior intervention staff should provide consultation with direct care staff and residential managers regarding providing instructional and supervisory interactions with individuals in a less intrusive manner. The goal would be to reduce the likelihood of the occurrence of behavior problems during mealtimes when the environment is more crowded.

3. HRC meeting minutes should indicate whether or not any restraint used had been approved or denied by the committee.

4. Retrain staff on completing both the Restraint checklist form and the Face-to-Face Assessment form. Forms should be reviewed for completion and accuracy and returned to the person completing the form to fill in information when it is not complete.

5. Trend analysis should include recommendations for reducing the number of restraints and compared quarter to quarter to monitor the effectiveness of recommendations.

6. References to the use of mechanical restraints should be removed from facility forms being used to document restraint incidents.

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: ○ Policy #002.1: Protection from Harm – Abuse, Neglect and Incident Management ○ EPSSLC Incident Trend Analysis Report for FY09 and 1st Quarter of FY10 ○ Review of staff training transcripts for four residential direct care staff ○ Morning incident meeting minutes for the following time periods • 8/10/09-8/14/09 • 9/8/09-9/10/09 • 11/2/09-11/6/09 • 12/7/09-12/11/09 ○ Unusual Incident Internal Investigation Reports • #09-160 7/21/09 Serious Injury Unknown Cause laceration • #09-164 7/23/09 Serious Injury Unknown Cause fracture • #09-171 8/6/09 Serious Injury Unknown Cause fracture • #09-174 8/21/09 Abuse/Neglect fracture • #09-178 9/30/09 Serious Injury Known Cause laceration • #10-005 9/17/09 Serious Injury Unknown Cause fracture • #10-014 10/05/09 Abuse ○ Closed DFPS Investigative Reports from 10/09-12/09 (16 total) ○ Employee background checks for four residential direct care staff Interviews and Meetings Held: ○ Staff interviews with four residential direct care staff ○ Interview with Mike Reed, Facility Investigator ○ Interviews with these individuals: • Individual #88 • Individual #42 • Individual #14 • Individual #62 ○ Discussions during campus tour with two campus administrators (new positions at EPSSLC): • Roseann Klimasara • Mario Gutierrez ○ Informal interviews with direct care staff at on-campus sites that provided day programming and activities ○ and cottages 506, 507, 508, 512 and 513

	<u>Observations Conducted</u>: ○ All on-campus sites that provided day programming and activities ○ All 3 residential dorms ○ 6 of the 8 cottages (506, 507, 508, 510, 512, 513)
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: EPSSLC had policies in place to address identifying, reporting and investigating incidents of abuse, neglect and exploitation. All staff interviewed were familiar with the policies and had received training consistent with agency policies. Information regarding identifying and reporting abuse and neglect is posted in each building in the facility and shared with individuals and their LAR annually at PSP meetings. A review of Department of Family and Protective Services (DFPS) investigations revealed a delay of more than one hour in reporting allegations to DFPS from the time the injuries were discovered in almost every case. The facility typically began an internal investigation immediately, but in some cases it was not referred to DFPS until days later when medical reports were reviewed by the facility. The facility needs to ensure incidents involving possible abuse and neglect are referred to DFPS for investigation immediately following injuries. Policies did not address the reporting of non-serious injuries of unknown cause for investigation. It is not clear as to how it was determined when or how non-serious injuries were to be investigated at the facility. There were many unexplained injuries at this facility. Almost every individual in the sample reviewed had unexplained bruises or lacerations. Many individuals were receiving antianxiety agents, such lorazepam for anxiety or pre-treatment sedation, diastat for prolonged seizures, and/or clonazepam for seizures. Unfortunately, these drugs are associated with drowsiness, blurred vision, and orthostatic hypotension. Many of the individuals with unexplained falls and injuries were receiving one of more of these drugs. It seemed clear that inadequate attention had been given to the role of these drugs in the high incidence of falls and injuries at the facility. Many of these same individuals were on a combination of other psychoactive drugs that can potentiate the effects of the benzodiazepines or vice versa. It was not evident that substantial efforts were being made towards medication reduction or enough consideration was being given to safeguarding individuals taking multiple medications. There was a system in place for completing internal investigations and referring investigations to DFPS and DADS regulatory for review. The internal investigation process was found on occasion to delay investigation by outside investigators. In two cases, investigation was delayed until the facility physician had a chance to review hospital x -ray reports of injuries. In other cases, investigation was delayed while the facility investigator tried to determine the cause and extent of injury.

	The facility tracked data collected on unusual incidents, and summarizes recommendations that came from individual incidents. Data were not used to make recommendations to address systematic issues that may have an impact on the number of incidents occurring.

#	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.	Assessment of this item required review of policies and an examination of implementation of those policies. The policy was labeled "Protection from Harm-Abuse, Neglect, and Incident Management." It was numbered 002.1, and was dated 11/6/09. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and staff reporting. This was the state policy and was adopted, in whole, by the facility. The policy clearly indicated that abuse and neglect of individuals would not be tolerated and required staff to report any abuse or neglect of individuals.	

D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	Policy 002.1 specified reporting requirements for all serious incidents and was in line with the provisions in the Settlement Agreement. The facility utilized a standardized reporting form for all serious incidents. A matrix was developed to give staff a quick reference for which incidents need to be reported, whom to report that incident to, and the timeline for reporting (Unusual Incident Report Coding and Reporting Matrix). The matrix did not include information on reporting non-serious injuries of unknown cause, for example, bruises and lacerations not requiring medical attention. It should state within 1 hour if abuse or neglect is suspected under Report to DFPS. Staff need to have clear guidance on when non-serious injuries should be reported to DFPS and other regulatory authorities. Late reporting of possible abuse or neglect, however, was found during the review of unusual incidents (09-174, 10-005, 10-014). Further, serious injuries (fractures) of unknown causes were not always reported to DFPS at all (for example, cases # 09-160 and 09-171). Internal investigations were completed and probable cause was documented as self-injury in both cases. There was not enough evidence, however, to support that the injuries were self-injury (i.e., that there was a known cause). The facility conducted its own preliminary investigation prior to reporting injuries of unknown cause to DFPS resulting in a delay in DFPS being able to conduct a prompt investigation. For example, even after a hospital report identified a fracture for an individual (10-005) on 9/17/09, it was not reported to DFPS until the medical director had a chance to review the x rays and made his own determination four days later on 9/21/09.	

	(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.	Policy 002.1 mandated immediate action and reporting of all allegations of abuse, neglect, and exploitation, and any serious injuries. Initial staff training included training on recognizing and reporting incidents of abuse and neglect (Course ABU0100). A sample of staff training transcripts showed initial training and annual retraining. The policy addressed the reassigning of alleged perpetrators, however, it was not always evident from facility unusual incident reports whether or not alleged perpetrators had been reassigned during the investigation. Staff interviews confirmed that staff were aware of the mandate to immediately protect the victim from further harm.	
	(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 facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation (ABU0100 and UNO0100). Documentation of training was kept by the facility and a sample of employee training transcripts was reviewed. Training transcripts for the employees interviewed showed both initial and annual retraining on abuse and neglect. During interviews, all employees were able to give accurate examples of abuse and neglect and verbalized their responsibility for reporting such incidents.	
	(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	The Policy 002.1 addressed mandatory reporters. All staff who were interviewed were aware of their obligation to report. Facility policy required employees to sign form 1020 (implemented July 2009) acknowledging their responsibility to report abuse, neglect and exploitation. A sample of staff personnel records was not reviewed during this initial review to verify the existence of the signed statement, however, this will be verified during future reviews. In all facilities toured during the review, posters stating the obligations of mandatory reporters were posted in common areas.	

(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to

The Policy 002.1 addressed mandatory reporters. All staff who were interviewed were aware of their obligation to report. Facility policy required employees to sign form 1020 (implemented July 2009) acknowledging their responsibility to report abuse, neglect and exploitation. A sample of staff personnel records was not reviewed during this initial review to verify the existence of the signed statement, however, this will be verified

	(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 policy stated that a training and resource guide on recognizing and reporting abuse and neglect will be provided by the facility to all individuals and their LAR at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect, and information for reporting suspected abuse and neglect. PSPs included documentation that this brochure was shared with the individual and his or her LAR (if applicable) at the annual PST meeting. Clear reporting information was also posted in each building in the facility. The monitoring team had the opportunity to interview four individuals: Individual #88, Individual #42, Individual #14, and Individual #62. All four had many positive things to say about living at EPSSLC. They described what they liked to do, what they were learning, and what might make them happier at EPSSLC. They were also asked what they would do if someone hurt them or treated them badly. Each of the individuals responded that she would tell a staff person. Two of the individuals named a specific staff member, and one of the individuals also said she would call the police.	
	(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.	All facility buildings toured had posters with a statement of individuals' rights called "You Have the Right" posted in common areas. These posters included information on reporting violation of rights. Information on the poster was clear and easy to understand, including pictures for individual's who could not read.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Policies addressed referring investigations to local law enforcement officials when a criminal act has occurred. Policies did not define criminal acts and it was not always evident whether or not law enforcement has been notified during investigations. Of the investigations reviewed, only one was referred to law enforcement officials by DFPS. This item will be further reviewed during upcoming monitoring visits.	
	(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	Policies prohibited retaliatory action for reports of an allegation of abuse or neglect. The policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment, and were able to state to whom incidents of abuse, neglect and mistreatment should be reported.	

	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of	Policies prohibited retaliatory action for reports of an allegation of abuse or neglect. The policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or	

	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility trended unusual incident data quarterly. Quarterly trending of unusual incidents for the 1st quarter of FY10 showed that 15 of 16 reported unusual incidents were investigated. Four of those investigated involved serious injury. Additional processes for auditing significant injuries was not apparent. This will be reviewed in further detail at upcoming reviews.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	Policy 002.1 addressed the conduct of investigations. It did not specify that DFPS or facility investigators need to have training in working with people with developmental disabilities. The policy did state that all investigators who are responsible for completing all or part of the Unusual Incident Report must complete the course, Comprehensive Investigator Training (CIT0100), within one month of employment or assignment as an investigator, and prior to completing an Unusual Incident Report. The Incident Management Coordinator and Primary Investigator(s) must complete the Labor Relations Alternative's (LRA) Fundamentals of Investigations training (INV0100) within six months of employment At EPSSLC, Michael Reed, facility investigator, was interviewed regarding specific training that he had received. He referred to LRA training and facility orientation on working with individuals with developmental disabilities. Prior to his current employment, he worked with individuals with disabilities at a community facility.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Policy 002.1 referred to cooperation with DFPS and law enforcement agencies in conducting investigations. Interview with the facility investigator, and review of a sample of investigations performed over the past year, indicated investigations were a cooperative effort with DFPS investigators. The investigator described incident types and the process for reporting to DFPS.	

	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect,	Policy 002.1 referred to cooperation with DFPS and law enforcement agencies in conducting investigations. Interview with the facility investigator, and review of a sample of investigations performed over the past year, indicated investigations were a cooperative effort with DFPS investigators. The investigator described incident types	

	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The investigation report section regarding documentation by DFPS was often left blank in regards to notifying law enforcement. There was no evidence that all allegations of abuse were reported to law enforcement. One of the sample of 16 investigations reviewed was reported to law enforcement; documentation indicated date and time of report.	
	(d) Provide for the safeguarding of evidence.	Policy 002.1 Section V.2 described procedures for safeguarding evidence in the event of a serious incident. The facility investigator described the procedure for safeguarding evidence and investigations and included a description of how evidence was secured at the investigation site.	
	(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.	Policy 002.1 Item VIII addressed timelines of investigations. The policy required that investigations commence within 24 hours, but currently allowed for investigations to be completed within 14 days (10 days after June 1, 2010). The policy did not currently meet requirements of this item of the Settlement Agreement. DFPS investigations commenced within 24 hours of notification for all incidents reviewed, but were not always completed within 10 days. For example, Case #33606590 was opened on 10/6/09 and completed 13 days later on 10/19/09, Case #33870331 was opened on 10/22/09 and completed 15 days later on 11/06/09, and Case # 33787370 was opened on 10/16/09 and completed 13 days later on 10/29/09. All investigations reviewed included a summary of the investigation, findings, and recommendations for corrective action. There was no documentation in investigation files on the follow up to recommendations made in the final report.	
	(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	Policy 002.1 Section VIII. H mandated consistent investigation procedures and recordkeeping including elements listed in this provision of the Settlement Agreement. All items listed in this item were included in each of the investigations reviewed. Investigation files were consistently compiled in a clear easy to follow format.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear	Policy 002.1 Section VIII. H mandated consistent investigation procedures and recordkeeping including elements listed in this provision of the Settlement Agreement. All items listed in this item were included in each of the investigations reviewed. Investigation files were consistently compiled in a clear easy to follow format.	

	(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.	Policy 002.1 required that a summary of the investigation be sent to DADS regulatory within 5 working days of the incident and that a final DFPS report be completed within 14 working days for review by DADS regulatory. The facility director reviewed final internal investigations. Reviews of internal investigations were delayed significantly in two of cases reviewed (09-164 and 09-174).	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Each written report of unusual incidents was written in a clear consistent manner. Reports included an in-depth summary of investigative procedures, relevant history and personal information about the individual, a list of immediate corrective actions to be taken, and an analysis of findings and recommendations for remedial action to be taken.	
	(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.	For incident files reviewed at the facility, there was some evidence that prompt action was taken to correct the situation and/or prevent reoccurrence when indicated necessary by the investigation. For example, during the review, it was observed that immediate action was taken to increase staffing levels for individuals with injuries. Further, physical therapy reviews were completed following fall incidents, if indicated. Actions were reviewed and documented during incident management meetings and information was shared at shift change meetings in the residential program. The daily incident management meeting occurred each morning. Senior management attended. The previous day's incidents were reviewed and follow-up from previous incidents was also reviewed. Additional actions were assigned and follow-up was to occur at subsequent meetings. This appeared to be a reasonable way for senior management to be informed, and to plan for follow-up, regarding incidents at the facility. It was not, however evident, that staff who were assigned to individuals when the allegation occurred were routinely reassigned, as was mandated in the facility policy, when serious injuries of unknown causes occurred. The issue of staff reassignment during an investigation will be reviewed further in upcoming reviews. It was noted though that during the review, five nurses were out on administrative leave due to allegations of abuse.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to	A review of investigation records from the past year confirmed that files were maintained and were easily accessible for review. Trend analysis reports were compiled by incidents involving particular individuals and by staff involved.	

D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had a system in place to track and trend unusual incidents and investigation results. Trends were tracked by incident type, staff involved, individual involved, location of incident, date and time of incident, cause of incident, and outcome of investigation. Quarterly reports were compiled and compared with the previous quarter, but it was not evident that analysis from these reports was used in a facility quality assurance plan to reduce the number of incidents. There were a total of 16 unusual incidents for the 1st quarter of FY10, 17 fewer than reported in the 1st quarter of FY09. This was also six fewer incidents than the previous quarter. The decrease was noted, but there was no indication of what the reason might have been for the decrease in incidents. Trying to identify reasons for change in the number of incidents would help the facility monitor the effectiveness of program changes in reducing incidents.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	Section 3000 of the DADS regulations on Volunteer Programs required criminal background checks on volunteers and the DADS Operational Handbook, Revision 09-21, required criminal background checks on employees of all state facilities Criminal background checks were reviewed for the four direct care staff interviewed. Background checks were in place for all four. Additional review this system for both employees and volunteers will be reviewed in upcoming monitoring visits	

Recommendations:

1. All incidents involving serious injuries of unknown cause should be reported to DFPS within one hour of discovery. Any injury of unknown cause involving an individual with 1:1 supervision should be referred as a possible abuse or neglect case. Facility policies should be updated to clarify the one-hour reporting requirement.

2. Policies regarding the reporting of non-serious injuries of unknown cause need to be developed and requirements should be included on the reporting matrix.

3. Staff involved in incidents that may possibly be abuse, neglect, or exploitation should be reassigned and that reassignment should be documented in the investigation file.

4. All investigations should state whether or not law enforcement was notified and, if notified, when and how, and the outcome of notification.

5. Completed investigations should be reviewed in a timely manner and there should be documentation that recommendations have either been completed or include justification if not completed.

6. The facility should use data collected on unusual incidents to develop recommendations for reducing incidents and incorporate these recommendations into a facility quality assurance plan. Further data should then be used to evaluate the effectiveness of recommendations in reducing incidents.

<table>
<tr><th>SECTION E: Quality Assurance</th><th></th></tr>
<tr><td rowspan="3">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:</td>
<td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o DADS Policy #003: Quality Enhancement, dated 11/13/09
o EPSSLC Plan of Improvement
o Incident Trend Analysis Report for FY09 and 1st Quarter of FY10
o Injury Trend Analysis Report for 1st Quarter of FY10
o Morning incident meeting minutes for the following time periods
• 8/10/09-8/14/09
• 9/8/09-9/10/09
• 11/2/09-11/6/09
• 12/7/09-12/11/09

<u>Observations Conducted</u>:
o All on-campus sites that provided day programming and activities
o All 3 residential dorms
o 6 of the 8 cottages (506, 507, 508, 510, 512, 513)
o Morning incident management meeting
o Mini-PSP/PST meeting for AK</td></tr>
<tr><td>Facility Self-Assessment:

A facility self-assessment was not provided because this was a baseline review.</td></tr>
<tr><td>Summary of Monitor's Assessment:

Many of the quality enhancement activities at EPSSLC were in the initial stages of development. The facility had a fragmented quality assurance system in place; it only addressed a small number of specific issues within the facility. For example, the facility gathered data on injuries and incidents and had a system for trending the information gathered, but the information appeared only to be used to address recommendations specific to single issues rather than addressing facility system issues that might have a broader impact on reducing or eliminating injuries and incidents.

Additionally, direct care staff reported that the facility had initiated additional monitoring specific to each discipline, but this also appeared to address specific issues, for example PNMT monitors frequently monitored individual supports in the residential setting and corrected issues or trained staff as necessary. There was no indication that system issues were being addressed if trends are identified by these monitoring visits. While this is a beneficial piece to the quality assurance process, these processes will need to be incorporated into a larger QE/QA plan that looks at facility-wide issues.</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
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 state policy regarding quality assurance was fully adopted by the facility. The policy was titled, "Quality Enhancement." It was numbered 003 and dated 11/13/09. The policy called for a quality assurance system that, if implemented, would meet the requirements of this provision of the Settlement Agreement. The policy had a number of addenda and forms that were to be used for the QE plan, corrective action plans, tracking of these plans, and operation of the performance improvement council. The facility, however, was only at the initial stages of the development and implementation of a comprehensive quality assurance and enhancement program as required by this provision. For example, the facility had a system in place to track data in regards to incidents and injuries. Data were trended by program area, living unit, work shift, protections, supports and services, area of care, individual staff providing support and individual. Information was compiled in a quarterly trend analysis report. The facility had systems in place for gathering data daily from direct care staff through daily shift notes. Any unusual incidents were shared at each shift change or reported immediately if warranted. Incidents/injuries occurring each day were shared at incident management meetings the following day, and it was observed that data on similar incidents/injuries could be pulled immediately to identify trends before follow up action steps were recommended. A more comprehensive QA/QE program is required. Data from a variety of areas of the facility's operations must be included. A number of these areas are listed in the policy (e.g., section III on page 10). Moreover, a number of provisions of the Settlement Agreement call for the development and implementation of a quality assurance process. These areas should also be included in the facility's QA/QE program. The facility had a Plan of Improvement (POI) that listed action steps facility staff were to take to meet provisions of the Settlement Agreement. This document and process can be part of a comprehensive QA/QE plan, but is not, by itself, a plan that can meet this provision of the Settlement Agreement. Moreover, the action steps of the POI should be evaluated to determine if the action steps are the correct actions for the facility. Facility and state staff might consider aligning the POI action steps with the content of the monitoring team's evaluative checklist tools. Finally, a typical outcome measure usually assessed and tracked at facilities, such as EPSSLC (and most agencies and companies) is the satisfaction of individuals, their families and LARS, staff, and affiliated providers (e.g., local hospital, community physicians, community employers). These groups are surveyed to assess their	

#	Provision	Assessment of Status	Compliance
		satisfaction across a range of areas, some broad, some very specific. It was surprising to the monitoring team that EPSSLC did not conduct any type of satisfaction assessment of any of these groups of people. It was surprising because the management and staff appeared so dedicated to the happiness and care of the individuals whom they supported. Apparently there was some type of survey of the individuals residing at EPSSLC done by a group called NACES, but the results were never shared with EPSSLC management. It was unclear how that survey was conducted and what questions were asked. There are many examples of these types of surveys, such as those used at other agencies and companies. Content attempts to assess satisfaction across broad areas, such as services received, opportunities for growth, involvement in decision making, and participation in community activities; as well as in specific areas, such as care of clothing, weekly phone contact with family members, and notification of significant incidents. EPSSLC should consider creating a system of assessing satisfaction, and, as is the case with other aspects of a QA program, developing a response to the assessment results to make improvements in services at the facility.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	Again, the facility had begun some QA/QE processes, specifically in regards to injuries and incidents. Administrative staff from each program area and discipline met daily to review incidents at the facility and address problems. Staff were assigned follow up and each item remained on the daily agenda to be discussed until action steps were completed. PSTs were pulled together for "mini" meetings to address problems and formulate plans of action following any unusual incident or when trends were identified as evidenced by record reviews and observation. For example, during the week of the on-site review, Individual #116 experienced a fall that was reported during the morning incident management meeting. Fall trends for Individual #116 were requested at the meeting and were distributed to meeting attendees within minutes. Members recommended a PT screen and referral for discussion by the PST. The PST met that same afternoon and reviewed a PT evaluation performed prior to the meeting and made recommendations for PT to retrain staff. Trend analysis reports contained a summary of trends for the quarter with recommendations and a follow up schedule specific to incidents. Each recommendation had action steps to be taken and a responsible person and due date were assigned. Status updates of recommendations and actions were summarized for the previous quarter.	

#	Provision	Assessment of Status	Compliance
		In the FY 2010 September Injury Trend Analysis Report, however, there was a recommendation for Individual #13 by the PT to obtain an orthopedic consultation by 9/9/09. The report dated 10/31/09 showed no evidence that this recommendation had been followed. It is not clear how these recommendations are monitored for follow up.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	For injuries and incidents, staff assignments were made for corrective action at morning incident management meetings. Information on incidents and action to be taken was distributed in meeting minutes. Specific maintenance and environmental issues were followed up in this same manner at incident management meetings. Administrative staff received meeting minutes by email when not present at the meetings. Though there were many processes in place to develop corrective action for specific issues identified, there did not appear to be a plan in place to address system issues that may contribute to these individual issues.	
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	For injuries and incidents, corrective action plans were monitored at morning incident management meetings and information stayed on the agenda until outcomes were met. If the problem still existed, additional action was recommended by committee members, as evidenced in the review of meeting minutes. Again, this process did not appear to address system changes that may reduce or eliminate individual issues.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	See E4 above.	

Recommendations:

1. Develop a comprehensive QA/QE program.
    - Ensure inclusion of all relevant aspects of facility operation, state policy, and Settlement Agreement provisions.
        - Consider the addition of satisfaction measures.
    - The POI may be a part of the QA/QE program, but should not be considered the facility's QA/QE plan.
    - Consider modifying the POI to align with the monitoring teams' evaluative checklist tools.

<table>
<tr><th>SECTION F: Integrated Protections, Services, Treatments, and Supports</th><th></th></tr>
<tr><td rowspan="3">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:</td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o Personal Support Teams-PDP Process Training Curriculum
o Individual PSPs for:
• Individual #46
• Individual #125
• Individual #114
• Individual #14
• Individual #78
• Individual #13
• Individual #104
• Individual #66
• Individual #116
o Records of 25 individuals (listed in section M-Nursing)
o Nursing policies and procedures

<u>Interviews and Meetings Held</u>:
o Staff interviews with four residential direct care staff
o Informal interviews with direct care staff on duty during observations in cottages 506, 507, 510, 512 and 513, and all day programs
o QMRPs
o Nursing management staff

<u>Observations Conducted</u>:
o All on-campus sites that provided day programming and activities
o All 3 residential dorms
o 6 of the 8 cottages (506, 507, 508, 510, 512, 513)
o Mini-PSP/PST meeting for AK</td></tr>
<tr><td>Facility Self-Assessment:

A facility self-assessment was not provided because this was a baseline review.</td></tr>
<tr><td>Summary of Monitor's Assessment:

The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items in this provision were either not developed or not yet implemented thoroughly</td></tr>
</table>

	enough to allow for monitoring. Further, the state was in the process of writing a policy to address this provision. The facility was awaiting this policy and further direction from the state. The monitoring team was given an old policy (dated 2003), however, it did not appear that the old policy was being implemented. Therefore, the comments in this section of the report are based upon the limited activities engaged in by the facility at this point in time. Overall, there was a lot of activity at the facility around the Personal Support Plans (e.g., planning for the meeting, creating documents), but little meaningful integration across disciplines. The annual multidisciplinary meeting to develop the Personal Support Plans (PSPs) was a good start, however, little evidence of departments and disciplines coming together throughout the year to provide integrated services was observed.

#	Provision	Assessment of Status	Compliance
F1	Interdisciplinary Teams - Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	The DADS policy for this section had not been developed at the time of this review. Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.	
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.	The IDT was called a Personal Support Teams (PST) at the facility. PSTs were facilitated by the assigned QMRP. The QMRP for each individual was assigned responsibility for developing, monitoring, and revising treatments, services, and supports. Informal interviews with QMRPs during the review process revealed that they were generally aware of the range of supports and services being offered to individuals whom they supported. PSP meetings were conducted for each individual. Each annual PSP meeting lasted approximately two hours. A great deal of work was done by the QMRP in order to prepare for each annual PSP meeting. The QMRP led the annual and interim (i.e., "mini") PSP meetings. At annual meetings observed during the review, much of the time was taken up by the reading of written reports. The latter part of the meeting involved more open discussion. QMRPs, however, might encourage more equal participation among team members during these discussions. A "mini" PSP meeting was observed during the week of the review. The team was called	

#	Provision	Assessment of Status	Compliance
		together to address a specific issue and even though members were only provided approximately four hours notification of the meeting, key members of the team were all present, including the individual, the QMRP, direct care staff, nurse case manager, program development, physical therapist, psychology staff, and director of behavioral services. The monitoring team did not focus on the adequacy of monitoring and revising treatments, services and supports during this baseline review. When the team has had the opportunity to evaluate the adequacy of the development process for assessments and supports, the monitoring team will comment further on this provision of the Settlement Agreement.	
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 persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	A review of a sample of Personal Support Team sign-in sheets documented attendance of the individual, LAR, QMRP, direct care staff, and other professionals who provided services and supports to the individual. Direct care staff interviewed confirmed that they attended team meetings and were given the opportunity for input into the plan both at the meeting and outside of the meeting by having ongoing discussion with the QMRP regarding supports and services. Direct care staff who were interviewed all reported that if a service or support was not adequately addressing an individual's need, they could discuss it with the QMRP or other team members, and that those team members would address the issue and call the team together if needed.	
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.	It was expected that the new state policy will provide direction to the facility regarding this provision item (e.g., the type and frequency of assessments). The new policy should include all of the many required assessments noted in provisions throughout the Settlement Agreement across a number of disciplines. Without a new policy to guide the facility, the QMRPs followed typical procedures. During the on-site review, the format of the PSP included sections for information regarding the individual's preferences and strengths. There was a method for summarizing routine assessments in the plan along with recommendations from each assessment. Not all plans, however, were signed and dated by the professional making the recommendations. For example, Individual #125's Discussion of Significant Problems, and Plan and Recommendations had not been signed and dated by the physician and his SLP assessment and recommendations had not been signed and dated by the SLP. Individual #114's behavioral assessment and recommendations had not been signed and dated by the psychologist. His Pre-Medication Assessment and Risk Screening Tool were also not signed and dated.	

#	Provision	Assessment of Status	Compliance
		As noted in a number of other sections in this report, the monitoring team found the quality of some assessments to be an area in need of improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed. This provision of the Settlement Agreement will continue to be reviewed during upcoming monitoring visits.	
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.	The narrative portion of the PSPs reviewed did summarize assessment findings along with supports and interventions recommended by the specialist. These recommendations, however, stood alone and were not integrated throughout the plan. Although numerous individual-specific assessments were in place prior to the development of the plan, outcomes were generally developed based on a generic assessment rather than individualized assessments. There was no systematic procedure for ensuring that assessment results were incorporated into the development and implementation of the PSP. PSP meetings, however, were convened to discuss changes and incidents as they occurred.	
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).	Again, addressing this item will require direction from the state's forthcoming policy.	
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:	This provision will be reviewed in greater detail by the monitoring team following the development of facility policies to address PSP development and implementation.	
	1. Addresses, in a manner building on the individual's	The PSPs that were reviewed addressed the individual's preferences and strengths, but did not prioritize needs or supports based on the individual's long-term goals. Outcome	

#	Provision	Assessment of Status	Compliance
	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;	development was not specific to the individual's needs and what was stated to be important to that individual. PSP objectives reviewed were generally generic statements that were not individualized based on each individual's needs and preferences. For example, the PSPs for Individual #125, Individual #46, and Individual #114 all contained the same three objectives: • … will be encouraged to maintain his/her current level of mental health to the best of his/her ability. • … will be encouraged to increase his/her current level of independence to the best of his/her ability. • … will be encouraged to increase and maintain his/her current level of health and personal care with assistance and to the best of his/her ability. Action steps under the each outcome varied for each person, but again, did not adequately provide a plan for helping each individual to reach his or her desired outcomes. See further discussion below regarding action steps, and also see Section S of this report, regarding habilitation and education. Additionally, outcomes were written by various disciplines and could be found in individual discipline plans, but were not integrated into one plan so that staff could easily identify all outcomes for an individual. This led to a disjointed lengthy plan that staff would have to search through to find which outcomes they should be implementing for each individual. In Individual #114's plan, for example, the action steps under his outcome of addressing health and personal care, listed a bathing program, an oral hygiene plan, a toileting to service objective, and a lotion/sensory program. It also stated that he will be assisted with all of his PNMP requirements. The PSP should be a coordinated easy to follow plan for direct care staff to implement all of his outcomes. The plans that were reviewed briefly addressed community participation, but did not offer outcomes and a schedule for individuals to go out into the community. For example, Individual #114's plan stated that he would "be offered a variety of opportunities to participate in scheduled community outings where he will have the opportunity to associate and interact with individuals out in the community." There were no clear strategies for providing these opportunities to Individual #114. A similar statement was found in the majority of plans reviewed.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies	Objectives were not written in measurable terms and did not contain strategies and a description of supports that would adequately direct staff to implement plans consistently or determine when outcomes were achieved. Supports needed to achieve outcomes were not included in many of the action plans reviewed.	

#	Provision	Assessment of Status	Compliance
	to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	For example, one of Individual #125's three outcomes was "He will be encouraged to maintain his current level of Mental Health to the best of his abilities" (also the same outcome for Individual #46 and Individual #114). Action steps included: 1. Visitation from his family 2. Walking in his gait trainer 3. Sports – playing with bouncing balls 4. Leisure activities 5. Watching television 6. Eating 7. Sitting in his recliner Some action steps to achieve Individual #114's outcome to maintain his current level of Mental Health to the best of his abilities were listed as: 1. He likes to sleep late 2. He enjoys eating 3. He enjoys having his own space 4. He prefers his hair short None of these action steps were measurable or observable and did not include information that would direct staff in how to implement these objectives consistently or determine when outcomes were completed and met.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	PSPs were developed with an apparent goal to capture each individual's needs, goals, preferences, and abilities in one document as described by each treating discipline. Recommendations by specialists were not integrated into action steps and teaching strategies.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	PSPs reviewed did not include specific methods for implementing outcomes or target dates for completion of outcomes. Plans did, however, designate staff responsible for implementation of the objectives by discipline.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and	PSPs did not address implementing functional learning in the community. Action plans in the PSPs that were reviewed were based on learning within the facility, usually in the classroom setting rather than where the skill might naturally be utilized. Observation in the day programs supported that implementation is primarily occurring in the classroom setting and this did not allow for as much learning as might be possible if community	

#	Provision	Assessment of Status	Compliance
	are practical and functional at the Facility and in community settings; and	settings were also used. Observations and interviews with staff indicated that the provision of clinical services by disciplines (e.g., psychology, psychiatry, medicine, nursing) was not functionally integrated. For example, the psychology staff did not write, monitor, or influence the skill acquisition plans for individuals. They were, however, attempting to teach individuals new skills (behaviors) to replace dangerous and disruptive behaviors. Skill acquisition plans would be more functional, and the development of replacement behaviors more effective, if psychologists and those writing the skill acquisition plans worked together to use similar methodologies, data collection, and monitoring procedures.	
	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.	The plans that were reviewed specified how data should be collected and the frequency of data collection. Some, but not all, action plans designated who should review and monitor implementation and progress towards outcomes.	
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.	The facility did not have a process to ensure coordination of all components of the PSP. Direction from the state and the new policy will likely provide guidance to the facility in meeting this item. Another example of where better integration of clinical services likely would produce better outcomes for individuals was in the area of medication management of disruptive behavior. Although psychology and psychiatry staff were together when individuals were seen by the psychiatrist, it was not clear that the most relevant data were provided to them, or that the psychiatrists told the psychologist what data would be most relevant and important to them.	
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	Policies, procedures, and guidelines were not in place regarding Section F. Informal interviews with staff in the residences revealed that not all staff referred to the PSP for directions on implementing individual objectives. The PSP was a compilation of all information and assessments on the individual, but did not provide clear, easy to decipher information that could guide direct care staff in providing necessary supports.	

#	Provision	Assessment of Status	Compliance
	responsible for implementing it.		
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.	PSPs were reviewed monthly by the QMRP. The reviews were, overall, cursory and the facility was awaiting direction from the state and from the new policy regarding the monthly review process for PSPs. "Mini" PSP meetings were convened regularly to review incidents and update assessments and recommendations, if indicated. Reviewers were able to observe this process when a fall incident (involving individual #116) was discussed during the morning incident meeting. After trends were reviewed and it was noted that she was falling more frequently, the incident management team recommended that the team meet to discuss a change in her status. A "mini" PSP meeting was convened that same afternoon following a PT reevaluation and supports were updated based on recommendations from team members.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are	For persons responsible for the development and implementation of the PSP, a curriculum for competency-based training on the Personal Support Teams, PSP development, and PSP documentation was provided to the monitoring team. This training was not documented in the four training records reviewed for tenured direct care staff. It was numbered PER-0200, and much of the content did not appear directly related to EPSSLC's PSP process or the typical types of components one would expect to find in PSPs for this population. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised, however, there is no system in place to ensure that this occurred and there was no documentation in place to show that staff were trained on individual plans initially or when they were updated or modified. Generally accepted practice is that all staff (e.g., QMRPs, Case managers, direct care staff) are trained in development of the PSP since they should all be equal partners in development of the plan. This provision of the Settlement Agreement will continue to be reviewed in upcoming monitoring visits to determine the adequacy of training in providing team members with the skills to develop and implement comprehensive, effective plans for individuals.	

#	Provision	Assessment of Status	Compliance
	responsible and staff shall receive updated competency- based training when the plans are revised.		
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.	All individuals reviewed had a current PSP. None were older than one year. Policies had not yet been developed to address this requirement. PSPs for persons recently admitted into the facility were not reviewed during this monitoring visit. The monitoring team will review for compliance of this provision during upcoming reviews.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	A recently developed Personal Support Plan Meeting Monitoring Checklist was developed to evaluate the agenda, format, and flow of the PSP meeting. It was not tied in to the facility's overall quality assurance program. As previously noted, Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.	

Recommendations:

1. Develop and implement policy.
2. Ensure all reports and assessments are appropriately edited and signed by the writer of the document.
3. Ensure staff are trained in their specific responsibilities relative to PSPs.
4. Develop measurable outcomes specific to the needs and preferences of each individual and include action steps and strategies to guide staff in consistent implementation.

5. Incorporate recommendations from assessments into outcome strategies.

6. PSTs should develop projected timelines for achieving outcomes based on each individual's rate of learning and meet to address barriers/revise outcomes if timelines are not met. Plans should also designate a team member to monitor implementation of the plan and review progress towards outcomes.

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:** General discussions held with facility director, Tony Ochoa, and department management staff.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the on-site tour to address this provision of the Settlement Agreement. As noted elsewhere in this report, meaningful integration of clinical services was not evident in most areas at the facility.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	A plan was not in place to address this item. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision.	
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	A plan was not in place to address this item. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision.	

#	Provision	Assessment of Status	Compliance
	IDT for integration with existing supports and services.		

Recommendations:

1. Develop and implement policy.
2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.
3. Consider assigning the monitoring of integration of clinical services to the QA/QE department at the facility.

