United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

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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 Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition 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 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 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 were considered baseline reviews. Compliance reviews began in July 2010, and are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of Lubbock State Supported Living Center (LBSSLC).

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 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 a section of the report for which another team member had primary responsibility. For this review of Lubbock SSLC, the following Monitoring Team members had primary responsibility

for reviewing the following areas: Elizabeth Jones reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, and supports, as well as quality assurance; Edwin Mikkelsen reviewed psychiatric care and services; Wayne Zwick reviewed medical care, dental services, and pharmacy services; Victoria Lund reviewed nursing care, restraint, and safe medication practices; Patrick Heick reviewed psychological care and services, restraint, and habilitation, training, education, and skill acquisition programs; Nancy Waglow reviewed minimum common elements of physical and nutritional supports, as well as physical and occupational therapy, and communication supports; and Maria Laurence reviewed integrated protections, services, treatments and supports, and 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 might 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 September 13 through 18, 2010, the Monitoring Team visited Lubbock 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 (CLDPs), 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. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, 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.

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.

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) **Facility's Self-Assessment:** No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;
(c) **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;
(d) **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 noncompliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated for reviews beginning in July 2010; 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. However, it is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the SA.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, Individual #45, Individual #101, etc.). 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

The Monitoring Team would like to thank the management team, all of the staff, and the individuals who live at LBSSLC for all of their assistance during the on-site monitoring visit, as well as in preparation before the visit, and the

production of many documents after the visit. Everyone with whom the Monitoring Team spent time during the on-site review was helpful in providing valuable information to assist the Monitoring Team in reviewing the Facility's status with regard to the Settlement Agreement.

At the outset, it is important to note that since the baseline review, many positive changes had occurred at the Facility, and these changes were beginning to have a positive impact on the protections, supports and services provided to individuals who were supported by LBSSLC. Since the last review, a new Director had begun to work with the Lubbock team, and together they had been able to revitalize some positive practices the Facility reportedly had in place in the past, and had initiated steps to correct other areas. Although the Facility had many improvements still to make, it appeared that there was an understanding across campus that the management team had high expectations and was holding people accountable, but was also there to support staff and assist in making needed modifications. Even when staff expressed concerns, they noted they were hopeful that changes were in process.

It is important to specifically note that a number of significant concerns related to the ability of LBSSLC to protect individuals from harm were noted in the baseline report. Since that time, a number of initiatives had been put in place to address many of these concerns. Overall, LBSSLC had made a good faith effort to develop safeguards that will protect the individuals and staff from harm.

The following summarizes some of the concerns identified in the baseline report, and the actions taken to address them:

- During the baseline review, concerns were noted with regard to inappropriate groupings of individuals with very different, often unique, needs for support. For example, there were too many individuals with behavior issues grouped together and the opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. The relocation of men who lived in 515 S. Cedar had had increasingly positive outcomes. It is recommended that all other living units be reviewed with regard to the number of individuals, the grouping of individuals, and the provision of individualized supports for active treatment. Such actions will be critical to reducing risk in this environment and to promoting the growth and development of the individuals who live at LBSSLC.
- During the baseline review, extremely serious staffing concerns were identified, including the assignment of newly hired, inexperienced staff to work with individuals with complex and challenging needs for support. There had been a concerted effort to recruit and retain qualified staff with positive attitudes and high energy.
- Another concern noted in the previous review was a reliance on overtime, and, as reported by staff, not entirely voluntary overtime, resulting in reliance on tired staff to implement critical responsibilities. The problems with payment for overtime were resolved in August 2010. Staff were given the option of being paid time and a half, or taking compensatory time. With the hiring of additional staff, as well as additional procedures implemented

with regard to overtime, the use of mandatory overtime was decreasing. As a result, staff morale appeared to be significantly improved.

- The annualized turnover rate of direct support professionals continued to be approximately 60%. The turnover rate was attributed, in part, to the employment of university students. The Facility recognized that continued work in this area was needed to ensure a stable workforce of well-trained staff. Such stabilization is also necessary to ensure that the policy directives regarding zero tolerance for abuse and neglect are engrained in the culture of this Facility.
- Inadequate independent safeguards also were noted as a problem in the Monitoring Team's initial review. Immediately following the baseline review, a State Office staff person was appointed as the Acting Director of LBSSLC until a new Director was identified and assumed the Director position. Overall, it appeared that the current State Office administration had begun to increase its presence and oversight of the SSLCs through the issuance of revised policies to which the SSLCs are required to adhere, coordination by discipline-specific coordinators at the State Office level, and data collection. The State Office also articulated plans to increase its monitoring activities. During the LBSSLC review, there was discussion about the newly required quality improvement councils. These entities will be leadership groups at each Facility charged with the responsibility to oversee quality improvement activities in a more holistic manner. This will be an important step in ensuring there are adequate processes in place to expand best practice, as well as identify areas needing improvement and ensure action is taken that results in positive outcomes for the individuals that LBSSLC supports.

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at Lubbock SSLC:

Restraints

- There was evidence of the careful analysis of the use of restraints. The restraint checklists documented the review of any restraint at the Unit meeting, the Incident Management Review meeting, and by the Facility Director or her designee, most often the Director of Behavioral Services. In addition, individual cases were presented at the monthly Restraint Reduction Committee meeting. During the monitoring visit, three individuals with recent incidents of restraint were discussed at the Restraint Reduction Committee, and the plans for less intrusive interventions were presented by the psychologists working with them. The Facility Director attended this meeting and participated in the discussion.

Abuse, Neglect and Incident Management

- The LBSSLC policy was unequivocal: there was zero tolerance of abuse and neglect. Implementation of the policy and its underlying principles was evident in the serious attention given to allegations; the immediate reassignment of alleged perpetrators; the disciplinary action taken when abuse and/or neglect was confirmed,

including the legal action taken against perpetrators; and the ongoing efforts to strengthen the investigation process and learn from its findings.

- The Interagency Memorandum of Understanding (MOU) Regarding the Investigation of Abuse and Neglect in State Supported Living Centers clearly delineated the role of the Department of Family Protective Services. This was an instructive document because it clarified agency responsibilities, including responsibility for the notification of law enforcement, and specified timeframes for the investigation process. This MOU was reflective of commitments made under the Settlement Agreement.
- Although few had called the intake line, when interviewed, all staff stated that they had a responsibility to report abuse and neglect. There was evidence that staff had signed a statement confirming their responsibility to report any mistreatment of the individuals residing at LBSSLC.

Quality Assurance

- LBSSLC had begun to establish a process for monitoring compliance with the Settlement Agreement. The Facility had begun to customize the review tools, had converted them to an Excel format to make calculations easier, and had begun the process of establishing inter-rater reliability. All of these were positive developments. However, there was still a need for specific instructions/directions, competency-based training of staff responsible for monitoring, and further refinement of the tools and the process of measuring inter-rater reliability.

Integrated Protections, Services, Treatments and Supports

- The DADS policy on integrated protections, services, treatments, and supports was issued at the end of July. Three LBSSLC staff had been certified as trainers, and all Qualified Mental Retardation Professionals (QMRPs) at the Facility had undergone the initial training. Training also had begun to be provided to all other Personal Support Team (PST) members. Beginning on 9/1/10, the Facility began using the new process.

Integrated Clinical Services

- There had been improvement in physician documentation of review, and documentation of the physician's agreement or not with consultant recommendations. However, further work was needed to develop a system to ensure this occurred consistently.

Minimum Common Elements of Clinical Care

- Progress had been made in ensuring medications had appropriate diagnoses linked to them that were consistent with ICF and DSM criteria.

Psychiatric Care and Services

- Since the baseline review, LBSSLC had hired an additional full-time Staff Psychiatrist.
- The review of the medical records indicated there was consistent monitoring for the following: psychoactive medication side effects; regular assessment of medication blood levels, when necessary; and electro-cardiograms, when indicated. The communication between the Departments of Psychiatry, Medicine, Psychology, and Neurology was impressive. Based on a review of a sample of individuals, the Psychiatrists had

assessed every individual receiving psychotropic medication on a monthly and quarterly basis. They had the capability of consulting on individuals daily, or two-to-three times a week, if an individual had been experiencing a psychiatric deterioration.

Psychological Care and Services

- The inclusion of additional LBSSLC staff, as well as an external BCBA-D consultant within the behavioral services peer review committee, had enhanced the membership's ability to provide critical peer review. Similarly, additions of individuals not employed by the Facility to the Human Rights Committee (HRC) also supported more independence in review of programming.
- Structural and Functional Behavior Assessment (SFBA) continued to be an area of strength within psychological services. These comprehensive reports appeared to be successful in identifying underlying function(s) of target behaviors, as well as evidenced-based interventions. Challenges remained with regard to identifying and defining specific replacement behaviors, as well as prescribing detailed teaching strategies necessary to promote effective skill acquisition.

Nursing Care

- Since the baseline review, LBSSLC had invested considerable effort into securing consistent nursing staff at the Facility. The Facility went from having only 57 percent filled nursing positions to 88 percent filled nursing positions. Clearly, the Facility's efforts and strategies were effective in securing a significant number of nursing staff, which should facilitate positive clinical outcomes for the individuals at LBSSLC.
- The Nursing Department was in the process of implementing some interventions associated with the medication administration system. The Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection or via tube, and the frequency of the medication observations for nurses was changed from annually to quarterly. The Facility had already completed a round of medication observations for most of the nurses. However, competency of the auditors will have to be determined for this area to ensure accurate data is generated from the observations.