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:** General discussions held with facility director, Tony Ochoa, and department management staff.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the on-site tour to address this provision of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	A plan was not in place to address this item. The medical director appeared to see individuals regularly at the facility's clinic, but he was behind on routine annual physicals and screening. The anticipated addition of nurse practitioner hours may help to address this issue. Monthly reviews by consulting psychiatrists amounted to record reviews and averaged less than five minutes per record. Further, the individual did not attend and was not directly observed for these monthly reviews. Quarterly reviews, however, included the individual. There were some individuals who did not have monthly reviews, however, all individuals had at least quarterly reviews. Moreover, those individuals with more serious problem behaviors were seen more often. An attempt was made by the consulting psychiatrists to follow lab tests and behavioral targets in record reviews.	
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	Psychiatric diagnoses seemed to follow the psychopharmacology regimen. There was very little time taken during each review to look at how appropriate each diagnosis was to that particular individual. The consulting psychiatrists noted that most of the diagnoses and the psychopharmacology regimens were present prior to their consultation at the facility. Neither psychiatrist was inclined to make changes when the individual was stable.	

#	Provision	Assessment of Status	Compliance
	Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.		
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The medical director held sick call hours each day of the week to address new or ongoing health issues. Monthly reviews in psychiatry were conducted without the psychiatrist observing or interacting with the individual. Quarterly reviews, however, included the individual. There was poor documentation of symptoms to justify the DSM-IV diagnoses. The target behaviors were reviewed in the sense that psychologists provided the "numbers" for each of the incidents regarding the target behaviors. During the psychiatry clinic visits, there was no meaningful discussion of behavioral interventions in use, modifications that might be implemented, or perhaps other ways to approach the individual's presenting challenging targeted problems.	
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.	A plan was not in place to address this across the variety of clinical disciplines at the facility.	
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.	A plan was not in place to address this item.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	A plan was not in place to address this item.	
H7	Commencing within six months of the Effective Date hereof and with	Policies, procedures, and guidelines were not in place regarding Section H.	

#	Provision	Assessment of Status	Compliance
	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.		

Recommendations:

1. Develop and implement policy.
2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.
3. Consider assigning the monitoring of the provision of minimum common elements of clinical care to the QA/QE department at the facility.
4. Review the caseload and workload of the medical director to determine how much additional support is needed.
5. Integrate psychiatry into the facility's program. One way is to have a full-time psychiatrist on staff to allow for adequate time with individuals, to review diagnoses and treatment plans, and to participate in the development and implementation of integrated services.

<table>
<tr><th>SECTION I: At-Risk Individuals</th><th></th></tr>
<tr><td rowspan="2">Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:</td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
○ DADS Policy #006: At Risk Individuals
○ DADS Risk Assessment Tools, dated 8/31/09
○ Training transcripts for four residential direct care staff
○ Risk Assessment Rating Tools, and Individual PSPs for:
• Individual #78
• Individual #13
• Individual #14
• Individual #125
• Individual #46
• Individual #114
○ Morning incident meeting minutes for the following time periods
• 8/10/09-8/14/09
• 9/8/09-9/10/09
• 11/2/09-11/6/09
• 12/7/09-12/11/09
○ A sample of unusual incident reports (see section D)
○ Incident Trend Analysis Report for FY09 and 1st Quarter of FY10
○ Injury Trend Analysis Report for 1st Quarter of FY10
○ Records of individuals (see listing in section J of this report)

<u>Interviews and Meetings Held</u>:
○ Staff interviews with four residential direct care staff
○ Informal interviews with direct care staff on duty during observations in cottages 506, 507, 510, 512 and 513
○ Staff listed in section J of this report

<u>Observations Conducted</u>:
○ All on-campus sites that provided day programming and activities
○ All 3 residential dorms
○ 6 of the 8 cottages (506, 507, 508, 510, 512, 513)
○ Mini-PSP/PST meeting for Individual #116
○ One morning incident management meeting</td></tr>
<tr><td>Facility Self-Assessment:

A facility self-assessment was not provided because this was a baseline review.</td></tr>
</table>

	Summary of Monitor's Assessment: Policy #006: At Risk Individuals had been developed to address assessing risks for individuals. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries and polypharmacy. Standardized risk assessments were completed for each individual reviewed. There was not a consistent process evident for reviewing and updating risk assessments when an individual's risk status changed. In most cases, assessments were not reflective of actual risk levels for individuals. Of importance to note is that if an individual had a plan in place to address a risk, the team usually did not consider him or her to still be at risk. When questioned, direct care staff were not always aware of the health risks for an individual and how to monitor for those risks. The monitoring of healthcare and PNM risk are addressed more thoroughly in other corresponding sections of this document.

#	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.	A state and facility policy existed to address this provision of the Settlement Agreement. The policy was labeled "At-Risk Individuals," numbered 006, and dated 10/5/09. It included a number of addenda and forms. This was the state policy and was adopted, in whole, by the facility. The policy mandated a risk review at least every six months for each individual by a Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. Standardized risk assessments were currently being used to assess each individual's risk for illness or injury. As per the policy, the facility had an HST to review individuals' risk across a variety of areas (e.g., choking, seizures). The HST held a one-hour meeting during which the risk levels of 24 individuals were reviewed. The medical director chaired the meeting. It ran for exactly 60 minutes. Team members in attendance gave a very brief prepared report. Then the medical director assigned the level of risk rating and then assigned a second rating comparing what the risk would be if the individual were living in the community (the risk level always was lower when rated for living in the facility). The rationale was to give proper credit to the great care the individuals received by the staff at the facility. This was not in line with the risk assessment policy of the facility. There was no meaningful discussion, interaction, or debate regarding risk assessment, due in some part, to the large number of individuals reviewed.	

#	Provision	Assessment of Status	Compliance
		Moreover, risk levels appeared to be assigned based upon the likelihood of injury, not the level of risk presented by the individual. This was also not in line with the policy, especially regarding the designation of low risk (level 3). For example, if an individual had comprehensive treatments and supports in place, he or she would likely have been given a rating of low risk. The policy, however, is quite clear that a level 3 low risk rating is for "conditions that are stable and require minimal or no active treatment" (page 5 of the policy).	
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 policy stated that when a risk was considered to be high, in any category, the team would meet within five working days to formulate a plan. The policy did not address what criteria were necessary to warrant a review of the risk assessment. Further, there were numerous cases of risk levels not aligning with injury and incident reports. This was a problem at EPSSLC and should be addressed. For example, Individual #14 was considered "medium" risk (level 2) even though she had 11 fall-related injuries between 3/09 and 7/09, and then she had another 32 injuries between 7/09 and 11/09. The physical therapist's statement in her risk plan noted that, "She requires verbal cues to slow down when walking. No other issues." There were no other recommendations to address her fall risk. Moreover, her risk level for aspiration/choking was not rated even though she received speech therapy swallowing exercises and was on a ground diet with thin liquids via an adaptive cup to address choking risk. Her initial risk assessment dated 2/09 had not been reviewed and signed by her healthcare provider and did not indicate review by physical therapy staff, even though her primary risk was injuries from falls. In another example, Individual #125's overall risk level was rated low even though he was at risk for aspiration, falls, constipation, and osteoporosis; had active seizures; and took multiple medications, including three psychotropic medications. Again, individuals often had risk ratings at low or medium level at the facility and a second rating that was higher if they were placed in the community. There was no justification for the difference in risk ratings.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to	The policy established a procedure for developing plans to minimize risks and a requirement for the monitoring of those plans by the PST. The PSPs that were reviewed included strategies to address identified risks. Cottage supervisors who were interviewed reported that they were notified of changes in plans by the therapist and implementation of changes began immediately. All staff were notified of changes in meetings held at each shift change.	

#	Provision	Assessment of Status	Compliance
	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.	Psychiatrists were not involved in any of the planning around addressing and managing risk, though many individuals reviewed were on multiple psychotropic medications with side effects that may have put them at risk. Informal interviews with direct care staff revealed that staff could generally identify safety risks for individuals whom they were assigned to support such as falls, choking, and pica behavior, however, they could not always describe the associated health risks. Many staff indicated that it was the responsibility of nursing staff to monitor healthcare issues. In interviews with cottage supervisors, when asked how they were trained on specific risk for each individual, staff reported that sometimes they reviewed each individual's card, particularly if the staff was not regularly assigned to work with an individual (e.g., filling in for an absent staff) to get risk information. The summary cards were a good quick reference for information about the person, but did not give enough detail to assure that staff could provide interventions and supports necessary to keep individuals safe. Staff who were interviewed reported that they received classroom training on general supports, such as transfers and mealtime, but not hands-on competency-based training for each individual.	

Recommendations:

1. Implement and follow written policy regarding assignment of risk level.

2. Risk levels should be evaluated considering the level of support needed in each area.

3. The risk level should be the same at the facility as it would be in the community for most items on the assessment since the same supports would be needed in both settings to maintain health and safety.

4. Establish written policies regarding the types of incidents that would require immediate review of the individual's risk assessment.

5. All staff should receive individual specific training on each safety and health care risk identified for the individual(s) they are assigned to support. Summary cards should not be used as a substitute for hands on competency-based training.

6. Support staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues.

7. Integrate psychiatrists into PSP meetings and meetings to address risk. This will help psychiatrists to be more aware if psychotropics may be the "cause" or the solution to agitation or other behaviors that may increase risk. For example, akathesia is often overlooked and consequently an additional medication might be added to the regimen and that might make the problem .

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:** <u>Documents Reviewed</u>: ○ Curriculum vitae of both psychiatrists, Drs. Rodriguez and Aleksander. ○ The following documents from the records of the individuals listed below: • Cover page, social work complete social history and most recent update • Psychological update (most recent) • Most recent annual medical summary, physician orders for the last 12 months • MOSES and DISCUS scales since July 2009 • Interdisciplinary progress notes from 9/09 to most recent • Medication administration records from 9/09 to most recent • All psychiatric progress notes and neurology consultations from 1/09 to most recent • Radiology reports from 1/09 to most recent, most recent EKG • Initial psychiatric evaluation, and comprehensive psychiatric evaluation • Most recent PSP and any addendums from July/09 to most recent • All restraint reports from 7/09 to most recent, all injury reports from 9/09 to most recent • All consents for treatment with psychotropic medications from 7/09 to most recent. • For these individuals: • Individual #14 • Individual #2 • Individual #100 • Individual #29 • Individual #83 • Individual #8 • Individual #112 • Individual #69 • Individual #94 • Individual #78 • Individual #40 • Individual #104 • Individual #75 • Individual #71 • Neurology consultation notes for the past year for these individuals: • Individual #9 • Individual #115 • Individual #25

	Interviews and Meetings Held: o Individual interviews and meetings with each of the two consulting psychiatrists o Josephine Gabriel from the psychology department regarding psychology staff's access to psychiatry Observations Conducted: o All three psychiatry clinic sessions; one each on Tuesday, Wednesday, and Thursday of the tour week. o Some of the residential cottages and dorms.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State and facility policies in psychiatry to address this provision of the settlement agreement were in development. It is expected that the new policies in psychiatry, plus additional direction from the state, will assist the facility in working towards meeting this provision of the Settlement Agreement. Overall, psychiatry services were very separated from, and were not at all integrated with, the rest of the treatment program at the facility. Cases were reviewed quickly and interactions among participants at psychiatric clinics were truncated. Unless the review was the quarterly one, the individual was not in attendance and there was no face-to-face interaction between the individual and the psychiatrist. It was simply a record review, a review of labs, and of the behavior targets (many of which are out of date and no longer relevant). Direct care staff did not participate. Psychiatrists were not a part of the PSP meeting and the sections of the PSP regarding medications, side effects, and monitoring of the medications were the responsibility of the psychology staff. Monitoring of side effects should be the requirement of the psychiatrist. For the DISCUS, the psychiatrist should be the administrator of this instrument, however, neither of the psychiatrist's at EPSLCC were familiar with this instrument and suggested the AIMS be used. The MOSES was the responsibility of nursing at EPSSLC. If nursing administers the MOSES, then the psychiatrists should comment on any abnormals noted by the nurses (e.g., either disagree or agree with each abnormal) and note this information in the body of the progress notes when they see the individual. It is possible that side effects were not thoroughly monitored or understood. For example, akathesia may have been mislabeled as anxiety or agitation. This was noted based upon observations in the clinic and the high number of individuals receiving benzodiazepines for aggression. Agitation was noted in numerous records, but there was no mention of akathesia as a potential factor. This led the monitoring team to

	wonder if akathesia was being overlooked, especially because it is a common problem. Two individuals who might have akathesia are Individual # 8 and Individual #104. First generation antipsychotics might also play a role and this is further complicated with individuals who are nonverbal. This is best studied via a team effort where the staff can be trained by the psychiatrists to look for akathesia. It was likely that the staff did not know the difference between anxiety and akathesia. Dr. Rodriguez was willing to provide staff training on this topic. Lab values were dictated into the progress notes for psychiatry, however, there was no real action taken by psychiatry to determine the cause of abnormal values. Psychiatry progress notes had not been transcribed for several months (this was addressed by the facility when it was brought to management's attention).

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Both psychiatrists were board certified in general psychiatry. They were extremely open in discussing their needs and operation of their services. As consulting, very part-time, psychiatrists, their involvement in the facility's operation was limited. Further, psychiatry did not, and could not, operate as a department in the same way the facility's other departments functioned (e.g., medical, rehabilitation, pharmacy, psychology). One of the psychiatrists had training in occupational therapy and worked in this type of residential setting prior to training as a psychiatrist in the 1970's. The other psychiatrist did not have any special training or experience with people with developmental disabilities. They had both been working at this facility for over two years; one of the psychiatrists worked at the facility a number of years ago, too.	
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.	This was not in place at the facility. Please see additional comments below at J-6.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications	Psychotropic medications did not appear to be used explicitly in the manner prohibited by the detail in this Settlement Agreement item, however, the lack of integration of psychiatry with other aspects of programming at the facility, combined with the need for behavioral and educational treatment improvements, made it possible that psychotropic	

#	Provision	Assessment of Status	Compliance
	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.	medications were prescribed in the absence of a comprehensive treatment program. Both psychiatrists were clear in their interviews that they never felt pressured by staff to medicate individuals in order to control behaviors. The psychiatrists were of the opinion, however, that there was now more of a need for chemical restraints since mechanical restraints are not in use. The psychiatrists were not called for the implementation of chemical restraints. The implementation of chemical restraints was handled by the medical director. Moreover, neither psychiatrist was involved in reviewing individuals after restraint, either for physical or chemical restraints. The psychiatrists relied upon staff to tell them (during psychiatry clinic sessions) if there had been restraints over the previous month, and if so, the number and type. They were not required to sign off on these restraints nor review the restraint checklists. Pharmacy implementation of drug utilization reviews may help the facility to obtain an overall picture of medication usage. It is recommended that this be done for benzodiazepine usage, especially for lorazepam a medication that has been shown in the literature to be associated with falls.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment 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.	The psychiatrists were not involved in this process. It was handled by the medical director. Although pre-treatment sedation was in effect for many individuals, and a number of individuals had programs designed to desensitize them to medical or dental treatment, its utilization did not appear to be thoroughly coordinated with other supports and services at the facility. It is expected that the new policy will provide guidance to the facility for this provision item. Please also see comments at Q.2 of this report regarding dental services.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two	It is expected that the new policy regarding psychiatry services will provide direction regarding the required number of psychiatrist FTEs.	

#	Provision	Assessment of Status	Compliance
	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.	At EPSSLC, services were provided by contracted part-time psychiatrists who had numerous other consulting responsibilities at other facilities and programs. The total number of hours was less than 16 per week. Thus, there were not enough hours contracted with psychiatrists to meet this provision and to allow for psychiatry to be integrated and involved in the treatment planning process. A minimum of 32 hours per week of psychiatry services is recommended to meet this provision. In order to try to meet some of the paperwork and reporting requirements, one of the psychiatrists spent some hours over and above his contracted hours in order to review records with one of the psychologists and to dictate a psychiatric assessment (albeit retrospectively).	
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.	Again, it is expected that the new policy regarding psychiatry services will provide direction and guidance to the facility in meeting this item. Appendix B lists the components of the psychiatric evaluation and case formulation. Some of the psychiatric assessments had been updated to include many of the elements noted per Appendix B (e.g., Axis I-III diagnoses), but other elements were missing (e.g., Axis IV and V diagnoses). Overall, the reviews were helpful in summarizing pertinent psychosocial behaviors over the years for some of the individuals, but more work will be needed to have the evaluations meet the standard and format required by Appendix B. In addition it is important to note that many assessments and diagnoses remained in the record or in place for many years. For example, some assessments were from the 1980's. Individual #83's diagnosis of record (Bipolar disorder, Mixed type) was from 1995. During the interviews, one of the psychiatrists noted that many of the diagnoses of record were there seemingly to justify the medication regimens. In a case where an old diagnosis was still valid, typical terminology should be used to indicate so, such as stating the diagnosis was by history, resolved, unresolved, remitted, or unremitted. Of the 15 records reviewed, the psychiatric assessment rarely included all five diagnostic axes. In some cases, there was no assessment. One of the psychiatrists was developing retrospective record reviews and these included relevant information. The psychiatrists, however, will need to be guided to ensure they are following the requirements of this provision item. Some records still included impulse control disorder as a diagnosis, in addition to several other diagnoses, to explain behavioral outbursts when a more comprehensive approach might lead to more effective and relevant diagnoses. For example, Individual #94 had dementia related to Trisomy 21 and also had an impulse control disorder as a diagnosis, however, the behaviors may have been more likely related to dementia.	

#	Provision	Assessment of Status	Compliance
		Another topic worthy of note is that during the on-site tour, it was discovered that psychiatric progress notes were not transcribed and entered into the individual's record for many months following the psychiatric consultation. Contemporaneous transcription of psychiatry progress notes would aid the psychiatrist in reviewing notes and comments from the previous monthly medication review. For example, in the case of Individual #8, the note from the psychiatric clinic on 9/1/09 was not transcribed until 12/17/09. This was the typical length of time between dictation and transcription at EPSSLC. The facility, however, put a plan into place to correct this delay immediately upon becoming aware of it during the on-site tour.	
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.	This item was not being addressed by the facility. This was confirmed during all three interviews. There was no current use of the Reiss Behavioral Screen. Further, psychiatry only saw individuals who were referred from the medical department, that is, the department did not do a screen of all new admissions, nor ensure that all individuals were screened (except for those who already had a current psychiatric 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	There was no system to integrate pharmacological treatments with behavioral strategies. This was a major problem at the facility and should be addressed. Moreover, there was really no treatment team in psychiatry. The nurse case manager, the QMRP, and one of the psychologists attended the psychiatric clinics, however, there was little input or discussion, such as whereby each member brings information to discuss various strategies for behavioral treatment. Even so, the psychiatrist noted that "a team conference was performed" even though, in the monitoring team's opinion, the meeting	

#	Provision	Assessment of Status	Compliance
	other interventions through combined assessment and case formulation.	was not a collaborative group process. The pharmacy services department was attempting to monitor and send quarterly reviews to the psychiatrists, who then signed off on these reviews. There was, however, rarely any comment other than the form's box being checked that said, "agree with pharmacist's recommendations." For example, this was found in the records for the Individual #78, Individual #29, Individual #2, and Individual #69. To determine whether an integration of pharmacological treatments at the facility is occurring, the monitoring team will look for the following: ▪ Facility description of the system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, ▪ Medical records for evidence of collaboration across disciplines, ▪ Evidence that behavioral data are considered in decisions regarding pharmacological treatments, ▪ Interviews with psychologists and nurses to ascertain process of collaboration, ▪ Evidence of coordinated care when psychiatric illness occurs, ▪ Existence of a treatment program for behavior disorders, and ▪ Participation and discussion during meetings regarding individuals.	
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,	This item was not being addressed at the facility. Psychiatrists were not involved in the PST. No meaningful integration between psychiatry and other departments, including medical and neurology was observed. This was also noted during the three interviews. The PSPs had no mention of psychiatry in any of the individual records reviewed by the monitoring team's psychiatrist. Further, the PBSPs reviewed had psychotropic medications listed in the plan, but only with very generic side effects. There were no specifics as to why the medication was chosen for that particular individual and what psychiatric symptoms were being targeted. One of the psychiatrists stated that he believed many of the current diagnoses were initially determined in order to justify the psychotropic regimen. In most of these cases, he inherited both the diagnoses and the medication regimens from previous psychiatrists. Consequently, he has worked diligently to get to the lowest effective dosage while balancing state policies with individual care. For example, he talked about a state directive to reduce and eliminate thioridazine. In one case, he attempted to do	

#	Provision	Assessment of Status	Compliance
	interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	this, but the individual decompensated and has never really gotten back to baseline. Both psychiatrists reported that they would like to have more up-to-date data on the behavioral targets.	
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.	This item was not being addressed at the facility. There was no evidence of discussion of weighing the possible harmful effects of mental illness versus the possible harmful effects of psychotropic medication (although there were some examples of psychiatrists notes regarding risks versus benefits noted on forms-see paragraph J-12 below). Nor was there any discussion towards reducing medications that were aimed at poorly defined disorders, such as lorazepam for treating anxiety. There were examples of discussions, however, that indicated a desire, and perhaps an attempt, to get each individual on the lowest amount of medication possible without risking a relapse of problem behaviors or psychiatric symptoms.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Quarterly polypharmacy reviews were in place, but there was not a sufficient facility-level system in place to adequately review and monitor polypharmacy. There also was no policy in place to guide the facility and psychiatrists in the monitoring of polypharmacy. Of the 87 individuals receiving psychotropic medications, 83% were receiving more than one psychotropic, and 60% of the individuals were receiving benzodiazepines as part of their psychotropic regimen. The quarterly reviews, however, were not being done systematically, regularly, or reliably across all individuals (for example as found in the records of Individual #104- one review on 12/14/09, Individual #40- two reviews on 9/16/09 and 11/10/09, and Individual #2- no reviews done). The absence of these reviews was important because the psychiatrists relied on this document for the review of polypharmacy. Moreover, the implementation of state policy will be helpful. For example, one of the psychiatrists commented that he did not attempt to decrease dosages when individuals were stable on the current dosage, that is, “if it’s not broken, don’t fix it.”	

#	Provision	Assessment of Status	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.	MOSES and DISCUS were used at the facility, but were not part of an organized system to monitor the side effects of medications. DISCUS was the tool used by the facility for assessing tardive dyskinesia. It was implemented on a three to six month basis per record review by the monitoring team. MOSES was the tool used by the facility for the assessment of side effects of psychotropics. Nursing staff did the assessment using these tools. The results were reviewed by the psychiatrist who sometimes wrote comments on the back of the form. Some comments noted that the observed side effects did not outweigh the benefits of the medication. For example, in Individual #78's record, the MOSES from 6/18/09 stated that the individual had side effects with unsteady gait-bumping into furniture. The comment said, "side effects do not outweigh the benefits." There was also mention of weight loss and vomiting on the MOSES, but it was not attended to in the psychiatric progress note of 7/1/09. Moreover, this individual was not seen or reviewed by psychiatry in June 2009. At EPSSLC, the MOSES appeared to be a paper exercise that was largely ignored by psychiatry. Both psychiatrists were not familiar with the DISCUS and would prefer to use the AIMS. It was very confusing as to why some individuals were on quarterly reviews while others were on 6-month reviews. The psychiatrists were not familiar with the DISCUS and would like to have the AIMS on each individual. The monitoring team noted that akathesia seemed to be prevalent for many individuals, but was mostly ignored by PSTs. There were many psychotropics in use that alone, and in combination with other drugs, could lead to akathesia. It was very unclear as to whether or not the nursing staff could recognize akathesia and be able to document its occurrence accurately. For example, in Individual #8's 7/21/09 psychiatry progress note, it was noted that Haldol was reduced to address self-injurious behaviors and agitation that might have been due to akathesia. The reduction, however, was never followed up on; the notes contain no mention of whether the decrease in Haldol helped the individual. Moreover, it is possible that many of the individuals who had "anxiety" as a part of their diagnosis may actually have akathesia.	
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	There were no psychiatric treatment plans in place (other than a listing of the medications the individual was receiving). Many progress notes simply stated, "no medication changes." Examples of such psychiatry progress notes were from 12/23/09- Individual #13, Individual #27, Individual #120, and Individual #76; and from 12/16/09- Individual #79.	

#	Provision	Assessment of Status	Compliance
	treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.		
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Once more, it is expected that the new policy regarding psychiatry services will provide direction and guidance to the facility in meeting this item. None of the records had consents for <u>all</u> psychotropic medications. Not all of the consents had detailed instructions about the medications, in fact, it was the exception to find "page 2" of the consent where the individual side effects for that particular medication (rather than for the class of the medication) might be listed. The consent process needs to be individualized and not "generic" as the present ones appeared to be. The psychotropic medication consent process appeared to be onerous. The psychiatrists said that the process was better than it was six months ago, but that it still could take 7-10 days to obtain approval, in part due to the requirement of an HRC review. One psychiatrist said that it has taken up to three weeks to obtain consent for medications to begin after he prescribed them. The medical director thought that HRC review was required for increasing the dosage of a medication, not only for initiating new medications. The pharmacy staff said that this was not true. More work needs to be done at the facility regarding implementation of consent processes for psychotropic medications.	
J15	Commencing within six months of	This was not in place at the facility. Neurologist services were on a consultant basis,	

#	Provision	Assessment of Status	Compliance
	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.	inconsistent, and not frequent enough. Both the medical director and one of the psychiatrists expressed their wish to have a neurologist more than once per month. Neurologists are in high demand in most parts of the country and there is a short supply. Nevertheless, the need for neurology consultations were noted for individuals who had co-occurring seizure disorders. There was poor communication and coordination between psychiatry and neurology. For example, the pharmacy noted that, at times, a psychiatrist would lower an AED mistakenly thinking it was for a psychiatric application when it had been originally prescribed by neurology. Although the pharmacy kept a record of AEDs being used for psychiatric purposes, this information was not always evident and available in the psychiatric progress notes. In another example, the record of Individual #112 showed a neurology note in April 2009 indicating the presence of tardive dyskinesia while a psychiatry note on 11/2/09 indicated that the DISCUS showed tardive dyskinesia. There was no follow-up or team discussion about this discrepancy.	

Recommendations:

1. Develop and implement a written policy regarding psychiatric services.

2. Provide more psychiatry hours, such as by hiring a full-time psychiatrist, but no less than providing 32 hours of psychiatry service per week. It is unlikely that a part-time psychiatrist could devote enough time to interdisciplinary team meetings and see individuals regularly. Each individual should be seen face-to-face as often as needed based upon their presenting symptoms and behaviors. Record reviews alone are inadequate to determine whether or not the individual might have side effects from psychotropic medication. More attention to diagnostic formulation and symptom recognition also require direct interaction and observation with the individual. Most individuals won't require all that much one-to-one time, however, the degree of sedation or agitation should be seen directly by the psychiatrist.

3. Consideration should be given to use of the AIMS with administration the responsibility of psychiatry. Both psychiatrists said that they preferred this as the monitor for tardive dyskinesia.

4. Better integration of the psychology behavioral targets into the psychiatry reviews and case formulations. This might be best done in a formal treatment team setting. Older targets that are no longer a focus could be retired, and newer ones followed. Both psychiatrists feel the data need to be reported on a timelier, up-to-date, weekly basis for better detail on how the individual is doing for each behavioral target.

5. Treatment team meetings should involve psychiatry participation so that an attempt is made to integrate the symptoms of focus for psychopharmacology into the behavioral targets. Without this, it can lead to diagnosis being based on the psychopharmacology instead of vice versa. This format would also allow the psychiatrists to do some teaching of team members regarding pertinent topics such as recognition of akathesia and other pertinent side effects of the medications and psychiatric conditions.

6. Psychiatry needs to be directly involved with monitoring drug usage. An example is located in L section under 4th recommendation.

7. More consideration should be given with a goal of decreasing the usage of benzodiazepines, especially the use of lorazepam. Buspirone is underutilized in this population and benzodiazepines appear over utilized. Since 78% of the individuals are at risk for serious injury from falling, this really needs to be a peer review focus as well as a drug utilization review focus.

8. The record needs better organization. The psychiatrists frequently asked for staff to find information, such as lab and radiology results during psychiatry clinic, but the information was not easily accessible.

9. Adhere more to DSM-IV-TR for diagnoses. Many individuals had the diagnosis of Psychosis NOS, or Psychosis without the NOS designation. There were, however, no symptoms in the progress notes to justify the diagnosis. In another example, a diagnosis of Generalized Anxiety Disorder was given to an individual who also had a diagnosis of Chronic Undifferentiated Schizophrenia and was also largely nonverbal. More adherence to the DSM standard would correct or avoid these examples of concerns.

10. Consider including a Pharm.D. at the facility. For example, the psychiatrists are attempting to taper individuals on chlorpromazine and thioridazine. There should be a plan of cross-titration and a schedule that they follow so they will be more likely to be successful. A Pharm.D would be helpful in this regard. Further, a Pharm.D. would help the psychiatrists and team members stay up to date on drug-drug interactions as well as polypharmacy issues.

11. Psychiatrists should be involved in some sort of peer review, perhaps with psychiatrists from UTEP.

12. Consent for psychotropic medications should be streamlined. Emergency consent should be "same day" as order written and regular consent should take no more than 48 hours. Perhaps the medical director can give the consent for emergency medications. A process that takes weeks for approval to be obtained is simply untenable and will lead to increase in morbidity from psychiatric illness.

SECTION K: Psychological Care and Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o 008 K- DADS Psychological and Behavioral Services Policy, 11/13/09 o List of top 10 individuals with highest injuries from 7/09 to 12/09 o List of psychology staff members o Training logs for positive behavior support plans from 7/09 o List of individuals with behavior plans and dates of review o List of restraints over the last four months o Autism staff training content and PowerPoint slides o Personal Support Plans for: • Individual #24 • Individual #13 • Individual #95 • Individual #44 • Individual #10 • Individual #116 • Individual #18 • Individual #110 • Individual #19 • Individual #50 • Individual #69 • Individual #104 o Positive Behavior Support Plans for: • Individual #69 • Individual #82 • Individual #10 • Individual #13 • Individual #81 • Individual #99 • Individual #100 • Individual #95 • Individual #44 • Individual #116 • Individual #18 • Individual #110 • Individual #19 • Individual #50 • Individual #104

	• Individual #31 • Individual #108. • Individual #12 o Monthly Reviews of PBSP data for: • Individual #110 • Individual #31 • Individual #108. • Individual #82 • Individual #12 • Individual #95 • Individual #99 • Individual #66 • Individual #10 o Functional Assessments for: • Individual #78 • Individual #13 • Individual #69 • Individual #99 • Individual #108. o Safety Plans for: • Individual #78 • Individual #13 • Individual #18 • Individual #14 o Psychological Updates for: • Individual #13 • Individual #18 • Individual #82 • Individual #69 • Individual #44 • Individual #10 • Individual #66 • Individual #95 • Individual #14 • Individual #100 o Training logs for PBSPs for: • Individual #78 • Individual #52 • Individual #119 • Individual #80 • Individual #124 • Individual #77

	• Individual #30 • Individual #69 • Individual #68 <u>Interviews and Meetings Held</u>: ○ Discussions were held with a variety of staff from clinical, administrative, and direct care. ○ Met with all members of the psychology staff, and one of the consulting psychiatrists. ○ Informal interactions with numerous direct care staff from both first and second shifts from each work/vocational location and all dorms and cottages at the facility. <u>Observations Conducted</u>: ○ Observations occurred in every day program and residence. ○ These observations occurred throughout the day and evening hours. ○ Observations included many direct staff interactions with individuals including, for example, • assisting with daily care routines (e.g., ambulation, eating, dressing), • participating in recreation and leisure activities, • providing training (e.g., skill acquisition programs), and • implementation of behavior support plans.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: It was obvious to the monitoring team that EPSSLC had made a commitment to the use of applied behavior analysis in the assessment and treatment of behavioral excesses and deficits of the individuals whom it served. Although clearly motivated and dedicated to improving the lives of these individuals, the monitoring team believed that the psychology staff currently lacked the advanced training and/or experience in applied behavior analysis to use it as effectively as it could be. The psychology staff's strengths in this area included the development and implementation of standard functional assessment and PBSP formats that generally were on their way to meeting the generally accepted standard of practice in applied behavior analysis. The areas that most needed improvement in the area of applied behavior analysis were psychology staff's general knowledge of applied behavior analysis assessment and treatment methodology, insensitive data collection and monitoring systems, absence of systems to assess data and treatment integrity, and incomplete functional assessments. Finally, the psychologists' currently lack the opportunity to share behavioral challenges and potential solutions both within and outside of the department by not having internal and external peer review meetings.

	The facility had done an excellent job in assuring that all individuals had annual psychological assessments. Even so, it was not evident to the monitoring team that the assessments were consistently sensitive to individual needs (i.e., the monitors found no examples where a new assessment was completed in response to a relevant change), or were complete and current (i.e., based on new testing rather than representing results of previous testing). Additionally, it was not evident that the assessments were used to identify psychological needs other than for a PBSP.

#	Provision	Assessment of Status	Compliance
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.	The psychology staff appeared to be an energetic and hard-working group of professionals who were clearly dedicated to improving the lives of the individuals they supported at EPSSLC. All of the psychology staff who were responsible for the tasks detailed in this provision item had master's degrees. Nevertheless, they lacked the advanced training and specialized skills in applied behavior analysis required to effectively promote the growth and independence, and decrease the dangerous behaviors, of the individuals they supported. In addition to the master's degree, the monitoring team looked for each psychology staff member to possess, or to be in the process of obtaining, certification as a Board Certified Behavior Analyst (BCBA). The required five course sequence and supervised experience would teach the psychology staff the skills necessary to conduct valid assessments and develop effective interventions that would lead to effective positive behavior support plans (PBSP) and skill acquisition plans, as required by the Settlement Agreement. Further, the continuing education requirements of the BCBA would greatly increase the likelihood that the psychology staff would continue to remain current in their applied behavior analysis skills.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility had very recently hired a new Director of Psychology (only a few days before the start of the on-site tour). She held a masters degree in special education as well as the BCBA certification. This may be very helpful to other psychology staff as they pursue the certification. For instance, it is likely that she can provide the necessary supervision. The monitoring team looked for the director of psychology to be licensed and to have at least five years of relevant experience. Although not licensed, the director had the BCBA certification. Her limited experience in supervision, the application of clinical services, working with adults, and working in a facility setting, however, may substantially decrease her effectiveness in her new role. This should be monitored by the facility director. On the other hand, her training and experience in working with individuals with autism,	

#	Provision	Assessment of Status	Compliance
		and in designing and implementing instructional skill acquisition programs should be very helpful to the facility, the psychology team, and other departments at the EPSSLC. Again, the facility director should ensure that she has the support to meet these challenges. The most important supports the psychology director will need to ensure that she is a qualified director of psychology is the close monitoring and, additional training if necessary, in the following areas: • the management of the psychology staff (many of whom have more professional experience than does she); • effectively interacting with other departments at EPSSLC (e.g., ensuring that the psychologists play a more integral role with psychiatry in the prescription and modification of individual's medications, working with the QMRPs to ensure that the psychologists are developing and monitoring replacement behaviors and skill acquisition plans that are consistent with their expertise) and; • serving as an effective leader of the psychology department. The Settlement Agreement requires the psychology department to make many changes in the way it conducts business. The monitoring team recognizes that meaningful change can be difficult to accomplish and sustain. Therefore, in addition to being an effective manager, the monitoring team believes that the psychology director will need to be an effective leader in order to achieve and maintain this new level of psychological care throughout the facility.	
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.	DADS established a policy that included the requirement for a peer-based system of review of PBSPs. No documents, or conversations with the psychology department staff, however, indicated that peer review occurred at the facility. An active peer review system would allow the psychology staff to share their strengths and insights with each other and would result in improved overall quality of PBSPs. Peer review at the facility should occur weekly and, at a minimum consist of PBSP authors and those who supervise the implementation of plans. Other staff are indicated as participants in the DADS policy, however, it is important that the facility's peer review system include peers, that is, others psychologists and behavior analysts at the facility. Additionally, monthly external peer review meetings consisting of, at minimum, other Texas BCBAs/supervisors (by teleconference) should be conducted. Operating procedures for these peer review committees will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with	The monitoring team was encouraged by observations of direct care staff collecting data, and their ability to accurately describe the target behaviors of the individuals they were	

#	Provision	Assessment of Status	Compliance
	full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	supporting and supervising. Nevertheless, the current data collection methodology, and data presentation formats, were not sufficiently sensitive to assess behavior change. If data are not sufficiently sensitive to capture behavior change, subsequent PBSPs based on those data will not be as effective as they need to be. Direct care staff recorded target behaviors when they occurred throughout the day. This practice, however, did not lend itself to reliable data collection, or to a method to assess the integrity of data collection. Instead, the data collection of target behaviors identified in each individual's PBSP should be collected by direct care staff, at minimum, across one hour time blocks. This would require that direct care staff record the presence or absence of data on at least an hourly basis. This modification in the data system would also allow the psychology staff to more easily assess compliance with data collection by noting if data for previous times had been collected. In addition, the variety of data collection systems should be expanded to respond to the unique data collection needs of individuals. In other words, some individual's behavioral needs may require different types of data systems, and the facility needs to be able to implement those systems when necessary. Examples of other data collection systems include varying the length of time periods (i.e., potentially more frequently than hourly), the use of frequency data, and the use of partial interval data collection. The monitoring of PBSP data occurred on a monthly basis. The data reviewed, moreover, were single data points, each representing one month's worth of data. Therefore, these reviews consisted of looking at one new datum point each month. This practice resulted in reviews that were insensitive to discrete environmental events, such as PBSP or PSP modifications or medication changes. These variables might cause immediate and/or temporary behavioral changes, but their effects would not be salient because the staff were only graphing one point a month. In addition, it was not evident that the PBSP, nor revisions to the PBSP, were evaluated and revised based on the behavior of the individual. For example, in reviewing nine records of individuals with PBSPs, all of the records were found to contain at least some monthly reviews of the target behaviors identified in the PBSP. All records, however, were missing at least one monthly review, and most importantly, no plan was ever reviewed more frequently then monthly, even in response to an increase in problematic issues, such as exhibition of dangerous behavior or the use of restraints. Further, there was no evidence that data-based decisions were occurring regarding the PBSPs. In the review of 22 PBSPs across all three psychologists, there were annual	

#	Provision	Assessment of Status	Compliance
		modifications, but no examples of changes before the end of one full year. This occurred even though several individuals' monthly data indicated substantial increases in target behaviors prior to the annual PBSP revision. For example, Individual #69's monthly data indicated a dramatic increase in dangerous behavior on the 1/09 data review, but his PBSP (and functional assessment), was not revised until his annual date of 6/09. Therefore, monthly data reviews should represent data graphed in a manner that better lends itself to the identification of behavioral trends and the immediate modification of PBSPs when indicated by the data. Specifically, data should be graphed, at a minimum weekly, and more frequently as the data, and individual circumstances, require. For example, daily, or more frequent data, may be necessary to identify the effects of medication changes on an individual's behavior. A sensitive data system that identifies this trend could, for example, assist the psychiatrist in the most effective use of a medication prescribed to effect behavior, or allow the treatment team to better understand how an environmental change is effecting an individual's behavior. These subtle behavioral changes could not be detected with the current data system that only graphs and reviews monthly data. Finally, when these potentially important trends in data are identified and hypotheses are developed, modifications to the PBSP need to be made immediately, that is, there should not be a wait until the annual review date.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	Annual psychological assessments were present for 100% of the records sampled. In addition, all records included a review of intellectual ability in a report called a psychological update and were based upon standardized intellectual assessments and diagnoses reported elsewhere in the individual's record. Even though this information was present, many reported scores and diagnoses were more than 10 years old (e.g., Individual #14 from 1999, Individual #13 from 1994), and several of the psychological updates did not indicate when the diagnoses or tests were conducted (e.g., Individual #82). It was not clear whether these updates contained any new assessments (other than perhaps a new adaptive assessment), although they did include a review of behavioral issues and current medications. The annual psychological assessment (and/or update) should include regular reassessment of intellectual ability (if needed), screening for psychopathology, potential reevaluation of diagnoses, and an assessment of medical status. Moreover, the annual psychology assessment should include the results of an updated functional assessment if the individual had a PBSP. The current functional assessment (FA) forms were, in general, very comprehensive (although some were mislabeled	

#	Provision	Assessment of Status	Compliance
		functional analysis), but they fell short in two important areas. First, all of the FA's reviewed only included indirect assessment measures (e.g., interviews, record review, MAS, FAST). Interviews with psychology staff verified that only indirect assessments were done for FAs. It is, however, generally accepted in the field of applied behavior analysis that a comprehensive FA should include both indirect and descriptive measures (e.g., time samples, ABC measures), and when necessary, experimental manipulations of hypothesized sources of motivation of target behaviors (i.e., functional analyses). Therefore, all FAs should include both indirect and descriptive methods. Additionally, when indirect and descriptive assessments have failed to identify a clear source of motivation, the use of a functional analysis should be considered. Finally, FAs (like PBSPs) were conducted on an annual basis rather than when an individual's behavior indicated that further assessment was necessary. For example, in two of the FA's reviewed, substantial increases in target behaviors occurred and the FA was not done until the annual review. First, Individual #69's target behaviors more than doubled in January of 2009, but his FA was not conducted until July of 2009. Similarly Individual #99's disruptive target behaviors increased substantially in March of 2009, but his FA was not done until September 2009. The PBSP would likely be more effective if the FAs were more thorough (i.e., included descriptive measures), and were conducted in response to individual behavior change, rather than on a calendar schedule.	
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.	It was not obvious from record reviews and interviews with psychology staff that annual assessments were consistently based on current or complete information. The record review indicated that psychological assessments were based on historical information that was often more than 10 years old, and the FAs were often incomplete (see comments above). A policy and practice should be developed to ensure that the information reported in psychological assessments is based on current, accurate, and complete clinical and behavioral data, and that specific psychological assessments (e.g., assessment of cognitive function, psychological diagnoses) be completed by a psychologist licensed or certified in the State of Texas to conduct and interpret psychological assessments.	
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	This item was not being addressed at the facility. Record reviews indicated that although psychological reviews were conducted for each individual, they were conducted on an annual basis, rather than on as needed based on an individual's behavior. In addition, the records for four individuals recently admitted to the facility were	

#	Provision	Assessment of Status	Compliance
	each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	reviewed. Individual #99, Individual #95, Individual #10, and Individual #68 were admitted in 7/08, 11/08, 2/09, and 4/09, respectively. Psychological assessments could not be found for any of these individuals.	
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.	The psychological assessments reviewed did not contain specific recommendations for other specific psychological services. The recommendations typically consisted of the continuation of various services, such as residential placement, psychiatric services, and behavioral support. Needed psychological services other than behavioral support, need to be identified in the psychological assessment and implemented within six weeks of the assessment. The monitoring team could only identify one individual at EPSSLC receiving psychological services other than PBSPs. Individual #13 was reported to be participating in CIRCLES, a counseling program. The psychologists at the facility, however, indicated that, due to staff shortages, CIRCLES was not conducted on a regular basis. Additionally, the monitoring team could not find documentation of this service or any indication that it was goal directed, reflected evidence-based practices, or that progress was documented or reviewed. Given the range of abilities and needs of the individuals at EPSSLC, more work needs to be done in this area of psychological services.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a	Twenty-two PBSPs were reviewed to assess compliance with this provision. In general, the PBSPs appeared to be comprehensive and included most of the components one would expect to find in a PBSP (e.g., rationale for selection of treatment, definitions of target and replacement behaviors, a response to behavior problems when they occur, a strategy for strengthening desired behavior, a description of the function of the target behavior, strategies addressing antecedent issues, and a description of data collection procedures. The PBSPs, however, did not include treatment expectations and time frames, a section that documented prior interventions that had been effective, or consideration of medical, psychiatric and healthcare issues. Strategies for teaching replacement behaviors were included in the PBSP, but they were often written in general and vague terms, and not specified in a matter that would lead to staff being able to implement training of these behaviors. Additionally, although both antecedent and consequent strategies for decreasing undesired and increasing alternative behaviors were included in the PBSPs, because of the limitations of the functional assessment (see section K5), the monitoring team believes that these interventions may not be maximally effective in producing desired behavior change.	

#	Provision	Assessment of Status	Compliance
	written extension based on extraordinary circumstances.	Finally, the monitoring team found no evidence of consents for PBSPs or safety plans. Consents and approvals, as per facility policy, need to be obtained for each PBSP and safety plan prior to implementation. In order to meet the provisions of the Settlement Agreement, all PBSPs, even those that do not involve restrictive procedures, must have signed consent. This position is supported by the BCBA ethical guidelines. Specifically, guideline 4.01 states that the behavior analyst must obtain the client's, or client's surrogate, approval in writing of behavior intervention procedures prior to implementation. This BCBA requirement is not restricted to restrictive procedures. Additionally, relevant information from the most recent FA should be included in the PBSP, and specific skill acquisition plans should be reliably implemented for replacement behaviors. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and specific instructions for how to conduct the training and collect data. One additional point is worthy of comment. A number of the individuals at EPSSLC had autism diagnoses, or appeared to have autism. The facility, and the psychology staff, did not appear to have any particular expertise in autism. Further, there did not seem to be any programming (in PBSPs or in skill acquisition plans) that indicated any special consideration for individuals with autism or autistic characteristics (e.g., type of routine, instructional format, response to challenging behavior). The statewide training program had recently added a section on autism (training course #AUT0100). The content included an appropriate overview of autism and its characteristics, however, it did not include important components about programming for individuals with autism. Instead, it included a lot of discussion about values-based support. Although this type of support is relevant to individuals with autism, it is no different than the type of positive programming and support one would do for anyone with disabilities at the facility. The training should be updated to include important considerations for this population and perhaps include descriptions of how the needs of individuals with autism may, or may not, be similar to other individuals who reside at the facility. The new director of the psychology department had training and experience working with individuals with autism and may be able to provide assistance to the facility in this area, that is, in the content of training for staff, the design of interventions in PBSPs, and in the way instructional skill acquisition plans are developed and monitored.	

#	Provision	Assessment of Status	Compliance
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	There was no evidence from observation or staff interviews that inter-observer agreement measures existed for PBSP data. Inter-observer agreement data should be collected at least monthly to better ensure that PBSP data are reliable. Additionally, as discussed above, a single datum point representing one month was insufficient to assess trends in data and, therefore, data should be graphed in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or PBSP). The graphs that did exist contained the necessary components of a graph (e.g., horizontal and vertical axis and labels, condition change lines and labels, and data points and path). There were, however, no examples of graphs that indicated changes in relevant events, such as medication, health status.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	It was good to see PBSP "working plans." These were a component of the PBSP that was detached from the PBSP and put in the residential file for direct care staff. Generally, the working plans were written in a manner that could be understood by direct care staff. During observations, staff were generally following the individuals' PBSPs. For example, in the residence, staff's behavior appeared consistent with the antecedent instructions in Individual #69's PBSP, such as keeping him busy and offering frequent praise. Although the occurrence of challenging behaviors were not observed by the monitoring team, direct care staff interviews indicated that staff were not always able to report how to implement specific consequences of an individual's PBSP. For example, in the residence, direct care staff working with Individual #78 were able to describe what they would do if she began engaging in self-injurious behavior (SIB). On the other hand, staff in the day program working with Individual #82 indicated that they would redirect him if SIB occurs, but his PBSP plan included a requirement for blocking, attempting to remove the cause of the SIB, and prompting to use his communication skills (and his communication book). Finally, observation and staff interviews indicated that a system to monitor and ensure treatment integrity did not exist.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years,	A review of a sample of staff training logs indicated that that the facility was providing competency-based training on the overall purpose and objectives of the specific components of individual's PBSPs. It appeared, however, that not all staff who provided	

#	Provision	Assessment of Status	Compliance
	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.	direct care had indeed received the necessary training in individuals' PBSPs and skill acquisition plans. It also was not clear how the facility tracked who was trained and who needed to be trained. Training log reviews and interviews with staff indicated that the training included a combination of didactic, modeled, and in-vivo training strategies. Training occurred both before implementation of the PBSP and throughout the duration of the PBSP. Staff training of the PBSPs was provided by the psychologist responsible for the plan or one of the psychology technicians.	
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.	At EPSSLC, there were four psychology staff for 142 individuals. This was slightly below the required 1:30 ratio. Also, there were two psychology assistants/technicians at the facility.	

Recommendations:

1. Pursue BCBA certification for psychology staff.
2. Ensure proper and thorough training, supervision, and support of the new director of psychology.
3. Establish peer review committees.
4. Improve data collection systems.
5. Improve the system of psychological assessments and functional assessments.
6. Ensure individuals are assessed for need for psychological services other than PBSPs (e.g., counseling).
7. Ensure PBSPs contain all required components.
8. Ensure consent process is followed for PBSPs.
9. Develop a plan to obtain interobserver agreement on PBSP data.

10. Ensure all staff are thoroughly trained in the individual's PBSP.

11. Meet the required psychology staff ratio.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ The requirements of the separate monitoring plan, identified as Health Care Guidelines ○ Policy and Procedure manual for the EPSSLC Medical Department ○ HST committee meeting minutes- Dec 16, 2009 and others ○ The following documents for 17 individuals: • Annual medical summaries • Progress notes (including medical) 9/1/09-1/13/09 • Lab data, radiology reports, and EKG's. ○ Osteoporosis tracking data maintained by the medical director ○ Clinical death review on Individual #48 ○ Record on Individual #101 Interviews and Meetings Held: ○ Three meetings with Dr. Ken Wiant, medical director
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Medical care was overseen by a very dedicated family physician who remained up-to-date and board certified in family practice (most recently 2006). He overall appeared to be very interested in providing excellent care for the individuals. He stated that staff reacted immediately to emergencies and that when they called 911, EMS was typically at the facility within five minutes. A nurse practitioner was scheduled to be joining the medical department starting at two days per week to help with annual medical summaries and other tasks. The medical director reviewed all lab data and outside consults, and signed each lab slip with a plan for either follow-up or treatment. Most problems appeared to be followed-up on in a timely fashion (however, see notes in other sections of this report, especially section D regarding abuse and neglect reporting, and section M regarding nursing). Overall, however, policy and procedures were needed to provide guidance and decision making to the facility management and to the medical department.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The state policy for this provision was not yet developed or in place. It is expected that the policy will provide guidance to the facility regarding this provision. The policies and procedures for the medical department at EPSSLC were grossly out of date. The most recently dated section in the policy and procedure manual was from 1995. The administration of oxygen policy was dated 1989, and the infectious disease section was dated 1986. The medical director was aware of the dates of the policy and procedure manual. Issues regarding overall routine, preventive, and emergency medical care are noted in various sections of this report, especially in the sections on nursing, pharmacy, psychiatry, and the health care guidelines. Overall, routine and emergency care appeared to be adequate, but further review of these areas of medical care will occur on future monitoring tours. One example of routine and preventative care systems at EPSSLC is worthy of further discussion. That is, it was unclear as to how the individuals were screened for such things as breast cancer and cervical/ovarian cancer. There was no routine pelvic examination (the rational was that it would require sedation for most individuals). Further, there was no policy on how often such examinations should occur in the facility. Examples of policies and recommendations for routine examinations exist at other facilities around the country and in policies developed by agencies in other states. These may be of value to the state in developing the new policy for his provision of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	A facility medical review and a medical peer review system did not exist at EPSSLC.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a	A medical quality improvement process did not exist at EPSSLC. The medical director, however, tracked some important data on his own. Some of this may be useful to the facility's QA department once it begins to develop a process for the	

#	Provision	Assessment of Status	Compliance
	medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	facility. The medical director's data included bone mineral density (BMD) scans for review of every individual at least once per every five years. Vitamin D and Calcium levels were recently added to this tracking data. Any individuals who were found to have decreased Vitamin D levels were in treatment. It was interesting to note that 47% of the individuals in the facility database (including some who have been discharged or had died) met criteria on BMD for osteoporosis, and 31% met criteria for osteopenia. Further, 78% of individuals in the facility were at serious risk for fractures from falling. The medical director's database also tracked PSA levels for the men in the facility, and lipid levels on all individuals. There was, however, no formal monitoring process to ensure that all individuals were being treated after diagnosis.	
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.	This provision item refers to the Health Care Guidelines, a detailed set of guidelines for medical care. Even though these applicable standards had been chosen by the parties, a policy had not yet been developed regarding implementation of these guidelines. It is expected that a new policy along with specific procedures will be required by the facility if it is to meet these standards and this provision item.	

Recommendations:

1. Develop and implement policy and procedures. These should come from the central DADS office. This would eliminate using valuable physician time to write such policies. Policies could be individualized in each facility in needed.

2. The medical department is in need of more hours from either another MD (internist), or alternatively, a full-time NP, to help keep up with the demands in the medical department, including on-call responsibilities (the medical director was on 24-hour on-call every day). The current medical director is retiring by October 1, 2010 and a search should begin immediately for his replacement. He will need to cross-train his replacement on his tracking system for trends in the facility. Sick call volume increased over the past few years. For example, on the final day

of the on-site tour, there were 13 cases for sick call by 10:00 a.m.

3. A procedure for routine healthcare such as pelvic, mammograms, and other routine screening needs to be worked out for the department. This is a special population with regard to these routine sorts of procedures and it will need to be taken into consideration that annual pelvic exams requiring sedation may not be in the best interest of the population. The physician should be given final say over the appropriateness of each individual for this sort of screening. This type of planning may include other invasive procedures like colonoscopy. It seems that this should be addressed when the policies and procedures are developed for this section of the Settlement Agreement.

4. Review of labs for psychotropic medications should be the responsibility of the psychiatrist consultant with support, coordination, and integration with the medical department. The psychiatrists should also review all of the various lab matrices that are pertinent to their prescribing of psychotropics. For example, if the lipid panel is such that it merits treatment, or the TSH is in need of treatment, then it should be referred to the medical director.

5. Psychiatrists should be involved at some level in the review of chemical and physical restraints for individuals under their care.

6. Medications for osteoporosis: consideration needs to be given to the more expensive forms of medication, such as Boniva (monthly) and Reclast- annual IV administration. An excellent example of an individual who needed a form that occurs less often than weekly was Individual #29. He had intractable seizures and was at risk for fractures. He missed three weekly doses over three months. Despite being on Alendronate- his last BMD was recorded as -4.2/-3.8. The facility needs to consider the cost of fractures/injuries in this population to the cost of the more expensive forms of these calcium metabolism agents. In a population with severe, intractable seizures, coupled with the subsequent risk of injury from falling and the prevalence of osteoporosis, a serious problem is created that needs a better resolution than a weekly treatment requiring individuals to arise at 5:30 a.m. to take the medication, and then remain upright for one hour prior to having breakfast. Moreover, restraints and persistent individual refusals occurred around administration of this drug, leading to inadequate treatment of the problem.

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: ○ Health Care Guidelines ○ Injury List August to December 2009 ○ Injury Reports August through December 2009 ○ Medication Administration General Guidelines ○ Medication Administration Observation Form ○ Medication Adverse Criteria Report ○ Medication Audit Criteria Guidelines ○ Medication Error Reports ○ Medication Error Information Reports ○ Medication/Treatment/Diet Record ○ Incident Management Meeting Notes ○ Notification of severe drug reaction ○ Nursing Clinical Review ○ Nursing Turnover ○ Weekly Nursing Report ○ Nursing Job descriptions ○ Osteoporosis Lists ○ Persons Enterally Fed ○ Pharmacy Services Manual ○ Pre-service Training for Direct Care Staff ○ Trend Analysis Report-Restraints FY10 First Quarter ○ Safety-Risk Management Accident Review ○ Severe Side Effects ○ Department of Aging and Disability Active Position Status Report ○ FY10 Fill and Turnover Summary Report ○ Health Risk Assessment Rating Tool ○ Medical records for these individuals: • Individual #14 • Individual #21 • Individual #23 • Individual #101 • Individual #100 • Individual #1 • Individual #104 • Individual #106 • Individual #71 • Individual #74

	• Individual #112 • Individual #69 • Individual #75 • Individual #115 • Individual #29 • Individual #78 • Individual #82 • Individual #83 • Individual #84 • Individual #89 • Individual #127 • Individual #48 • Individual #94 • Individual #93 Interviews and Meetings Held: ○ A number of nursing and other clinical staff were interviewed to determine how nursing functioned in the facility as well as their roles and interactions with the interdisciplinary teams. Nursing administration and risk management was also a focus of these discussions. ○ Sandy DeLong, Chief Nurse Executive ○ Mary Ann Clark, Nursing Operations Officer ○ Dr. Ken Wiant, Medical Director ○ Debbie DeSantis, Head of Pharmacy ○ Dr. Rydell, part-time facility dentist ○ Anderson Hicks, Director of Habilitation Services ○ Full time dental hygienists, Jennifer Pacheco and Raquel Rodriquez. ○ Irania Rodriguez, Nurse case manager ○ Miriam Valdez, Diet Technician II Observations Conducted: ○ Weekly “Bin Exchange Procedure” ○ Medication Pass and Tube Feedings on the Systems program ○ 4 pm medication passes: • in Cottage 13 by Mario Guzman, LVN • in Cottage 12 by Bernie Medina
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.

	Summary of Monitor's Assessment: The EPSSLC nursing department was comprised of a dedicated and skilled staff. In meetings and observations, the monitoring team observed their attention to multiple simultaneous tasks, including ongoing interactions with individuals, discipline heads, residential management, and direct care staff. As detailed in this section of the report, nursing care provided at EPSSLC did not meet the requirements outlined in this provision of the Settlement Agreement. There were serious shortages in nursing coverage that impacted directly on the facility's ability to meet these requirements. There were substantial documentation problems that also made it difficult to assess a good deal of the nursing practice. Nurses were failing to document medications at a very high frequency. Further, illness and injury were seldom tracked to resolution making it difficult to know if services were provided or not. Nursing procedures for administering medications did not meet the standard of practice and, as a result, there may be a much higher error rate than was being recorded at the facility.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	EPSSLC had a dedicated and skilled nursing staff. As noted in the review of this entire provision M of the Settlement Agreement, their workload, organization of assignments, and competing responsibilities made it difficult for many nursing and medical tasks to be thoroughly completed. Selected sections of 25 records of 25 individuals were reviewed and many nursing problems in documentation were found. In general, legibility of documentation was a major issue, particularly in some of the progress notes, where long entries were almost impossible to read. Another problem in the standard practice at EPSSLC were large sections of blank lines that were not crossed out, as they should have been. Many pages were also blank on the back, and many pages were out of continuity, making the progress notes more difficult to read. Further, many entries were either irrelevant or subjective for a nursing record (e.g., "had a good day," "sleeping well") and made it more difficult to find the relevant information. Much of the information in nursing entries could be recorded via flow sheets, and progress notes thereby restricted to new events of clinical interest. For example, recording intake and output in the progress notes is impossible to track, as is anything that includes tracking change over time. DAP (Data, Analysis, Plan) recording by nurses was intermittent and did not seem to be well understood by nursing staff at the residences.	

#	Provision	Assessment of Status	Compliance
		Many health care issues were identified in the record that had a failure in follow through to resolution. Below are a number of examples: • Individual #14: 9/29/09: cellulitis of left elbow noted, but not recorded to resolution. • Individual #21: 10/22/09: oral herpes noted, but not followed to resolution. 1/11/10 hit on back of head. Head injury protocol (HIP) required 12 neuro checks over a three to four day period. The first two were completed, then no others were noted. • Individual #100: lots of illegible entries, neuro checks did not follow HIP protocol. Many seizures were not described behaviorally; only the duration was noted. • Individual #23: 10/6/09: 10 bruises not recorded to resolution. • Individual #104: 8/28/09: acetaminophen for crying and anxiety was given. There was no follow-up; the next entry was 8/30. 9/28/09: 2000, injury to head noted. No assessment and no HIP neuro checks appeared to have been done. • Individual #75: 10/2/09: physician note stated he was called to see infected incision. No nursing note was in record to support this. Further, the nursing notes from 10/4 through 10/6 had no entries regarding this incision issue. • Individual #115: 8/20/09: head injury noted, but notes indicated missing 7 of 12 required checks. This individual was noted as having many seizures and falls. The seizures were poorly described in the record. • Individual #29: No progress notes were in the record from 6/17/09-7/6/09; medication administration was not documented at all on 12/26/09 for five medications. • Individual #78: 10/29/09: Notation of self-injurious behavior to head. No neuro checks were indicated in any documents. • Individual #82: 11/14/09 and 12/07/09: Injury to head from self-injurious behavior was noted. No neuro checks were found in the record for either event. • Individual #83: 12/4/09: a number of injuries were noted, but with no follow-up to resolution, including a fall with injuries to shin. The next entry was 12/8 and then no entries until 12/11. • Individual #84: 12/25/09: hit head against wall. Then 7 of 12 required neuro checks were completed. 10/14/09: note by physician regarding injury to right forehead. The next entry regarding forehead was 10/19 and then 10/22. 11/13: medication for pneumonia was only documented for 2 of 10 days. Many other medications were not signed for.	
M2	Commencing within six months of	All of the 25 records reviewed contained annual and quarterly nursing assessments.	

#	Provision	Assessment of Status	Compliance
	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.	Overall, the quality and quantity of information in these assessments were good. For all individuals, these assessments, completed by the nurse case managers, were thorough, informative, and provided a summary of the health status of the individual.	
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.	Nurse case managers were also in charge of developing care plans for their assigned individuals. Acute health care plans were found in the medical record and chronic health care plans were kept in the record at the residence. The nurses, however, needed assistance when writing acute and chronic health care plans. The "Care Plan Library" from which they chose standardized information was missing many topics that were relevant to this population. As a consequence, some major issues were not adequately addressed. This was especially true for those conditions that can have serious outcomes if not managed aggressively, such as self-injurious behavior, GERD, and reflux esophagitis. <u>Chronic conditions</u>: Overall, many chronic conditions were dealt with appropriately, while many others will require attention and coordination from EPSSLC in order to be addressed in a manner that meets generally accepted standards of practice. Examples of chronic conditions dealt with in a satisfactory manner included diabetes, aging, and hypertension. There was evidence on the living units that staff had been trained appropriately in these areas. Below are conditions that will require more attention from the facility. GERD: Gastroesophageal reflux disease is endemic in this population and difficult to manage without a well-coordinated interdisciplinary process. EPSSLC needs to develop this coordination. This will require understanding the relationship between physical and nutritional management and GERD, and the need for joint problem solving to fix it. For example, there were many individuals with tubes of various sorts at the facility. Many of these individuals received their feedings via pumps over an extended period of time. This, however, is not how the stomach was designed to work and can contribute to GERD. There was also little awareness that certain behaviors, such as PICA, hands-in-mouth, and some forms of self-injurious behavior can have a direct correlation to reflux esophagitis (as much as 30% of the time). It is, therefore, possible that behavior problems due to GERD were being treated with behavioral and pharmacological programming in lieu of a coordinated interdisciplinary process. Incontinence: Health care plans for incontinence and urinary tract infections were	

#	Provision	Assessment of Status	Compliance
		adequate, however, more work needed to be done in training direct care staff in appropriate perineal care. This was evidenced by the urinary tract infections that involved E.coli, a sign of fecal contamination. Bowel management: Many components of the systems to address this area at EPSSLC needed attention. First, protocols at EPSSLC did not, but should, recognize (a) the importance of fiber and fluid, and (b) that there is a strong relationship between therapeutic positioning and bowel function. Second, quarterly documentation did not thoroughly report on whether or not progress was being made. Third, tracking of PRN interventions and their outcomes were difficult to find in the progress notes. Most of the time, the information was missing altogether. Fourth, direct care staff reliability and accuracy of reporting bowel output was questionable and more training is required. A final other important issue that needed recognition was that bowel symptoms often require a full physical assessment. For example, an individual admitted to acute care for bowel obstruction may in fact have a respiratory issue. Further, nurses failed to recognize that the absence of bowel sounds is not the only sign of bowel obstruction. High pitched, high frequency, tinkling sounds above the belly button are often the first signs of a small bowel obstruction. There was no recognition of this fact in the physical assessments reviewed in the nursing documentation Chronic respiratory problems. The treatment of chronic respiratory distress was difficult to assess at EPSSLC. Although there was evidence of intermittent assessments of respiratory status, documentation was so fragmented and difficult to read, that the quality of assessment was impossible to determine. In particular, oxygen saturations (O_2 saturation levels) were done regularly as a part of vital signs, but assessments of breath sounds, particularly quality, locus, rate, and rhythm, were seldom done. In addition, there was no documentation of any individual's response to respiratory medications, nor was there evidence that positioning to facilitate respiration was done. There was some indication that respiratory issues were reported to the physician, however, that was evidenced by the physician's notes, rather than in any documentation regarding notification done by nursing. Finally, EPSSLC did not have a respiratory therapist, either as an employee or consultant. Skin integrity: The condition of skin integrity was fairly well managed at EPSSLC. Nursing staff recognized that individuals at EPSSLC were particularly vulnerable to skin breakdown, especially when they were in alternative settings, such as acute care. For the most part, there was an attempt to make a note of weekly skin assessments in the record, although it may make more sense for this task to focus upon only those individuals who were at risk for skin integrity problems.	

#	Provision	Assessment of Status	Compliance
		Seizure management: As is typically the case with this population, many individuals at EPSSLC had seizure disorders. Of the 142 individuals at the facility, many had seizure disorders that required some sort of treatment, usually via medication. There were, however, major issues with seizure management at EPSSLC, due in part to at least the following factors: • Documentation of seizures (e.g., frequency, details of each seizure) was very poor, done inconsistently, and was often incomplete. • Direct care staff seemed to be inadequately trained to recognize and assist with seizure management and often did not report seizure activity to the nursing or medical staff. • Staff did not appear to understand that while seizures are divided into two large classifications, partial and generalized, there are more than 40 distinct types within these two classifications. This is important to know because medications and treatment will vary greatly depending upon the seizure type. For example, absence and tonic/clonic seizures are both generalized, but the medication to treat the absence seizures will likely be far different than that used for tonic/clonic seizures. If the physician, or neurologist, does not have adequate information about the seizure type(s), treatment is seldom as effective as it could be. • There was little documentation of nursing assessment and documentation of vital signs following a seizure. • There was no indication of seizure type in the diagnoses, and most documentation in the progress notes was limited to duration (e.g., 30 second seizure, 10 second seizure). Below are some examples from the records of individuals reviewed: • Individual #100: had a diagnosis in the record of epilepsy, intractable. An 11/24/09 note merely said 35-second seizure. There were many seizures noted in the progress notes, but few were described in any way that could provide valuable information to treating medical staff. • Individual #1: had a diagnosis of Lennox Gastaut Syndrome. This condition involves a combination of several seizure types and is notoriously difficult to control. This individual's seizures, which were frequent, were recorded, but not described. As a consequence, there was no way of knowing which particular type of seizure had occurred. Further, there were no assessment or vital signs documented for any of the following seizures: on 1/7/10: a 15 sec seizure; and on 1/8/10: a 10 second seizure and a 15 second seizure. Seizure activity that occurred more than once in a day were simply recorded as tallied events rather than being described behaviorally and individually. Each seizure required, by	

#	Provision	Assessment of Status	Compliance
		policy, an individual assessment, including an assessment of vital signs, however, this was not done. • Individual #69: was having seizures, often several times a day, but usually early I the day. Changes in Lamictal were ordered; it was being titrated up from 100 mg to 150 mg and finally to 150 mg. There was not, however, documentation that these orders were implemented from 12/12/09 to 12/29/09. Several other medications were missing proper documentation as well. • Individual #29: had 62 seizures and had Diastat seven times in the last 12 months. It was impossible to determine from the record the conditions under which the emergency drug was administered. Please note that seizure management is discussed again in this report in the section on Health Care Guideline II, regarding seizure management Chronic health care plans: A chronic health care plan could not be found for many important medical issues for many individuals. For example: • Individual #21: no health care plan existed for constipation, even though it was one of her major diagnoses. • Individual #100: no health care plans existed for falls, reflux esophagitis, or history of GI bleed. These were all conditions that are likely to occur again. • Individual #23: no health care plans existed for constipation, weight instability, or impaired skin integrity. He also had low albumin and protein that left him vulnerable to infection and skin breakdown and fractures. • Individual #75: had GERD with reflux esophagitis, but it was not listed in the nursing diagnoses. • Individual #115: had lost 22 pounds in the last five months, but there was no health care plan to address this issue. • Individual #29: had a hiatal hernia. This required upright positioning for both mealtimes and post-mealtimes. It was not mentioned in the PNMP and neither a diagnosis nor a health care plan could be found. • Individual #78: had insidious weight loss, anemia and a hiatal hernia along with GERD, and many unexplained injuries. She was very unsteady, lethargic, and fell. There was a nursing diagnosis for GERD, but no health care plan. • Individual #84: had health care plans for constipation, nasal drainage, and unsteady gait, but none for GERD. Acute illness and injury: There was evidence that nurses, for the most part, responded to events that indicated either injury or illness. There was, however, little evidence that nurses did a full body assessment under these conditions. They usually obtained vital signs and occasionally	

#	Provision	Assessment of Status	Compliance
		did abdominal assessments. They only fully implemented the head injury protocol some of the time, often not at all. This protocol required two neurological checks an hour apart, then every four hours for the next 24 hours, and then once each shift for another two days. This called for a total of 12 checks followed by documentation of resolution of the problem. It is important to know that head injuries can begin to show complications, such as a subdural hematoma, up to several days after the event. There were many unexplained injuries at this facility. Almost every individual in the sample had unexplained bruises or lacerations. Many individuals were receiving antianxiety agents, such lorazepam for anxiety or pre-treatment sedation, diastat for prolonged seizures, and/or clonazepam for seizures. Unfortunately, these drugs are associated with drowsiness, blurred vision, and orthostatic hypotension. Many of the individuals with unexplained falls and injuries were receiving one of more of these drugs. It seemed clear that inadequate attention had been given to the role of these drugs in the high incidence of falls and injuries in the facility. Many of these same individuals were on a combination of other psychoactive drugs that can potentiate the effects of the benzodiazepines or vice versa. Prevention is key here. Assessments of injuries and acute illness were inadequate. For example: • Individual #14: 12/31/09: Direct care staff reported emesis three times in 10 minutes, a liquid brown color. The nurse did not do anything but an impaction check, which was negative. The nurse failed to assess the abdomen, which was appropriate to do with this set of symptoms. There were also no vital signs taken. Two other times, 11/18 and 11/3, individual complained of abdominal pain and loose stools. The physician was notified, but no nursing assessment was performed. • Individual #21: had continuous nasal drainage. Vital signs were taken, but no chest or abdominal assessment was completed. The individual was crying at the time of the vital signs being taken, but was only given Tylenol for possible pain. • Individual #100: 11/24/09: Fell, but there was no notification of nurse. Later the same day, the individual vomited five times, without any assessment. • Individual #23: weight on 10/5/09 was 129. On 11/1 it was 124. It was another 17 days until the physician commented in the progress note. Further, in this record, on 10/16/09, 10 bruises were noted, but not recorded to resolution. Rules for nursing assessment were not clear, but there needs to be a specific protocol for this process and nurses must prove their assessment competence at least annually.	

#	Provision	Assessment of Status	Compliance
		Prevention: Comments about prevention were included in both the annual and quarterly assessments, but there were content issues as discussed above. Overall, prevention was only dealt with superficially in some areas and not at all in other areas. There was very little interdisciplinary collaboration and, as a consequence, there were insufficient prevention plans, especially for the following areas: • GERD • Respiratory issues • Bowel function • Physical and nutritional management, particularly as it relates to gastric flow and emptying Infection Control**:** While there was a system for collecting data regarding infection control at the facility, the person responsible for infection control processes and monitoring was on extended leave and, as a result, the position could not be filled. Thus, there was no leadership in this area. Data were collected, but there was no system in place to ensure the reliability of the data, the analysis of trends, or any follow-up to findings. Restraints**:** Few examples of restraints were available in the sample. Only one of 25 individuals was restrained and nursing documentation for that single episode was inadequate.	
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.	Please see the comments throughout this section M. In addition, comment regarding nursing staffing is warranted here. Nursing staff at EPSSLC had an annual turnover of 88%. This was higher than in other departments, such as the direct care staff, which had significantly less turnover in this facility than did nursing. There were 46 nursing positions (not including the chief nurse executive) distributed as follows: • 1 nursing operations officer (ADON) • 2 nurse managers (shift supervisors) • 1 infection control nurse who is out on leave, and the position could not be filled. Although many of this position's duties were assigned to others, and data were being collected, the major duties of this position were not occurring at the time of the on-site tour. • 1 nurse recruiter • 1 QA nurse; although not in department, counted in the total number of staff • 1 nurse educator/hospital liaison	

#	Provision	Assessment of Status	Compliance
		• 6 RN3 case managers • 33 RN2s and LVNs who provide shift coverage on the residences for three shifts, seven days per week It is important to note that of these 33 direct service nurse positions, five were on administrative leave. During these times, the nurse was not allowed to work on the residence. This reduced the number of active nursing positions to 28 nurses to cover 11 residences, 24 hours per day. The effects of planned time out, training, and illness reduced actual nursing capacity even further. As of 12/31/09, there were 35.6 nursing positions filled of 46 budgeted positions in nursing. These vacancies further impacted nursing availability for the residences. The chief nurse executive reported that she had no trouble with recruitment of nurses in the El Paso area. The problem was with retention. This vacancy rate averaged between five and seven positions per month over the last six months. Thus, it was clear that the actual number of nursing positions available to staff this facility is actually much lower than the 28 noted above. The nursing department had to cover these vacancies either with overtime or with nurses from temporary staffing agencies. Job satisfaction is an important component of retention. One aspect for nursing staff was supervisory issues at EPSSLC. Consider that nurses do not supervise direct care staff at EPSSLC (or at most facilities of this type). When medical issues and needs arise that require assistance from direct care staff, conflict between these two groups can arise. Rather than cooperation, refusals to assist and allegations of abuse can occur. Such was reported at EPSSLC. Nurses at EPSSLC were concerned about unfounded allegations of abuse being filed on nurses. Indeed, there were a number of cases being investigated at the time of the on-site tour. Another aspect of job satisfaction is the ability to complete one's job thoroughly. EPSSLC appeared to usually operate with the barest of minimal nursing coverage possible. Only licensed nurses were allowed by state policy to administer medications. At the same time, nurses were required to respond immediately in the event of a behavioral or medical event, whether they were in the middle of administering medication or not, or if they were involved in any of the other important requirements of their jobs.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop	As noted in other areas of this report regarding other provisions of the Settlement Agreement, the system for assessing risk at EPSSLC needed attention, especially regarding the definitions of risk level and the manner in which risk was assigned to individuals.	