Pharmacy Services and Safe Medication Practices

- The Pharmacy Department had made a number of improvements in addressing issues such as documenting interventions with new orders when they were Level 1 alerts (i.e., no drug dispensed until clarifications received due to significant drug interactions, drug allergies, and other contraindications). However, this had not been resolved for Level 2 and 3 alerts for which pharmacists were allowed to use their professional discretion in notifying the medical providers and initiating appropriate changes, such as timing of doses to minimize drug interactions.

Physical and Nutritional Supports

- The Physical and Nutritional Management Team (PNMT) initiated the first PNMT comprehensive assessment for an individual in July 2010. A dedicated team had been assigned, except that a dedicated nurse had not been assigned to the team at the time of the on-site review. Review of clinical instruction documentation for the

current PNMT members showed that all members had had clinical instruction and professional development in the area of physical and nutritional supports.

Dental Services

- Progress had been made in the cooperation between Habilitation Services and the Dental Departments with regard to ensuring that the Physical and Nutritional Management Plans (PNMPs) for individuals were available to and implemented by the Dental Department. Also, there had been improved monitoring after pre-treatment sedation had been administered.

Habilitation, Training, Education, and Skill Acquisition Programs

- Since the baseline review, LBSSLC had made progress by developing an Active Treatment Policy that included a new process and format for the development, implementation, and monitoring of skill acquisition programs (SAPs). This change was based on previous feedback and was necessary to improve the quality of current skill acquisition programs, as well as improve ongoing monitoring. Newly developed Performance Probes and Learning Based Support Data Graphs are likely to promote improved treatment integrity and consistent data collection.
- Since the baseline review, LBSSLC also had made progress in the area of engagement. During the recent visit, engagement across residential programs was estimated at 72%, showing an improvement since baseline. However, little of the engagement observed involved the implementation of teaching or skill acquisition programs.

Most Integrated Setting

- Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, they all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed.

Consent

- LBSSLC had taken steps to attempt to identify guardians for individuals whose teams had identified the need for a guardian. One of the most promising possibilities was a newly formed relationship between LBSSLC staff and community groups who also needed assistance in identifying guardians for individuals who lived in the community.

Recordkeeping and General Plan Implementation

- Significant progress had been made in converting the active records to the new Table of Contents required by the State Office. At the time of the review, the records in all but three of the homes on campus had been converted. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the records management staff.
- Since the baseline review, a process that required review of policies prior to their finalization had been revitalized. This process required that policies be sent to the leadership group for review. The group reviewed

any draft policies to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at Lubbock SSLC:

Restraints

- There was continued concern that programming, including the consideration of environmental modifications, was not sufficient to determine that restraint was not used as a substitute for adequate programming. Although the PBSPs included replacement behaviors, staff did not consistently attempt to have individuals use such behaviors as part of a "graduated range of less restrictive options," or they did not document that they had. In addition, because staff had not included a thorough chronology of events leading to the restraint on some of the forms, it could not be determined if an appropriate range of less restrictive alternatives had been attempted, or if the individual posed an immediate and serious risk of harm to self or others at the time that restraint was applied.

Abuse, Neglect and Incident Management

- A number of concerns were noted about the investigation reports completed by both Department of Family and Protective Services (DFPS) and the Facility. These concerns included timeliness and completeness of the final report.

Quality Assurance

- As reported during the baseline review, even though the monitoring and data collection systems needed to be refined, at the time of the review, useful information was being collected, and distributed to decision-making staff. However, it generally did not appear that this raw data was analyzed in any meaningful way, or that responses to these reports, particularly in the form of concrete actions plans, were developed, documented, and implemented. In order for the Facility to have a fully functioning quality enhancement process in place, it is essential that this occur.
- In addition, trending of some basic quality indicators was being conducted. Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to individuals served by LBSSLC.

Integrated Protections, Services, Treatments and Supports

- As is noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning.

- Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen.
- The State and the Facility will need to ensure that person-centered concepts are incorporated to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

Integrated Clinical Services

- Although there were some examples of the integration of clinical care at LBSSLC, there remained a number of significant areas in which integration was needed to improve the care of the individuals. These included, but were not limited to Health Status Meetings at which information was presented, but interdisciplinary, integrated discussion did not consistently occur; cooperation between the Dental Department and the Qualified Mental Retardation Professional (QMRP)/home manager to resolve refusals of attendance at dental appointments; as well as the Dental Department and the QMRP/Psychology Department to implement desensitization programs, as well as other strategies to reduce reliance on pre-treatment sedation and/or restraint.

Minimum Common Elements of Clinical Care

- There was a need to ensure the completion of timely annual medical evaluations, as well as inconsistency in approach to the needs of the individuals across the campus. This would be improved through the use of clinical pathways that include timelines so that the same steps are taken at the appropriate time for all individuals with the same diagnosis, unless contraindicated.

At-Risk Individuals

- The Facility had developed its own risk assessment program, but there were concerns regarding the validity of the risk stratification. In the meantime, the State Office had been actively developing a risk assessment process to be used at all Facilities. At the time of the review, it had not been finalized.

Psychiatric Care and Services

- Based on a review of a sample of individuals who were prescribed psychoactive medications, there were concerns about the classification of specific behaviors as being both a symptom of a psychiatric disorder and being present on a learned or operant basis.
- Additional concerns derived from this analysis related to the degree to which the efficacy of psychoactive medication had been empirically established, and the observation that most narrative sections related to weighing the risks and benefits of psychoactive medication were extremely general in nature, often using terminology that was nearly identical in many of the records.
- A related issue was the lack of documentation of the specific symptoms that provided confirmation for the psychiatric diagnosis of record.

Psychological Care and Services

- Progress also had been made in the area of data collection and monitoring of PBSPs, and skill acquisition programs. However, concerns regarding the adequacy and timeliness of data collection remained. Improvements included new standardized formats. The effectiveness of this new standardized data collection format will need to be examined at the next review. Although inter-observer data collection had not yet started, plans were underway to identify an acceptable system. In addition, new methods of monitoring treatment integrity were soon to be initiated.
- With regard to Positive Behavior Support Plans, areas for improvement included ensuring adequate operational definitions for replacement behaviors, prescribing specific teaching strategies, and the integration of sufficient reinforcement. Systems examining the treatment integrity of PBSP implementation had been developed, but not systematically implemented. Once in place, staff should be able to more systematically examine the effectiveness of staff training. Indeed, competency-based training continued to be an area of significant concern.

Medical Care

- The main area that needed improvement was with regard to the critical thinking used by medical staff. Critical thinking needed to occur to determine, for example, why someone had recurrent aspiration, a fracture, abdominal pain and vomiting, etc.
- Efforts had been made to have a non-Facility physician review completed. However, a physician from Denton SSLC conducted the review without any involvement from a "non-Facility" physician. The sample size was small (less than three percent of the population), and the review did not result in a cumulative report that identified any systemic issues. In addition, there was no action plan based on this visit. The contents of the individual reports were helpful, and should have been used as an opportunity for additional medical system improvement at LBSSLC.
- Many clinical guidelines had been created, and this was an important step. However, some of the more pressing medical issues did not have a clinical guideline. In addition, there was little in the way of timelines to ensure physicians completed the next step in the process in a timely manner, and to ensure care was consistent across the campus.

Nursing Care

- Consistent with the findings from the baseline review, there continued to be a significant number of problematic issues regarding the nursing documentation addressing complete and adequate nursing assessments of symptoms for acute changes in status. There were problems noted regarding the lack of adequate documentation when the individual began showing symptoms of a change in status, and of assessments prior to the transfer to an off-site medical center, as well as upon return to the Facility.
- Since the baseline review, the State Office had modified the procedure Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. The Facility had implemented the modified Comprehensive Assessment form and the new Nursing Care Plan templates at the time of the review.

However, no competency-based training was provided prior to implementation. Consequently, there was no improvement found in the quality of the assessments or care plans.

Pharmacy Services and Safe Medication Practices

- Quarterly Drug Regimen Reviews had improved, but had not yet addressed all areas, such as the use of benzodiazepines, anticholinergics, and polypharmacy.
- MOSES and DISCUS were tracked, but there was some noncompliance in the completion of these screenings, as identified by the Facility's own tracking form. No evidence of immediate follow-up and/or resolution was found.
- Medication error review and monitoring remained in their early stages of implementation. A Medication Error Committee had begun meeting, and errors were being analyzed in a logical progression in order to ensure quality of data. However, additional work needed to be done to ensure accurate reporting, to collect and analyze data, and to develop and follow-through on recommendations to improve the system.

Physical and Nutritional Supports

- The Facility was to be commended for identifying and providing training to Mealtime Coordinators (MTC). Mealtime Coordinators were staff designated by residential services to coordinate the services provided to individuals during meal times. However, there were some areas of concern noted. Although they had responsibilities related to ensuring that dining plans were implemented as written, during the Monitoring Team's observations, MTCs did not intervene to address issues such as individuals not being in proper alignment and support, or the instructions on dining plans not being followed.
- Likewise, there was no competency-based written test and/or skills-based performance check-off to establish competency of PNMP Coordinators. The Monitoring Team's observation of a PNMP Coordinator in a dining area did not indicate that the PNMP Coordinator was competent to provide coaching, mentoring and monitoring to the staff during mealtimes.
- Based on review of the Facility's policy, LBSSLC did not have an adequate policy defining the monitoring system for PNMPs and meal observation. A policy should be developed to ensure that a system is in place to monitor staff implementation of PNMPs, including mealtime plans.
- A review of Facility reports, including those from Quality Improvement/Quality Enhancement, did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM Team for analysis leading to the identification of and ensuring the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators.

Physical and Occupational Therapy

- The large caseloads of Occupational Therapists (OTs) and Physical Therapists (PTs) along with the assigned responsibilities that included, but were not limited to completing evaluations, developing and revising PNMPs, and participating in PNMP clinics did not leave adequate time to provide direct therapy. This was evidenced by the absence of formal OT/PT therapy services found in the individual records reviewed. The OT/PT annual

evaluation recommendations were generic in nature and did not provide functional recommendations to the PST for consideration.

- A defined monitoring system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions.

Dental Services

- A high rate of missed appointments translated into delays in care and inefficient use of time. To resolve this issue, accurate information will need to be collected regarding the reasons for missed appointments, and there will need to be coordination and cooperation with the homes and PSTs.
- According to the Dental Director, there were 163 dental desensitization plans in place. According to the Lubbock SSLC Plan of Improvement, many had not been updated recently. Further, according to the Dental Director, few if any of these plans had been implemented, and there was little information concerning any monitoring regarding implementation. The revision/development and implementation of desensitization plans and other strategies to reduce the need for sedation will require significant coordination with and assistance from the Psychology Department. At the time of the review, the Dental Department had not received sufficient assistance, and as a result, there was an overuse of chemical sedation and IV sedation/general anesthesia.

Communication

- At the time of the review, the caseloads for Speech Language Pathologists (SLPs) would not allow therapists to be active members of individuals' Personal Support Teams, or provide adequate functional communication supports to individuals and their teams. This will provide significant challenges in meeting the requirements of Section R of the SA.
- While Speech Language Pathologists were completing evaluations that identified the need for augmentative/alternative communication devices, there were not sufficient resources to provide direct and/or indirect speech therapy supports for individuals with an identified need. To the credit of the SLPs, there were multiple individuals with communication devices on campus (low tech and high tech), as well as many generic devices, but there was not a current framework within the PSP process to integrate these devices into formal, teachable moments, such as integration into skills acquisition programs.
- A review of individuals' evaluation updates and/or screenings did not support that SLPs were collaborating with psychology staff to assess and explore functional communication strategies for individuals involved in challenging behaviors. Procedures needed to be developed to define the SLPs' role in working with individuals with challenging behaviors, including collaboration with the individuals' psychologists and PSTs.

Habilitation, Training, Education, and Skill Acquisition Programs

- Training of staff continued to be an area of great concern. Baseline reviews and more recent observations continued to produce mixed findings regarding staff knowledge of and competencies in implementing skill acquisition plans. The Monitoring Team looks forward to reviewing the content and process of the new competency-based trainings, as well as related outcomes during the next visit.

Most Integrated Setting

- At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. Although Community Living Options Discussion Records included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations.
- Since the baseline review, when no obstacles to individuals' movement to the most integrated setting were identified in PSPs, improvements had occurred in that the newer plans included obstacles and plans to overcome them. However, the following issues were noted: 1) the obstacles often were listed as need areas for the individual, such as behavioral issues, medical concerns, etc., as opposed to identifying services or supports that either were unavailable or did not exist in the community; 2) the plans to overcome the obstacles often were not measurable, did not identify person(s) responsible or timeframes for completion; and 3) the strategies often involved services to be provided to the individuals at the Facility, but did not include identifying support configurations in the community that would address individuals' needs.
- The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways.

Consent

- At the time of the review, DADS State Office was still in the process of finalizing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. LBSSLC indicated that there "was not any instrument or process to determine functional capacity," or "any instruments or processes used to prioritize the needs of individuals" for guardians. It was anticipated that the State Office policy would provide guidance with regard to these issues.

Recordkeeping and General Plan Implementation

- As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development.
- No action plans had been developed yet to address issues related to records. Less formally, steps had been taken to address issues that had been identified in records. Concerns of the Monitoring Team regarding the quality and availability of records should be addressed.

V. 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: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o Do Not Restrain with a Crisis Intervention Physical Restraint List;
o Lists of all staff authorized to implement restraints;
o DADS Policy: “Use of Restraint,” dated 8/31/09;
o LBSSLC Policy: “Positive Behavior Support: Limitation of Restraint as a Crisis Intervention,” dated 11/25/09;
o LBSSLC Policy: “Positive Behavior Support Practices,” dated 8/31/10;
o LBSSLC Policy: “Individual to Individual Aggression,” dated 2/11/10;
o LBSSLC Policy: “Assigning Levels of Supervision,” dated 7/16/10;
o Restraint Checklists and Debriefing Forms for 6/10, 7/10, and 8/10, involving Individual #82, Individual #134, Individual #288, Individual #298, Individual #33, Individual #320, and Individual #213;
o Human Rights Committee Meeting Minutes, from 3/3/10 through 8/25/10;
o Presentation Book for Section C;
o LBSSLC Restraint Report, Report Date: 1/1/10 to 7/31/10 (TX-LB-1009-II.4);
o LBSSLC Restraint Checklists for the months of June, July and August (TX-LB-1009-PH-14.1 a-c);
o LBSSLC List of Individuals Who Have a Safety Plan (TX-LB-1009-VIII.7);
o LBSSLC Summary Grid of Individuals with Safety Plans, handout at Restraint Reduction Committee;
o The PSP, PSP Addendums, Psychological Assessment, Structural and Functional Assessment Report (SFAR), Positive Behavior Support Plan (PBSP), Safety Plan for Crisis Intervention (SPCI), PSP Monthly and/or Quarterly Reviews and Integrated Progress Notes (for the last six months, if available), and Safety Plan Progress Note (for the last three months, if available), as available for Individual #213, Individual #82, Individual #320, and Individual #298; and
o FY 10 Third Quarter Restraint Summary.
▪ Interviews with:
o Jim Forbes, M.ED., C.B.A., Director of Behavioral Services;
o Bob Robbins, Program Compliance Officer; and
o Dawn Ripley, Director of Quality Enhancement.
▪ Observations of:
o Incident Management Review Team Meetings, from 9/13 through 9/16/10;
o Restraint Reduction Meeting, on 9/16/10;
o Human Rights Committee Meeting, on 9/16/10;
o Performance Improvement Committee Meeting, on 9/14/10; and
o Site visits to all living units, the workshop, and day program areas in the Lily and Pines</td></tr>
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	Buildings. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees, as well as some of the individuals.
	Facility Self-Assessment: In its most recent Plan of Improvement, the Facility concluded that it was in substantial compliance with the requirements in C.1 that prone restraint be prohibited, and that restraint not be used as punishment. The Facility determined that it was not in compliance at this time with the other requirements of this Section. As discussed below, the Monitoring Team agreed that LBSSLC had taken action to prohibit the use of prone restraint and the use of restraint as punishment. However, the other requirements in C.1, and Section C as a whole had not been met. Nonetheless, there was evidence of steady progress towards compliance with Section C.
	Summary of Monitor's Assessment: The Director of Behavioral Services should be commended for his commitment to reduce the use of restraint at LBSSLC. His leadership and his mentoring of psychologists had been important factors in the ongoing examination of restraint at the Facility. As psychologists at LBSSLC worked to better understand the behavior of individuals with complex needs and histories, the involvement of local university-affiliated clinicians also was a positive addition. Since the baseline review, some positive changes had occurred specifically with regard to individuals' movement to a less crowded, more structured environment. As a result, there had been positive outcomes for individuals who historically had required significant supervision and intervention. The men who lived in 515 South Cedar Avenue were moved to other homes on campus. At the time of the baseline review, this residence was chaotic, and had a notable record of injuries and disruptive behaviors. The moves had afforded the men more defined space and less congestion, and the changes seemed to have been therapeutic. For example, Individual #60 had decreased his stereotypical behaviors and isolation. Individual #239 was reported to be more easily redirected and engaged, and his last restraint occurred in April. Unfortunately, the efforts of the Director of Behavioral Services and his clinical staff to improve behavioral outcomes for individuals were hampered by the environments at LBSSLC that continued to require multiple individuals with conflicting and competing needs for support to live and work together in settings that housed many individuals, and, many of which, were not configured to allow individuals adequate personal space. In general, privacy was still very limited at LBSSLC. The lack of privacy and the lack of options in the residential areas appeared to have led to disruptive behavior on the part of certain individuals. For example, in August 2010, Individual #82 became angry, and was restrained twice when she was not permitted to change bedrooms because of conflicts with a roommate. The Facility's leadership was strongly encouraged to review the current configuration of all living units, as well as the staff's ability to manage a significant number of individuals who require attention to meet their needs for adequate habilitation, protection, and support.