#	Provision	Assessment of Status	Compliance
	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.		
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The administration of medications was an area of great concern to the monitoring team during this on-site tour. The Medication Administration Record (MAR) system at EPSSLC was a challenge in terms of facilitating effective nursing function. In most systems, the MAR and TAR (Treatment Administrative Record) are electronically generated from the pharmacy. This is recommended for EPSSLC. In this type of system, routine medications for each individual are documented on the front of the form. Medications given when needed (prn) are documented only when needed, such as for pain, fever, or constipation. The response to the medication is normally documented in a space designated on the back of the generated form. This allows the tracking of both frequency and response to these interventions in an easy to use format. EPSSLC's MARs and TARs were generated via a printer, but they were blank on the back and do not have the utility that the above process provides. What made the review of the MARs at EPSSLC even more confusing and difficult was that every record had a different dating sequence, instead of all being a standard month from the first day of the calendar month to the last day of the calendar month. For example, one individual's MAR could begin on the 7th of a particular month, whereas another individual's MAR might begin on the 15th. Furthermore, at EPSSLC, the MAR was not commercially generated and the back of the form was blank. Some nurses tracked information on the blank side of the form, others recorded information in the progress notes. Nurse case managers were required to provide information in both the quarterly and annual assessments, as well as in a variety of other report, such as the psychiatric and seizure clinics, risk assessment team, and PNMP meetings. Understanding administration of medications and response to medication (including PRNs) required them to look in two very separate places and to read through many progress notes that were not all directly related to medications. As a consequence, this process was overly time consuming and information was difficult to retrieve and often inaccurate. Constipation provided a good example of the problems with this system. This condition is a typical problem for individuals with developmental disabilities, especially those who	

#	Provision	Assessment of Status	Compliance
		live in facilities such as EPSSLC. Management and treatment were made more difficult when data were hiding in three or more different places (e.g., the MAR, TAR, IDT progress notes, the bowel record). This means that the individual with obstipation (constipation bordering on obstruction) can be at particular higher risk. Furthermore, there were significant issues with the way medications were delivered to the residences. There was a cumbersome weekly bin exchange procedure because there was no unit dose system or other modern format in place. Drugs for the coming week were counted in, left over drugs were counted out, and any remaining drugs were accounted for. This required that two nurses hand count each and every drug supplied, as well as the drugs not used and returned to the pharmacy. This took two nurses about 30 minutes on each residence. This procedure, by estimate, consumed about 11 hours of nursing time per week (572 hours per year). Further, this time consuming process was interrupted many times by ongoing needs of the program and the individuals. Clearly, the current medication practice was very outdated and consumed an inordinate amount of staff time. Newer and safer systems are available that would not only increase staff productivity, but make medication administration safer and error free. During the last six months, 64 medication errors were reported (approximately 10 per month). In addition, according to the pharmacy, there were between 100-200 medications returned to the pharmacy each week that could not be accounted for (such as if the individual was away on leave or hospitalized). This meant that the probability of an actual error rate of 2,600 to 5,200 per year could be occurring. Another practice within the medication administration process at EPSSLC is of concern. That is, the practice of initialing the medication before it was administered. This is not a typical practice and should be reviewed. It may have contributed to the medication return problem. This may be so because nursing staff levels were often at minimums. If an emergency or emergency-type situation occurred between the time the nurse initialed the MAR for the drug and the point where it actually was administered to the individual (e.g., into the individual's mouth and swallowed) it may have failed to have been administered. Consider that when the nurse returned from the emergency event, he or she might have no way of knowing if the individual actually received the medication because it was signed before, instead of after, it was administered. Thus, individuals with seizures or behavioral issues might not, at times, have received their medications as ordered, even though the MAR indicated that they were administered and received. A unit dose or Pixus sytem is needed. This which would render medication administration nearly error free. At this point, a review of 25 medical records revealed	

#	Provision	Assessment of Status	Compliance
		just how serious these medication errors were. Other nursing and medical staff interviewed during the on-site tour also expressed concern about the possibility that medications were sometimes not received by the individuals. Some examples of medication adminsitration errors are described below: • Individual #14: No nursing initials were in the MAR on 12/25/09 at 2100 for Amylase, Abilify, Calcium, or Clonidine. Topical Vitamin E was not initialed at 2100 on 12/25/09 and 1/5/10, and the morning dose not initialed on 1/10/10. A hydrocortisone order for three times per day for four days was only documented as administered for two of these 12 doses. Diazepam 5 mg was not initialed at 1600 and 2100 on 1/1/10. Clonidine was not initialed at 1200 on 1/13/10. There was no record of the individual's responses to PRNs on the back of the MAR. There was a medication error on 10/4/09 when diazepam 10 mg and Levonosgestrel were not given as ordered. • Individual #21: The individual was given the wrong medication (Tegretol instead of Trazadone) on 11/24/09. Administration of alendronate was not documented on 12/16/09 and 12/23/09. Tegretol, flurazepan and levothyroxine administrations were not documented on 12/15/09. • Individual #100: No documentation was in the MAR for calcium carbonate on 11/27/09; for citirizine, folic acid, keppra, multi-vitamin, omeprazole, KCl on 12/6/09; or for benzoyl peroxide on 12/4/09. Multivitamin, psyllium, simvastatin, trazadone, and ziptrasidone administrations were not signed from 12/15/09 to 12/23/09. This was nine days for five medications (45 errors). Depakote 500 was ordered to start on 12/15/09, but administration was not signed at all from 12/15/09 to 12/26/09. • Individual #106: There were "holes" in the diabetic record on 11/10/09 and on 11/15/09 a clinitest was not implemented as ordered. • Individual #104: An order for TAO for the right lower index finger five times per day was not documented 16 times. Simvastatin, quietipine, phenytoin and chlorhexidine administrations were not signed for on 10/30/09. Selsun shampoo was not signed for on 9/8/09 and 9/10/09. • Individual #71: No initials were on the MAR for 0730 doses on 12/30/09 for calcium carbonate, lamotrigine, lansoprazole, metoclopramide, multivitamin, chlorhexadine, and for an 0830 dose of ciprofloxacin. • Individual #112: On 12/11/09, the following medications were not signed for at 1600: amantadine, calcium D 1600, and chloral hydrate and divalproex at 2100. • Individual #69: On 10/29/09, the following medications were not initialed: adderall, calcium carbonate, lamotrigine, phenobarbital, quietipine, banzel, and ammonium lactate. Lamictal dose changes were ordered over a multi-week	

#	Provision	Assessment of Status	Compliance
		period, but administrations were not signed for 12/12/ through 12/29 and on 12/31. The individual was having seizures daily, often several times daily during this period. To reiterate, serious documentation errors were found in 15 of the 25 records reviewed for this purpose; and many of these errors involved important medications, such as anticonvulsants, psychotropics, and drugs for GERD. Further, the monitoring team found and noted numerous medication administration errors (such as those listed above) that were not included in the facility's own monitoring and tracking of medication errors. This is dangerous and difficult to understand. A more up-to-date medication dispensing and administration system could address most of these issues. Some summary comments on medication administration are below: • Lack of adequate nursing staff set the occasion for medication errors to occur. • Medication administration procedures did not meet the standard of nursing practice (e.g. signing for medications before they were administered), and contributed to the occurrence of medication errors. • Medication errors were under-reported, in part, due to item #2 immediately above. • Observations of actual medication administrations were without error (with the exception of documenting the medication before it is administered). Enterally-fed individuals were checked for residuals and proper placement appropriately. • Response to PRN and stat medications were difficult to track and need to be documented on the back of the MAR. The current protocol for writing this information into the progress notes was inadequate and an indication of the individual's response to the medication was rarely noted.	

Recommendations:

1. Attend to detail of record entry legibility, signatures, error notations, and blank spaces.

2. The documentation system at EPSSLC needs to be simplified so that it is "patient friendly." Finding relevant data to analyze and manage was currently too difficult because the data were scattered and difficult to analyze. Progress notes were cluttered with irrelevant and unnecessary comments like "slept well," and "had a good day." Even though then nurses used DAP charting, they were putting data into the progress notes that would be better managed on a flow sheet, while at the same time they were ignoring relevant comments. This is a case of purging the irrelevant information and replacing it with functional information, such as mentioned in examples in the comments above.

3. These Settlement Agreement and Health Care Guidelines requirements cannot be met as long as nursing staffing is so inadequate. These standards impose a very high level of performance for nursing. Nurses cannot pick up the workload for other medical and health care

components of the EPSSLC service team without compromising their own work.

4. Provide clerical support to nursing so that clerical tasks can be competed more competently and efficiently by clerical staff and not take up nurses' limited time.

5. Obtain and implement a modern pharmacy dispensing system, such as Pyxis. Medication errors at EPSSLC were too high and potentially too dangerous to this population.

6. Provide training to nurses in physical assessment and seizure identification and management. Only physicians were allowed to diagnose seizures, which as difficult for them to do if they did not get adequate seizure descriptions. Seizures fall out into two broad divisions and more than 40 discrete types fall under either partial or generalized. Appropriate management by the specialists is impossible if they do not have an adequate diagnosis. That is not possible under the current system because the specialist only gets seizure duration and no other description of the event. The result is that staff are diagnosing seizures, rather than giving the physician the information needed to do so.

7. Direct care staff need training to provide objective descriptions of behavior occurring before, during, and after seizure-like activity. They also need to be held responsible for assisting in implementing first aid required during or after the event, such as helping get an individual to his or her bedroom so that a suppository can be given to stop a prolonged seizure.

8. Find a replacement for the medical director as soon as possible. Also, evaluate the facility's need for physicians and nurse practitioners. Consider having a minimum of two physicians plus a medical director. There should also be a Doctor of Pharmacology to assist with the management and appropriate use of the heavy load of psychoactive and neuroleptic medications given in this facility.

9. Medication administration procedure that involves signing for the medication before it is administered should be changed to come in line with standards of nursing practice, which require that the drug not be signed for until after it is given.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o Formulary- State of Texas 2009 o Pharmacy and Therapeutics (P&T) committee report- October 22, 2009 o Lab matrix o Adverse Drug Reaction Reports- December 2009 o Quarterly Polypharmacy reviews for all individual records that were reviewed- see section J above o MARs for three months on all records reviewed- see section J above <u>Interviews and Meetings Held</u>: o Interview with the Head of the Pharmacy on two separate days for 1.5 hours each. On Friday, there was additional discussion about the various areas noted.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Please see comments below. Overall, the facility had some standard pharmacy services and safe medication practices in place, however, an anticipated new policy from central office DADS will provide the facility with direction and guidance in this area.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the	Evidence of activities to meet this item could not be found and it appeared that a process to meet this item was not in place at EPSSLC. Quarterly drug reviews, however, frequently included the latest lab work. Even so, the reports appeared generic and templated, that is, not individualized. For psychotropic medications, the psychiatrists sometimes commented on why they were continuing the regimen. If so, the reason typically was that the risks of making changes outweighed the benefits. As noted throughout this section of the report, many pharmacy activities were in their	

#	Provision	Assessment of Status	Compliance
	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.	early stages and there remained a need to assess work load and task assignments. For example, the pharmacist's time was often taken up with clerical-type tasks, such as obtaining prior authorizations, trying to find the appropriate Medicare D for each individual, and the daily running of the pharmacy service. Attention from the facility's senior management may help in determining the assignment of resources.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	There was evidence that this process had begun, but it was not yet being completed consistently across all individuals at the facility. The records reviewed contained from one to three quarterly polypharmacy reviews in the six-month period from 7/1/09 to 12/31/09. The facility's pharmacist was working to complete these for all individuals, but had limited hours to do so. Adding a Pharm.D. to the medical team would be helpful in completing these reviews and would allow for the pharmacy department staff to attend psychiatry clinics and discuss medication issues more contemporaneously with the psychiatrists.	
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.	This process was not in place at EPSSLC. Again, the quarterly review process was in place, but it did not address all of the requirements of this provision item.	

#	Provision	Assessment of Status	Compliance
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The requirements of this provision item were also not active and in place at EPSSLC. Overall, there was no indication that treating medical practitioners thoroughly considered pharmacist's recommendations. It seemed that there was no system for the pharmacist's recommendations to be presented to treating medical practitioners in a meaningful manner. The system in place was merely a check box for the treating practitioner that indicated an agreement with the pharmacist's recommendation. This appeared to be largely a paper exercise. Out of all of the records reviewed, only one comment was noted by a treating practitioner. This example was a comment by one of the psychiatrists regarding the possibility of multiple neuroleptics creating a potential cardiac risk. The psychiatrist noted that he would make a medication change to lower the cardiac risk.	
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.	Although some of this process was in place, it was not done in a qualitative and thorough manner. DISCUS measures were in the records of some individuals. The psychiatrists would prefer to use the AIMS measure. This is a topic for review at the state central office. It appeared, based upon record reviews and observations, that more individuals had tardive dyskinesia than the rating instruments, and the facility's system, was capturing. Some tardive dyskinesia movements and reports were noted in the psychiatry clinic notes, but the DISCUS for the same individual was rated as not having tardive dyskinesia.	
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.	This was an area that needed work and a process needed to be put into place. For example, akathesia was probably overlooked in many of the individuals at the facility and should be fully explored on an individual basis. Further, the possible causes of agitation and anxiety also needed to be explored to determine their relationship to any drugs being prescribed. It is, on the other hand, possible that for some individuals, these behaviors might be self-stimulatory and might better be managed by behavioral interventions than benzodiazepines. Drug-drug interactions were probably more prevalent than realized at EPSSLC. There were only three adverse drug reports reviewed while on-site. More training may be necessary for medical and direct care staff to understand what to look for in terms of symptoms and behaviors.	

#	Provision	Assessment of Status	Compliance
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Drug utilization reviews had just begun at this facility. This item, like many others in this provision, will be evaluated during the next on-site tour.	
N8	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.	Please also see the many comments in section M of this report regarding medication administration. Regarding medication variances, the pharmacy recorded and tracked the number of medications returned, but was unable to track which individuals missed medication doses, especially because the MAR indicated that all dosages had been given.	

Recommendations:

1. Consider bringing on an in-house Pharm.D. to help provide more enhanced services as well as a consultative role to the medical department and to the psychiatrists during in their clinics. This person could provide excellent reviews of polypharmacy and drug-drug interactions. Even a Pharm.D. intern would be helpful to provide this service to the director of pharmacy.

2. Conduct drug utilization reviews of benzodiazepines, chlorpromazine, and thioridazine.

3. Conduct drug utilization reviews for individuals on multiple neuroleptics.

4. Update the lab matrix to include prolactin levels in individuals taking Paroxetine.

5. Obtain and share more comprehensive information regarding side effects of neuroleptics directly from psychiatry, especially regarding akathesia and other extra pyramidal symptoms.

6. Consider a system such as the Pyxis system for medication administration. As noted above, there were more than 100 returned doses of

medication each week to the pharmacy, even though these medications were shown as having been administered on the MARs. Further, every MAR reviewed in the sample had at least one missed dose documented per record. Some records had many missed doses on a single day (often there was no explanation on the MAR for the entire day being missed). This was a serious problem in a population on psychiatric medications. There are frequently discontinuation symptoms that occur when these medications are missed, however, most of the individuals at this facility would be unable to verbalize these conditions, such as nausea, headaches, and dizziness.

7. Conduct better tracking of medication errors of omission.

8. The Pharmacy and Therapeutics committee needs to meet monthly until a considerable amount of the back logged work is completed. Psychiatry needs to be an integral part of this committee.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: ○ Common Elements of Physical and Nutritional Management ○ Applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management ○ Personal notes taken week of 01/11 – 01/15/09 ○ Current Census by Home (01/11/10) ○ Individual's Served Information (01/08/10) ○ Physical Nutritional Management policy #012, 12/17/09 ○ Nutritional Management Policy #013, 12/17/09 ○ Draft Policy, Operations: Physical Nutritional Management (05/20/09) ○ Draft Policy, Operations: Physical Nutritional Management (07/29/09) ○ Nutritional Management Committee Policy and Procedure (03/01/05) ○ At Risk Individuals Policy #006, 10/05/09 ○ Handbook, Habilitation Therapies Physical Nutritional Management, by Karen Hardwick, Ph.D., OTR, FAOTA (September 2007) ○ Best Practice Guidelines (July 2008) ○ Checklist for Internal Compliance Review of Critical Process Indicators Related to PNM (04/08/08) ○ EPSSLC Plan of Improvement for PNM ○ Resumes for all PNM staff ○ Continuing Education records for the speech and language therapist and the occupational therapist ○ List of contract providers ○ Budgeted, Filled, and Unfilled Positions by Job Code (Medical Series) 12/14/09 ○ Sign-in sheets for Webinars (08/04/09 to 12/30/09) ○ PSPs for (current within 12 months unless otherwise indicated): • Individual #1 (2008 and 2009), Individual #106 (2008), Individual #56 (2008), Individual #59 (2008), Individual #103, Individual #110, Individual #74, Individual #114, Individual #29 (2008 and 2009), Individual #35, Individual #79 (2008), Individual #74 (2008), Individual #86, Individual #89, Individual #125, Individual #45, Individual #46, Individual #58 (2008), Individual #55, Individual #57 (partial, 6 pages only), and Individual #71 ○ PSP Quarterly Review: • Individual #106 (07 to 09/2009) submitted as PSP for 2009 ○ Nutritional Assessments for: • Individual #18, Individual #59, Individual #109, Individual #85, Individual #7, Individual #15, Individual #43, Individual #73, Individual #112, Individual #81, Individual #110, Individual #40, Individual #97, Individual #114, Individual #65, Individual #89, Individual #79, Individual #1, Individual #103, Individual #106, Individual #100, Individual #8,

	Individual #77, Individual #5, Individual #88, Individual #76, Individual #126, Individual #4, Individual #99, Individual #102, Individual #62, Individual #68, Individual #34, Individual #111, Individual #48, Individual #108., Individual #75, Individual #53, Individual #32, Individual #47, Individual #78, Individual #51, Individual #17, Individual #11, Individual #33, Individual #22, Individual #93, Individual #83, Individual #35, Individual #45, Individual #20, Individual #86, Individual #23, Individual #57, Individual #58, Individual #46, Individual #55, Individual #56, Individual #29, and Individual #125. o Weights, BMI Readings (11/01/09 – 11/20/09) o List of names: individuals who had 10% unplanned weight change in 6 months (undated) o List of names: individuals on modified diet textures and/or liquid consistencies downgraded in past 12 months o List of names for individuals on modified diets o Schedule of meals by home o PNMP/NMT meeting minutes (12/10/08; 01/14/09; 02/11/09; 03/11/09; 04/08/09; 05/13/09; 06/10/09; 07/08/09; 08/12/09; 09/09/09; 10/14/09; 11/04/09) o PNMP/NMT meeting agendas: 01/13/10 o Communication Updates (all current within the last 12 months unless otherwise indicated): • Individual #101, Individual #2, Individual #103, Individual #6 (01/06/09), Individual #71, Individual #48, Individual #46, Individual #106, Individual #4, Individual #1, Individual #100, Individual #8, Individual #114, Individual #58, Individual #21, Individual #29, Individual #127, Individual #89, Individual #93, Individual #79, Individual #65, Individual #70, Individual #97, Individual #125, Individual #95, Individual #69, Individual #84, and Individual #52. o EPSSLC Table of Organization o Habilitation PNMP Monitoring Forms completed 10/01/09 – 01/10/10 o Template Mealtime Observation Sheet o Draft schedule of PNMP Monitoring o Active Employee Participation Report Physical Management 12/09/09 o Personal Record documents including: Nutritional Assessments; OT/PT Assessments; Communication Assessments; OT/PT/SLP Updates; Special Review/Consults by OT, PT, SLP; Bedside Dysphagia Evaluation; PNMPS for last 12 months; PSP and Addendums; Progress Summaries for OT/PT/SLP; Identifying Data sheets; Annual Medical Summary and Physical Examination; Nursing Assessments (last four quarters); Drug Regimen Review (most current); X-rays section; Consult section; PALS assessment; SPO Activity Plans for the following individuals: • Individual #2, Individual #71, Individual #103, Individual #21, Individual #58, Individual #6, Individual #95, Individual #52, Individual #75, Individual #97, Individual #69, Individual #70, Individual #29, Individual #127, Individual #93, Individual #84, and Individual #4. o EPSSLC Health Status List (01/05/10) o Meeting Minutes of Health Status Team meetings: (01/21/09;02/18/09; 03/19/09; 04/15/09; 05/20/09; 06/17/09; 07/22/09; 08/19/09; 09/16/09; 10/21/09; 11/18/09; and 12/16/09) o Health Risk Assessment Rating Tool (Individual #14, 0826/09)

	○ Safety/Risk Management Accident Review Committee Agenda (07/23/09 and 10/22/09) ○ Hospital Liaison Log in Town Hospitals ○ List of all incidents or injuries since July 1, 2009 ○ Database related to diet textures and/or liquid consistencies downgraded in the last 12 months with summary of swallowing evaluations and follow-up plans ○ PNMP Definitions and Purpose (Section V.A.1) ○ Instructions for PNMP Clinics ○ PNM Maintenance log tracking modifications from 07/01/09 through 12/30/09 ○ Physical/Nutritional Management Plan for each individual ○ Dining Plans for all individuals ○ Data regarding number of individuals with: • PNMPs, reviewed by NMT, seen by PNM Teams • Dining Plans; • Comprehensive OT/PT assessments, with Communication assessments • Tube feedings assessed for less intrusive feeding ○ Physical Management Training Modules (Section VIII.A.1) ○ Pre-Service/New Employee Orientation Training Schedule for New Employees December 2009 Interviews and Meetings Held: ○ Anderson Hicks, OTR/, CEAS, Habilitation Therapies Director ○ Susan Acosta, MPT ○ Amy Gleaton, OTR ○ Francisco Montelongo, OTR ○ Alfredo Diaz de Leon, COTA ○ Jessica Alvarez, MPT ○ Henry Kielb, MA, CCC-SLP ○ Jennifer Pacheco, Dental Hygienist ○ Raquel Rodriguez, Dental Hygienist ○ Vicki De La O, PNMP Coordinator ○ Donna Rice RD, LD ○ Miriam Valdez, Diet Technician II ○ Brief conversations with various food service staff ○ Brief conversations with food service staff Observations Conducted: ○ Mealtimes ○ Living areas and day program areas ○ Occupational Therapy Department meeting ○ PNMP/NMT meeting 01/13/10, 1:30 PM ○ Seating assessment 01/12/10 ○ Attended Habilitation Therapies Director's Webinar 01/13/2010, 12:30 PM

	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: EPSSLC had a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. This team (PNMP/NMT), however, did not include critical team members, such as the physician, physician assistant, nurse practitioner, or PT. The participation by the registered dietitians was extremely limited. Some team members had background, experience, and continuing education, but this was not available to each of those participating on the PNMP/NMT. The focus of the meetings held were so broad in scope that it was not possible to effectively review all those with PNM concerns with sufficient frequency to address their needs based on level of PNM risk. Documentation was not well organized and did not reflect PNM problems triggering review by the PNMP/NMT, routine comprehensive review by the committee, or clear documentation of efficacy of intervention resulting in problem resolution. Follow-up was inconsistent and did not continue until the original concern was resolved. The current systems intended to assign and manage risk issues were not coordinated and integrated; they functioned in a parallel manner. Assignment of risk did not consider thresholds and outcomes related to recommendations and interventions. In some cases, risk levels were reduced based solely on the fact that a plan had been developed, rather than based upon how long a particular health concern had been stabilized as a result of effective plan implementation. A number of issues were observed by the monitoring team to indicate that PNMPs were not consistently and properly implemented. Staff training was not competency-based and monitoring did not occur with sufficient frequency to ensure that staff compliance was routine. The existing monitoring methods were evolving at the time of this review, but plans were not in place to use risk levels to drive the intensity and frequency of PNMP monitoring. There was also no plan in place to track and trend findings to permit targeted and timely staff training.

#	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	<u>PNM team consists of qualified SLP, OT, PT, RD and as needed, consultation with MD, PA, RNP</u>. The Habilitation Therapies Physical Nutritional Management Handbook, revised 09/07, was provided and identified as current. The current state-approved policy, dated 12/09/09, was not submitted with the documentation submitted and was reviewed after the on-site tour. Per this policy, "the NMT is typically comprised of the: a. Physician; b. Occupational Therapist (OT); c. Speech Language Pathologist (SLP); d. Registered Nurse (RN); e. Dietician [sic]; and f. Other disciplines as indicated by need including but not	

#	Provision	Assessment of Status	Compliance
	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, 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.	limited to Physical Therapy, Certified Occupational Therapy Assistant, Licensed Vocational Nurse (LVN), psychologist, QMRP, home staff, and others." The purpose of the Nutritional Management Team was to: 1. Identify individuals at risk for dysphagia/aspiration; 2. Ensure individuals receive adequate nutritional intake; 3. Decrease instances of choking/aspiration; 4. Decrease health problems secondary to aspiration; 5. Identify individuals with gastroesophageal reflux and other gastrointestinal (GI) conditions; 6. Make evaluation and treatment recommendations; 7. Provide training to staff in Nutritional Management issues; and 8. To conduct other activities as appropriate to ensure safe eating and adequate physical and nutritional health. A PNM team was in place at EPSSLC, but membership included OT, SLP, RN case managers, QMRPs, a dietitian, and a diet technician only. PTs or MDs/PA/RNP did not participate. By report, this group at EPSSLC was referred to as PNMP/NMT. These individuals were in attendance during the meeting attended and observed by the monitoring team on 01/13/10: OT, SLP, RN case managers, QMRPs, dietitian, and a diet technician. No PT, MD, PA, or RNP representatives were in attendance on that date. Sign-in sheets (PNMP Committee Meeting Participants) were not included for four meetings held in 2009 for which documentation was submitted (01/14/09; 12/09/09; dates were illegible on documentation for the other two meetings). An OT representative was present at all meetings with the exceptions of 05/13/09 and 10/14/09. Nursing representation was noted for all meetings for which sign-in sheets were submitted. The diet technician attended four of the eight meetings (5/13/09, 08/12/09, 09/09/09, and 11/04/09). A registered dietitian had attended three of the eight meetings in 2009 on 08/12/09, 09/09/09, and 11/04/09 only. Participation by PT, psychology, or the physician was not noted on any of the sign-in sheets. <u>There is documentation that members of the PNM team have specialized training or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management need</u>. Each of the team members held degrees in their specific areas per the resumes/CVs submitted. Specific experience serving people with developmental disabilities, however, was limited in many cases to the time employed at EPSSLC. Previous background experience in providing PNM supports and services was limited to the chairperson. Others had related experience but not specifically with this population. Amy Gleaton, the chairperson for the team was a licensed OTR with a BS in Occupational Therapy. Documentation indicated a number of appropriate and related continuing education activities. The other OTR on the team, Francisco Montelongo, held a BS in	

#	Provision	Assessment of Status	Compliance
		Occupational Therapy. He was employed at EPSSLC since 2008, but with no evidence of continuing education since that time. Henry Kielb was the only speech-language pathologist employed at the facility at the time of this on-site tour. He had a master's degree and his work history and continuing education showed background in the area of dysphagia, though his experience with developmental disabilities appeared to be limited to his current employment since 2008 at EPSSLC. He held certification in Vital Stim Therapy. Each of the RN case managers for whom resumes were submitted had one or more years of experience with developmental disabilities from their employment at EPSSLC, but no evidence of specific experience related to PNM. Each of the QMRPs for whom resumes were submitted appeared to have background as direct care staff and as supervisors in programs for people with developmental disabilities. They had bachelor's degrees. The dieticians and dietary staff seemed to have relevant training and background experience. Miriam Valdez worked for several years at EPSSLC and worked as a Dietetics Technician II since 2004. The dietitians included Adriana Rascon-Lopez and Donna Rice. Ms. Rascon-Lopez held a MS degree in Family Consumer Sciences-Nutrition and was a licensed and registered dietitian. She has extensive teaching and other work experience in the area of nutrition and food services. Her experience with people with developmental disabilities, however, appeared to be limited to her part-time work at EPSSLC. State policy identified that "each regular member of the NMT should complete ongoing training in the area of physical and nutritional management for persons with developmental disabilities." Per documentation submitted by EPSSLC, PNM-related training was evident only for the OT who served as chairperson and the SLP during the last 12 months. Sign-in sheets for PNMP and Wheelchair Clinic Teleconferences from 08/04/09 through 12/30/09 were submitted. It was unclear, however, from this documentation as to the content of these regularly occurring sessions though they were attended routinely by OTRs and/or COTAs, with 12/29/09 also attended by the PT. There was no evidence submitted that SLPs, RDs, RNs, or other PNMP/NMT members participated in these sessions or in other PNM-related educational opportunities. Thus, there was no indication that EPSSLC had a plan for training and, therefore, all PNMT members were not receiving any ongoing training specific to their duties and responsibilities on the PNMT.	

#	Provision	Assessment of Status	Compliance
		PNM team meets regularly to address change in status, assessments, clinical data and monitoring results. While the PNMP/NMT met monthly since December 2008, the agenda, content, and style of the meetings, did not allow for any type of thorough review of cases. Per the Chairperson and Director, the purpose of this group, referred to as PNMP/NMT, was to review and revise PNM plans prior to the PSP meeting scheduled for the month subsequent to these reviews; review individuals per their risk designation for aspiration/choking; and review those who presented with weight loss/gain, change in diet orders, or other nutritional related concerns. For example, during the meeting held on 01/12/10 (and attended by the monitoring team), the agenda included 100 individuals reviewed from 1:30 p.m. to 6:00 p.m. The majority of the meeting agenda was organized by QMRP. For example, individuals assigned to each QMRP were grouped together for discussion and then that QMRP left the meeting and the next QMRP came into the meeting for discussion on another group of individuals assigned to that QMRP. Discussion included review of the PNMP as indicated, aspiration/choking risk assignment, and staffing reviews of nutritional management concerns. There were 39 individuals who were reviewed for weight follow-ups only per a monthly, quarterly or bi-annual review schedule for weight gain or loss. There was no evidence that monitoring results or findings were reviewed or analyzed during these meetings at the time of this review. Per state policy, meetings were to be held at least monthly, with additional meetings held related to the following: eating/health problems, changes in risk level by the HST, after esophagrams or other medical or diagnostic tests, before finalizing treatment decisions, to address follow-up activities, and at any phase in the Nutritional Management process. Meeting minutes were submitted with evidence that the PNMP/NMT met monthly during 2009. Documentation served a dual purpose as both agenda and meeting minutes and was in a spreadsheet format including: name, home, last review, next review, reason for review and PNM problems, risk level, and discussion and recommendations. The agenda/meeting minutes were maintained by an administrative assistant. This responsibility was soon to be shifted to a COTA who was newly hired and a new graduate. Per the meeting minutes, the purpose of review was to be identified. Per the agenda used for the meeting attended, these were listed as "staffing review" (13), "diet order" (10), "update files" (3), or, "aspiration risk review" (9), "weight notifications" (8), "weight updates" (3), and "weight review" (13). Other reasons for review were identified as review of swallow study results, SLP recommendations, or physician orders. In some, cases multiple reasons were listed. An additional 35 individuals were listed as reviewed related to weight gain (25), loss (9), and underweight status (1), and four individuals had no specification noted. Other than	

#	Provision	Assessment of Status	Compliance
		weight loss or gain, only seven other individuals had specific health risk issues clearly identified as a reason for review and included: emesis (Individual #58, Individual #71, Individual #6, Individual #100, Individual #123), hospitalization (Individual #71, Individual #97, Individual #101, Individual #52), aspiration (Individual #71), and pneumonia (Individual #97). Nutritional risk levels were identified for only 22 of the individuals reviewed that month. Health status review risk levels were not referenced, with the exception of brief discussion to complete the aspiration/choking risk assessment for nine individuals. Meeting minutes did not clearly state the problem or concern for each individual, the steps and strategies implemented to address the concern, or clear documentation of problem resolution. Dates listed for last review and/or next review were not consistently listed for individuals reviewed and in some cases were incorrect. Some examples included approximately 68 errors/69 individuals reviewed in January 2009, 88/95 in April 2009, 93/93 in July 2009, and 93/103 in December 2009 (an agenda rather than meeting minutes was submitted). It was also noted that full text was not printed in the minutes resulting in the omission of information. Some examples included the reviews for: • Individual #84, Individual #106, Individual #65, Individual #3, Individual #18, Individual #61, Individual #83, Individual #57, Individual #4, and Individual #17 in February 2009; Individual #45, Individual #61, Individual #82, Individual #59, and Individual #40 in May 2009; Individual #9, Individual #106, Individual #52, Individual #62, Individual #65, Individual #18, Individual #35, Individual #102, Individual #7, Individual #82, Individual #4, Individual #96, Individual #80, Individual #48, and Individual #126 in August 2009, as well as in meeting minutes for other months. While this information was likely available from the original electronic version of the minutes, the hard copies produced did not consistently reveal the full text in each cell. This was also noted in the hard copy agenda intended for use by team members during the meetings held in December 2009 and January 2010. Review date omissions/errors were noted for approximately 90 of 100 individuals reviewed during the January meeting, and text omissions were noted for approximately 8 out of 100. All team members did not have copies of the individual's PNMP for appropriate review of those plans. The chairperson read the plans very rapidly prior to discussion. Personal records were available only for individuals identified with staffing reviews and rarely referred to during the meeting observed. This was of particular concern in the review for Individual #71 who had experienced three recent hospitalizations and for Individual #97 whose discussion was related to previous dental issues. No records were available to team members for any other type of review. In some cases further discussion was deferred	

#	Provision	Assessment of Status	Compliance
		another month due to a lack of pertinent information. PNM plans are incorporated into individuals' Personal Support Plans (PSPs). Overall, there was inclusion of the PNM plans into the PSP documents, but there was little thorough integration of the plans. That is, the PNMPs were noted, but the impact of the information upon the individual's daily life was not thoroughly considered. Further, there were a number of inconsistencies and the relationship of information in the PNMP to nursing, psychology, habilitation, and other aspects of daily living outside of direct positioning and feeding was not part of the PSPs. PSP documents were reviewed to determine the integration of PNMPs into the process. There was a section identified as "Review of Physical and Nutritional Management Plan for accuracy/changes." Six out of 20 PSPs submitted for review were not current (they took place in 2008): • Individual #56, Individual #58, Individual #106, Individual #79, Individual #74, Individual #59 There was general documentation related to the PNMP in the OT/PT/SLP sections of the PSP with recommendations to continue, but recommendations for changes to the PNMP were not summarized in the section of the PSP designated for PNMP review. Examples of cases of inconsistencies between the PSP and PNMP are below: • In the case of Individual #114, there was a discrepancy noted related to the elevation of the head of bed (PSP dated 11/10/09, PNMP dated 11/23/09). • In the case of Individual #125, a communication book and Hip Talker were identified as required to meet his communication needs in the speech section of the PSP (11/09/09). They were listed in his PNMP (01/14/10) as assistive equipment, but not included under the communication section to describe the methods he used for expression. Other similar discrepancies are outlined in the Communication section R of this report below. • The PSP for Individual #46, dated 10/08/09, included a section for bathing that was not addressed in the PNMP of the same date. Additionally, bathing equipment per the PSP was identified as a gurney with an adjustable elevated head. The current plan listed a bath trolley with wedge used to elevate her head during bathing. Addendums were not submitted with these PSPs, so it could not be determined if changes in the plan had been made and reviewed/approved by the PST. • There was no evidence of PNMP review in the PSP submitted for Individual #57 Progress noted: There was a section in the PSPs designated as review of the PNMP for changes and inaccuracies. Discussion of PNMPs was also addressed in the sections for	

#	Provision	Assessment of Status	Compliance
		OT, PT and Speech. <u>Identification, assessment, interventions, monitoring, and training as outlined in sections O-2 through O-8 as described below.</u> See below.	
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>A process is in place that identifies individuals with PNM concerns</u>. Per the Handbook identified above, as well as the current policy slated for implementation by 01/31/10, a Nutritional Management Screening Tool was utilized in the "discovery or referral phase" of the process to identify each individual's Nutritional Management Risk. Risk indicators were identified across 3 levels of risk: High (Level 1), Medium (Level 2), and Low (Level 3). Per the screening tool submitted by EPSSLC, risk factors were for aspiration pneumonia, choking, weight loss, GERD, and so on. Identification of the risk level was to drive further assessment, intervention, and frequency of review of risk status. The screening was too narrow in focus related to physical management concerns that may impact health status. Further, at EPSSLC there was no coordination of information to allow for the tool to be completed in a thorough manner. For example, the screening tool was not administered in conjunction with the health status review checklists and the two were essentially not related to each other. By report, the SLP completed the aspiration/choking risk screening tool required for the Health Status Review meeting, but had limited input from the PNMP/NMT members. In some cases, assignment of risk was determined based on whether a plan was in place to address aspiration or choking risk rather than upon the individual's actual risk for aspiration or choking. A database table titled "Yearly NMT Spreadsheet" was submitted. It included headings, such as "choking and aspiration" and "aspiration risk level" for 141 individuals, but nutritional management risk levels obtained via the NMT screening were not indicated or included in this spreadsheet. Only 31 individuals were identified with a "no" related to choking and aspiration risk, while the remaining 110 individuals were identified with a "yes" (indicating concerns in these areas). Eighty-four of these 110 individuals, however, were simultaneously, considered to be at "low" risk for aspiration per the Health Status Review checklist for aspiration risk. Another 34 were considered to be at medium risk, and only six were identified at high risk for aspiration: Individual #103, Individual #48, Individual #113, Individual #71, Individual #2, Individual #112). Two other individuals had no aspiration risk level designated on the spreadsheet (Individual #19 and Individual #116) despite the fact that each was identified to have choking and/or aspiration concerns (The Health Status List, dated 01/05/10, identified these two individuals with a Level 3 risk of aspiration: low risk). In some cases, the rationale used to justify a lowered risk designation was that a plan had been developed that prescribed food texture and/or liquid consistency modifications or	

#	Provision	Assessment of Status	Compliance
		adaptive equipment, as well as strategies to prompt a slower pace, smaller bites, etc. per the communication update report written by the SLP (Individual #89, Individual #69, Individual #95, Individual #52, Individual #65, Individual #100, and Individual #70 Observations conducted by the monitoring team, however, found that implementation of dining plans across a number of homes was insufficient to ensure safety for all those with choking and/or aspiration concerns particularly with regard to position, alignment and support as well as food texture, liquids consistency, adaptive equipment, and assistance strategies. In addition, positioning was not generally considered with regard to safe swallowing as indicated by a review of the oral motor function/feeding section of the Communication Skills Update Evaluations. Reference to position, support, and alignment was not typically addressed. When it was mentioned, it most often related to GERD precautions, such as being upright after meals or having the head of the bed elevated (Individual #65, Individual #79, Individual #95, Individual #97, Individual #52). This was surprising given that the records showed excellent assessment of functional oral motor function during eating and drinking in the majority of assessments reviewed. The monitoring team noted many examples of problems in addressing individual's positioning needs. Some are listed below: • The monitoring team observed numerous instances of inadequate alignment and support during meals. Some examples were: Individual #94, Individual #49, Individual #40 (on two occasions), Individual #21, Individual #105 (on two occasions), Individual #1, Individual #28, Individual #117, Individual #93, Individual #118, and Individual #11 Inadequate trunk alignment and support, foot support, and/or head alignment was noted for each of these individuals. • It was also noted in Individual #70's update that at one time he tipped his head back slightly when presented with an adaptive cup during assessment observation. In no case, was position described or cited as a concern with regard to safe and efficient swallowing. • There was reference to a recommendation from a swallow study recommending that Individual #93 be in optimal alignment during meals to promote gastric emptying and reduce aspiration risk. Nevertheless, on one occasion, the EPSSLC therapist was prompted by the monitoring team member to correct her alignment during the meal. It was also noted that the picture on her dining plan did not match the seating system she was in at that time. It was reported that the system was new and the picture had not yet been changed. Per documentation, the start date was 06/26/09 with a proposed completion date for a new system on 09/30/09. No delivery date was listed.	