	There was continued concern that programming, including the consideration of environmental modifications, was not sufficient to determine that restraint was not used as a substitute for adequate programming. Although the PBSPs included replacement behaviors, staff did not consistently attempt to have individuals use such behaviors as part of a "graduated range of less restrictive options," or they did not document that they had. In addition, because staff had not included a thorough chronology of events leading to the restraint on some of the forms, it could not be determined if an appropriate range of less restrictive alternatives had been attempted, or if the individual posed an immediate and serious risk of harm to self or others at the time that restraint was applied. The use of restraint increased between the second quarter and in the third quarter of FY 10, primarily due to the restraints used for three individuals who had Safety Plans. According to the FY 10 Third Quarter Report's Restraint Trend Analysis for 9/09 through 3/10, at LBSSLC, there were a total of 108 restraints. In Quarter 1, there were 24 restraints; Quarter 2 had 27 restraints; and Quarter 3 had 57 restraints documented. There was evidence of the careful analysis of the use of restraints. The restraint checklists documented the review of any restraint at the Unit meeting, the Incident Management Review meeting, and by the Facility Director or her designee, most often the Director of Behavioral Services. In addition, individual cases were presented at the monthly Restraint Reduction Committee meeting. During the monitoring visit, three individuals, Individual #33, Individual #82, and Individual #288, with recent incidents of restraint were discussed at the Restraint Reduction Committee, and the plans for less intrusive interventions were presented by the psychologists working with them. The Facility Director attended this meeting and participated in the discussion.

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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	During both the baseline review and this monitoring site visit, there was no evidence of prone restraint at LBSSLC. According to LBSSLC policy, prone physical restraints were prohibited, as was prone mechanical restraint. On 8/19/10, the Director of Behavioral Services documented that there had been zero instances of prone restraints documented or reported during the past six months (2/1/10 through 7/31/10). When queried, the Director of Behavioral Services responded that there was a lengthy history of no prone restraints at LBSSLC. Specifically, he indicated that staff have been instructed, through training, that this was considered a prohibited technique; there had been no incident reports documenting the use of prone restraint; his own observations had not identified the use of prone restraint; the restraint monitors had not reported any use of prone restraint; there had been no reports from individuals regarding the use of prone restraints; there had been no injuries reported from the use of prone restraints; and staff training had emphasized the mandate to release an individual from restraint, if the approved position could not be maintained, and there had been one or two cases where this occurred and the individual was	Noncompliance

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	accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	released, and these releases were documented in the restraint checklists. In addition, the Campus Coordinators and On Duty staff persons go to any homes that require random heightened monitoring. These staff persons had been instructed to look for any signs of trauma and/or issues related to restraint, and had not found any evidence of the use of prone restraint. LBSSLC had a stated commitment to reduce the use of restraints. In interviews, it was stated that it was a goal of the Facility to become restraint-free. As of 9/7/10, there were 736 staff persons trained in Prevention and Management of Aggressive Behavior (PMAB) Basic and, as of 9/15/10, there were 628 staff persons who have completed the PMAB 4 course. Reportedly, there were approximately 20 Campus Coordinators and Psychologists who monitored the use of restraint. The Director of Behavioral Services had trained these staff members. The LBSSLC policy entitled "Positive Behavior Support: Limitation of Restraint as a Crisis Intervention" was dated 11/25/09. It stated that restraints may only be used if the individual posed an immediate and serious risk of harm to him/herself or others; and after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Although the intent of the policy seemed to be consistent with that of the Settlement Agreement, phrasing regarding the Limitations Governing Restraint in A. 3 and 4, on page 5 of the Policy, was somewhat confusing as written. The restraint checklists for 6/10 through 8/10 documented the use of restraint for eight Individuals. All of the checklists were reviewed for each individual with the exception of Individual #33 and Individual #213, for whom a sample of 50% for each was selected. In total, 41 checklists and debriefing forms were reviewed. In reviewing these forms, it appeared that only approved restraints were used. In addition, descriptions provided indicated that individuals were engaging in aggression towards peers or staff or property destruction for all restraints except for Individual #33. She had only self-injurious behavior checked. Her restraint was approved in the safety plan due to the injuries she had experienced in the past that required nursing care. However, as is discussed in more detail below, it was not always clear that individuals presented an immediate and serious risk of harm when restraint was applied. The following are examples of the circumstances under which restraint occurred: ▪ Individual #33 had the most incidents of restraint due to her self-injurious behavior. All of these incidents occurred in her living unit, primarily in the common area. There was no evidence that her behavior had required restraint in the day program or when she was on a community outing. In the Restraint Reduction Committee meeting, it was noted that she did not like to be around a lot of people. Although Individual #33 lives in a house with more experienced	

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		and attentive staff, it has a total of 17 women living there. ▪ Individual #82 was restrained twice when she became angry after being told that she could not change bedrooms immediately after being bothered by a roommate. Apparently, there was an empty room available where she could have spent the night. This restraint episode and the overall Behavioral Support Plan for this Individual were both discussed at the Restraint Reduction Committee meeting during the monitoring site visit. The Facility Director pointed out that the request was a reasonable one and should have been honored. At the time of the review, it did not appear that Individual #82's team had properly explored other arrangements that could have addressed the environment, which appeared to be exacerbating Individual #82's behavior. In light of such examples, observations made throughout the monitoring visit, and the more in-depth review of individuals' plans described below with regard to Section C.7, there continues to be concern that programming, including the consideration of environmental modifications, was not sufficient to determine that restraint was not used as a substitute for adequate programming. In addition, the environmental factors of poor design, crowding, and the lack of privacy discussed above likely influence behavior and might provoke undesirable reactions from certain individuals. As required by Section C.7.b of the SA, such environmental factors should be considered and addressed as part of the design of individualized plans. Requested documentation was reviewed to examine whether or not staff had implemented appropriate less restrictive measures prior to utilizing restraint. Individuals selected for this sample included Individual #213 and Individual #320, and involved five restraint episodes. The documents reviewed included recent Restraint Checklists, Positive Behavior Support Plans (PBSPs), Safety Plans for Crisis Intervention (SPCI), and Personal Support Plan (PSPs). As is illustrated below, although the PBSPs included replacement behaviors, staff did not consistently attempt to have individuals use such behaviors as part of a "graduated range of less restrictive options," or they did not document that they had. In addition, because staff had not included a thorough chronology of events leading to the restraint on some of the forms, it could not be determined if an appropriate range of less restrictive alternatives had been attempted, or if the individual posed an immediate and serious risk of harm to self or others at the time that restraint was applied. The following summarizes the findings with regard to this review: ▪ Individual #213 had a PBSP that had been recently updated on 8/9/10, to include a new replacement behavior. That is, the previous PBSP, implemented on 4/29/10, utilized use of a calendar as a replacement behavior and this was changed, according to documentation, to include a more functional choice board. In addition, this individual had a SPCI, dated 6/30/10. Given the amount of data	

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		collected and presented on these plans, they appeared to have been in place for some time (at least a year). A review of restraint reports revealed that this individual was involved in a number of restraints during the month of June 2010. According to these restraint reports, dated 6/2/10 and 6/3/10, staff utilized a variety of verbal redirection, verbal prompting of calming techniques (e.g., breathing and counting), and blocking techniques in efforts to avoid restraint. It appeared that verbal redirection and blocking were prescribed within the PBSP, but calming strategies, in this case "breathing techniques" and "counting from 1 to 10" were not. However, self-calming techniques were mentioned in the SPCI and PSP, but were not systematically described in the PBSP. It was unclear why, given the frequent use of these techniques, they would not be more fully described in the PBSP. In addition, it was unclear why alternative replacement behaviors listed in the previous and current PBSP (i.e., use of a calendar or choice board) were not attempted (or described) in any of the recent restraint reports. Lastly, staff inaccurately indicated the use of "replacement behaviors" or "interventions in the PBSP" were utilized when, in fact, the interventions described were not included in the PBSP (i.e., Restraint Report on 6/2/10 at 8:29 a.m., and 6/3/10 at 7:14 a.m.). ▪ Individual #320 had a PBSP, dated 9/10/10, designed to reduce aggressive behavior through the use of a more functional alternative replacement behavior (i.e., appropriate communication). At the time of the review, there did not appear to be a SPCI in effect. A review of restraint reports revealed that this individual was involved in a number of restraints in the months of June and August 2010. According to these documents (dated on 6/4/10, 6/16/10, and 8/26/10), staff utilized a number of techniques in an effort to avoid restraint. These efforts included verbal redirection, physical redirection (moving others to other locations), offering alternative activities/ environments, trading out staff, and protection skills taught through Prevention and Management of Aggressive Behavior (PMAB). The use of these strategies was consistent with strategies outlined in his PBSP. However, it was surprising that staff did not attempt (or, if they did, document) efforts at encouraging him to appropriately communicate with staff. That is, appropriate communication was identified as the functional replacement behavior in his PBSP. Lastly, staff did not adequately describe the events leading to the behavior that resulted in restraint. For example, although events inside the residence were described, the actual events preceding aggression and Self-Injurious Behavior (SIB) in the vehicle (where the restraint took place) were not adequately described (i.e., Restraint Report dated 8/26/10 at 1:11). In addition, staff did not adequately describe the interventions that were attempted to avoid restraint for the episode of restraint that occurred on 8/26/10.	

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C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Following the baseline visit, the restraint checklist used at LBSSLC was revised to specify that an individual should be released immediately when he/she was no longer an immediate and serious risk of harm to self/others. This revision was implemented to ensure that restraint was as brief as possible and that the previous measure for release, namely that the individual was calm, was replaced by the assessment of the risk of harm. In 40 out of the 41 restraint records reviewed (98%), the documentation showed that individuals were released when they "were no longer an immediate and serious risk of harm to self/others." With the exception of Individual #33 who was restrained for seven, eight, and 10 minutes, and a 12-minute restraint for Individual #213, in general, the duration of restraint in the 41 instances reviewed was relatively brief, usually just a few minutes. However, both Individual #33 and Individual #213 had multiple back-to-back restraints in one day. Individual #33 was restrained for a total of 18 minutes, and Individual #213 was restrained for a total of 13 minutes. The code marked for the release of Individual #213 was "7L" which meant calm/released when no longer immediate and serious risk of harm to self or others. The code for Individual #33 was "7," which meant "calm", and then, a minute later, L was recorded and she was released. Although staff had been trained on the revised checklist, it did not appear in this instance that the appropriate standard for release is being observed consistently. A finding of compliance is being made. Given the importance of this requirement, the Facility is reminded that careful monitoring of restraint and restraint documentation needs to continue to occur to ensure that staff fully understand and implement the appropriate standards for release from restraint.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall	The DADS Policy: "Use of Restraint," dated 8/31/09, and the LBSSLC Policy: "Positive Behavior Support: Limitation of Restraint as a Crisis Intervention," dated 11/25/09, governed the use of restraints at LBSSLC. The DADS policy complied with the requirements of C3. The LBSSLC policy emphasized that restraint was not therapeutic, was potentially traumatizing, and should be avoided unless absolutely necessary. According to the LBSSLC policy, staff training was required, and a Restraint Monitor must be on duty at all times. The restraint checklists reviewed for this report documented the presence of the Restraint Monitor. In fact, the Restraint Monitor ended at least two instances of restraint because staff could not maintain the approved hold. At the time of the review, there reportedly were 20 Restraint Monitors at LBSSLC. Staff training was required for all staff responsible for applying restraint techniques. Training documentation was provided for the 736 staff who have completed the PMAB Basic course, and for the 628 staff who had completed the PMAB 4 course. According to the Director of Behavioral Services, all relevant staff persons have not yet completed the	Noncompliance

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	have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	requisite training. The percentage of staff trained was reported to be over 90%. The Facility recognized that given the risks associated with restraint, ensuring all staff were trained was a key component of compliance. The restraint checklists reviewed during this monitoring visit documented that a Restraint Monitor was present within 15 minutes at each of the restraint episodes. In fact, the Restraint Monitor ended the use of a restraint hold for Individual #320 because the position was incorrect.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	As indicated on the restraint checklist, any restraint, other than a medical restraint, must be utilized only for crisis intervention. There were 10 of the 41 restraint checklists (24%) in which the type of restraint was not marked. The type of restraint included: crisis intervention restraint specified in a Safety Plan; crisis intervention restraint not specified in a Safety Plan; crisis intervention chemical restraint; medical restraint; or dental restraint. LBSSLC had issued a Do Not Restrain with a Crisis Intervention Physical Restraint List to safeguard the health and wellbeing of individuals with emotional trauma, psychiatric illness, and/or medical concerns such as osteoporosis that contraindicated the use of restraint. There were 153 individuals on this list, representing 67% of the census of 229 individuals. As is discussed in greater detail below with regard to Section J.4 and Q.2, desensitization plans and other strategies to minimize the need for restraint for medical or dental procedures were not being consistently implemented, monitored, and/or modified. At the time of the review, it was reported that the Psychology Department was going to be taking more of a lead role in the development, revision, and monitoring of these plans. In the past, this had been the responsibility of the Qualified Mental Retardation Professionals (QMRPs).	Noncompliance
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint.	As referenced above, the Restraint Monitor was present within 15 minutes for each of the 41 restraints reviewed for this report (100%). A review of 39 episodes of physical restraints for seven individuals found that in 31 episodes (79%) the vital signs were documented within 30 minutes of the initiation of the restraint. For example: ▪ On 6/10/10, Individual #213 was released from restraint at 8:32 a.m. The nurse documented his physical and mental status at 9:40 a.m. ▪ On 6/2/10, Individual #213 was released from restraint at 8:21 a.m., and the nurse recorded his blood pressure and mental status at 10:30 a.m.	Noncompliance

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	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.	There were three episodes where the mental status section and/or respirations were marked as "refused" by the nurse, nine episodes where the nurse documented the mental status as "normal for the individual" which is not descriptive and not appropriate documentation, and three episodes where the documentation for the mental status was noted as "no change." A total of 24 of the 39 records (62%) contained appropriate documentation with regard to mental status and/or respirations. None of the reviewed restraints took place outside of the Facility.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In	The restraint checklists followed the format in Appendix A of the SA. From a nursing perspective, a review of 39 episodes of restraint for seven individuals showed documentation indicating that in 34 episodes (87%) the individual was checked for injury following the restraint episode. There were three restraint-related injuries noted: Individual #213 had an abrasion; Individual #288 received a scratch and abrasion; Individual #298 experienced two small skin tears, multiple scratches and the reopening of a lesion on the bridge of her nose. It was not clear whether or not a physician was notified for the first two incidents. However, nursing presence appeared to have been sufficient. A doctor was notified for Individual #298. None of the restrained individuals were offered food, fluids, exercise or the opportunity to use the toilet. Although the majority of restraint episodes were brief, there were instances where the restraint lasted from eight to 13 minutes. In these episodes, the offer of fluids or the use of the bathroom might have been important to the comfort of the restrained individual.	Noncompliance

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	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.	Thirty-seven of the 41 checklists (90%) indicated that one-to-one supervision was provided. Three of the restraint checklists omitted this information. One form indicated enhanced supervision. It is essential that one-to-one supervision be provided to individuals in restraint to ensure their safety.	
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:	According to the LBSSLC Restraint Report (1/1/10 to 7/31/10), approximately six individuals had more than three restraints in a 30-day period from January 1, 2010 to July 31, 2010. Of this group, three individuals were selected for review (i.e., reflecting a sample of 50 percent), and included Individual #213, Individual #82, and Individual #320. The PSP, PSP Addendums, psychological assessment, Structural and Functional Behavioral Assessment, Positive Behavior Support Plan, Safety Plan for Crisis Intervention, and PSP monthly reviews (for the last six months), and Safety Plan Progress Notes (last three months), as available, were reviewed for each individual sampled. The following is a summary of restraint data for each individual selected: ▪ Individual #213 had more than three restraints in a rolling 30-day period during the months of March, April, May, June, and July 2010. Review of restraint data suggested that horizontal restraint was predominately the method utilized, and restraint was utilized in response to aggression toward peers or staff, and typically occurred in the residence. ▪ Individual #82 had more than three restraints in a rolling 30-day period within the months of April and May 2010. Review of data indicated that horizontal restraints were typically utilized in response to her aggression toward peers at home and at work (campus workshop). ▪ Individual #320 had more than three restraints in a rolling 30-day period during the month of June 2010. Review of restraint data suggested horizontal restraints were typically utilized in response to aggression to peers or staff at home (living room).	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	In general, available documentation was reviewed to assess the completion of required psychological assessments as well as to assess the completion of PSP Addendum meetings held in response to more than three restraints in a 30-day period. As is described below, for only one of the three individuals in the sample (33%), did it appear that the teams consistently conducted an adequate review of the individuals' adaptive skills, and biological, medical, and psychosocial factors: ▪ According to available documentation, Individual #213 had a current psychological assessment, dated 5/24/10, and SFAR, dated 7/6/10. Available documentation indicated that, in addition to the PSP meeting on 6/10/10, the PST met several other times to discuss his aggressive behavior. According to meeting minutes, discussion at the PSP included information from ongoing	Noncompliance