#	Provision	Assessment of Status	Compliance
		The annual OT/PT assessment update on 09/10/09 reported that the new system was still in process. Pressure mapping had been completed on 10/20/09. The PNMP submitted as current did not reflect the new system. A picture of a completed system should be taken at delivery and immediately integrated into all plans and documentation. It was of further concern that this error was not identified and corrected via the PNMP monitoring system. Surprisingly, there was evidence of documented monitoring on 10/01, 11/03, and 12/01/09 with no concern noted. It was also reported during this review that informal monitoring occurred numerous times each week, particularly in C Dorm where she lived, yet this issue had not been identified and resolved. It was further noted that choking or near-choking events requiring intervention did not result in the identification of appropriate risk levels. While the response by the speech clinician was timely, there was an insufficient sense of urgency for serious events and the follow-up by the PNMP/NMT and HST was inadequate. For example: • Individual #69 was reported to experience a choking event in school on 05/07/09 that required the Heimlich procedure. He was not reviewed by the Health Status Team in a timely manner subsequent to this event. When he was finally reviewed by the HST on 06/17/09 his risk designation for aspiration/choking was listed as "low" per the meeting minutes. There was no evidence that the PST met following this choking incident, but the NMT meeting minutes reported a PDP review in which his risk level was increased from low to medium due to a recent incident of choking. The minutes further stated "Monitoring quarterly at this time. No other issues to address at this time." The next month there was a report of the SLPs findings from a special review, but there was no further review of his status relative to this event. It was of concern that neither of these teams, both responsible for assessing and addressing risk concerns, addressed this life-threatening event in a comprehensive and timely manner. A PSP addendum dated 11/18/09 reflected that the HST had again reviewed and discussed his risk level for his scheduled six-month review and that his risk for aspiration and choking remained at a Level 2 or medium risk. The Heath Risk Assessment Tool attached to this addendum identified the following issues for him: "highly isolated choking episode with the last episode occurring on 05/07/09 at school, frequent mealtime refusals, and requires altered diet textures (chopped foods to be "chopped by the Kitchen only"). This tool stated that he was a Level 2 or medium risk "provided that there is compliance with ordered diet textures, and swallow safety guidelines listed on the PNMP." His plan also	

#	Provision	Assessment of Status	Compliance
		stated that he should be redirected from laughing and talking when food is in his mouth and is swallowing. The assessment tool further stated, "He laughs, talks, and consumes lunches at school which are supposed to be chopped to State School specifications but this is not under our 'direct control'." It was of serious concern that EPSSLC had not recognized his choking risk immediately following a life threatening event requiring the Heimlich and then six months later justified his risk level in this area to medium based on the concept that this event was considered to be "isolated" and "provided" that the dining plan was implemented as written at home and at school, though the school environment was considered to be not under "direct control" of EPSSLC staff. Further there was no evidence that the SLP had conducted assessment at the school following this event or to date at the time of this review. There was no evidence that he was monitored in his home per the monitoring documents submitted. This episode was not listed as an incident on the list submitted by EPSSLC to include incidents or injuries from 07/01/09 – 11/3/09. • Individual #95 experienced a "severe coughing episode" on 01/20/09 while eating salad at lunch. A chest x-ray was completed with no evidence of infiltrate. The SLP conducted a mealtime/swallowing assessment at the evening meal the same day as well as at the noon and evening meals the following day. In response to this event, his diet order was modified to include a ground salad alternative (e.g., V-8 juice, ground carrot salad, ground cucumber-tomato salad), as well as the use of a Wonder-flo cup to reduce rate and quantity of liquid intake. He had a previous history of possible penetration/aspiration episodes. A special review was conducted by the SLP on 05/15/09 following the annual staffing held on 05/14/09 recommending that his food texture be modified to puree with thin liquids via a Wonder-flo cup with implementation on 05/18/09. Also recommended were GERD precautions to remain upright after all meals, to include medications and snacks, as well as to crush all medications "that can be crushed." While the change to puree appeared to lessen the frequency of coughing per bedside evaluation by the SLP on 06/03/09, he had experienced another "severe coughing episode at breakfast on that date. A repeat swallow study was recommended. The MBS dated 06/18/09 revealed that his oral phase swallow was within functional limits for all presentations of thin liquids and pureed solids. It was reported that he demonstrated a "safe/efficient pharyngeal swallow" with pureed food and thin liquids.	

#	Provision	Assessment of Status	Compliance
		By report, he had a history of erosive gastritis; GERD coughing episodes elevated temperature and wheezing. The most recent dental hygiene six-month review dated 09/10/09 reported "advanced periodontal disease and severe gingivitis" and he was considered to be "at risk for infection". The PNMP submitted as current was dated 12/03/09 noted a PNM focus to "reduce the risk of choking from fast eating with diet texture, equipment and mealtime monitoring". Process includes level of risk based upon physical and nutritional history, current status and includes specific criteria for guiding placement of individuals in specific risk levels. Again, the assessment of risk was not made in a thorough and comprehensive manner. The NMC Risk Assessment tool was loosely utilized during the NMT meeting attended by the monitoring team in that "risk level" was identified in the agenda/meeting minutes for 20 of the 104 individuals reviewed. "Review" of the aspiration/choking risk assessment tool was referred to, but generally the SLP stated his opinion of the current risk level with no further discussion by the other team members during the meeting attended (Individual #14 and Individual #3). In one case, no discussion occurred because the current SLP did not have the information on the individual (Individual #113) at the time of the meeting due to recent SLP vacancy. Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team. All PNM-related assessments were completed per the annual staffing schedule rather than based on increased risk level. Interim special reviews were conducted for some individuals based on referral as described for Individual #95 and Individual #69 above. In each of these cases, however, there was no evidence that the assessment was comprehensive, that is, that it involved other team members. The SLP documented observations, impressions, and recommendations, but they were only his. No other team members participated in those special reviews. By report, mealtime observations were not conducted with either dietitian. The Health Status Review Committee met monthly to review all individuals living at EPSSLC and assigned the following risk levels in 18 domains: **High Risk (Level 1)**: This rating typically applies to an acute or unstable condition that requires timely collaboration and increased intensity of intervention to achieve an optimal health outcome. A physician can determine that any condition is High Risk at any time without collaboration from the HST. Individuals discharged from the hospital should have their risk level reviewed by the physician. Once a High Risk condition is identified, the PST will meet within 5 working days to formulate a plan. The plan will be implemented within 14 days. The PST will meet at least every 30 days to monitor	

#	Provision	Assessment of Status	Compliance
		the effectiveness of the plan of care until the individual's condition is stabilized and the risk level is reduced. **Medium Risk (Level 2)**: This rating typically applies to ongoing conditions that are stable but require active monitoring to insure optimal health outcomes. This level also applies to conditions that may normally be considered high risk but have appropriate supports in place that have rendered the condition stable over time. Individuals at Medium Risk are reviewed and monitored by appropriate members of the PST at intervals between 30 and 180 days. The PCP or members of the PST will determine how often the PST will meet to monitor the effectiveness of the plan of care. **Low Risk (Level 3)**: This rating typically applies to conditions that are stable and require minimal or no active treatment. Individuals at Low Risk are monitored by appropriate members of the PST at intervals greater than 180 days but at least annually unless there is a change in the health condition and risk rating. As reported above, there was no evidence submitted that the PST or NMT met regarding Individual #95 proactively to review his health status, but rather in reaction to issues or concerns, none of which triggered a comprehensive assessment by multiple team members. All comprehensive assessments are conducted by the PNM Team, identify the causes of such problems, and contain proper analysis of findings and measureable, functional outcomes. Comprehensive assessments were generally not conducted outside of the annual staffing schedule. There was evidence of special reviews conducted by SLPs, OTs, and PTs, but these were generally not collaborative and were focused on a problem, rather than on a comprehensive analysis of the individual's physical and nutritional health status. Annual assessments were "updates" with extensive documentation of facts, but with little analysis conducted and no measureable outcomes generated. Continuing the PNMP or dining plan was typically recommended with little to no evidence of collaboration with other disciplines during the process. As stated in the OT/PT section of this report, it appeared that the OT and PT often did their portion of the assessment on different days even though the report was co-written. Examples included: • Individual #71 (OT on 09/17/09), Individual #29 (PT on 11/17/09), Individual #6 (PT on 04/08/09), Individual #21 (OT on 04/24/09), Individual #97 (SLP on 12/08/09), and Individual #69 (SLP on 05/12/09). • The case of Individual #97 deserves additional mention because it exemplified EPSSLC's disjointed approach to PNMP modifications and provides further evidence of insufficient interdisciplinary integration. Each of the assessments for this individual seemed to focus on a different aspect of a single problem or	

#	Provision	Assessment of Status	Compliance
		upon different issues all together rather than as a comprehensive analysis of the health status of the individual that might have resulted in a coordinated effort to provide appropriate supports. The SLP conducted a clinical dysphagia evaluation for him on 12/08/09 following a hospitalization (12/01/09 to 12/08/09) for "possible pneumonia." Observation revealed that he exhibited a "safe and effective swallow" with pureed foods and thin liquids from a Wonder-flo cup while seated in his wheelchair with adequate head support. By report, he had a history of hyperextending his neck that required staff redirection in order "to reduce the risk of GERD" and to reposition him before meals "to ensure adequate gastric emptying." There were at least four other reports by a second SLP, the OT and the PT that documented various aspects of the PNMP/dining plan, but did not reflect a collaborative, comprehensive approach to problem solving for this individual. The PNMP for this individual prior to these hospitalizations in December was dated 09/28/09. In December, there were four changes to his PNMP with most of these related to his dining plan and reflecting the recommendations on each of the separate assessment updates. This was confusing to staff and complicated staff training and monitoring. A brief update by the OT on 01/05/10 documented that she had observed him "at numerous times" after discharge with a final PNMP modification on that date. The recommendations included instructions for staff related to repositioning him before meals and redirecting hyperextension of his head were discontinued because "he will now eat in his wheelchair." The dining plan submitted as current was undated and did not have any photos to reflect the prescribed positioning during the meal. Of further concern was the fact that professional staff would "discontinue" instructions related to repositioning and head alignment. These two concerns must always be attended to by staff, regardless of whether the individual is seated in a regular chair, adaptive chair, or wheelchair. By discontinuing them, the message to staff was that they no longer were required to attend to his position and alignment. As described above, numerous examples of individuals out of alignment in their wheelchairs during meals were observed during the on-site visit, thus placing them at increased risk for aspiration, choking, and GE reflux. In the case of Individual #97, there was no documentary evidence of collaboration for assessment, problem solving, or design of the intervention/support plan. Further, there were no measurable outcomes or a plan for follow-up and review.	

#	Provision	Assessment of Status	Compliance
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.	All individuals identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP). Each individual living at EPSSLC had a PNMP and a dining plan. The format was generally consistent, but as noted throughout this report, gaps in information and numerous inconsistencies were evident. As appropriate, PNMP consists of interventions /recommendations regarding: a. Positioning/alignment; b. Oral intake strategies for mealtime, snacks, medication administration, and oral hygiene; c. Food/Fluid texture; Adaptive equipment; d. Transfers; e. Bathing; f. Personal care; g. In-bed positioning/alignment; h. General positioning (i.e., wheelchair, alternate positioning); i. Communication; and j. Behavioral concerns related to intake. The format for PNMPs included supports and strategies related to assistive equipment, communication, mobility, transfers, movement techniques, positioning (seating, bed), bathing/toileting, dining equipment, and dining plan. Pictures of assistive equipment were to be attached. Each individual had a PNMP. The staffing date and date of revision were documented. A system of arrows designated specific changes made to the plan. This was intended to highlight the differences in the current plan from the previous one for staff. The PNMPs were generally comprehensive with regard to the format, though it was not always evident that the stated focus of the plan and interventions outlined addressed the individual's identified PNM risk concerns. As described throughout this section there were omissions, errors, and inconsistencies that also impacted the quality of the plans produced by clinical staff. Individuals who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above. As stated above, all individuals at EPSSLC had PNMPs and dining plans even if they were NPO, receiving all their hydration and nutrition via enteral tube. PNMPs are developed with input from the IDT, home staff, medical and nursing staff and the physical and nutritional management team. During the PNMP/NMT meeting it was noted that the PNMP was read rapidly by the chairperson. The team members did not have a copy of the plan being reviewed. Minimal discussion was generated and was primarily therapist directed. The plan was approved or modified by the PNMP/NMT for submission prior to the PST the next month. Actual team discussion of the plans was not evident in the PSPs reviewed however. PNMPs are reviewed annually at the PSP meeting, and updated as needed. See above. PNMPS are reviewed and updated as indicated by a change in the person's status,	

#	Provision	Assessment of Status	Compliance
		transition (change in setting) or as dictated by monitoring results. Clinicians appeared to routinely modify the PNMP as indicated by a change in status. The records reviewed included multiple versions of plans with revision dates. The arrow system used identified new changes for staff. In some cases there was evidence of a review or consult documented by the clinician with a program change form submitted to trigger an addendum to the PSP (Individual #84). However, in other cases it was unclear how the changes recommended by the clinician were communicated to the PST (Individual #69). There was no evidence that PNMP monitoring triggered any changes in the PNMPs. There is congruency between strategies/interventions/recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. There was generally congruency between what the therapy clinicians recommended in the annual update or interim updates. In some cases, however, plans were not updated in a timely manner (Individual #93).	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan. A number of PNMPs were not implemented in the manner outlined in the PNMP and dining plan and included: • Individual #102 was eating large pieces of tortilla; some pieces were close to two inches long even though his diet order was for foods chopped or half-inch in size. He was also taking large bites. • Individual #90 drank a full carton of chocolate milk without stopping. • Individual #18's dining plan stated he should have his meals in a quiet setting, but he was eating in the dining area with everyone and it was not quiet. • Individual #52's milk was supposed to be nectar thick, but it was not thickened at all. • Individual #10 was on a chopped diet, but was eating pieces of tortilla that were larger than one inch. • Individual #127 drank two full glasses of liquid without pausing, but her plan stated that staff should provide cues to eat and drink at a slow pace. There were no staff present to provide the necessary cues even though there were precautions on her dining plan related to aspiration and choking risk. • Individual #93's plan stated that her head should be in midline, but it was turned to the left throughout the meal.	

#	Provision	Assessment of Status	Compliance
		• Individual #11's plan provided instructions for staff to support her at her left elbow to encourage her to be independent with scooping, but no staff were present to assist her eat her meal for over 10 minutes until the OT sat down to assist her. • Individual #94's plan stated to provide verbal and physical cues to slow him down, but only verbal cues were provided by staff. Throat clearing and coughing were noted numerous times throughout the meal. The plan also directed staff to provide hand-over-hand assistance to present liquids, but staff poured over three ounces of liquid in the cup (his plan prescribed only one to two ounces only at a time) and permitted him to gulp it down quickly. • Individual #1's plan stated to alternate foods with small sips of liquid. Staff, however, presented numerous bites of food, up to seven, before offering fluids. • Individual #104 was eating observed eating rapidly. • Individual #38's plan required use of a dycem mat, but it was not provided. When staff recognized that the monitoring team was observing this, he asked if he should get the dycem mat and was requested to do so. The staff person stated that he had not provided it on that date because he had "flu-like symptoms." He was also observed to eat very fast. When asked about his mealtime risks, staff reported that he was at risk for aspiration and choking. Individuals are in proper alignment and position. As cited above, a number of individuals were noted by the monitoring team to be in improper alignment. Plans are properly implemented across all activities that are likely to provoke swallowing difficulties and/or increased risk of aspiration. The intent of the PNMPs and dining plans was that they be followed across all settings. Opportunity to observe this in action at off-campus locations was not possible during this site visit. The following examples, demonstrate that implementation of PNMPs was inadequate: • Individual #69 had experienced a choking incident requiring the Heimlich on 05/07/09 during lunch at an off-site school as described above. • It was reported in the communication update for Individual #57, dated 09/22/09, that he was found to have a piece of meat in his mouth while at the workshop on 09/22/08. He was NPO, receiving all of his nutritional intake and hydration via tube. He was found a second time, eating a pear and coughing. In	

#	Provision	Assessment of Status	Compliance
		each case, it was not identified as to how he obtained these food items. He was at serious risk of death when eating these items. It was not possible to review the follow-up of either of these incidents because the dates of occurrence were not included in the document request samples. Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP. When errors were identified by the monitoring team with regard to diet texture, staff were able to verbalize the correct diet texture and rationale. It was of concern, however, that they had not advocated making the correction before serving it to the individual.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff. Per the December training schedule submitted, PNM-related training for new employees occurred on the 9th day for 7.5 hours of the 12-day training. Foundational training was provided to new employees in the area of physical management in course PHY0100. Learning objectives included recognizing staff responsibilities related to PNM, performing therapeutic handling and positioning techniques, and recognizing and performing optimal eating techniques. Training related to lifting people (LIF0200) was also conducted. Learning objectives included lifting using ideal or alternative procedures, identifying potential slip and trip fall hazards, fall prevention, recognizing responsibility related to lifting and transferring people, recalling of information about lifting people, recognizing staff actions that comply with lifting guidelines, and performing stand-pivot, 2-person lift and mechanical lift transfers. Content was taught by a COTA and PT aide. As this training offered very limited opportunities for hands-on practice (transfers and thickening liquids only) and no skills-based competency check off, other than for transfers, it was insufficient to ensure that staff were competent to implement PNMPs, particularly in the area of mealtime and communication supports. Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/posttest, which may also include return demonstration as applicable. By report, skills-based competency check offs were limited to transfers only. Other competencies were practiced in some cases as in thickening liquids, but check-off of specific skills was not conducted in other areas of PNM supports. Testing in those areas consisted of a multiple-choice test. Review of the training materials and tests revealed significant amounts of text written in professional jargon and requiring advanced reading skills. All foundational trainings are updated annually. Per the Director of Habilitation Therapies, annual re-training was conducted related to transfers and thickening of liquids. There was no evidence of content or dates delivered submitted by EPSSLC. Other	

#	Provision	Assessment of Status	Compliance
		PNM training was not updated annually at the time of this review per his report. Staff are provided person-specific training of the PNMP by the appropriate trained personnel. Staff training provided was not necessarily competency-based. Not all training was documented with sign-in sheets by report. PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff that have successfully completed competency-based training specific to the individual. Staff had not received competency-based training specific to the individual. Clinical staff provided inservice training to supervisors and "whoever is there at the time" which may have included verbal instruction and/or demonstration. After this training, the supervisor was responsible to complete the training for his or her staff. There was no consistent method used to provide PNM-related training and no consistent method to document it. Staff are trained prior to working with individuals and retrained as changes occur with the PNMP. Same as above. Changes to the plan were often e-mailed to the supervisor who was responsible for conveying the change to staff.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	A system is in place that monitors staff implementation of the PNMPs. On a regular basis (at least monthly), all staff will be monitored for their continued competence in implementing the PNMPs. Staff implementation of the PNMP was monitored on a very limited basis. Only 120 monitoring forms were completed between 10/01/09 and 01/10/10. Only 31 direct support staff across five homes were monitored during that time. Further, there were 14 forms that did not identify the name of the staff person monitored and another 14 forms indicated multiple staff members on the same form. There were five dedicated PNMP Coordinators who were to be responsible for monitoring. These monitors were scheduled to work across all shifts (2 day, 2 evening, and 1 night shift). A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. EPSSLC did not submit a policy that addressed the monitoring process. Policy #012 Physical Nutritional Management, approved on 12/17/09 with implementation on 01/31/10, was provided after the on-site visit. It included a section on PNM monitoring which outlined the following: • PNMPs should be monitored as scheduled and as needed by residential supervisors, nursing, therapy and other professional staff to assess effectiveness of plans and to make changes as indicated; • Supervisors should report problems and training needs; • Professional staff should monitor for proper use of equipment and intervention	

#	Provision	Assessment of Status	Compliance
		strategies; ensure proper implementation and to correct problems; • Individuals with identified PNM issues to be monitored regularly by NMT; • Daily monitoring of cleanliness , wear and need for repair by direct support staff; • Monitoring of equipment at least annually and as needed by therapy staff. The policy was not yet implemented at the time of this review. By report, therapy staff had initiated training of other professional staff and supervisors in anticipation of implementation of this system. There were no plans to routinely validate monitors to ensure consistency and accuracy. <u>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities)</u>. At the time of this review, a schedule had been developed for the PNMP coordinators as well as other staff. The schedule was not driven by level of risk, but was designed to cover all homes on a monthly basis. The primary focus was related to mealtimes and the presence of plans and equipment. Condition and cleanliness of equipment was reviewed using the tool, but effectiveness was not. Focus on positioning was limited. It was not apparent that monitoring of bedtime and bathing positions were observed routinely. <u>All members of the PNM team conduct monitoring</u>. At the time of this review, only SLPs had conducted formal PNM monitoring. Other clinical staff reported routine monitoring, but there was no documentation of this. In the event of a referral, an update was written by therapists to document the problem and recommendations for changes in supports and written plans. There was, however, no documentation of follow-up to ensure effectiveness of interventions. As stated above, other EPSSLC professional staff and supervisors were to conduct monitoring, though this system was not yet in place. <u>Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team. The PNM team identified trends, and addresses such trends, for example, to enhance and focus the training agenda</u>. There was no trend analysis of PNMP monitoring at the time of this review. Plans to do this had not been developed. Only 15/120 or 13% of completed monitoring forms identified any concerns. Issues reported included the following: availability/condition of equipment (10), current photo sheet (5), PNMP current and in training book (3), staff following home program schedules (3), staff initials on log sheet (4), and availability of supplies for thickening liquids (1). Nevertheless, the monitoring team observed individuals eating in improper alignment or support during the on-site review. Some examples were: • On 01/11/10 included Individual #40, Individual #105, Individual #93, Individual #118, Individual #11, and on 01/12/10 included Individual #94,	

#	Provision	Assessment of Status	Compliance
		Individual #40, Individual #21, Individual #105, Individual #1, Individual #28, and Individual #117 Diet texture or liquid consistency errors were also noted. Some examples included: • Individual #102, Individual #52, and Individual #10. An unsafe transfer was observed for Individual #29 on 01/11/10. Even so, no diet texture, position/alignment or transfer compliance errors were noted by any EPSSLC monitor from 10/01/09 through 01/10/10. Validity of this system and competence of the monitors was of concern. Immediate intervention is provided if the person is determined to be at risk of harm. There was no evidence of intervention at the time of this on-site tour. Issues identified were documented on the form, but there was no well-established system for follow-up. On 12/31/09, the SLP identified that Individual #65 was not eating and was only drinking Ensure. No referrals or plans to follow-up were documented on the monitoring form. The form included a place to document a referral to OT, PT, Speech or Other, but this section was not utilized. Other deficiencies noted during monitoring are corrected within an appropriate period of time based on the level of risk that they pose. Photos used for dining plans and PNMPs did not always demonstrate optimal alignment for the individual for whom the plans were designed. Some examples on dining plans included: • Individual #30, Individual #61, Individual #90, Individual #72, Individual #95, Individual #75, Individual #27, Individual #112, Individual #15, Individual #41, Individual #113, Individual #70, Individual #103, Individual #4, Individual #68, and Individual #89. • The plan submitted for Individual #97 did not have a photo of his mealtime position. • Individual #93's plan did not match her current seating system. • One dining plan submitted for a individual who was NPO did not have a name on it. These deficiencies had not been identified via the monitoring process and had not been corrected in a timely manner. System exists through which results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor. By report, supervisors were notified of issues identified via monitoring. There was, however, no documentation to this effect.	

#	Provision	Assessment of Status	Compliance
		Process includes intermittent internal validation checks to ensure accuracy. No validation checks were conducted at EPSSLC at the time of this review by report or documentary evidence submitted.	
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.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. PNMP/NMT meetings were held monthly, but the agenda was so lengthy there was insufficient opportunity to adequately review, track and analyze individual health status indicators. For example, Individual #95 presented with numerous concerns related to aspiration, emesis, GERD and GI bleed ongoing over at least the last year as detailed above. Considering the frequency of events that occurred over the last year, it was of concern that the NMT considered his status stable given that he had significant events in January, July, September and December 2009. It was of further concern that the aspect of "active monitoring" was not a responsibility assumed by the NMT on a sufficiently frequent basis. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators. PNMP monitoring was conducted using the Habilitation PNMP Monitoring Form and focused on staff compliance with implementation of the PNMP. Only 1 out of 21 indicators on that form pertained to the individual's status ("incident of coughing/choking noted?"). Other indicators addressed the presence and condition of equipment and staff performance related to implementation of the PNMP. Only 120 monitoring forms across Homes 506, 507, 513 and C dorm were submitted, completed between 10/01/09 and 01/10/09 for approximately 55 individuals only, or 40% of the facility census. Frequency of monitoring was insufficient to address each individual's PNM needs and to ensure that the PNMP was effective. Frequency of monitoring was not driven in any way by need or risk level. Monitoring conducted was as follows per documentation submitted: A Dorm: 1 on 01/09/10 only Others reviewed documentation via memo only rather than monitoring form C Dorm: 15 individuals monitored 3 times from October through December 2009 1 individual monitored 4 times in that period Home 506: 5 individuals monitored 3 times from October through December 9 individuals were monitored 3 times, from November through December Home 507: No evidence of monitoring during October through December 12 individuals monitored in January 2010 Home 513: 8 individuals monitored one time in December only 3 others monitored twice, in October and December only 1 individual was not monitored during that time	

#	Provision	Assessment of Status	Compliance
		No further evidence of monitoring was submitted by EPSSLC. The following individuals were some examples of those with PNM concerns who would warrant frequent monitoring: • Individual #16: High risk related to weight • Individual #18: High risk related to respiratory concerns • Individual #101: High overall risk • Individual #2: High overall risk including aspiration and choking • Individual #103: High risk of aspiration and choking • Individual #69: Medium risk for aspiration/choking but with choking incident in the last year and high overall risk • Individual #71: High overall including aspiration and choking • Individual #113: High overall including aspiration and choking • Individual #29: High overall risk • Individual #97: High risk for osteoporosis • Individual #52: High overall risk with medium risk for aspiration and choking Of these, only Individual #18 (one time), Individual #52 (one time), and Individual #2 (three times) were monitored from October through 01/10/10. On the other hand, there were 10 individuals considered at Level 3 or low risk monitored one time and 11 others monitored two to three times. There were nine individuals considered at Level 2 overall as well as aspiration and choking and were monitored three times and two others monitored only once each. There were 19 individuals who were Level 2 overall risk but at low risk related to aspiration and choking and were monitored one to three times. At least 18 others considered to be at medium risk of aspiration and choking were not monitored at all during that period. Individual #103, Individual #71, Individual #113, and Individual #2 were each considered to be at high risk for aspiration and choking per the HST. Of these, only Individual #2 was monitored. Individual #101, Individual #69, Individual #71, Individual #113, Individual #115, Individual #29, Individual #52, and Individual #2 were considered to be at High risk overall. Of these only Individual #52 (one time only) and Individual #2 were monitored (three times). Person-specific monitoring by clinicians was generally in response to a request, referral, or identification of a problem rather than scheduled routine monitoring of health status and the effectiveness of supports to address identified PNM health risk indicators. These were documented by special reviews or updates rather than on a monitoring form. There was no mechanism is place to tabulate findings from follow-up monitoring for trend analysis per individual or system wide.	

#	Provision	Assessment of Status	Compliance
		<u>Issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted</u>. There was no evidence that the PNMP/NMT reviewed the findings of PNMP monitoring. In the example above, Individual #95 was not monitored in 2009. Other than quarterly monitoring of his weight and his annual staffing, all reviews of his status were reactionary to events or changes in health status only. There was no evidence of proactive review or monitoring by the NMT. <u>The individual's PNM status is reviewed annually at the PSP, and all PNMPs are updated as needed</u>. Annual updates were completed by OT/PT and SLPs on an annual basis. A summary of findings from those reports was included in the PSP. There was a section identified as "Review of Physical and Nutritional Management Plan for accuracy/changes." There was generally discussion of the PNMP in the OT/PT/SLP sections of the PSP with recommendations to continue, but recommendations for changes to the PNMP were not summarized in the section of the PSP designated as PNMP review. Examples of inconsistencies between the PSP and PNMP were described above for: • Individual #114 • Individual #125 • Individual #46 • Individual #57 <u>On at least a monthly basis or more often as needed, the individual's PNM status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results</u>. There was no evidence in the personal records submitted of routine monthly review by the PST or member(s) of the NMT. <u>Members of the PNM team complete monitoring system</u>. Approximately 50% of completed monitoring forms were signed by only two speech clinicians. Most were signed by a speech clinician who was no longer employed at EPSSLC at the time of the on-site tour. There was no evidence of other NMT members conducting formal monitoring. <u>Immediate interventions are provided when the individual is determined to be at an increased risk of harm</u>. Issues related to improper implementation of plans related to diet texture, dining plan instructions, and position and alignment were not noted in the monitoring tools submitted, though a number of these were identified based on the observations of the monitoring team and described above. It was of concern that no issues of this nature were identified on the monitoring submitted. It would be unlikely that the facility would have 100% compliance in these areas during the three months	

#	Provision	Assessment of Status	Compliance
		prior to the monitoring team's visit, given the numerous errors observed by the monitoring team. Since they were not previously identified, they clearly would not be addressed even though it placed the individual at risk of harm. When errors were pointed out by the monitoring team, the staff responded quickly to remedy the concern. Most issues identified via facility monitoring were related to missing equipment or the need for repairs (Individual #117 on 11/06/09, Individual #120 on 12/22/09, Individual #125 on 10/01/09). There was evidence that the issues identified were addressed for both individuals per the PNM Maintenance log. Individual #120's communication book was missing and it was not possible to determine if it had been located via review of documentation. A memo with multiple attachments was submitted with subject "Individual #16 PNMP monitoring" on 01/09/10. Numerous issues were identified on that date for him as well as others in all dorms during breakfast and equipment review. Work orders were generated to address at least five issues identified on that date. There was no evidence that this was done routinely however. It was not possible to track completion of these work orders as the tracking log submitted was only through 12/30/09. On 01/03/10 it was noted that the "supervision card" stated that the food texture for Individual #98 was chopped, but it had been changed to ground. There was no documentation that these concerns were addressed. A system to permit tracking of issues identified and resolution would be necessary to ensure that all individuals with identified needs received the proper supports in a timely manner.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status</u>. There were 14 individuals with gastrostomy tubes per an undated, untitled database related to nutritional intake and mealtimes. Three of the 14 also received some level of oral intake and included Individual #54, Individual #114, and Individual #1 Individuals who received enteral nutrition included in the sample were assessed by the SLP in the last year. These assessments addressed the area of oral motor function and feeding. Based on these communication updates, with the exception of Individual #1, all were NPO, that is, with the primary source of nutrition and hydration via enteral tube. Each, except Individual #57, was offered a small amount of water or puree solid by mouth to document response. Each was recommended to continue with non-oral intake secondary to inadequate oral/pharyngeal responses upon presentation.	

#	Provision	Assessment of Status	Compliance
		Individual #1 continued to have a tube for supplements after meal refusals and as an alternate method for medication administration. She also had received an update by the SLP in the last year. Only Individual #2 and Individual #71 were considered to be at high risk of aspiration and choking per the Health Status Review List dated 01/05/10. These assessments were conducted only by the SLP as part of a communication update. There was no evidence of collaboration with other team members so it was unclear if issues related to position, alignment, support and alternate presentation methods or adaptive utensils were also considered. The need for continued enteral nutrition is integrated into the PSP. There was documentation in the PSP with regard to NPO status in the section related to rights restrictions. The statements in that section appeared to be the statement by the SLP, describing oral status, response to oral intake trials, and, in the cases of Individual #2 and Individual #71 for whom PSPs were submitted, the recommendation that they remain NPO. When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used. It was not possible to assess this item during the baseline review. No individuals had recently returned or was being considered for return to oral intake. There is evidence of discussion by the PST regarding continued need for enteral nutrition. As stated above, the PSP documented NPO status as a rights restriction. There was insufficient evidence, however, that the PST discussed the individual's condition and that enteral nutrition continued to be medically necessary. A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT). State policy did not clearly define the depth of assessment required. These assessments were conducted by SLPs at EPSSLC on an annual basis as a part of the communication update. There did not appear to be a standard for how these assessments were to be completed and there did not appear to be collaboration with other disciplines. Discipline-specific assessments did not provide a thorough history related to each individual's physical and nutritional health. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. In most cases, strategies were limited to diet texture and liquid consistency modifications, as well as assistance techniques to modulate pace and flow. In some cases, however, SLPs provided oral motor intervention and Vital Stim	

#	Provision	Assessment of Status	Compliance
		therapy to improve oral intake, swallow efficiency, to minimize reliance on non-oral intake. The communication assessment dated 11/02/09 reported that Individual #1 ate orally but also had a gastrostomy tube. As a result of successful interventions with Vital Stim therapy, it was reported that she demonstrated improved initiation of swallow, improved tongue base retraction and no residue post swallow. The tube was used only for meal refusals and to administer medications as needed. No baseline was established, however, related to tube use, oral intake levels, meal refusals, weight or other health parameters in order to better demonstrate success of this intervention for her. Based on the communication updates submitted, seven individuals were NPO, with the primary source of nutrition and hydration via enteral tube. They were re-evaluated at least one time in the last year with trials of oral presentations of water and/or pureed solid to determine if they presented with potential for any level of oral intake. While none were recommended for pleasure or therapeutic feedings, these clinicians should be commended for their efforts. It was noted that the presentations of water were via cup which would be quite difficult for the individual to manage with success. Other methods of presentation should be considered in these assessments.	