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		psychiatric consultation, as well as summary of behavioral interventions and restraint utilizations. In addition to the PSP, the PST met approximately seven times, to discuss ongoing behavioral issues. On 7/6/10, a team meeting documented comprehensive discussion regarding restraints in June and July 2010. At that time, the team reviewed each restraint and associated psychiatric, psychosocial, and behavioral risk factors; however, it was unclear if adaptive skills or medical factors were discussed. Available documentation did not reflect the same level of comprehensive review, at Personal Support Plan Addendum meetings or following other instances where more than three restraints occurred in a 30-day period in the months of March, April, or May. It should be noted that it was not clear if the Facility provided all PSP addendums, including those associated with the previous PSP. ▪ According to available documentation, Individual #82 had a current psychological assessment, dated 3/1/10 (it should be noted that documentation from the recent PSP on 8/12/10 was not provided for this review), and a SFAR, dated 8/25/10. Based on available documentation, it appeared that, in addition to the PSP meeting on 3/31/10, the PST met approximately three times to discuss issues related to increased risk due to challenging behaviors, related restraints, and issues surrounding polypharmacy. This documentation, especially for meetings immediately following the increase in restraint usage (on 5/19/10 and 5/21/10), however, did not provide enough detail to allow determination of the content or the level of analysis or discussion that took place. Summary information of restraint usage on the Safety Plan Progress Note (August 2010), however, reviewed potential environmental variables associated with a more recent aggressive outburst. ▪ According to available documentation, Individual #320 had a current psychological assessment, dated 7/30/10, and a SFAR, dated 8/17/10. Based on available documentation, it appeared that, in addition to the PSP meeting on 8/13/09, the PST met approximately nine times to discuss issues related to his (or others') behavior, including aggression and unauthorized departures, and resulting changes to risk status and level of support. On 6/15/10, a comprehensive PST meeting was held specifically in response to the increase in restraints. According to meeting minutes, PST members examined the recent restraints and discussed potential risk factors, including biological and medical factors, environmental variables, immediate antecedents, and consequences of his aggressive behavior. The PST recommended the development of a SPCI due to increase in restraint usage. It was unclear whether or not this safety plan was ever developed and implemented. There appeared to be a format (e.g., PSP Addendum, dated 7/6/10, for Individual #213 and PSP Addendum, dated 6/15/10, for Individual #320) for PSP Addendum meetings	

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		that are held following more than three restraints in a 30-day period. The Facility should add one or more section(s) to the form that prompts the PST to discuss the role of adaptive skills, biological, medical, and psychosocial factors. In addition, each section should be summarized as available samples indicated significant amounts of descriptive data were not sufficiently summarized.	
	(b) review possibly contributing environmental conditions;	For one of the three individuals in the sample (33%), documentation was available to confirm that possibly contributing environmental conditions were reviewed consistently by the teams when more than three restraints occurred in a 30-day rolling period. More specifically: ▪ According to available documentation, Individual #213 had a current psychological assessment, dated 5/24/10, and SFAR, dated 7/6/10. These assessments considered the potential influence of environmental factors in contributing to behavioral issues. As previously described above with regard to Section C.7.a of the SA, available documentation indicated that the PST held multiple meetings in the months of June and July and reviewed restraints and potential contributing factors of aggression. However, such review was not documented for other months in which Individual #213 had experienced more than three restraints in a 30-day rolling period, specifically March, April, or May. ▪ According to available documentation, Individual #82 has a current psychological assessment, dated 3/1/10, and SFAR, dated 8/25/10. These assessments considered the potential influence of environmental factors in contributing to behavioral issues. As previously described above with regard to Section C.7.a of the SA, available documentation indicated that the PST held several meetings in May due to increased risk and change of health status. However, due to the inadequacy of available meeting minutes, it was unclear if the PST reviewed potential environmental conditions as contributing to the aggression and subsequent restraint. ▪ According to available documentation, Individual #320 had a current psychological assessment, dated 7/30/10, and SFAR, dated 8/17/10. These assessments considered the potential influence of environmental factors in contributing to behavioral issues. As previously described above with regard to Section C.7.a of the SA, available documentation indicated that the PST held multiple meetings from April through July in response to negative interactions with peers (he was the victim of aggression), as well as behavioral incidents, including aggression and unauthorized departures, at home and in the community. According to meeting minutes, PST members examined the recent restraints and reviewed potential environmental conditions as contributing to the displayed aggression and subsequent restraint.	Noncompliance
	(c) review or perform structural	For one of the three individuals in the sample (33%), documentation was available to	Noncompliance

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	assessments of the behavior provoking restraints;	confirm that the teams consistently reviewed or performed structural assessments of the behavior provoking the restraint when more than three restraints occurred in a 30-day rolling period. More specifically: ▪ According to available documentation, Individual #213 had a current psychological assessment, dated 5/24/10, and SFAR, dated 7/6/10. These documents, especially the SFAR, typically examined variables or contingencies that might influence the likelihood of aggressive behavior. As previously described above with regard to Section C.7.a of the SA, available documentation indicated that the PST held multiple meetings in the months of June and July and reviewed restraints and potential contributing factors to aggression. However, Individual #213 had had three or more restraints in 30-rolling days in March, April and May for which such documentation was not provided. ▪ According to available documentation, Individual #82 had a current psychological assessment, dated 3/1/10, and SFAR, dated 8/25/10. These documents, especially the SFAR, typically examined variables or contingencies that might influence the likelihood of aggressive behavior. As previously described with regard to Section C.7.a of the SA, available documentation indicated that the PST held several meetings in May due to increased risk and change of health status. However, due to the inadequacy of available meeting minutes, it was unclear if the PST reviewed structural assessments of the aggressive episodes leading to restraint. ▪ According to available documentation, Individual #320 had a current psychological assessment, dated 7/30/10, and SFAR, dated 8/17/10. These assessments typically examined variable or contingencies that might influence the likelihood of aggressive behavior. As previously described with regard to Section C.7.a of the SA, available documentation indicated that the PST held multiple meetings from April through July, and reviewed restraints and potential contributing factors to aggression leading to restraint.	
	(d) review or perform functional assessments of the behavior provoking restraints;	For one of the three individuals in the sample (33%), documentation was available to confirm that teams reviewed or performed functional assessments of the behavior provoking restraints when more than three restraints occurred in a 30-day rolling period. More specifically: ▪ According to available documentation, Individual #213 had a current psychological assessment, dated 5/24/10, and SFAR, dated 7/6/10. These documents, especially the SFAR, typically examined variables or contingencies that might influence the likelihood of aggressive behavior. As previously described with regard to Section C.7.a of the SA, available documentation indicated that the PST held multiple meetings in the months of June and July and reviewed restraints and potential contributing factors to aggression. However, Individual #213 had had three or more restraints in 30-rolling days in March,	Noncompliance

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		April and May for which such documentation was not provided. ▪ According to available documentation, Individual #82 had a current psychological assessment, dated 3/1/10, and SFAR, dated 8/25/10. These documents, especially the SFAR, typically examined variables or contingencies that might influence the likelihood of aggressive behavior. As previously described with regard to Section C.7.a of the SA, available documentation indicated that the PST held several meetings in May due to increased risk and change in status. However, due to the inadequacy of available meeting minutes, it was unclear if the PST reviewed potential functions underlying the aggression. ▪ According to available documentation, Individual #320 had a current psychological assessment, dated 7/30/10, and SFAR, dated 8/17/10. These assessments typically examined variable or contingencies that might influence the likelihood of aggressive behavior. As previously described with regard to Section C.7.a of the SA, available documentation indicated that the PST held multiple meetings from April through July, and reviewed restraints and potential contributing factors to aggression leading to restraint.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	All three of the individuals reviewed (100%) had PBSPs that identified the target behavior, as well as replacement behaviors. Two out of three of the individuals reviewed (67%) had Safety Plans for Crisis Intervention (SPCIs) that clearly defined the type of restraint authorized, the maximum duration, and the release criteria. More specifically: ▪ According to available documentation, Individual #213 had a current PBSP, dated 8/9/10, and SPCI, dated 6/30/10. The current PBSP and SPCI both included interventions targeting aggression toward staff and peers. A replacement behavior also was identified. The SPCI identified the specific restraint authorized, the maximum duration, and the release criteria. ▪ According to available documentation, Individual #82 had a current PBSP, dated 8/11/10, and SPCI, dated 12/17/09. Both plans prescribed strategies to ameliorate the targeted aggression, as well as outlined strategies aimed at promoting replacement behaviors. The current SPCI clearly indicated the type of restraint authorized, the maximum duration, and the release criteria. ▪ According to available documentation, Individual #320 had a current PBSP, dated 9/10/10, targeting aggression, unauthorized departures, and property destruction. A replacement behavior (functional communication) was also identified. Although a SPCI was recommended, it was unclear whether or not a SPCI was developed. Consequently, it was unknown if a current SPCI, if it existed, clearly indicated the type of restraint authorized, the maximum duration, and the release criteria. Based on the sample, one out of three individuals (33%) did not have an SPCI that defined the type of restraint authorized, the restraint's maximum duration, the	Noncompliance

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		designated approved restraint situation, and the criteria for terminating the use of the restraint as required by the Settlement Agreement.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	In general, there was no evidence that treatment integrity of the PBSP or SPCI was systematically measured for any of the selected individuals. ▪ According to Integrated Progress Notes for Individual #213, data on aggression and restraint had been in place since at least May 2007 (only raw data from 2009 was presented, however). Although data was consistently collected on aggression and restraint, it appeared that monthly data on replacement behaviors was not available from March to August 2010. This missing data suggested that staff were not collecting data on replacement behaviors. Consequently, it was unknown if staff were teaching and encouraging the use of these replacements at this time. ▪ Similar issues with missing replacement behavior data were noted in Integrated Progress Note from March to August for Individual #82. Available documentation reflected the collection and summary of replacement behavior in the past (May to June 2009). Consequently, it was unclear why after returning from a failed community placement, data was not taken on replacement behavior(s).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	In general, it was difficult to determine if PBSPs were revised due to increases in target behaviors, due to the use of restraint, and/or because annual revision of the PBSP coincided with the PSP meeting. ▪ The PSP for Individual #213 was held in June 2010 and, as expected, the psychological assessment was updated in preparation for the PSP. The SFAR was completed in July and the PBSP was implemented in August. It did not appear that the PBSP was revised in relation to the level of restraints observed between March and July 2010. ▪ The PSP for Individual #82 was held in March 2010, and the psychological assessment, dated 3/1/10, was completed in preparation for that meeting. There was no evidence that the PBSP that was implemented on 8/11/10 was revised due to increases in restraint. However, rationale on the PBSP indicated that on 5/26/10, it was revised due to the diagnosis and treatment of depression. Available Integrated Progress Notes and Safety Plan Progress Notes described and summarized data on monthly aggression and use of restraints. However, data on replacement behaviors was not recorded. In addition, although certain hypotheses (e.g., wanted a new room, staying in bed due to work refusals) were detailed in these documents, there was no indication that changes to behavioral programming was being considered, implemented, or were (or were not) necessary. ▪ The PSP for Individual #320 was held in August (document was not available for	Noncompliance

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		review) and the current psychological assessment, dated 7/30/10, was completed in preparation for that meeting. There was no evidence that the PBSP, implemented on 9/10/10, was revised due to increases in restraint. As presented earlier with regard to Section C.7.a of the SA, on 6/15/10, a comprehensive PST meeting was held in response to his increased use of restraints in June 2010. At this meeting, the PST recommended the development of a SPCI. However, available documentation did not include evidence that a SPCI was subsequently developed or implemented. More specifically, a SPCI was not included in documentation provided as requested following the recent compliance visit, and this individual was not listed on summary grids (revised as of 9/13/10) of individuals with safety plans. It is very difficult to determine how long a PBSP or SPCI has been in place given the information provided on these documents. In addition, it is not always obvious if a psychological assessment or SFAR was completed for a reason other than the typical annual update. Providing dates when the plan(s) was initially implemented, subsequently revised or updated, and the rationale for any revisions or updates, would facilitate a more comprehensive understanding of the nature of behavioral assessment and programming.	
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.	It was expected practice at LBSSLC that each use of restraint would be reviewed at the Unit Meeting and at the Incident Management Review Team meeting. Both of these meetings were held each weekday morning. During the monitoring visit, it was evident that these meetings were valuable, participants were well informed, and there were thoughtful discussions about proactive strategies to reduce the use of restraint. For example, the participants appeared very familiar personally with the individuals discussed at the meeting, and there were examples provided of an individual's interests and preferences in analyzing how restraints or behavioral crises could be avoided. The knowledge about an individual was not limited just to the Unit staff assigned responsibility for that person. The restraint checklists indicated the date of the Unit meeting. With one exception, this information was included on each checklist reviewed. The review by the Incident Management Meeting and by the Director or her designee was reflected on the Debriefing form. Debriefing forms were provided for every restraint. However, two Debriefing forms lacked the documentation certifying that the restraints had been reviewed in the Incident Management Meeting. It should be noted, however, that the Director of Behavioral Services reviewed most of the Debriefing forms, and included clarifying or instructive comments on several of them.	Noncompliance

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		As noted above with regard to Section C.7 of the SA, it was not always clear that modifications had been made to individuals PBSPs or PSPs as a result of reviews of restraint episodes.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility's efforts to reduce the use of restraint should continue. This should continuously include a review of the impact of environmental factors (such as the lack of privacy, the number of individuals in each living unit, and the characteristics of individuals living together), as well as medical, functional, biological, and psychosocial factors to ensure that any factors possibly precipitating the use of restraint are minimized and eventually eliminated.
2. The Quarterly Restraint Summaries are comprehensive and provide useful detail about the use of restraint with certain individuals. This data should continue to be used to determine the need for clinical case conferences with outside consultants or at the Restraint Reduction meetings.
3. In an effort to ensure and monitor that alternative interventions are sufficiently utilized or attempted prior to employing restraint, review of each restraint should include a determination of whether: 1) the actual replacement behavior described in the PBSP was utilized; and 2) staff who implemented the restraint received training on the PBSP and SPCI. In addition, restraint monitors and/or psychologists who sign off on restraint reports should ensure that the interventions used to avoid restraint are included within PBSP and/or SPCI, and are those on which staff have been specifically trained.
4. The Facility should add one or more section(s) to the format for the PSP Addendum meetings that are held following more than three restraints in a 30-day period that prompts the PST to discuss the role of adaptive skills, biological, medical, and psychosocial factors. In addition, each section should be summarized as available samples indicated significant amounts of descriptive data were not sufficiently summarized.
5. PBSPs and SPCIs should include dates when the plan(s) was initially implemented, subsequently revised or updated, and the rationale for any revisions or updates, because this would facilitate a more comprehensive understanding of the nature of behavioral assessment and programming.
6. The PSP policy should be revised to include a requirement for the completion of a comprehensive review following the observation of more than three restraints in a 30-day period. PST members should be provided further training in scheduling this meeting, ensuring sufficient attendance and participation, summarizing the PST discussion and findings, and coordinating the successful completion of related recommendations.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation slides from 6/3/10 conference call with DADS and the Department of Family and Protective Services (DFPS) regarding Adult Protective Services (APS) compliance with the Settlement Agreement; o Interagency Memorandum of Understanding Regarding Investigations of Abuse and Neglect in State Supported Living Centers, dated 5/28/10; o Senate Bill No. 643; o Human Rights Committee Minutes for March through August 2010; o DADS Policy Number 021: Protection from Harm: Abuse, Neglect and Exploitation, dated 6/18/10; o DADS Policy No. 042.1: Video Surveillance, dated 4/2/10; o DADS Policy Number 004: Procedures for Personal Support Plan Process, Personal Support Plan Instructions, Personal Focus Assessment, and Permanency Planning, dated 7/10; o DADS Draft Policy Number 00.1: Death of an Individual, dated 8/24/10; o DADS Policy Number 002.2: Incident Management (including the procedure for Client Injury Reporting), dated 6/18/10; o DADS Draft Policy Number 006: At Risk Individuals, undated; o LBSSLC Policies: Incident Management of Abuse, Neglect or Exploitation, dated 7/30/10; Safety Committee, dated 2/2/10; Critical Incident Team, dated 7/15/10; Managing Unusual Incidents, dated 7/15/10; Electronic Documentation of Injuries in the Clinician Work Station, dated 7/14/10; Hot Water Temperatures, dated 7/1/10; Emergency Medical Response, dated 4/29/10; Emergency Medical Equipment, dated 6/29/10; Training Requirements and Procedures, dated 2/11/10; and Administrator on Duty, dated 8/1/10; o Report of Unusual Incidents: Individuals Involved, from 1/1/10 to 7/31/10; o Minutes from the DFPS Quarterly Meeting, dated 5/26/10; o Minutes from the Incident Management Review Team Meetings, from 5/10 through 6/10; o Report of DFPS Allegations-Employees Involved: 1/1/10 to 7/31/10; o Rights Poster; o CRS Crystal Reports: Client Injury Daily Summary, dated 8/17/10; o Allegations of Abuse/Neglect/Exploitation Trend Report for 6/1/10 to 8/31/10; and o Available documents regarding the deaths of Individual #208, Individual #246 and Individual #229; o A sample of 33 DFPS Investigation Reports for 23 Individuals, including the Unusual Incident Report itself; o A sample of four investigation reports completed by the Facility after referral from DFPS.

	▪ **Interviews with**: o Libby Allen, Facility Director; o Bob Robbins, Program Compliance Monitor, and former Director of Incident and Risk Management; o Juli Brown, Investigator; o Mindy Voight, Risk Manager; o Jim Forbes, M.ED., C.B.A., Director of Behavioral Services; o Donna Jessee, DADS, Director of Operations for State Supported Living Centers; and o Informal interviews/conversations with staff, Foster Grandparents and individuals; ▪ **Observations of:** o Incident Management Review Team Meetings, on 9/13 through 9/16/10; o Restraint Reduction Meeting, on 9/16/10; o Human Rights Committee Meeting, on 9/16/10; o Performance Improvement Committee Meeting, on 9/14/10; and o Site visits to all living units, the workshop, and day program areas in the Lily and Pines Buildings. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees as well as some of the individuals.
	Facility Self-Assessment: The Facility stated in its Plan of Improvement (POI) that it was in substantial compliance with key requirements of Section D. Specifically, the POI indicated that the Facility had issued the requisite policies and had stated that it had no tolerance for abuse and neglect; it had trained staff to report abuse and neglect in the new employee orientation and employees signed a statement confirming the obligation to report. Facility investigators were not in the direct line of supervision of alleged perpetrators (APs), had been trained in the investigative process, and there was coordination with law enforcement. The monitoring visit conducted from 10/4/10 to 10/8/10 confirmed that the appropriate policies had been issued; that staff were trained to report abuse and neglect; that staff signed a statement to that effect; that the Facility investigators were not in the direct line of supervision of the APs whom they were investigating; and that there was coordination with law enforcement.
	Summary of Monitor's Assessment: The LBSSLC policy was unequivocal: there was zero tolerance of abuse and neglect. Implementation of the policy and its underlying principles was evident in the serious attention given to allegations; the immediate reassignment of alleged perpetrators; the disciplinary action taken when abuse and/or neglect was confirmed, including legal action taken against perpetrators; and the ongoing efforts to strengthen the investigation process and learn from its findings. The Facility Director had strengthened the review of investigations by implementing a protocol that required the consideration of systemic issues at the onset of the investigation and upon receipt of the five-day preliminary report; administrative review of the preliminary findings and the formulation of recommendations to address emerging concerns; examination of the investigation report by the Quality Enhancement staff; and final review and sign off of the final investigation report by the Assistant Ombudsman.