Recommendations:

1. Include PT staff in PNMP/NMT meetings,

2. Continue annual continuing education opportunities to include all PNM team members

3. Re-organize the PNMP/NMT to allow for greater focus of review on those with high-risk indicators. Establish measurable outcomes related to occurrences of risk indicators or identified PNM concerns. Necessary information must be available to all team members prior to and during meetings to ensure effective problem solving.

4. Consider including need for changes to the PNMP in the discipline specific assessments, and then address these in the PSP meeting rather than the PNM meeting. The main goal, however, is that there is an opportunity for meaningful review, assessment, and discussion for each individual.

5. Create opportunities for greater collaboration across disciplines for assessment, development and revision of support plans and for review of health status and efficacy of interventions.

6. Revise current assessment format to include analysis of objective data to drive a comprehensive approach to interventions. Ensure that consideration is given to assessment of potentials and functional skill acquisition as described in OT/PT and Communication sections below.

7. Utilize monitoring system to fine tune PNMPs and dining plans for consistency and accuracy.

8. Revise current new employee training to ensure that it addresses skills-based competencies rather than only knowledge-based learning objectives. Competency check-offs should include an activity analysis, highlighting the skills necessary to complete the task. Staff should be expected to perform each skill to criteria to achieve competency. Create annual refresher courses with competency-based check-offs to ensure continued competence.

9. All individual-specific training must be competency-based and documented with staff sign-in sheets. Only staff who have been checked off should work with those at highest risk.

10. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency.

11. Consider revision of monitoring tool to better assess staff performance of basic skills. Findings should drive staff training plans.

12. Ensure that re-validation of monitors occurs on a regular basis to ensure consistency and accuracy.

13. Conduct trend analysis of all monitoring data. Review findings and make system adjustments.

14. Review the existing systems of risk assessment to ensure greater integration. Risk levels should be determined by potential risk of harm. Implementation of supports and services to minimize risk do not automatically reduce the individual's potential for risk of harm. The interventions must be in effectively in place long enough to attain and maintain stable risk status for a prescribed length of time before risk level is downgraded.

15. PNM review should focus on PNM concerns with follow-up through problem resolution. Set outcome measures with regard to specific risk indicators and timeframes for achievement. For example, Mary will be pneumonia free for six months. Interventions should support achievement of identified outcomes. PNMP/NMT should continue to monitor until the individual attains and maintains at the goal level. Reasons for review should be based more on PNM concerns rather than housekeeping tasks.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Reviewed Settlement Agreement: Section XI. Physical and Nutritional Management, P. Physical and Occupational Therapy o Reviewed the applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management o Current Census by Home (01/11/10) o Person's Served Information (01/08/10) o Physical Nutritional Management policy #012, 12/17/09 o Nutritional Management policy #013, 12/17/09 o Draft Policy Operations: Physical Nutritional Management (05/20/09) o Draft Policy Operations: Physical Nutritional Management (07/29/09) o Nutritional Management Committee Policy and Procedure (03/01/05) o At Risk Individuals policy #006, 10/05/09 o Handbook, Habilitation Therapies Physical Nutritional Management, by Karen Hardwick, Ph.D., OTR, FAOTA (September 2007) o Best Practice Guidelines (July 2008) o Checklist for Internal Compliance Review of Critical Process Indicators Related to PNM (04/08/08) o EPSLC Plan of Improvement for OT/PT o Resumes submitted for OT and PT clinical staff o Continuing Education records submitted o List of contract providers o Budgeted, Filled, and Unfilled Positions by Job Code (Medical Series) 12/14/09 o Sign-in sheets for Webinars (08/04/09 to 12/30/09) o PSPs for (current within 12 months unless otherwise indicated): • Individual #1 (2008 and 2009), Individual #106 (2008), Individual #56 (2008), Individual #59 (2008), Individual #103, Individual #110, Individual #74, Individual #114, Individual #29 (2008 and 2009), Individual #35, Individual #79 (2008), Individual #74 (2008), Individual #86, Individual #89, Individual #125, Individual #45, Individual #46, Individual #58 (2008), Individual #55, Individual #57 (partial, 6 pages only), and Individual #71 o PSP Quarterly Review: • Individual #106 (07 to 09/2009) submitted as PSP for 2009 o PNMP/NMT meeting minutes (12/10/08; 01/14/09; 02/11/09; 03/11/09; 04/08/09; 05/13/09; 06/10/09; 07/08/09; 08/12/09; 09/09/09; 10/14/09; 11/04/09) o PNMP/NMT meeting agendas: 01/13/10 o Communication Updates (all current within the last 12 months unless otherwise indicated): • Individual #101, Individual #2, Individual #103, Individual #6 (01/06/09), Individual #71, Individual #48, Individual #46, Individual #106, Individual #4, Individual #1,

	Individual #100, Individual #8, Individual #114, Individual #58, Individual #21, Individual #29, Individual #127, Individual #89, Individual #93, Individual #79, Individual #65, Individual #70, Individual #97, Individual #125, Individual #95, Individual #69, Individual #84, and Individual #52. ○ EPSSLC Table of Organization ○ Habilitation PNMP Monitoring Forms completed 10/01/09 – 01/10/10 ○ Template Mealtime Observation Sheet ○ Draft schedule of PNMP Monitoring ○ Active Employee Participation Report Physical Management 12/09/09 ○ Personal Record documents including: Nutritional Assessments; OT/PT Assessments; Communication Assessments; OT/PT/SLP Updates; Special Review/Consults by OT, PT, SLP; Bedside Dysphagia Evaluation; PNMPS for last 12 months; PSP and Addendums; Progress Summaries for OT/PT/SLP; Identifying Data sheets; Annual Medical Summary and Physical Examination; Nursing Assessments (last 4 quarters); Drug Regimen Review (most current); X-rays section; Consult section; PALS assessment; and SPO Activity Plans for the following individuals: • Individual #2, Individual #71, Individual #103, Individual #21, Individual #58, Individual #6, Individual #95, Individual #52, Individual #75, Individual #97, Individual #69, Individual #70, Individual #29, Individual #127, Individual #93, Individual #84, and Individual #4. ○ EPSLC Health Status List (01/05/10) ○ Meeting Minutes of Health Status Team meetings (01/21/09;02/18/09; 03/19/09; 04/15/09; 05/20/09; 06/17/09; 07/22/09; 08/19/09; 09/16/09; 10/21/09; 11/18/09; and 12/16/09) ○ Health Risk Assessment Rating Tool (Individual #14, 08/26/09) ○ Safety/Risk Management Accident Review Committee Agenda (07/23/09 and 10/22/09) ○ PNMP Definitions and Purpose (Section V.A.1) ○ Instructions for PNMP Clinics ○ Physical/Nutritional Management Plan for each individual ○ Dining Plans for all individuals ○ Data regarding number of individuals with: • PNMPs, reviewed by NMT, seen by PNM Teams • Dining Plans; • Comprehensive OT/PT assessments, with Communication assessments • tube feedings assessed for less intrusive feeding ○ Physical Management Training Modules (Section VIII.A.1) ○ PreService/NEO Training Schedule for New Employees December 2009 ○ Personal notes taken week of 01/11 – 01/15/09 <u>Interviews and Meetings Held</u>: ○ Anderson Hicks, OTR/, CEAS, Habilitation Therapies Director ○ Susan Acosta, MPT ○ Amy Gleaton, OTR ○ Francisо Montelongo, OTR

	○ Alfredo Diaz de Leon, COTA ○ Jessica Alvarez, MPT ○ Henry Kielb, MA, CCC-SLP Observations Conducted: ○ Mealtimes ○ Living areas and day program areas ○ Occupational Therapy Department meeting ○ PNMP/NMT meeting 01/13/10, 1:30 PM ○ Seating assessment/ mat evaluation for Individual#2 on 01/12/10 ○ Attended Habilitation Therapies Director's Webinar 01/13/2010, 12:30 PM
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: EPSLSC had a number of talented and dedicated clinicians and this will serve as a foundation for ongoing progress with regard to this section of the Settlement Agreement. They conducted combined OT/PT assessments, but often collaboration appeared to be via the written report only, rather than via purposeful integration. The dates of the PT assessment and OT assessment were different, often with a gap of a week or more. All staff will need to work smarter and more efficiently to compensate for weakened staff ratios; the development of strategies to better analyze and optimize staffing needs and ensure successful recruitment will be necessary by administration. Assessment should lay the foundation for functional and meaningful intervention strategies. The current assessments were thorough but mechanical in nature and essentially formulated a list of equipment and problems, but generated little with respect to acknowledgement of potentials for learning and skill acquisition. There was no evidence of clinical reasoning or analysis of objective data reported to justify the determination that intervention was or was not indicated. Interventions were not clearly integrated into the PSP as training or learning objectives. Activity plans developed and implemented by habilitation therapy staff were extremely limited and narrow in focus. In most cases, baseline findings were not reported so as to enable the clinician and PST assess possible progress as a result of the specific intervention recommended. Clinical reasoning and analysis was the missing link to drive greater relevance in intervention strategies and collaboration with other team members to ensure that the clinical expertise of OTs and PTs is better integrated across all settings at the facility, including, for example, the day program.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. The census at EPSSLC was approximately 142 at the time of this baseline review. The department director, Anderson Hicks, was an occupational therapist. Unlicensed OT and PT technicians provided administrative supports as well as assistance with tracking, monitoring, and training. OTRs are typically licensed to conduct assessments whereas COTAs are typically licensed to provide supports and services under the direction of a licensed OTR and may only assist in the assessment process. OT services were provided by two full-time occupational therapists, two full-time certified occupational therapy assistants, and one full-time occupational therapy technician. Each of these staff were state employees. At the census of 142, maximum caseloads for each OTR included approximately 71 individuals in conjunction with one COTA each. Only eight individuals had an activity plan developed by OT. The focus of these interventions included functional handwriting for four of the eight individuals and fine motor coordination, range of motion, mobility, and lotion massage to address self-stimulation for the other four individuals. Intervention plans were designed for 8-12 weeks and interventions provided one to five times per week. Other supports and services provided included PNM plans, dining plans, splinting, seating, and positioning. There were two OTs and two COTAs, thus, staffing for OT was marginally sufficient. It was of concern that so few individuals received OT intervention and that 50% were related to handwriting rather than addressing pressing health concerns. While handwriting was a functional outcome for the individuals to whom it was provided there were numerous others who would benefit from OT. A newly hired COTA, who was also a new graduate, was to be assigned administrative responsibilities for documentation of the PNMP/NMC meetings as described above. These duties will greatly impact her availability for supports and services specifically related to OT. There was one unlicensed occupational therapist who provided art therapy services at the facility and did not provide OT services, but collaborated with the licensed clinicians. Careful analysis of OT staffing is indicated to ensure that all elements of the Settlement Agreement may be implemented and sustained. PTs are typically licensed to conduct assessments while PTAs are typically licensed to	

#	Provision	Assessment of Status	Compliance
		provide supports and services under the direction of a licensed PT and may only assist in the assessment process. PT services were provided by three contract physical therapists working part-time, one full-time physical therapy assistant, two PTAs and two full time physical therapy technicians. At the current census, caseloads for the physical therapists were approximately 47.34 each in conjunction with one PTA and two technicians. Each physical therapist had a maximum number of hours he or she could provide during the contract year, so year round full time services were not possible for two of the three clinicians. By report, Susan Acosta provided services under two part-time contracts, thus, she generally filled a nearly full time equivalent position. The other two PTs were part-time only. These three clinicians were responsible for all physical therapy assessments. Only 10 individuals had an activity plan developed by PT (Individual #105, Individual #97, Individual #90, Individual #92, Individual #106, Individual #18, Individual #77, Individual #71, Individual #9, and Individual #29). These interventions generally focused on gait, standing, and transfers. One plan addressed cervical, thoracic, and hip extensor flexibility and another addressed power wheelchair mobility. Seven of the 10 plans were to be implemented 1-5 times per week "or upon PT availability." The other three plans were to be implemented one to two times per week "or upon PT availability." Other supports and services provided included PNM plans, lower extremity splinting/braces, seating, and positioning. As two of the three clinicians were part-time only, staffing for PT was not sufficient. PTs did not participate in PNMP/NMC meetings at the time of this review. Careful analysis of PT staffing is needed to ensure that all elements of the Settlement Agreement can be implemented and sustained. It was of concern that so few individuals received PT intervention . Fabrication of seating systems occurred on site. Fabricators were responsible for collaborating with therapy clinicians to design seating systems for individuals living at EPSSLC, fabricating custom components, and completing repairs and modifications. At the time of this review, there was only one full-time fabricator. A second fabricator had recently been re-assigned to a different position in the facility, however, the vacancy was not going to be filled. A part-time technician had recently been hired to assist the fabricator with needed repairs. Staffing for fabrication, maintenance, and repairs of seating and positioning equipment was insufficient at the time of this review. All individuals have received an OT and PT screening. If newly admitted, this occurred within 30 days of admission. By report and record review, each individual received a screening and/or an OT/PT assessment within 30 days of admission. This was not validated during this baseline review because the sample did not include any individual who was newly admitted. Validation will be necessary in a subsequent review.	

#	Provision	Assessment of Status	Compliance
		Most of those included in the sample had been in residence for more than 10 years. Admission dates for Individual #97 and Individual #69 were not listed on the Identifying Data sheets submitted. • Individual #97 had received an OT/PT update rather than an initial assessment so it was presumed he was not a new admission to the facility. His PSP, dated 08/22/08, referenced an admission date and included OT/PT recommendations dated well within the 30 day requirement. • Individual #69 was provided an "initial" OT/PT assessment on 05/20/09, so it was not clear if he was a new admission or had just received an OT/PT assessment for the first time. His PSP (06/16/09), however, indicated that he had been in residence at EPSSLC for two years. • Individual #18 also received an "initial" OT/PT assessment though had lived at EPSSLC for five years per his PSP dated11/02/09. The format and content did not vary between the updates and the initial evaluations. Continued routine screening would not generally be indicated once a comprehensive assessment had been completed for an individual. Annual updates/assessments would be indicated for those receiving direct and/or indirect services. See below. <u>All individuals identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification</u>. Each individual living at EPSSLC received some level of direct and/or indirect supports and services. For example, each individual had a PNMP and a dining plan. Assessments or updates were submitted for 22 individuals for review. Of those, two were not current within the last 12 months including: Individual #84 (01/06/09) and Individual #127 (12/15/08). Two others expired during the week of this review and included: Individual #70 (01/12/09) and Individual #6 (01/16/09). Interim assessments or consults by OT and PT were noted for acute concerns. Physician orders had not been a part of the document request so it was not possible to evaluate the timeliness of clinician response to these referrals. <u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status</u>. Twenty-one of 22 OT/PT assessments and/or updates recommended a subsequent assessment in one year. These would not be considered comprehensive or adequate even as an interim update as they lacked sufficient medical history or background and were lacking analysis of findings or clinical reasoning to justify recommendations. Initial assessments followed the same format as the updates. A	

#	Provision	Assessment of Status	Compliance
		three-year series of assessments was not requested so it was not possible to assess whether a comprehensive assessment was completed every three years. The updates, however, varied very little from the two initial assessments reviewed. Individual #21's update, dated 03/07/09 and 02/19/09, did not include any recommendations, and appeared to be incomplete. As stated above, a copy of the most current assessment/update was not submitted for Individual #97 so recommendations were not reviewed. An initial OT/PT assessment was noted for Individual #69 and Individual #18. OT/PT Updates were noted for 16 of an additional 17 records reviewed and 12 of these were current within the last 12 months. In the case of Individual #75, there was reference to OT and PT assessments in his PSP dated 08/06/09, but the actual assessments were not submitted by EPSSLC as requested. Neither the initial assessments nor the updates included background or medical history, but merely included a list of active problems and medications. The assessment format used was generally thorough, though frequent use of abbreviations and professional jargon was noted making it difficult for non-therapists to read and interpret information included in the report. An abbreviation section was included at the beginning of the report, but other abbreviations not identified were used throughout the reports and even so, abbreviations impacted readability for the layperson. In many cases, there was insufficient baseline outlined in the assessment to use for assessing progress as a result of intervention. Neither an analysis of findings nor a rationale was provided as a foundation for the recommendations identified. • The assessment for Individual #70 recommended that he continue in a PT activity plan for gait, stretching, and swinging, however, an activity plan had not been submitted even though all activity plans had been requested by the monitoring team. • An activity plan for Individual #29 was submitted to address cervical, thoracic and hip extensor flexibility. His assessment on 09/30/09 stated that he had sufficient functional range of motion for functional mobility with only mild limitations in knee extension and ankle dorsiflexion. He presented with a "forward head, rounded shoulders and thoracic spine kyphosis" and elevated right shoulder. Recommendations stated that, "no formal PT intervention was required." However, just over 1 month later, on 11/06/09, a wheelchair assessment was conducted during which it was noted that he had increased kyphosis and would benefit from a positioning plan. An activity plan (11/09/09) outlined that he was to participate in the therapeutic activity one to five times per week dependent on availability of PT. PT was to provide documentation for each treatment and a monthly summary. This concern should have been identified in the annual assessment with intervention recommended at the time of his PSP. His PSP, dated 12/02/09, made no	

#	Provision	Assessment of Status	Compliance
		reference to the addition of this intervention nor was there documentation submitted to addend the PSP related to this activity. A physical therapy progress summary with "coverage dates" of 11/09/09 to 12/13/09 indicated that he had participated in 16 sessions during that month. As no baseline was identified via assessment, it was unclear that progress had been made during that month. The recommendation was to continue the activity plan with an outcome to include "eventual" short distance ambulation. Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral. This standard was not specifically reviewed because the sample did not include individuals who did not receive some level of therapy supports and services. For example, all individuals were provided a PNMP and a dining plan. Each received an OT/PT update. By report, this was provided, but will require further validation in a subsequent review. Findings of comprehensive assessment drive the need for further assessment such a wheelchair/ seating assessment. Per the 22 assessment/updates reviewed, all but one required the use of a wheelchair. Of the other 21 assessments, only eight documented appropriateness of the existing seating system. Of those eight, only Individual #58 (09/09/09), Individual #70 (01/12/09), and Individual #125 (09/30/09) had seating systems that met their needs. A number of examples, however, indicated that more attention to wheelchair and mobility issues was needed at EPSSLC. Some of these examples are listed below: • Individual #70's update expired during the week of this review, so it was not clear if that was still the case. In the other cases, merely a description of the equipment was documented with no assessment of the fit or function for the individual. • In the case of Individual #29, the OT/PT assessment (09/30/09) stated that his device was "not optimal," but was "meeting his needs for mobility and positioning." A work order was submitted to address the arm rests and left leg rest handle on the push bar. It was stated that the habilitation team would further modify his wheelchair "as appropriate" in the next year. • Recommendations from the OT/PT update (10/13/09) for Individual #114 included a new seating system and possible new wheelchair frame, however, this was considered a low to medium priority because his current system was deemed to be safe. • Individual #4 was identified as requiring a new wheelchair system based on a mat evaluation conducted on 06/18/09, however, recommendations in his update stated only that his wheelchair was to be included in the database for	

#	Provision	Assessment of Status	Compliance
		further modifications. • Per a mat evaluation conducted on 07/09/09, Individual #97's wheelchair required minor modifications to "better meet his therapeutic needs." Per the update, those changes had been completed and the wheelchair re-issued. There was no specific statement, however, that the changes were appropriate with regard to fit and function for him. • The OT/PT Update for Individual #71 (02/04/09) indicated that his wheelchair was too narrow "to allow therapeutic benefits" and that he was at risk for skin breakdown due to pressure on his hips and thighs from the lateral canes. He was further at risk for worsening of his kyphosis because the back was too narrow and promoted "shoulder internal rotation and collapsed chest." The clinicians documented that he would benefit from an appropriately fitting wheelchair. Per documentation, it appeared that a new frame had been delivered on 06/08/09. Modifications were scheduled to begin on 06/25/09 with a proposed completion date of 08/25/09, however the documented delivery date was 09/17/09, more than seven months after the initial identification of need. Clearly given that the device was considered so extremely unsuitable, he had likely been in need of a new seating system prior to the time of the mat evaluation in February 2009 and had been identified to be at HIGH risk of aspiration via the Health Status Review checklist. Delay of this significance in meeting his needs was unacceptable. Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. Active problems were listed in each of the OT/PT assessments with medications, however, these were not current in some cases. For example, OT/PT Updates for Individual #110 (10/05/09) and Individual #18 (10/13/09) listed active problems and medications "as of October 2008." Individual #114's OT/PT Update (10/19/09) listed active problems "as of November 2008." Other specific risk indicators were listed only with regard to the focus of the PNMP, but did not necessarily correlate with risk assessments connected to the NMC and Health Status Review systems. There was not a clear correlation between interventions, supports and services, and risk identification via analysis of findings for each individual who received an OT/PT assessment update. Recommendations were generally rote in nature and pertained primarily to the provision of plans "to address needs" or to state that formal OT and/or PT were not indicated. Evidence of communication and or collaboration is present in the OT/PT assessments. Occupational therapy and physical therapy completed a combined assessment report, but collaboration was not clearly evident because the actual assessment dates were different. For example:	

#	Provision	Assessment of Status	Compliance
		• The PT assessment for Individual #18 was completed on 09/28/09 while the OT portion was completed over two weeks later on 10/13/09 for his annual staffing held on 11/02/09. • The PT assessment for Individual #114 was completed on 10/13/09, while the OT portion was completed one week later on 10/19/09 for his annual staffing held on 11/10/09. • The PT assessment for Individual #125 was completed on 09/30/09, while the OT portion was completed three weeks later on 10/21/09 for his annual staffing on 11/09/09. • Six others were not completed within at least a week of each other included; these ranged from 10 days to nearly three weeks apart. • In only five cases, OT and PT conducted the assessment in whole or in part on the same day (Individual #28, Individual #4, Individual #93, Individual #2, and Individual #97). It was unclear, however, if these had been conducted by OT and PT together or separately on the same day.	
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>Within 30 days of a comprehensive assessment, or sooner as required for health or safety, a plan has been developed as part of the PSP</u>. Plans developed were limited to PNMPs, dining plans, and in a few cases, activity plans. Plan development was the responsibility of habilitation staff and, in the case of PNMPs and dining plans; implementation was by direct care staff. In the case of an activity plan, implementation was by therapy services staff. Each of the PNMPs and dining plans developed included the staffing date and in many cases there was a revision date to reflect changes to the plan since the annual staffing. It appeared that the majority of plans were developed at the time of the annual PSP or within 30 days, however, not all PSPs and PNMPs were current in the documents submitted. There were 140 PNMPs submitted. Of the plans reviewed, there were three plans that expired the week of this site visit; only one had been revised since the staffing held 12 months prior. There were an additional 11 PNMPs that were associated with PSPs that were over 12 months old, although each had been revised at least one time since the annual staffing. Two others were associated with PSPs that were over 12 months old with no plan revisions during that time. It could not be determined if these had not been completed or that the wrong documents were submitted. In some cases, there were notations stating that a QMRP was no longer working at EPSLC and that current PSPs were not available. It was of concern that annual planning had not been completed for these individuals in a timely manner. <u>Within 30 days of development of the plan, it was implemented</u>. Implementation dates were not evident based on the documentation submitted. By report, all plans were in place and, in cases where a revision was necessary, each of the plans was modified with	

#	Provision	Assessment of Status	Compliance
		immediate implementation. • In the case of Individual #29, a PT assessment was conducted on 11/06/09 with the recommendation for an Activity Plan to address cervical, thoracic, and hip extension mobility implemented on 11/09/09. An additional assessment was conducted on 11/17/09 due to non-weight bearing on his lower extremities during gait. His Activity Plan was revised on that date to incorporate gait training. • In the case of Individual #97, a gait training activity plan had been previously implemented on 07/24/08, within 24 hours of his admission to EPSSLC. A PT assessment was dated 01/13/10 which recommended that a PT activity plan be initiated to address gait and transfers. An activity plan was developed on that date. Implementation could not be reviewed as documentation was completed on a monthly basis and had not yet occurred at the time of the on-site tour. • Program changes were noted for Individual #21, including sit-to-stand in-and-out of the gait trainer with maximum assistance of one to two people with a gait belt on 10/28/09. There was evidence of a staff inservice on the same date. A PNMP was submitted and also dated 10/28/09 with this change included. Other program changes were noted for her with implementation dates within 24 hours. There was no evidence of staff inservice for these other changes. In one case, the change had been made to her PNMP on the same date; in another within 24 hours and in three other cases it occurred in less than 30 days. <u>Appropriate intervention plans are: a. Integrated into the PSP; b. individualized; c. Based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies; and c. Contain objective, measurable and functional outcomes</u>. Only eight individuals had an activity plan developed by OT. The focus of these interventions included functional handwriting for four of the eight individuals, and fine motor coordination, range of motion, mobility, and lotion massage to address self-stimulation for the other four individuals. Intervention plans were designed for 8-12 weeks and interventions provided one to five times per week. Other supports and services provided included PNM plans, dining plans, splinting, seating, and positioning. Only 10 individuals had an activity plan developed by PT. These interventions generally focused on gait, standing, and transfers. One plan addressed cervical, thoracic, and hip extensor flexibility and another addressed power wheelchair mobility. Seven of the 10 plans were to be implemented one to five times per week "or upon PT availability." The other three plans were to be implemented one to two times per week "or upon PT availability." Other supports and services provided included PNM plans, lower extremity splinting/braces, seating, and positioning.	

#	Provision	Assessment of Status	Compliance
		Only four of 17 activity plans reviewed contained objective, measurable outcomes. Each of these were OT plans related to participation in a functional handwriting group. None of the OT/PT assessments contained sufficient analysis of findings to justify interventions and other recommendations. In the case of Individual #18, the OT/PT assessment dated 09/28/09 described him as non-ambulatory and indicated that he was not appropriate for skilled PT intervention. On 11/02/09, however, an activity plan was implemented "to encourage and optimize mobility status" with gait activity to be implemented by PT staff one to five times week or upon PT availability. There was no apparent rationale for the implementation of this plan. In the case of Individual #114, the OT/PT assessment indicated that an activity plan for "lotion massage" was recommended to provide sensory input for reduction of self-stimulatory behaviors and for "better skin care" related to dryness and calluses. Per this assessment report, his annual staffing was scheduled for 11/10/09. The activity plan developed by OT was dated 11/16/09 with implementation by OT staff three to five times per week for eight weeks. There was reference to dryness of his hands and the presence of calluses secondary to self-propelling his wheelchair. Reference to self-stimulatory behavior during the assessment included finger flicking, waving his fingers in front of his face, and shaking his head side to side. It was documented that he was effectively redirected when offered a manipulative that he enjoyed such as a ball or by using a calm quiet voice and firm, gentle touch. He reportedly responded to lotion massage and put his hands out for more during the assessment session. The assessment stated that "no formal OT intervention is recommended at this time" on page 2, though the lotion massage was recommended on page 5 as a part of OT programming. Per Individual #86's PSP, no OT intervention was indicated, however an activity plan was implemented on 11/06/09 to address proper head positioning during writing sessions and to write his home address on an envelope three of five times. There was no rationale provided as to his baseline for this activity or documentation related to an established need to address this skill. <u>Interventions are present to enhance: a. movement; b. mobility; c. range of motion; independence; and d. as needed to minimize regression</u>. There were only 18 intervention plans designed and implemented by OT or PT. Each of the 10 PT activity plans was designed to address range of motion, gait/ambulation, etc. OT activity plans were designed to address functional writing skills (4), sensory input and skin integrity (1), fine motor coordination (1), range of motion (1), and independent mobility skills (1). As stated above, only four of the OT plans and none of the PT plans included measurable goals/objectives. In most cases, there was no baseline clearly stated within the assessment, so measurement of progress would be difficult.	

#	Provision	Assessment of Status	Compliance
		The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used. Each of the PNMPs reviewed listed specific assistive technology and equipment to address the person's needs. In most cases, rationale established via assessment was insufficient. Therapists provide verbal justification and functional rationale for recommended interventions. Though each of the activity plans contained a stated purpose, baseline status was not clearly identified, outcomes were generally not measurable, and as a result, progress could not be appropriately documented. On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. • No progress notes were noted related to the Activity Plan for Individual #29 • Monthly progress summaries were noted for Individual #97, but program implementation was inconsistent and documentation of rationale to initiate, continue, resume or terminate intervention was sketchy and incomplete. • For Individual #71, monthly progress summaries were noted inconsistently for a standing plan dated 11/17/08. There was no evidence of summaries for the year 2008, yet summaries were noted from 05/14/09 through 08/13/09, and again from 10/14/09 through 1/13/10. The plan submitted with the personal record information only contained the plan dated 11/17/08, yet Habilitation Therapies submitted a plan dated 11/09/09 with revision on 11/17/09.	
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.	Staff implements recommendations identified by OT/PT. In most cases, the recommended equipment was available for use, however, staff implementation of safe transfer techniques was inadequate or alignment and support was insufficient for safe and optimal function (see below). Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. The only competency-based training aspect of new employee orientation provided in the area of OT and PT supports was related to transfers. Practice checklists were used to guide participants in the steps required to complete safe stand-pivot transfers, two-person manual lifts, and a mechanical lift. This documentation was not maintained or used to evaluate continued competency. Training in other areas relied on written test questions and classroom participation. While on occasion opportunities for practice were offered for person-specific training, staff performance was not documented and was inconsistently provided. In several cases, staff implementation of safe transfer techniques was inadequate (Individual #29) or alignment and support was insufficient for safe and	

#	Provision	Assessment of Status	Compliance
		optimal function (Individual #93; Individual #40; Individual #105; Individual #118; Individual #11; Individual #94; Individual #21; Individual #1; Individual #28; and Individual #117). Staff verbalizes rationale for interventions. When asked, staff were generally not able to recognize that an individual was not in adequate alignment and, as such, were not able to identify the rationale for interventions. When asked, one staff member who was assisting Individual #28 to eat in a stander, stated that she did not know why she ate standing up. Rationale was not documented on the PNMP or dining plan.	
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.	System exists to routinely evaluate: a. fit; b. availability; function; and c. condition of all adaptive equipment/assistive technology. By report, fabricators, therapists and technicians conducted regular monitoring for fit and function. In addition, direct care staff were reported to notify Habilitation Therapies for concerns related to adaptive equipment and assistive technology. PNMP monitoring was intended to address equipment issues. As identified below a limited number of individuals were monitored on a monthly basis. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. At the time of this review, there was no formal policy regarding a monitoring system related to program/plan implementation. Review was generally informal with reported on-the-spot staff coaching when issues related to implementation were observed. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. Approximately 120 monitoring forms were submitted indicating that only 31 staff across five homes were monitored since 10/01/09 through 01/10/10. This represented less than 50% of the homes and perhaps 1/3 of the staff working at EPSSLC. There were 14 forms that did not identify the name of the staff person monitored and another 14 forms indicated multiple staff members on the same form. Once competency is clearly established, staff should be monitored at least 1-2 times per year in addition to the person-specific monitoring conducted based on level of PNM risk. For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff. Staff were held responsible to read the PNMP and supervisors were to ensure that supervisees were familiar with each plan for individuals to whom they were assigned. A system of risk identification was not clearly established at EPSSLC and risk indicators were identified for only 10 individuals related	

#	Provision	Assessment of Status	Compliance
		to their dining plan. The same risk issues for choking and aspiration identified in these 10 dining plans were not listed in the dining plan section of the PNMP. Responses to monitoring findings are clearly documented from identification to resolution of any issues identified. The current system for monitoring did not provide a place to document problem resolution in the event that an issue was identified. The monitoring team noted on 01/11/10 that the dining plan and PNMP for Individual #93 did not include a picture of her current seating device. The monitoring form completed for Individual #8 on 01/03/10 identified that he must wear weightlifting gloves to protect his hands from biting and that these were not included on his PNMP. The PNMP (12/14/09) submitted as current for him did not list these under assistive equipment. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. The kitchen staff assigned to the home was to provide the appropriate mealtime equipment. The supervisor double checked each tray to ensure that the appropriate equipment was available. Individual #93's dining plan identified that a wedge was required behind her back and head. She had received a new seating system and the plan had not been revised to address this change. Direct care staff, supervisors, clinicians, and EPSSLC monitors had not previously identified this error. PNMP Coordinators (5) were recently hired and were being trained to provide routine monitoring and were to be responsible for obtaining and/or reporting missing equipment and need for repair. This system was too new to evaluate its effectiveness. A supervisor at the ABC Dorm dining area indicated that in some cases there were duplicates of mealtime equipment, but not always. Other adaptive equipment needs were reported and a work order generated for repairs. Monthly maintenance reviews for repairs was in place, but had not been implemented consistently due in part to only having one fabricator over the last seven months. The newly hired technician was responsible to identify maintenance needs and make simple repairs. The system was primarily reactionary, with staff reporting a problem rather than a proactive system that quickly and routinely identified missing and dirty equipment as well as repair and preventative maintenance needs. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs. PNMP monitoring was a new system at EPSSLC and was not well formalized. • During October 2009, monitoring was conducted in C Dorm for 16 individuals, in Home 513 for 3 individuals, and in Home 506 for 7 individuals. Issues were identified for 16% of the individuals monitored. • During the month of November, monitoring was conducted in Home 506 for 21 individuals and in C Dorm for 18 individuals. Issues were identified for 8% of	

#	Provision	Assessment of Status	Compliance
		individuals monitored. Concerns related to implementation of one of the individual's PNMP were cited in October and November; issues related to availability and working condition of equipment were noted each month. • During the month of December monitoring was conducted in C dorm for 15 individuals, in Home 513 for 11 individuals and in Home 506 for 13 individuals. Issues were identified for 16% of individuals monitored. • During the month of January 2010 through 01/10/10, monitoring was conducted in Home 507 for 12 individuals and in A Dorm for 1 individual. Issues were identified for 54% of individuals monitored. • There were three individuals in Home 513 who were monitored two times from October 2009 through 01/10/10, 12 individuals in Home 506 were monitored three times, two individuals were monitored twice, and one individual was monitored once during that time period. In C dorm, 13 individuals were monitored three times, one individual two times, and two individuals four times in that time period. All others (21 individuals) were monitored only one time in over three months. • There was no evidence that PNMP monitoring had occurred since October 1, 2009 for more than 60% of individuals with PNMPs. Data collection method is validated by the program's author(s). There was no standard system of validation of data collection by the program author. Implementation of plans that required data collection was done by Habilitation Therapies staff only.	

Recommendations:

1. Careful analysis of OT/PT staffing is indicated to ensure that all elements of the Settlement Agreement can be implemented and sustained.

2. Replacement of vacancy for fabricator will be critical to ensure that fabrication schedules can be met while also meeting repair and maintenance needs in a timely manner.

3. Ensure that all PSPs are current and present in each individual's record.

4. Ensure that the most current OT/PT assessment is present in each individual's record.

5. At the time of the annual staffing, OT and PT should review all existing plans for appropriateness and accuracy of text and pictures. This should be indicated by changing the PDP staffing date. Subsequent revisions should be designated by the date the plan was revised.

6. Training of PNMP monitors must be competency-based to include didactic presentation of monitoring strategies, follow-up steps, documentation and interaction with staff and supervisors as well as hands-on opportunities to complete the monitoring form and validation by

a licensed clinician to ensure accuracy and consistency. Documentation should verify successful performance of all skills based competencies. Minimum criteria should be established and independent monitoring should not be permitted for each PNMP Coordinator until those criteria are met. Routine monitoring of the PNMP Coordinators should be conducted to validate continued competency.

7. PNMP monitoring should be completed routinely to ensure that all individuals with a PNMP are monitored and that frequency of monitoring is driven by health/PNM risk indicators. Monitoring should also ensure that a sufficient sample is obtained for staff compliance review.

8. The monitoring system must include a mechanism to ensure that issues and concerns identified are addressed with documentation of problem resolution. Each identified concern must be addressed via a mini-plan of correction with evidence of completion such as staff training, submission of work order, equipment replacement, etc.

9. All monitoring results must be tabulated for trend analysis to identify systems issues to guide training and follow-up as well as to celebrate areas of excellence.

10. All staff training must be competency-based to include activity analysis of specific steps and skills required to successfully execute plan implementation. Checklists developed should be used to guide training with demonstration, practice, return demonstration to establish competency and subsequent rechecks for continued compliance.

11. OT/PT assessments should present a better picture of the individual and his or her baseline. This should include likes, dislikes, functional abilities, potential for skill acquisition, and analysis of barriers to successful life skills performance. Specific risk assessment must be included to ensure that supports and services coordinate to minimize these concerns and to identify the impact those risks have relative to participation in meaningful activities throughout the day. This analysis will provide the foundation for appropriate interventions to promote functional skill development and further recommendations of supports and services necessary for success. Goals should be measurable and meaningful to the individual. Creative use of groups will ensure greater capacity to provide appropriate therapeutic intervention.

12. Provide greater integration of therapy supports into the development of more meaningful programming in the day areas.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: <u>Interviews and Meetings Held</u>: o Dr. Rydell, part-time facility Dentist o Anderson Hicks, Director of Habilitation Services o Two full time dental hygienists, Jennifer Pacheco and Raquel Rodriquez.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Dental care issues were in transition at EPSSLC. There was a change in service providers and the facility was getting support and direction from Dr. Rydell, who worked at one of the other facilities in the DADS system. The facility was also awaiting new policy and procedural direction from the central DADS office regarding dental services. Dental services were also in great need of attention because there was no full-time facility dentist and the on-site clinic had not yet been completed. The clinic, which will allow general anesthesia to be administered to individuals who otherwise would not tolerate dental care, was not available to individuals due to construction issues that had stalled the completion of the space for many months.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental	Until recently, EPSSLLC met the dental needs of its individuals with the use of three dentists on contract. Annual dental evaluations were done by a Dr. Perk. Since there had not been a dentist at the facility for a number of months, the facility was not in compliance with most of the requirements of the settlement agreement and health care guidelines for dental care. Initial and annual exams were being completed, but documentation of routine dental problems was not done; many of the individuals had extractions due apparently to the lack of routine dental care. At the time of the on-site tour, there was little to no restorative care being provided. Many of individuals required sedation in order to have any dental treatment. The two dental hygienists followed the individuals in their residences by instructing	

#	Provision	Assessment of Status	Compliance
	disabilities shall satisfy these standards.	direct care staff on oral care, and checking the hygiene status of their assigned individuals. They initially began on a part time basis. Four years ago, the two hygienists shared 10 hours per week at the facility, and gradually worked their way up to full time. They have been full-time employees since September. Work had begun on a dental clinic that would allow on-site work and provide adequate coverage for those individuals requiring sedation. This, when completed, will also likely include services to allow individuals to be managed through sedation recovery. Unfortunately, there were construction problems and the completion of this dental clinic had been repeatedly postponed. For example, there was maintenance work that needed to be done to the clinic floor, but that had yet to be done. Until the clinic is completed, dental care was not moving forward. This was a critical service that was affecting the health and welfare for a large portion of this population. It needs to move forward as soon as possible.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to 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	EPSSLC's dental service, as noted above, was in a transition state. Plans need to be put into place to move this along so that individuals can receive full dental services. Also, as noted above, the facility was awaiting direction from the DADS central office regarding policy and procedures to meet this provision item. Of note, however, was the facility's programming for medical and dental procedures. Fifty-eight individuals were identified as needing some sort of sedation prior to medical and/or dental procedures (however, it was unclear as to the type of sedation that was provided, e.g., general anesthesia, oral medication). All of these individuals had some sort of plan to help them to be more accepting of these procedures, that is, each individual had a desensitization plan to assist him or her to tolerate, and eventually avoid, the use of pre-treatment sedation medication, thus, the rationale for the desensitization plans had a clear functional purpose and goal. Although it was good to see that the facility was addressing this need, overall, the procedures did not make use of effective instructional methodology that would likely result in the desired outcomes for the individuals. Moreover, the comprehensiveness of the teaching plans varied greatly among individuals. Some (e.g., use of an electric tooth brush for Individual #16) contained, few if any, teaching instructions, while others (e.g., Individual #27) were more complete and included operational definitions, baseline instructions, detailed general instructions, and specific instructions on how to respond if the behavior occurred, and what to do if the desired behavior did not occur. Overall, as	

#	Provision	Assessment of Status	Compliance
	medications and dental restraints.	discussed in other sections of this report, teaching plans need to incorporate effective instructions, prompts, reinforcers, and shaping technologies. In addition, many of the plans reviewed looked very similar, suggesting that they were not individualized. Further, it was not clear as to how the plans were monitored, and if they were modified as a function of the individual's progress or lack of progress. A very important consideration in evaluating the overall quality of these plans, however, is a review of their results. In other words, there should be a regular assessment to determine if the plans resulted in an individual now tolerating the medical or dental intervention without sedation or with less sedation. An important question is whether most individuals have been on the same plan for years while still requiring sedation to tolerate the procedures. Without these outcome data, review of the plans' quality will remain limited.	

Recommendations:

1. Develop and implement new policy and procedures.
2. The facility needs a full time dentist, and access to a dental anesthesiologist.
3. Most importantly, the completion of the dental clinic should be moved to a high priority.
4. Improve instructional procedures used to help individuals tolerate medical and dental procedures.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Reviewed Settlement Agreement: Section XI. Physical and Nutritional Management, and R. Communication o Personal notes taken week of 01/11 – 01/15/09 o Current Census by Home (01/11/10) o Person's Served Information (01/08/10) o Communication Services policy #016, 10/07/09 o Resumes of speech department staff o Continuing Education records for speech department staff o List of contract providers o Budgeted, Filled, and Unfilled Positions by Job Code (Medical Series) 12/14/09 o Sign-in sheets for Webinars (08/04/09 – 12/30/09) o PSPs for (current within 12 months unless otherwise indicated): • Individual #1 (2008 and 2009), Individual #106 (2008), Individual #56 (2008), Individual #59 (2008), Individual #103, Individual #110, Individual #74, Individual #114, Individual #29 (2008 and 2009), Individual #35, Individual #79 (2008), Individual #74 (2008), Individual #86, Individual #89, Individual #125, Individual #45, Individual #46, Individual #58 (2008), Individual #55, Individual #57 (partial, 6 pages only), and Individual #71 o PSP Quarterly Review: • Individual #106 (07 to 09/2009) submitted as PSP for 2009 o Communication Updates (all current within the last 12 months unless otherwise indicated): • Individual #101, Individual #2, Individual #103, Individual #6 (01/06/09), Individual #71, Individual #48, Individual #46, Individual #106, Individual #4, Individual #1, Individual #100, Individual #8, Individual #114, Individual #58, Individual #21, Individual #29, Individual #127, Individual #89, Individual #93, Individual #79, Individual #65, Individual #70, Individual #97, Individual #125, Individual #95, Individual #69, Individual #84, and Individual #52. o EPSSLC Table of Organization o Habilitation PNMP Monitoring Forms completed 10/01/09 – 01/10/10 o Personal Record documents including: OT/PT Assessments; Communication Assessments; OT/PT/SLP Updates; Special Review/Consults by OT, PT, SLP; Bedside Dysphagia Evaluation; PNMPS for last 12 months; PSP and Addendums; Progress Summaries for OT/PT/SLP; Identifying Data sheets; Annual Medical Summary and Physical Examination; Nursing Assessments (last four quarters); Drug Regimen Review (most current); X-rays section; Consult section; PALS assessment; and SPO Activity Plans for the following individuals: • Individual #2, Individual #71, Individual #103, Individual #21, Individual #58, Individual #6, Individual #95, Individual #52, Individual #75, Individual #97, Individual #69, Individual #70, Individual #29, Individual #127, Individual #93, Individual #84, and

	Individual #4.
	○ PNMP Definitions and Purpose (Section V.A.1)
	○ Instructions for PNMP Clinics
	○ Physical/Nutritional Management Plan for each individual
	○ Dining Plans for all individuals
	○ Data regarding number of individuals with:
	  • PNMPs, reviewed by NMT, seen by PNM Teams
	  • Dining Plans;
	  • Comprehensive OT/PT assessments, with Communication assessments
	  • tube feedings assessed for less intrusive feeding
	○ Physical Management Training Modules (Section VIII.A.1) and other training materials submitted
	○ PreService/NEO Training Schedule for New Employees December 2009
	
	Interviews and Meetings Held:
	○ Anderson Hicks, OTR/, CEAS, Habilitation Therapies Director
	○ Susan Acosta, MPT
	○ Amy Gleaton, OTR
	○ Henry Kielb, MA, CCC-SLP
	○ Communication with various supervisors and direct care staff
	○ Communication with various day program staff
	
	Observations Conducted:
	○ Mealtimes
	○ Living areas and day program areas
	○ Occupational Therapy Department meeting
	○ PNMP/NMT meeting 01/13/10, 1:30 PM
	○ Seating assessment 01/12/10
	○ Attended Habilitation Therapies Director's Webinar 01/13/2010, 12:30 PM

	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Up until December 2009, EPSSLC employed only two Speech and Language Pathologists to provide services to each of nearly 140 individuals in the areas of communication and dysphagia/oral motor/mealtime. That level of staffing would be inadequate staffing to meet the needs of those living at EPSSLC in both of those areas. At the time of this on-site tour, there was only one speech clinician responsible for supports and services. It would not be possible to provide appropriate, relevant supports and services to 139 individuals in the area of communication, let alone with responsibilities also in the area of mealtimes.

	Every one eats and everyone communicates in some manner and this was much too large a caseload for one clinician to effectively meet each individual's special needs in both areas. Nevertheless, the SLPs attempt to provide individual therapy was to be commended. It will, therefore, be important that interventions and supports optimize communication opportunities across environments that are meaningful to each individual: home, work, day program, leisure activities, meals, self-care time, etc. To that end, serious recruitment to select well-qualified speech clinicians with experience serving people with developmental disabilities is critical. Efforts to implement communication books and picture wall boards for everyone was a good start, but stopped well short of effectively meeting the communication needs of each individual at EPSSLC and would not satisfy the expectations as outlined in the Settlement Agreement. These were not sufficiently individualized and there was a significant poverty of voice output devices (low and high tech) in use. The adage, "what is good for one, is good for all, "is not an acceptable approach to the provision of meaningful communication supports. A greater variety of creative methods to augment communication in an individualized manner based on a more comprehensive assessment will be necessary. Collaboration with other disciplines was limited and impacted the relevance and integration of communication supports across environments. Devices were often restricted during times that were potentially significant communication opportunities. In other cases, availability of devices was "scheduled" rather than available to users throughout their day, every day.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	<u>The facility provides an adequate number of speech language pathologists or other professionals with specialized training or experience</u>. At the time of the on-site tour, there was only one full time speech and language pathologist. This was of concern because each individual living at EPSSLC communicated in some manner and as a result required the direct and/or indirect supports from a speech language pathologist. There was evidence that the speech and language pathologist had attended continued education related to swallow studies, was certified as a Vital Stim Therapy Provider (related to swallowing), and completed a two-hour course titled Physical and Nutritional Management for SLPs. All of these educational activities had occurred just since June 2009. There was, however, no evidence that he had attended any continuing education in the area of communication or assistive technology/AAC in the last year. <u>Supports are provided to individuals based on need and not staff availability</u>. When there had been a second SLP (up until December 2009), each clinician had a caseload of approximately 70 individuals in two critical service areas: communication and mealtime supports. Given this ratio, it would have been difficult to meet the needs of the	

#	Provision	Assessment of Status	Compliance
		individuals at EPSSLP. Certainly, one SLP will not be able to meet the needs in the area of communication, let alone also those indicated in the area of mealtime supports. In an effort to provide supports and services in the area of communication, the clinician(s) had used many "canned" methods and strategies in order to manage their time and resources. As described below much of what was provided was not individualized based on skill level, potential, or need and, as a consequence, was often not meaningful or functional.	
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.	All individuals have received a communication screening. If newly admitted, this occurred within 30 days of admission. Each individual living at EPSSLC had received a communication assessment, according to reports. This was not validated during this baseline review because the sample did not include any individual who was newly admitted. Validation will be necessary in a subsequent review. A sample of communication assessments was requested and 31 of the 32 assessment reports were received (the only exception being for Individual #75). Most of those included in the sample had been in residence for more than 10 years. Admission dates for Individual #97 and Individual #69 were not listed on the Identifying Data sheets submitted but did not appear to be new admissions within the last year per additional documentation submitted. Each report was identified as a Communication Skills Update and was current within the previous 12 months with two exceptions (Individual #6, 01/06/09 and Individual #113, date illegible on copy). Each of the individuals in the sample reviewed had been at EPSSLC for more than one year, so it was not possible to review assessments for individuals newly admitted to EPSSLC. Assessment of this indicator will be conducted in subsequent reviews to include a sample of recent admissions. All individuals identified with therapy needs have received a comprehensive communication assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities, and development of new skills. Each individual living at EPSSLC received some level of direct and/or indirect communication based supports and services. For example, each individual had a communication dictionary in his or her PSP, a communication book and communication picture wall boards were located in each home. The assessments reviewed were not comprehensive, particularly with regard to the area of AAC. Assessments were referred to as annual updates and a more comprehensive assessment was not generally completed, except in the case of a new admission. As stated above, it was not possible to validate this during the baseline review because the sample did not include any individual who was newly admitted. Validation will be necessary in a subsequent review. The update described hearing and vision, receptive and expressive language, pragmatic social language and	

#	Provision	Assessment of Status	Compliance
		both verbal and nonverbal communication. A very limited section on augmentative communication was included. Within the sample, there was no evidence in the update that careful consideration had been given to the selection of the assistive communication system for each individual. There was no rationale offered for the selection of an AAC system for communication. With the exception of Individual #125 and Individual #106, all individuals, for whom an assessment was submitted, were identified as benefitting from an "individualized augmentative communication book" (7), or an "Augmentative Communication Picture Book" and "Communication Picture Wall Board" (16). The paragraph describing each of these two options was a canned statement and consisted of exactly the same words for each individual even when the clinician conducting the assessment varied. While the augmentative communication section of the report for five other individuals was different, they only varied slightly from one another. Although the communication books were described as "individualized," the books contained the same picture icons with one page at the front of the book that contained more uniquely applicable icons for the individual for whom it was designed. The assessment did not provide a description of how the device was used by the individual for functional communication. Of those individuals included in the sample, only Individual #125 and Individual #106 had additional assistive devices available to them to use for communication. <u>If receiving services, direct or indirect, the individual is provided a comprehensive Speech-language assessment every 3 years, with annual interim updates or as indicated by a change in status</u>. Each individual received an annual update only. A more comprehensive assessment was not conducted every three years. <u>For persons receiving behavioral supports or interventions, the facility has a screening and assessment process designed to identify who would benefit from AAC. Note: This may be included in PBSP</u>. There was no system to prioritize assessments or vary AAC services based on the need for behavioral supports. While it was reported that the SLP collaborated with the PST to address these needs, the process was not formalized. <u>Individuals determined via comprehensive assessment to not require direct or indirect Speech Language services receive subsequent comprehensive assessment as indicated by change in status or PST referral</u>. At the time of this review, all assessments were annual updates and were provided to each individual living at EPSSLC. Referrals were generally related to swallowing or mealtime concerns. Intervention plans were implemented throughout the PSP year for a number of individuals, but were not based on a comprehensive assessment. In many cases, the annual update had stated that services	

#	Provision	Assessment of Status	Compliance
		were not indicated, but a plan was later developed. Communication interventions were initiated for approximately 32 individuals, although three of the programs submitted for review were dated in 2008 (Individual #87, Individual #92, and Individual #69). In some cases, intervention plans were not individualized and a baseline for use prior to intervention was not well documented. Though objectives for the plans were measurable, the skill being measured was not well defined. For example, a communication assessment was completed on 02/03/09 for Individual #71 at which time it was reported that speech therapy services were not indicated and that he should continue to use his communication book. In the records submitted, there was no evidence that an additional comprehensive assessment had been completed, though a speech intervention plan, dated 10/05/09, was implemented which cited "baseline" performance of basic communication abilities on 08/07/09, and it was recommended that he participate in "augmentative communication therapy" using a talking photo album and communication book. The plan was to be implemented two times per week for one month. No baseline for use of the talking photo album or the communication book was reported in the assessment. The objective stated that Individual #71 would use his AAC device with 70% accuracy in a simple/functional conversational setting. There was no evidence of data collection and the only monthly note appeared to indicate that he had previously exhibited 50% accuracy in the ability to use his talking photo album. A progress note further stated that as of 11/19/09, he was able to use the talking photo album with 70% accuracy with maximum verbal and tactile cues. This was interpreted by the speech clinician/program author that the individual had achieved his goal, although the actual plan did not specify that he would require maximum assistance. It was unclear as to whose accuracy was assessed if maximum verbal and tactile cues were required for AAC use. On 11/19/09 it was recommended that the therapy be discontinued because he had achieved the goal and that his talking photo album should be provided to him from 10:30-11:30 Monday through Friday and again from 3:00 to 4:00. Staff were to provide hand-over-hand assistance to turn the pages and assist him to press the play button for each page. Intervention was provided but there was no evidence of progress documented. In the case of Individual #113, the communication intervention plan was also dated 10/05/09, the baseline was also established on 08/07/09, and the wording of each of the documents was essentially the same as that for Individual #71. The plan was discontinued on the same date and his previous accuracy was also 50%. Intervention was discontinued because he had also reportedly "met" his goal of 70% accuracy.	

#	Provision	Assessment of Status	Compliance
		A similar scenario was noted for 11 others. Clearly interventions were not sufficiently individualized to meet the needs of each individual. Policy exists that outlines assessment schedule and staff responsibilities. The state policy dated 10/07/09 required that review and revision of the "communication provisions of the PSP as needed, but at least annually." There was also reference to a schedule of comprehensive communication assessments "set forth" in the Communication Master Plan. According to the tracking tool submitted, everyone had received a communication assessment, though the assessments could not be considered comprehensive in nature. Little exploration of potentials for AAC use was evident and, as described above, the approach was very general, with the same programming provided to most everyone. A large portion of the "communication skills update" included a section on oral motor function and feeding. The evaluation summary often only addressed mealtime issues and, to a much lesser degree, addressed communication. Findings of comprehensive assessment drive the need for further assessment in augmentative communication. Only two of 29 assessments reviewed recommended communication therapy (Individual #79, 11/29/09 and Individual #69, 05/26/09). Documentation within the assessment as well as in progress notes did not provide clear justification of a need for communication supports. In some cases, individuals received supports that were not functional while others received no individualized supports at all. The two examples are below: • Individual #79 was described as having "excellent verbal skills" and able to communicate effectively with short sentences and phrases even though her word retrieval was deficient. She was also reported to "write short sentences with intermittent spelling error." A speech therapy intervention plan dated 01/22/09, identified that on 07/16/08, she demonstrated writing/copying written words with 95% legibility though this had not been reported in her annual assessment. The goal of the intervention was to write "appropriate words, phrases, sentences to communicate her needs, wants, desires and choices with 100% legibility by 06/30/09. The program was to be implemented two times per month. Intervention was to continue until she met criteria and demonstrated stable performance for three months at 100% accuracy. There was no justification for why this was determined to be a functional priority for her to achieve a 5% improvement in writing legibility. While the assessment update stated that she "participated well," "showed enjoyment," and a showed "sense of accomplishment" with "consistent motivation to participate," there was no measure of her progress with this objective as a result of her participation in this group. Regardless, it was recommended that she should continue. A goal or objective statement for continued therapy was not identified in the update.	

#	Provision	Assessment of Status	Compliance
		• Individual #69 also participated in direct speech therapy per his update on 05/26/09. He was reported to present with diminished movement excursion for labial speech sounds produced without full lip closure, lacking muscle weakness, proper range, and speed. He also presented with drooling during speech and at rest, but not with eating. Formal testing was used to evaluate his receptive and expressive language skills with evidence that he had made progress over the last year attributed to the services he received. There were, however, no specific measurable goals or objectives identified as a focus of supports and services provided so it was unclear how this was determined. The recommendation for the subsequent year was merely to continue speech therapy to increase his language skills. Reimbursement for speech services based on this assessment in the public sector would likely be denied. Further the assessment identified that he required behavioral supports because he "exhibited significant aberrant behaviors" that interfered with his social, nutritional, and communication development. His pragmatic social language often included refusals and inappropriate actions such as spitting, cursing, and throwing items. Rather than recommend collaboration with psychology services to address this concern, his clinician recommended that he "continue to live in the DADS network." The speech intervention plan was dated 12/05/08 had a stated goal for therapy to "show approximately 30% increase in range and speed of labial and lingual movement" and to "show length of utterance of four to six words when describing action pictures with greater vocabulary and immediate and short term memory" by 05/30/09. There was no evidence of integration of speech and behavioral supports to address a priority need for improved functional communication to address maladaptive social interactions. Other assessments generally recommended no "speech therapy services" and continued use of an existing system that, in most cases, consisted only of a communication book and/or Communication Wall Board (in 24 of 29 assessments reviewed). In six of those cases, a talking photo album was provided on 11/19/09. The assessments for three of the individuals had been completed just prior to that in November or the month before in October and made no reference to that as a need. If a comprehensive assessment had been completed, the use of a talking photo album would have been investigated at the time of the assessment. It was also reported in the speech therapy plans submitted that "baseline" used for these devices had been established in August 2009, but the devices were not provided until November to 12 individuals in the same home. If completed in August, this "baseline" information would have been available to the clinician for inclusion in assessments for four individuals provided with a talking photo album, however, it was not reported in the annual assessment. Only the following	

#	Provision	Assessment of Status	Compliance
		individuals had any assistive technology other than a communication book, talking photo album and/or the communication picture wall board available in common areas in each home: • Individual #7 (3 band amplification device) • Individual #39 (Hip Talker) • Individual #63 (Hip Talker) • Individual #10 (hearing aid) • Individual #16 (Step Talker and environmental control switch) • Individual #41 (4 keypad Tech Talker) • Individual #92 (Tech Talker 8) • Individual #106 (Go Talk 20) • Individual #125 (Hip Talker) • Individual #93 (personal headphones) The availability and variety of appropriate AAC devices was severely inadequate. It appeared that the only time that communication was possible for these individuals was from 10:30-11:30 and 3:00–4:00 on weekdays and not at all on the weekends. Appropriate recommendations for AAC would not be possible without a comprehensive communication assessment. Some examples are presented below. • Individual #125's communication update, dated 10/12/09, stated that speech therapy services were not recommended and that he should continue to use his Hip Talker, communication book, and the picture wall board. It was reported that he had participated in one month of AAC therapy in 2009. It was stated that he had learned quickly and adapted to "daily use" to convey his basic needs. The goal identified in the speech therapy intervention plan stated that he would use his AAC devices with 80% accuracy. The device was not included as a communication method in that section of the PNMP. Unfortunately, he was "scheduled" to use his Hip Talker from 10:30-11:30 and 3:00- 4:00 Monday through Friday only during training per his PNMP. The plan expressly instructed that he was not to have access to the device during his meals. It was unclear how he would convey his basic needs at times other than these two hours, 5 days a week. • Individual #93 was reported to have a personal radio with headphones to listen to a soft music station "to enhance her receptive auditory sensory input" per her communication update on 09/08/09. There was no rationale as to how this would contribute to enhancing her functional communication abilities. Again She was only permitted to use the radio and headphones at 10:00- 11:30 and 3:30 – 4:30 Monday through Friday. It did not appear that she had a way to request the radio and headphones and there was no description as to how it was	

#	Provision	Assessment of Status	Compliance
		known by staff that she enjoyed or preferred this activity. Speech therapy services were not recommended for her, although she was to continue use of the headphones and radio, communication book and picture wall boards in her home. • Individual #106 was reported to have a Go Talk 20, in addition to a communication book, and picture wall boards in his home per his communication update on 11/05/09. He was not recommended for speech therapy intervention related to communication. He participated in two months of speech therapy and "achieved his goals and objectives to express his daily needs and wants. The intervention planned included a goal that he would use his AAC devices with 85% accuracy. The description of his expressive language in the update described the many ways he communicated with pointing, reaching, speech, gestures, and eye contact. The only aspect not described was how he used his communication book or Go Talk 20 other than that he used it daily. His PNMP listed the device, merely stating "see for ways of interacting with him." A functional description as to how he used the device was not documented in the plan. Again, his access to his communication device that he was able to use to express his basic needs was only available to him from 10:30-11:30 and 3:00–4:00, Monday through Friday. And again it was expressly forbidden during his meals.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP</u>. The rationales were not well-established (via clinical impressions) and, as result, were not integrated into the PSP. The systems were mentioned in the PNMP and, in the case of some devices, these plans outlined during what times of day the device was to be used, such as for the talking photo albums. As shown below in some examples, more work needs to be done to integrate meaningful, functional, and practical processes into the communication device usage of many individuals at EPSSLC. • In the case of Individual #125, his PNMP listed that he had a Hip Talker, but it did not describe its use and function in the communication section. • In Individual #41's PNMP, there was reference to the fact that she had a "communication device," but there was no description of how she used it to communicate. She was to use her talking photo album from 10:30 – 11:30 and 3:00 to 4:00; the same times designated for the other 12 individuals provided these devices. • Individual #10 was listed as having a hearing aid, but this was not listed or referenced in his PNMP. Staff were directed to talk loudly to his right side. • Individual #63 was described as non-verbal, using pointing and leading behaviors with communicative intent. There was no mention of how he used his	

#	Provision	Assessment of Status	Compliance
		Hip Talker other than to list it as adaptive equipment in addition to his communication book. The PSP contains information regarding how the individual communicates and strategies staff may utilize to enhance communication. The PSP contained two sections related to speech that documented findings from the communication assessment. Each of the plans reviewed contained an extensive communication dictionary that described how the individual indicated yes/no, indicated discomfort or pain, and needed attention, for example. The communication dictionary for Individual #125, however, did not indicate that he used his Hip Talker device for any functional communication. He was described to use facial expressions, grab, kick or push away, and clap his hands. The same was true also for Individual #106. The communication dictionary did not indicate that he used his Go Talk 20 device for functional communication. He was described to use gestures, grab, clap his hands, reach out or push away. AAC devices are portable and functional in a variety of settings. Though very limited in number and variety, the AAC devices provided were portable and thereby had potential to be functional across a variety of settings. Most devices were not used functionally in most settings at EPSSLC. For example, in the day program area, staff were observed to name items in the books without functional use in an activity. Talking photo books, which were very portable, were only made available at specific times of the day, totaling two hours and only in the home environment. Explicit instructions prohibited the use of the devices during a meal. Individual #16 had a Step Talker per his PNMP, but it was only available to him at 10:30 and 3:00 for one hour only and not during meals. The same was true for Individual #125 and Individual #106. AAC devices are meaningful to the individual. In most cases, it did not appear that the AAC systems were meaningful and functional because the electronic devices were not included in descriptions of how the individual communicated. In a number of cases, the communication books were listed under equipment, but not described under the section about how the individual communicated. There were five individuals identified as independent speakers, functional communicators, or users of complete sentences who also had communication books. While a book of this nature made sense for individuals who were verbal (for use as talking points with communication partners and to supplement language skill deficiencies), it was of concern that everyone had a book and that they were not unique to each individual based on interest and needs. Staff are trained in the use of the AAC. There was no evidence of staff training related to the use of AAC except in response to state CMS survey findings on 06/26/09 that indicated EPSSLC had failed to provide AAC devices. The POC directed inservice for staff in 506 and 507 regarding the use of communication books and to also provide inservice	

#	Provision	Assessment of Status	Compliance
		training to supervisors, QMRPs, workshop supervisors, Active Treatment Coordinators, and select nursing staff on the use of communication books. These staff were to, in turn, provide inservice training for their staff. An annual refresher for staff was to be conducted as well. SLPs were to conduct random weekly monitoring with additional monitoring of PNMPs conducted by therapy staff. Documentation was submitted that reflected provision of some of the staff training outlined in the POC. The training provided however was limited in scope, focusing on only a small number of staff in a few homes and appeared to be the only training provided to staff related to communication in the last year. The intent of this training would be to ensure that all staff, across all environments, were competent to engage as communication partners with people living at EPSSLC and to implement specific communication plans or use AAC devices. Unfortunately the training provided did not appear to be competency-based. The small group practice sessions were practice only with no skills-based check off component. Other training seemed to include a written test without testing staff abilities to demonstrate what they had learned. The annual re-training was "set up" per a memo from the speech- language pathologist dated 12/22/09 and the first session was held on 12/18/09. It included a number of staff in the systems building. He reported that both direct support staff and supervisors were to participate in a refresher session on 12/30/09. He stated that they would take a "short test" to assess whether they had learned the information. He did not indicate whether this would be a skills-based test of competency. Per his report, this information had been included in New Employee Orientation since Fall 2009, but the curriculum was not submitted with the document request response materials. Attached documentation indicated that practice sessions related to use of communication books were conducted for eight staff in 506 on 12/22/09, seven staff in 507 on 12/22/09, six staff in 508 on 12/22/09, two staff in 510 on 12/21/09, three staff in 511 on 12/21/09, and four staff in 513 on 12/23/09. Per a memo dated 12/22/09, staff were being trained on how the communication books were to be used and where they are supposed to be throughout the day. Training regarding use of the Communication Wall Boards was submitted showing that approximately 32 staff had been inserviced from 06/11/09 through 07/22/09, although there was no documentation as to which homes received the training. It was of interest that 18 staff had received this training on 06/11/09, just two weeks before the CMS survey on 06/26/09. One of these sign in sheets showed that the trainers had signed the sheets on 06/25/09 (the day before the survey), but that staff had not signed the sheets until 07/01/09, 07/15/09, or 07/23/09 (after the survey). It was unclear as to who had actually provided this training for staff. One other training sign-in sheet was submitted, documenting training related to communication books in Homes 506 and 507 for 26 individuals. The trainers had signed the sheet on 07/22/09, but staff had signed in as	

#	Provision	Assessment of Status	Compliance
		trained on 07/22, 07/23, and 07/24/09, so again, it was unclear as to who had provided the actual training on each of those dates. Additional training related to the use of "sign boards" was provided on 12/16/09 for 32 individuals; one additional participant had not dated the signature. This training was not conducted by either of the licensed speech clinicians. The topic was a method identified to teach sign language to individuals living at EPSSLC. There was no documentation as to the homes to which the staff trained were assigned. It was of concern that not only had EPSSLC failed to complete the actions outlined in the plan of correction for this identified concern, but this appeared to be the only staff training documented to have been provided to staff in the area of communication in the last 12 months. <u>Communication strategies/devices are integrated into the PSP and PNMP</u>. Refer to previous discussion regarding sections of PSP related to communication above. In the case of some devices the PNMP outlined during what times of day the device was to be used. Some examples are listed below: • In Individual #41's PNMP, there was reference to the fact that she had a "communication device" but there was no description of how she used it to communicate. She was to use her talking photo album from 10:30 – 11:30 and 3:00 to 4:00; the same times designated for the other individuals provided these devices. • Individual #16 had a Step Talker per his PNMP, but it was only available to him at 10:30 and 3:00 for one hour only and not during meals. • Individual #10 was listed as using a hearing aid, although this was not listed or referenced in his PNMP. Staff were instructed to talk loudly to his right side. • Individual #63 was described as non-verbal, using pointing and leading behaviors with communicative intent. There was no mention of how he used his Hip Talker other than to list it as adaptive equipment in addition to his communication book. • Individual #87's PNMP listed a 4x4 communication book and stated that she was able to communicate her wants and needs via an attention buzzer on her wheelchair, communication book use, and a laptop computer (although not listed under her assistive equipment). There were approximately 52 individuals who had communication books listed as assistive equipment in their PNMPs, but there was no reference to the functional use of the book in the Communication section of their plans. There were only 73 individuals with communication books with reference to the books in the Communication section of their PNMP. • Individual #113 and Individual #1 were listed with both communication books and talking photo albums, but were not listed as such in their PNMPs.	

#	Provision	Assessment of Status	Compliance
		• The communication section of the PNMP referenced a communication book but it was not listed as assistive equipment for Individual #19, Individual #66, and Individual #36 • A communication book was listed as assistive equipment for Individual #61, but there was no communication section in her PNMP dated 09/24/09. Communication strategies/devices are implemented and used. As stated above, a number of individuals had devices but there was no evidence of functional use throughout the day. In some cases, devices were prescribed to be used at specific times such as with the talking photo albums. For example, many individuals had access to their talking photo album at 10:30 and 3:00 for one hour each time and these were not described under the communication section of the PNMP. General AAC devices are available in common areas. A limited number of devices were available in common areas, but consisted only of the wall picture boards rather than single message switches, for example.	
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.	Monitoring system is in place that tracks: a. the presence of the AAC; b. working condition of the AAC; c. the implementation of the device; and d. effectiveness of the device. Completed Habilitation PNMP Monitoring Forms (also discussed above in section O of this report) were submitted in response to the request for forms completed in the last quarter. Tools submitted were for Homes 506, 513, and C Dorm only for October through December 2009. There were two items in this tool that addressed AAC, including a review that the picture on the PNMP was current and that the equipment was present and in good working order. There was no review of implementation and effectiveness. In addition, the Augmentative Device/Communication Book Checklist 2009-2010 was submitted consisting of a spreadsheet listing each individual's communication device and a date of review on a monthly basis. The dates and names of individuals monitored in this document did not line-up with the completed PNMP monitoring forms. For example, the forms for Home 506 completed in December were dated 12/18/09, while the spreadsheet was dated 12/11/09, and in some cases also 12/21/09. The tracking sheet had information for individuals living in homes 507, 508, 509, 510, 511, 512, A Dorm, and B Dorm. Also, every individual was not monitored in each of the three months in the homes for which PNMP monitoring tools were submitted, but the tracking spreadsheet indicated that all were reviewed at least once each month. No other tools were submitted with this tracking sheet. It was unclear as to who or how this monitoring was conducted and whether it reviewed not only the presence of the device and working condition but also implementation and effectiveness. Below are some examples:	

#	Provision	Assessment of Status	Compliance
		• In the case of Individual #92, her PNMP indicated that she used a Go Talk 20 communication device, but the tracking sheet identified that she had a Tech Talk 8 device. It was of concern that this had not been picked up on by anyone conducting the monitoring or data entry for tracking. Her personal record had not been included in the sample requested, so the monitoring team was not able to investigate documentation in her PSP. Her PNMP indicated that she "used" her device which was not noted for others with AAC devices. As identified above, there were numerous errors in the PNMPs themselves that had not been identified by the current system of monitoring. • It was unclear if Individual #2, Individual #122, and Individual #67 had been monitored at all. As noted above, PNMP monitoring was a relatively new system, with training for recently hired PNMP Coordinators occurring at the time of this on-site tour. The primary monitors were not licensed technicians and therefore would not be qualified to make judgments as to proper implementation and effectiveness. Clear documentation of those determinations would be required rather than merely tracking completion of monitoring in a data base system. In addition, in response to the request for monitoring tool templates, the same spreadsheet cited above was submitted along with an additional spreadsheet that listed each individual's name, home, communication mode (verbal, non-verbal, etc.), last speech assessment, assessment tool used, staffing date, next evaluation due date, communication dictionary, and AAC system(s). Each individual had a communication dictionary according to this tracking tool, but none were submitted as requested. <u>Monitoring covers the use of the AAC during all aspects of the individual's daily life in and out of the home</u>. There was no clear consideration or schedule to ensure that each device was monitored across all aspects of the individual's day. <u>Validation checks are built into the monitoring process and conducted by the plan's author</u>. At the time of the on-site tour, there was no evidence that validation checks were occurring at EPSSLC to ensure ongoing consistency of findings across monitors and across time. The tracking database did not include a number of individuals. It was of concern that these individuals had not been monitored and that this omission was not noted by the monitors or clinicians.	

Recommendations:

1. Aggressively recruit experienced speech clinicians to ensure all communication needs are appropriately met.

2. Initiate a more functional approach to communication assessment and intervention. Evaluate the use of existing devices and describe how and when they are to be used by each individual. Identify potentials, at least annually, for further individual growth in the use of existing systems, and/or ways to move on to more complex AAC systems to expand meaning and function, across settings and communication partners.

3. Introduce more single message switches and shape these to "communication-based" programs with messages appropriate to the situation. Change messages on single message VOCAs regularly to increase motivation for communication and interest levels by the individual and staff who are responding.

4. For individuals effectively using single message devices, move toward access of multiple VOCAs and the start of dual switch use. Individuals do not need to understand the message to have a response; language is learned through response. There are no prerequisite skills needed to address AAC/AT skills in the area of communication.

5. SLPs should take an active role in the mat assessments currently completed by OT and PT. Look at all aspects: swallowing, respiration, and switch access sites, in a variety of positions.

6. Implement more communication during mealtimes. Individuals can initiate requests, interact with peers, and make social comments.

7. Remember the communication dictionary is a reference sheet. The methods used in these can be shaped into more easily recognized communication. For example, if someone is pushing something away to say "no," replace with a message, "I don't want this".

8. Initiate group interaction in the day programs. Model communication and interaction methods and strategies for staff in those programs. Much of staff interaction was on a one-to-one basis rather than the facilitation of interaction among the group participants. Use a collaborative team approach to accomplish this.

9. Ensure that plans, assessments, and other documentation are consistent with regard to communication devices and how they are used.

10. Collaborate with psychology to design communication and behavior support plans to ensure coordination and effective intervention strategies.

11. Ensure that the monitoring system is regularly scheduled across all homes and is communication-focused to determine if the interventions and strategies that are being used continue to be functional, meaningful, and appropriately implemented.

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 Skill Acquisition Plans for: • Individual #44 • Individual #10 • Individual #95 • Individual #13 • Individual #100 • Individual #57 • Individual #106 • Individual #5 • Individual #89 • Individual #52 • Individual #18 • Individual #99 • Individual #19 • Individual #77 • Individual #119 • Individual #116 • Individual #110 • Individual #82 o Personal Support Plans for: • Individual #24 • Individual #13 • Individual #95 • Individual #44 • Individual #10 • Individual #116 • Individual #18 • Individual #110 • Individual #19 • Individual #50 • Individual #69 • Individual #104

	<u>Interviews and Meetings Held</u>: o Meetings with the psychology staff o Informal interactions with numerous direct care staff from both first and second shifts from each work/vocational location and all dorms and cottages at the facility <u>Observations Conducted</u>: o Observations occurred in every day program and residence. o These observations occurred throughout the day and evening hours. o Observations included many direct staff interactions with individuals including, for example, • assisting with daily care routines (e.g., ambulation, eating, dressing), • participating in recreation and leisure activities, • providing training (e.g., skill acquisition programs), and • implementation of behavior support plans.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: All individuals at EPSSLC had skill acquisition programs. Some individuals had as many as seven skill acquisition programs. Although it was great to see that EPSSLC was addressing skill training needs, it was not clear how, or why, many of these programs were chosen for the individual. Additionally, many skill acquisition programs looked the same, suggesting that the programs were not individualized. Another factor reducing the value and functionality of the skill acquisition programs was that many of them were found to be missing critical training components demonstrated to be necessary for learning and skill development. Finally, although data were collected during skill acquisition training sessions, the monitoring team could not identify any systematic method of measuring the integrity of the program's implementation. In general, most of the programs sampled failed to promote the growth, development, and independence of the individuals served. The monitoring team was encouraged by the positive and pleasant interactions observed between staff and the individuals served at EPSSLC. Actual measures of individual engagement indicated that there was much room to improve individual engagement levels in all settings at the facility. It was clear that individuals had regular access to community activities. Both individuals and staff talked of interesting community outings, however, it was not clear that these community activities were developed to address the individual's needs for services or his or her preferences.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision incorporates a wide variety of aspects of programming at the facility regarding skill acquisition, engagement in activities, and staff training. To monitor this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. Review of records, observations of staff implementing habilitation plans, and interviews with staff revealed that skill acquisition plans had been developed and implemented for each individual at EPSSLC, however, the quality and content of the plans will require a great deal of attention before they meet the generally accepted standard. <u>Choosing skills to teach</u>: All records reviewed contained at least two skill acquisition plans (e.g., Individual #18) and as many as 10 (e.g., Individual #89). In reviewing 20 skill acquisition plans, however, neither the direct care staff conducting the plans, nor the psychologists identifying skills to replace disruptive or dangerous behaviors, could explain why many of these particular skill acquisition plans were chosen for each individual. Skill acquisition plans need to address needs identified in documents, such as the psychological assessment, psychiatric assessment, language and communication assessment, personal support plan, positive behavior support plan, and relevant medical assessments. The PSP should clearly indicate the integration of these documents and their contents into the decision process of choosing skills to teach individuals at the facility. The overall goal of skill acquisition programming should be made clear to direct care staff implementing the plans, and others who might read the plan, that these plans were developed to promote growth, development, and independence. <u>Creating instructional plans</u>. Typically staff could not explain how the plans were developed, or how progress was monitored. EPSSLC, like many facilities, did not have an organized or systematic way to develop instructional skill acquisition plans. Many of the plans were written by two staff members who were called program developers. Their job responsibilities were primarily, if not solely, to write skill plans related to activities of daily living. As far as the monitoring team could tell, the program developers did not have extensive training in the use of effective, evidence-based instructional methodology for individuals with developmental disabilities. Other skill plans were written by speech and language staff, and some plans might have been written by rehabilitation or vocational staff. None of the plans were written by the psychologists.	

#	Provision	Assessment of Status	Compliance
		Contents of instructional plans. The comprehensiveness of the plans varied greatly. For example, Individual #99's PSP contained one skill acquisition plan to improve communication. It contained objectives, operational definitions, baseline data, clear instructions, and a specific evaluative criterion. However other plans were missing many of the key components that are required for an adequate skill plan; others included weak examples of these components. Many of the plans were almost identical. Examples of key components of effective acquisition plans include well-written behavioral objectives that define behavior and conditions, operational definitions of target behaviors in observable terms, detailed and clear teaching instructions (e.g., shaping, prompting, fading of prompts), and specific consequences for correct and incorrect responses (including individualized use of positive reinforcement). The results of the plan need to be regularly monitored, and modified or discontinued if objectives are met or progress is stalled. Implementation of instructional plans. In observing a skill plan conducted for Individual #51 (engage in activities), it was not clear if the staff conducting the program understood the objective of the plan, what the steps were, the goal, or how to record the data. Implementation of plans was often quick. A method for monitoring the fidelity of implementation is also a need at this facility. Engagement and interactions: 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. The monitoring team was very pleased with the positive and pleasant interactions observed in every residence and day program environment at EPSSLC. It appeared that staff enjoyed working with the individuals, and that the individuals generally appeared to enjoy their interactions with staff. Engagement of individuals in the day and residences at the facility was measured. It was measured multiple times, in multiple locations, and across days and time of day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed below.	

#	Provision	Assessment of Status	Compliance
		Overall, the engagement level was at 36%. An engagement level of 75% is a typical target in a facility like EPSSLC. So although the observed quality of the interactions was good, the engagement of the individuals has considerable room to improve. The facility might target this outcome with specific goals for each of the cottages, and day programming sites. Variability is expected, based upon the type and number of individuals and staff in each setting.	

Engagement Observations

Location	Engaged	Staff-to-individual ratio
Cottage 508	2/7	4:7
" "	3/7	4:7
" "	7/7	4:7
Cottage 509	11/11	3:11
Day Program	0/20	-
" "	0/20	-
" "	2/18	-
Pre-voc Center	3/6	2:6
Day Program	5/20	-
" "	6/20	-
Cottage 512	0/5	5:4
" "	2/5	5:4
Cottage 506	2/5	3:5
" "	2/6	3:6
" "	4/7	3:7
Cottage 510	3/7	3:7
" "	3/10	3:10
" "	3/7	3:7
Dorm C	3/14	3:14
Dorm B	1/12	3:12
Cottage 507	1/5	2:5
" "	2/6	2:6
" "	2/7	2:7
" "	3/6	2:6
Cottage 511	2/7	-
" "	5/9	-
" "	3/7	-

#	Provision	Assessment of Status	Compliance
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.	Review of individual records indicated that across the PSPs, functional assessments, and positive behavior support plans, the facility did consistently report annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration. Evidence of formal assessments in these areas could not be found. In addition, a tool called the Positive Adaptive Living Survey (PALS) was also completed for each individual. This assessment evaluated various skill areas, and provided additional information on individual preferences, strengths, and skills. It was unclear, however, how (and if) the information from the PALS was used in any systematic way to either assess if the individual had made any progress from previous years, or to choose skills to teach during the upcoming PSP year. There was some discussion of barriers to community integration at the PSP meetings and was indicated on the Living Options discussion page of the PSP. This is discussed in more detail in the review of provision T of this report. The field of applied behavior analysis has established formal preference assessments as a standard of a good behavioral assessment. Formal preference assessments should be conducted for each individual as needed and, at a minimum, annually.	
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:	As discussed above, it was not clear from staff interviews, observation, or record review that current skill acquisition plans were individualized and functional. Review of plans and data sheets in each day program and residence indicated that skill acquisition plans were implemented according to a specified schedule, and contained data documenting implementation. It was unclear, however, how and if the data were recorded reliably and if they were evaluated. Data from written acquisition plans should be graphed and evaluated as necessary to ensure that the plan is producing the desired behavior change. Additionally, although it was clear that individuals did have regular access to community activities, it was not clear these community activities were developed to address individual's needs for services or preferences. Each individual should be provided with training in the community that appropriately addresses his or her needs and preferences.	
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's	See discussion above in all paragraphs of this section of the report.	

#	Provision	Assessment of Status	Compliance
	needs, and		
	(b) Include to the degree practicable training opportunities in community settings.	No formal structured training opportunities were occurring in the community. There were no examples of skill acquisition programs occurring in community settings. Only one individual, Individual #37, was involved in community supported employment. It appeared to the monitoring team that many individuals could benefit, and would enjoy, working in community settings. One obstacle might have been the lack of one-to-one job coaches and job developers. The monitoring team learned about DARS-funded employment services and recommends that the facility explore the possibility of becoming a DARS vendor.	

Recommendations:

1. Ensure that skill acquisition programs are based on each individual's needs as identified in their current assessments (e.g., psychological, psychiatric, language and communication, functional assessment, etc.).

2. Ensure that every one who writes skill acquisition plans has received adequate training in instructional methodology, and that all programs contain the necessary components for maximizing skill development.

3. Ensure that skill acquisition programs are closely monitored and decisions to modify, discontinue, or continue a program are based on the performance of the individual served.

4. Utilize available "experts" at the facility to develop, implement, and monitor skill acquisition programs in their areas of expertise (e.g., psychologists develop and monitor replacement behaviors, and desensitization of medical procedure plans; SLPs develop and monitor communication skills, etc.).

5. Establish a method for monitoring the fidelity of the implementation of skill acquisition programs.

6. Develop a plan to monitor and maintain reasonable levels of individual engagement in all settings at the facility, including cottages, day programs, and work sites.

7. Provide systematic preference assessments to each individual as needed and, at minimum, annually.

8. Ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.

9. Improve employment training opportunities for individuals in locations in the community. Explore whether EPSSLC can become a DARS vendor. Implement a vocational assessment for individuals when appropriate.

<table>
<tr><th>SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs</th><th></th></tr>
<tr><td></td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o Texas DADS SSLC Policy: Most Integrated Setting Practices, 10/30/09, and six attachments (exhibits)
o Job descriptions for two staff responsible for admissions, transitions, and discharges
o List of seven individuals referred for placement
o List of one individual who had moved to the community
o PSPs for six individuals
o A list of visits made by individuals to community providers, including those scheduled for January 2010
o A listing of educational activities for families, LARs, and staff
o List of five staff who attended a training on Most Integrated Setting
o Tracking sheets for CLOIPs and Permanancy Plans for previous three months
o Completed post-move monitoring checklist for the one individual who moved during the past six months
o CLOIP for eight individuals
o CLDP for three individuals, one who moved during the past six months, two who are in transition
o The Revised Texas Promoting Independence Plan

<u>Interviews and Meetings Held</u>:
o Olga Arciniega, Director of Admissions, Placement, and Family Relations
o Alice Villalobos, Post-Move Monitor
o Ramona Gutierrez, MRA staff member
o Interviews with four individuals
• Individual #88
• Individual #42
• Individual #62
• Individual #14

<u>Observations Conducted</u>:
o Attended two annual PSP meetings
• Individual #49
• Individual #120</td></tr>
<tr><td></td><td>Facility Self-Assessment:

A facility self-assessment was not provided because this was a baseline review.</td></tr>
</table>

	Summary of Monitor's Assessment: EPSSLC was at the early stages of implementing the new state policy. Observations of two PSP meetings, interviews with individuals, and meetings with staff responsible for implementing the policy indicated that initial steps have been taken, but more work will need to be done to meet this provision.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. A new DADS policy on Most Integrated Setting Practices was written dated 10-30-09. EPSSLC managers told me that it was their intent to follow the newly written policy and that there was not a separate facility policy. The policy explicitly stated the state's intention to encourage and assist individuals to be served in the most integrated setting appropriate to their needs. The policy called for doing so consistent with the determination of professionals on the individual's PST that community placement was appropriate; that the transfer was not opposed by the individual or the individual's LAR; and that the transfer was consistent with the individual's PSP. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations. The monitoring team looked to see if the policies and procedures were being implemented consistently. EPSSLC staff were just beginning to apply the new policies. The Director of Admissions and Placement was familiar with the policy, and the Post-Move Monitor had recently been hired. The PSP documents and PSP meetings included many of the components of the policies. It is too early to comment on the implementation of the policies at EPSSLC because implementation was so recently initiated. Moreover, the state is expected to provide additional guidance to the facilities regarding a number of aspects of the policy and it is likely that some procedures and forms will be modified. The question of community provider capacity is one that deserves further attention. The	

#	Provision	Assessment of Status	Compliance
		monitoring team learned that there were only eight providers of residential services in El Paso. One of the providers was solely a foster care placement agency. Further, it appeared that there was a lack of psychiatric care available throughout the community, too. Thus, the providers' capacity to serve individuals in the community who present challenging behavioral and/or medical issues was unclear. It seemed likely, however, that the provider network might need a great deal of support, training, and resources if they were to be willing, and capable, of serving a wide range of individuals with a wide range of needs.	
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:		
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The identification of protections, services, and supports to be provided while living at EPSSLC was included in the PSP. Some information about what would be required in a more integrated setting was found in the Living Options Discussion section of the PSP, and in parts of the Community Living Discharge Plan (for those individuals who had been referred for placement). During each PSP meeting and then documented in the PSP document, were details regarding obstacles to the individual's movement to a most integrated setting. In addition, Exhibit D of the new policy included a checklist of potential obstacles that was to be completed after each PSP meeting. There was no indication of a plan to implement strategies to overcome these identified obstacles. This was a new process, so it is impossible to determine whether or not this has occurred at least annually. A number of aspects of this process, however, deserve further consideration. First, there were at least four aspects to the current process that competed with the team's ability to work collaboratively, and to think creatively, about the individual's transition to a most integrated setting. These were (a) focusing primarily on obstacles, (b) considering the LAR's preference to be an obstacle that required a strategy to be overcome, (c) only fully exploring community options after a referral had been made, and (d) requiring transition within 180 days of referral. This last aspect makes many LARs quite hesitant to support	

#	Provision	Assessment of Status	Compliance
		transition because once the referral is made, they no longer have control or decision-making about whether transition will or will not happen. It also can lead to the pursuit of guardianship solely in order to prevent transition. Second, more work and planning needs to be done to include parents and LARs in the process. One way is to talk about the kind of setting that would meet all of the individual's needs and preferences without there being a need for an immediate decision on transition and placement. Then, exploration can be done to see if these types of settings exist or can be created in the community. Some of the PSP documents had a short paragraph titled "Optimistic Vision in a Less Restrictive Setting" within the Living Options Discussion Record page. These types of discussions may lead to more productive planning and an increase in options for individuals. At this point, the "optimistic vision" discussion was very brief at the PSP meeting and was a very short component of the PSP document Third, LARs and PST members must be knowledgeable and be assured that the community has the resources to support individuals in these individualized ways. Safety, medical care, independence, and socialization are of the most importance to most family members and LARs.	
	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.	EPSSLC had a community provider fair at the facility campus. A number of local providers attended. Many facility staff attended, but few family members or LARs attended. DADS, through the MRA, provided individuals and LARs with a number of documents about community placement and services. Individuals went on tours and visits of community providers, but it was unclear whether or not these were effective ways of educating many of the individuals, especially those who were not capable of understanding the purpose of the visit. It is impossible to gauge an individual's preference for a community placement based on a single short visit, especially if the individual is non-verbal and has profound cognitive disabilities. It is possible, moreover, that the visits only served to confuse and agitate many of the individuals. EPSSLC is at the beginning stages of addressing the providing of adequate education and information to individuals and their families and more work needs to be done in this area.	
	3. Within eighteen months of	EPSSLC used the CLOIP as its assessment tool. This tool documented the MRA staff	

#	Provision	Assessment of Status	Compliance
	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.	person's presentation of placement information to the individual and to the LAR and/or family member, and described the response of the individual, LAR and/or family member. It also included the MRA staff person's comments that merely summarized these discussions and also included a sentence about EPSSLC staff member's opinions about placement. It seems likely, however, that the staff's opinions were more varied and complex than can be summarized in a simple sentence. Based on this review, the CLOIP did not appear to be a valid tool for assessing an individual for community placement. EPSSLC (and DADS) needs to develop a tool that can be considered an assessment of the individual for placement. The assessment would need to include the individual's needs, strengths, and preferences. It should include what is required to address the individual's needs, support his or her strengths, and meet his or her preferences. As noted above, the context of the assessment should be the PST's vision of the components and characteristics of an ideal living setting for the individual. The assessment should draw on PST members and family members/LARs. Some aspects of this process exist at EPSSLC, such as some of the components of the CLDP, and the PSP Living Options Discussion Record. The new policy called for an annual assessment. At EPSSLC, the assessment was to be conducted as part of the planning for the annual PSP meeting. Once an appropriate assessment is developed, it is likely that EPSSLS will meet the intent of this provision item.	
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 new DADS policy on Most Integrated Setting Practices, dated 10-30-09, included a section regarding the CLDP and an attachment outlining the components of the CLDP. EPSSLC had transitioned one individual to the community since July 1. The transition occurred on 12-21-09. Seven other individuals were identified by EPSSLC as being referred for placement by the PST. Of these seven, one had chosen a service provider, and a location was identified (a new home was being built). A second individual was in the process of choosing a provider. The other five individuals were in various stages of the process, such as waiting for MRA packets to be completed and/or waiting for the MRA to provide something called "freedom of choice." All seven of these individuals either served as their own guardians, or did not have a guardian appointed at this time. Guardianship was being pursued by the family members of some of these individuals. A CLDP was written and implemented for the individual who had transitioned. A CLDP had been started for the other the individual who was next to transition, however, it had not been fully completed because the specific home was still under construction. The CLDP cover page was available for the third individual, but it was not completed because	

#	Provision	Assessment of Status	Compliance
		a provider and setting had not been chosen. Therefore, it is not possible to fully comment on the facility's compliance with this provision item due to the recency of its implementation and the facility's experience with only one individual to date.	
	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.	Section IV of the CLDP listed the essential and non-essential supports required for the individual , the person responsible for ensuring the support is put in place, and the target date for completion. For the one completed CLDP, a variety of support areas were addressed, such as residential, health, and safety needs.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	For the one completed CLDP, responsible persons were identified with target dates for completion. Some of the actions were required to be completed by SSLC staff, others by provider or MRA staff.	
	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.	For the one completed CLDP, it was unclear as to whether the CLDP was reviewed with the individual. Some of the reports indicated that she would be unlikely to understand the content of the plan. She did not have an appointed LAR.	
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.	For the one completed CLDP, the plan specified that a set of assessments were provided to the new provider.	
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	For the one completed CLDP and transition, as noted above, the plan included a listing of essential and non-essential supports. There was no document indicating that the essential supports were in place on the day of the move. Non-essential supports had target dates included in the CLDP.	

#	Provision	Assessment of Status	Compliance
	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.		
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.	A quality assurance process was not in place at EPSSLC to ensure that CLDPs were developed and implemented consistent with this Section T.	
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	This information was not gathered and the processes required in this item were not yet implemented.	

#	Provision	Assessment of Status	Compliance
	statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility	EPSSLC listed the individuals at the facility who's PSTs referred them for placement. The list submitted contained six names; a seventh individual was identified during the on-site tour.	

#	Provision	Assessment of Status	Compliance
	Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	The state's policy detailed how the facility was to conduct post-move monitoring visits. For the one transition completed since the Effective Date, one 7-day post-move monitoring visit was conducted. The individual moved on 12-21-09 and the first visit occurred on 12-23-09. The visit was conducted by the newly hired post-move monitor. During the visit, the post-move monitor completed the Post-Move Monitoring checklist (Appendix C of the Settlement Agreement). The contents of the completed checklist corresponded with the information in the CLDP. Moreover, each of the items marked as "no" had a short description of the actions to be taken by provider or EPSSLC staff. Two points, however, require additional discussion. First, one item marked "no" was for an essential support. It was not in place on the day of transition nor two days later at the post-move monitoring visit. The action plan called for obtaining a physician's order to obtain a piece of essential adaptive equipment. This was an essential support and, therefore, it should have been in place prior to move, or shortly thereafter. The post-move monitoring sections of the policy are unclear as to when the action plan needs to be reviewed by the post-move monitor. For example, for this item, the post-move monitor should not wait until the next monitoring at 45 days to ensure that this essential support was provided. Second, a number of items were listed on the action list "for any items marked 'no,'" however, these items were checked as "yes" on page one of the checklist. Perhaps this was indicating follow-up to a previous checklist (i.e., one done on the day of transition). If so, the checklist might be modified to account for completed actions versus actions still required.	
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	This was not assessed because there had only been one placement from EPSSLC.	

#	Provision	Assessment of Status	Compliance
	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.		
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.	EPSSLC reported that there were no alleged offenders at the facility.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the	EPSSLC reported that this provision item did not apply to anyone at the facility.	

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

Recommendations:

1. Review and modify the planning process for transition planning, especially regarding a focus upon discussion of the type of setting that would meet all of the individual's needs and preferences without solely focusing upon obstacles to placement. Further, review the practice of referring to LAR preference as an obstacle requiring a strategy to be overcome (that is, address LAR concerns in a collaborative manner), and review the contingencies that are in place once a referral is made compared to when a referral is deferred or denied.

2. Ensure that LARs and facility staff are knowledgeable about community provider resources, capabilities, and limitations.

3. Improve the system and procedures for educating LARs about community placement options. Assess the relevance of individuals visiting community providers as part of the educational process.

4. Develop an appropriate and valid assessment tool for community placement.

5. Develop a quality assurance process.

6. Develop a process for gathering and addressing information gained from implementation of this provision, including obstacles to placement.

7. Modify the post-move checklist to separate previous versus new action items and follow-up. Address the need for there to be more immediate follow-up by the post-move monitor for any essential supports that are found to not be in place.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o List of all individuals that indicated the types of notification requested by family members; the list was also color-coded to indicate guardianship status o Email about facility contact with a local judge regarding assistance and guidance in obtaining guardians o A flyer looking for guardians that was mailed to many local groups (English and Spanish versions) o A planning questionnaire given to family members in which they indicate if they want to learn more about pursuing guardianship (English and Spanish versions) Interviews and Meetings Held: o Olga Arciniega, Director of Admissions, Placement, and Family Relations Observations Conducted: o Not applicable
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: EPSSLC had taken some initial steps towards meeting the items in this provision, however, the facility was awaiting a policy and other guidance from DADS.

#	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	A listing that met the criteria in this item was not yet in place. The Director of Admissions and Placement had begun to code a listing of all individuals to indicate those who had a guardian, needed a guardian, or who's family was in the process of working on obtaining guardianship.	

#	Provision	Assessment of Status	Compliance
	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.		
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.	EPSSLC took some initial actions, such as sending out flyers, communicating with a local judge, and asking parents if they wanted more information about guardianship. A more coordinated and comprehensive effort is required in order for EPSSLC to meet this provision item.	

Recommendations:

1. Develop a policy and set of procedures to guide the facility in meeting this provision, including, but not limited to:
   - a process, including tools and criteria, to determine whether an individual needs a guardian
   - a process to prioritize individuals in need of a guardian
   - expected ways to seek out, and educate, people who might serve as guardians.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: ○ Texas DADS SSLC Policy: Recordkeeping Practices, 9/28/09 ○ Residential Book, Medical Book, and Individual Notebooks for 10 individuals ○ EPSSLC record index <u>Interviews and Meetings Held</u>: ○ Numerous discussions with the facility's manager of documents <u>Observations Conducted</u>: ○ Not applicable
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: EPSSLC was just beginning to implement this policy. The facility was waiting for more guidance from DADS regarding implementation of a new record order (table of contents).

#	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 was just beginning to address this item. The current records did not meet all of the criteria listed in Appendix D of the Settlement Agreement. Because the records were going to be revised and re-ordered, an extensive review of the records was not conducted during this on-site tour. One aspect of the recordkeeping policy required further attention and was addressed by EPSSLC and DADS shortly after the conclusion of the on-site tour. This was a clarification in the definition of the contents of each component of the unified record.	
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	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy.	

#	Provision	Assessment of Status	Compliance
	develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.		
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	A quality assurance procedure to ensure a unified record was not in place.	
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.	This provision item cannot be addressed until the records are organized under the new updated format and the new policy is fully implemented, including section IV of the policy.	

Recommendations:

1. Implement the new policy, including, but not limited to:
   - modify records following new record guidelines order (table of contents)
   - develop and implement quality assurance process
   - ensure records are used in making care, medical treatment, and training decisions.

Health Care Guidelines

SECTION I: Documentation	
	Steps Taken to Assess Compliance: Please see above sections of this report.
	Facility Self-Assessment: Not provided because this was a baseline review.
	Summary of Monitor's Assessment:
Recommendations: No additional recommendations are offered at this time.	

SECTION II: Seizure Management	
	Steps Taken to Assess Compliance: Seizure Health Care Guidelines 18 records- see section J Neurology consultation notes Attended psychiatry clinics all three mornings of site visit
	Facility Self-Assessment:
	Summary of Monitor's Assessment: Seizures were not always classified. There were several individuals with seizures that occurred in clusters and were uncontrolled at the time of the on-site tour. For example, Individual #69 had a neurology consult noted in the annual summary on 4/27/09, however, it was not in the record. He was having cluster seizures in December and it did not look like neurology had been called or requested to re-consult. The documentation of the seizures was poor in the progress notes and there was no seizure log. In another example, Individual #112 was deteriorating and had a recurrence of seizures, but had not seen neurology even though he had been "going down hill" for the past two months according to staff at the facility.

HCG#	Abbreviated Description	Assessment of Status
II1a	Documentation of seizure frequency, duration, and characteristics	Documentation in the progress notes indicated only the duration of the seizure, not any type of description, in most cases. Only one record of the sample had a seizure "log" that was actually filled out. The neurology consultant noted that seizure logs were confusing, not filled out, and when filled out, provided little description of the seizure. For example, see the record for Individual #115. The neurologist stated in the record that "seizure records reviewed: recent seizures 5/31 (cluster/multiple) 5/26, 5/25 (at least two)- recording of seizures seems patchy/unreliable, record forms confusing." This was also the experience of the monitoring team when reading the record of Individual #69 who had cluster seizures. The record indicated the number and length, but no specifics, and there was no seizure log or record located for this individual.
II1b	Evaluation of initial or change in seizure pattern	There did not seem to be a thorough evaluation in the one case reviewed of an initial incident of seizure activity. The individual was Individual #115. He had a new onset of seizure in 3/09. He was initially hospitalized, then taken off medication after six months, had a second seizure and showed continued deterioration in mental status without additional consult to neurology, even though neurology had advised for there to be a re-consult. Also, there was no current imaging; the last imaging was done on 3/09 during his hospitalization and it was CT scan of the head.
II1c	Neurologist is involved	For the Individual #115 case, the neurologist was not recalled after second seizure in the Fall of 2009, despite they're being a request to be called in the record. For other records reviewed, it appeared that neurology was called for consults. Individual #69 had cluster seizures throughout November and December, however, there was no request for neurology in December evident in the record.
II1d	See neurologist at least once year if poorly controlled	This was occurring at EPSSLC.
II1e	See neurologist at once every 2 years if controlled	This was occurring at EPSSLC.
II1f	Primary care physician and pharmacist evaluate medical regimen	At EPSSLC, the medical director appeared to be the professional who evaluated the regimen from neurology and psychiatry. There did not seem to be active pharmacist involvement.
II1g	Monotherapy is preferred mode of treatment	If possible, the neurologist appeared to attempt monotherapy, however, most of cases reviewed were labeled as "intractable" and needed polypharmacy. Of the 18 cases reviewed, four were monotherapy regimens.
II1h	Rationale provided if more than one anticonvulsant used	Rationales were not noted in the record.
II1i	Consideration of other treatments if not controlled	Other treatments were considered. For example, vagus nerve stimulation was recommended or in place for some individuals, for example, see the record for Individual #9
II1j	Medication is consistent with type of seizure	The type of seizure condition was not documented in almost half of the sample reviewed.
II1k	Seizure classification follows Epilepsy Foundation	Most seizure diagnoses noted in the records were not classified. When classification was noted, it was by the neurology consultant. Examples included Lennox-Gastaut, intractable epilepsy, epilepsy, NOS, or generalized epilepsy.
II1l	Blood levels at six months	This appeared to be within parameters and was occurring at EPSSLC.

HCG#	Abbreviated Description	Assessment of Status
II1m	Blood tests for medication side effects at six months	This also appeared to be within parameters and occurring at EPSSLC. Prolactin levels in Paroxetine users, however, were not monitored.
II1n	More frequent blood levels for new medications	This was occurring at EPSSLC.
II1o	Diagnostic and treatment regimen in PSP	Very little information regarding seizures was included in the PSPs reviewed. Typically, a reference was made to there being a seizure disorder under treatment, with no mention of type of seizure or treatment.
II1p	Cluster seizures identified and treated	These were identified, however, the treatment regimen did not change. For example, Individual#69 was having cluster seizures in December- January, but there was no re-consultation noted to neurology. These began in early November (11/2 progress notes) and progressed to 11 days of seizures- some clusters in December. A neurology consult was ordered in April, but no consultation was noted on the record. Branzel was added as a medication for seizures, but follow-up from neurology was not evident.
II1q	Status epilepticus defined	This was not seen in the record sample.
II1r	Status epilepticus treated as emergency	No examples were reviewed, but appeared that the system at EPSSLC would be for the medical director to handle these emergencies.
II1s	Weaning of medications if 5 years seizure free	There was only one example in the sample reviewed. This was for Individual #75. His record included a neurology consult from 9/2/09 with a note that the individual had been stable since 1998 and therefore to "consider a slow taper." There was no further follow-up and a taper was not ordered.
II1t	Medication reductions done slowly and monitored	This appeared to be the case for neurology. Some examples in psychiatry, however, appeared to have occurred rapidly, especially with some antipsychotics and benzodiazepines.
II1u	If side effects impact life, PST will consider rationale	No examples were noted.
II2a	Prompt intervention when seizure occurs	Examples were not well documented in interdisciplinary progress notes. As noted above, only duration without any type of real description. The standard treatment at EPSSLC was to contact the medical director who treated with rectal diazepam.

Recommendations:

1. Increase neurology consultations, such as to four hours every two weeks.
2. Ensure better integration and communication between psychiatry, neurology, and medical.
3. Nursing and direct care staff need basic instruction on how to document seizures. They also need a seizure log on each individual that has seizures and to be able to access it for recording of the types of movements. In order to type the seizures, neurology needs accurate input from direct care staff and nursing. Neurology appeared to be very frustrated with the poor documentation. This was also the case in across the entire sample reviewed for this report.

SECTION III: Psychotropics/Positive Behavior Support	
	Steps Taken to Assess Compliance: Psychotropic Health Care Guidelines 18 records- see section J, including lab data, EKGs, etc. Attended psychiatry clinics all three mornings of site visit
	Facility Self-Assessment:
	Summary of Monitor's Assessment: Overall, it appeared this was an area of strength for the facility. The pharmacy quarterly reviews provided a prompt if psychiatry missed placing a medication order in a timely fashion and was noted in the psychiatrist's notes. Nursing typically ordered the labs per the matrix and psychiatrist signed off on them. This process seemed to be working well in getting labs drawn on schedule. There was a high level of compliance in the record sample regarding the lab matrix monitors for therapeutic medications in neurology and psychiatry. It was possible that any absence of reporting was simply because it might have been one month beyond the time window. One issue observed was that the medical director was responsible for every individual's lab monitoring. Psychiatry should be responsible for tracking its own labs and then integrating with the medical director. Individuals taking clozapine or other medications requiring lipid and glucose or HGbA1c monitoring (such as second-generation neuroleptics) should be the responsibility of the psychiatrist. An example of when the medical director would be contacted would be if an individual taking lithium showed an abnormal thyroid test result.

HCG#	Abbreviated Description	Assessment of Status
III1a	Initial psychiatric evaluation contents (7 items)	These were done retrospectively by one of the psychiatrists. There was no Axis IV or V in the records. There were no comprehensive assessments that were contemporaneous. In many cases, only the original assessment was present, and in some cases it might be 30 years old.
III1b	General monitoring documentation (3 items)	There appeared to be some times when the individual was not reviewed monthly. It was difficult to determine whether the individual was not seen or if the notes had not been sent or transcribed as discovered during the on-site tour. In one case, Individual #100's record was missing all psychiatric progress notes.
III1c	Monitoring for anti-epileptics used for psychiatry	The lab matrix appeared to be followed.

HCG#	Abbreviated Description	Assessment of Status
III1d	Monitoring for lithium	The lab matrix appeared to be followed.
III1e	Monitoring for tri-cyc anti-depressants and trazadone	EKGs were in the records as required.
III1f	Monitoring for beta-blocker when used for psychiatry	No information was available.
III1g	Monitoring for antipsychotics (6 items)	Eye exams, if present in the record, made no mention of review for thioridazine- or chlorpromazine-related issues. Lipids, CMP, CBC with diff all appeared to be conducted as appropriate. In the case of abnormal labs, psychiatry needed to follow up on the abnormal results, not simply note that they were elevated. For example, Individual #40's Prolactin went up as high as 91.8 from 4/09-12/23/09. It was noted in the progress notes, but there was no discussion about the possible need to lower the risperidone, nor any discussion of ordering imaging. In the case of Individual #115, the risperidone was discontinued with elevated prolactin levels (51.6), however, there was no follow-up prolactin lab done to be sure it was normalized after discontinuing the medication.
III2a	Nursing management of medications (9 detailed items)	See comments in section M of this report.
III2b	Nurse role in positive behavior support (6 items)	See comments in section M of this report.
III2c	Medication error management (5 items)	See comments in section M of this report.

Recommendations:

1. Add prolactin to lab matrix for paroxetine usage.

2. Have psychiatry or neurology be responsible for ordering their own lab monitors and follow-ups, sign offs, etc. A system for coordination and integration with the medical director should be developed, especially for handling abnormal labs, unless they are critical values that cannot wait until the next clinic day.

3. Neurology on an every two week basis would be helpful in providing more consultation time and following up on problems in a more timely manner. It appeared that the current consulting neurologist followed up by phone.

4. Create a more "user friendly" record so lab data is not so difficult to find for the psychiatrist on clinic day.

5. Eye exams for individuals who have been placed on thioridazine or chlorpromazine need to be dilated so pigment deposits can be seen if present. This should be noted on the consultation to the eye care provider; otherwise, it may be a simple screening examination. The records reviewed had no eye exam consults within the record. The annual summary noted eye exam, but not the details.

6. Add HgbA1C to the lab matrix for fasting blood sugar >110.

SECTION IV: Management of Acute Illness and Injury	
	Steps Taken to Assess Compliance: Please see above sections of this report.
	Facility Self-Assessment: Not provided because this was a baseline review.
	Summary of Monitor's Assessment:
Recommendations: No additional recommendations are offered at this time.	

SECTION V: Prevention	
	Steps Taken to Assess Compliance: Please see above sections of this report.
	Facility Self-Assessment: Not provided because this was a baseline review.
	Summary of Monitor's Assessment:
Recommendations: No additional recommendations are offered at this time.	

SECTION VI: Nutritional Management Planning	
	Steps Taken to Assess Compliance: Please see above sections of this report.
	Facility Self-Assessment: Not provided because this was a baseline review.
	Summary of Monitor's Assessment:
Recommendations: No additional recommendations are offered at this time.	

SECTION VII: Management of Chronic Conditions	
	Steps Taken to Assess Compliance: Please see above sections of this report.
	Facility Self-Assessment: Not provided because this was a baseline review.
	Summary of Monitor's Assessment:
Recommendations: No additional recommendations are offered at this time.	

SECTION VIII: Physical Management	
	Steps Taken to Assess Compliance: Please see above sections of this report.
	Facility Self-Assessment: Not provided because this was a baseline review.
	Summary of Monitor's Assessment:
Recommendations: No additional recommendations are offered at this time.	

SECTION IX: Pain Management	
	Steps Taken to Assess Compliance: Please see above sections of this report.
	Facility Self-Assessment: Not provided because this was a baseline review.
	Summary of Monitor's Assessment:
Recommendations: No additional recommendations are offered at this time.	

List of Acronyms Used in This Report

Acronym	Meaning
ABC	Antecedent-Behavior-Consequence
ADON	Assistant Director of Nursing
AED	Anti-Epileptic Drug
AIMS	Abnormal Involuntary Movement Scale
BCBA	Board Certified Behavior Analyst
BMI	Body Mass Index
BMD	Bone Mineral Density
BS	Bachelor of Science
CBC	Complete Blood Count
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
COTA	Certified Occupational Therapy Assistant
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	U.S. Department of Justice
DSM	Diagnostic and Statistical Manual of the American Psychiatric Association
DUR	Drug Utilization Review
EKG	Electrocardiogram
EMS	Emergency Medical Services
EPSSLC	El Paso State Supported Living Center
FA	Functional Analysis or Functional Assessment
FAST	Functional Analysis Screening Tool
FAOTA	Fellow, American Occupational Therapy Association
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
HCG	Health Care Guidelines
HIP	Head Injury Protocol
HRC	Human rights committee
HST	Health Status Team

IDT	Interdisciplinary Team
LAR	Legally Authorized Representative
LRA	Labor Relations Alternatives
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MAS	Motivation Assessment Scale
MBS	Modified Barium Swallow
MD	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MRA	Mental Retardation Authority
NACES	Nurse Aide Competency Evaluation Service
NEO	New Employee Orientation
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NPO	Nil Per Os (nothing by mouth)
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
PA	Physician Assistant
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PDP	Personal Development Plan
PMAB	Physical Management of Aggressive Behavior
POC	Plan of Correction
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PST	Personal Support Team
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PT	Physical Therapy
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
SA	Settlement Agreement
SIB	Self-injurious Behavior

SLP	Speech and Language Pathologist
SSLC	State Supported Living Center
SPO	Specific Program Objective
TAO	Triple Antibiotic Ointment
TAR	Treatment Administration Record
TSH	Thyroid Stimulating Hormone
UTEP	University of Texas El Paso
VOCA	Voice Output Communication Aid