	The Interagency Memorandum of Understanding (MOU) Regarding the Investigation of Abuse and Neglect in State Supported Living Centers clearly delineated the role of the Department of Family Protective Services. This was an instructive document because it clarified agency responsibilities, including responsibility for the notification of law enforcement, and specified timeframes for the investigation process. This MOU was reflective of commitments made under the Settlement Agreement. A second investigator had been hired. Although the position for the Director of Incident and Risk Management position was vacant, recruitment was ongoing. The qualifications for this position had been upgraded, and a college degree was now required. The respective roles of the Human Rights Officer and the Assistant Ombudsman required clarification. However, their presence provided additional safeguards for protecting individuals from harm. Although few had called the intake line, when interviewed, all staff stated that they had a responsibility to report abuse and neglect. There was evidence that staff had signed a statement confirming their responsibility to report any mistreatment of the individuals residing at LBSSLC. A number of concerns were noted about the investigation reports completed by both DFPS and the Facility. These concerns included timeliness and the completeness of the final report. A number of significant concerns related to the ability to protect individuals from harm were noted in the baseline report for LBSSLC. Since that time, a new Director had been hired, and a number of initiatives had been put in place to address many of these concerns. Overall, LBSSLC had made a good faith effort to develop safeguards that will protect the individuals and staff from harm. The following summarizes some of the concerns identified in the baseline report, and the actions taken to address them: ▪ During the baseline review, concerns were noted with regard to inappropriate groupings of individuals with very different, often unique, needs for support, for example, there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. The relocation of men who lived in 515 S. Cedar had increasingly positive outcomes. It is recommended that all other living units be reviewed with regard to the number of individuals, the grouping of individuals, and the provision of individualized supports for active treatment. Such actions will be critical to reducing risk in this environment and to promoting the growth and development of the individuals who live at LBSSLC. ▪ During the baseline review, extremely serious staffing concerns were identified, including the assignment of newly hired, inexperienced staff to work with individuals with complex and challenging needs for support. There had been a concerted effort to recruit and retain qualified staff with positive attitudes and high energy. ▪ Another concern noted in the previous review was a reliance on overtime, and, as reported by

	staff, not entirely voluntary overtime, resulting in reliance on tired staff to implement critical responsibilities. The problems with payment for overtime were resolved in August 2010. Staff were given the option of being paid time and a half, or taking compensatory time. With the hiring of additional staff, as well as additional procedures implemented with regard to overtime, the use of mandatory overtime was decreasing. As a result, staff morale appeared to be significantly improved. ▪ The annualized turnover rate of direct support professionals continued to be approximately 60%. The turnover rate was attributed, in part, to the employment of university students. The Facility recognized that continued work in this area was needed to ensure a stable workforce of well-trained staff. Such stabilization is also necessary to ensure that the policy directives regarding zero tolerance for abuse and neglect are engrained in the culture of this Facility. ▪ Inadequate independent safeguards also were noted as a problem in the Monitoring Team's initial review. Immediately following the baseline review, a State Office staff person was appointed as the Acting Director of LBSSLC until a new Director was identified and assumed the position. Overall, it appeared that the current State Office administration had begun to increase its presence and oversight of the SSLCs through the issuance of revised policies to which the SSLCs are required to adhere, coordination by discipline-specific coordinators at the State Office level, and data collection. The State Office also articulated plans to increase its monitoring activities. During the LBSSLC review, there was discussion about the newly required quality improvement councils. These entities will be leadership groups at each Facility charged with the responsibility to oversee quality improvement activities in a more holistic manner. This will be an important step in ensuring that there are adequate processes in place to expand best practice, as well as identify areas needing improvement and ensure action is taken that results in positive outcomes for the individuals that LBSSLC supports.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	LBSSLC had promulgated policies that established procedures for the identification, reporting, analysis, and prevention of Unusual Incidents, including abuse, neglect, and exploitation. The LBSSLC Policy entitled Incident Management, Managing Unusual Incidents was issued on 7/15/10. It stated that LBSSLC must assure consistent and effective implementation of this policy by "demonstrating a zero tolerance for harm or threat of harm to individuals." The Policy entitled Incident Management, Abuse, Neglect or Exploitation, dated 7/30/10, reaffirmed that commitment and the obligation to report allegations of abuse or neglect. The obligation to report was stressed at new employee orientation, and was confirmed by a signed statement acknowledging the employee's duty to report. This statement must be signed annually. Competency-based training on incident reporting procedures	Substantial Compliance

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		was required annually as well. Posters reminding employees and visitors to report abuse and neglect were posted throughout the Facility.	
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.	Based on a review of Facility policy, upon discovering or witnessing a serious incident, staff persons were required to take immediate and appropriate action to protect the rights and safety of individuals involved. Immediately, within one hour of the discovery or observance of the incident, staff were to report the incident to the Director or designee. Incidents or suspicions of abuse, neglect, and exploitation were to be reported by calling the toll-free telephone number staffed by the Department of Family and Protective Services (DFPS), Adult Protective Services (APS). The APS intake worker had the responsibility of notifying the Facility Director or her designee. The Facility Investigators or, in the evenings and on weekends, the Campus Coordinator were assigned the responsibility to assist with ensuring the safety of the individual, taking preliminary steps to ascertain the facts, and to secure any evidence. APS has the responsibility of notifying law enforcement. In order to determine whether allegations or serious injuries were reported within one hour of discovery to either DFPS or the Facility Director or her designee, 17 (27%) of the 62 investigations provided were examined for reporting time. The following summarizes the results of this review: ▪ There was timely reporting in seven cases (42%). The investigation reports documented that a bruise, serious injury or alleged neglect were discovered and reported within one hour. In one incident, the Unit Director assisted Individual #239 with reporting the allegation of emotional abuse as soon as it was described to him. ▪ There were eight instances of late reporting (47%). In two of these cases, there was self-reporting by the affected individuals. Two of the alleged incidents occurred in the morning, but the individuals did not report the complaints until the evening. In one of these two incidents, the Night Residential Coordinator	Noncompliance

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		received disciplinary action for failure to report an allegation promptly. In regards to the remaining six incidents that were not reported within an hour, two of these incidents were reported five to seven minutes late. In the other four incidents, delays ranged from 34 minutes to 98 minutes. ▪ In two incidents (12%), the time of discovery was not documented. Therefore, the timeliness of reporting could not be determined. Standardized reporting forms had been developed and were used at LBSSLC. These were the forms required at each of the SSLCs.	
	(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.	Upon review, there was documentation to confirm that alleged perpetrators were reassigned without delay. In each of the 32 cases reviewed, if the alleged perpetrator was known, reassignment to work without contact with the individuals residing at LBSSLC was promptly ordered by the Director or her designee. For the most serious allegations, alleged perpetrators were directed to remain at home until further notice. In the review of investigation reports, there were examples of other measures taken to protect the individuals from further harm including: increased levels of supervision and the provision of in-service training to staff. These interventions were planned and implemented under the guidance of the Personal Support Team (PST). In the Incident Management Meetings, these types of measures also were discussed, and there was evidence in the individual's record that the proposed recommendations were implemented. However, with the exception of the relocation from 515 S. Cedar, there was no evidence of consideration given to re-organizing the living units or reducing the number of individuals residing in each house.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	Annual training on the reporting of abuse, neglect, exploitation, and other unusual incidents was mandatory. Training was documented in a database that listed the employee's name, position, date of the training, the course title, and the duration of the instructional session. A random sample of 14 employees was selected to determine whether the required training was provided on an annual basis. A review of each training record documented that all of these employees were retrained in recognizing and reporting potential signs of abuse, neglect, and exploitation during 2009 or 2010. Additionally, the Facility provided documentation of training in Presentation Book D. The sign-in sheets acknowledged that, with the exception of employees on leave, training had been provided to LBSSLC employees in 7/10 or 8/10.	Substantial Compliance
	(d) Notification of all staff when commencing employment and	During unannounced visits to each living unit and day program area, staff were asked whether they understood the obligation to report abuse, neglect, or exploitation. Each	Substantial Compliance

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	at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	staff person affirmed that they had been instructed about this reporting obligation and had signed a statement at the time of employment and annually thereafter. Copies of the signed statements were requested for 25 randomly selected employees. The statements were submitted as requested and documented that staff had reaffirmed, on an annual basis, their reporting obligation. In addition, copies of the signed statements were requested for all employees hired since April 2010. Statements signed at LBSSLC were provided for 210 of the 211 employees hired during that timeframe. One employee's statement could not be located at LBSSLC, but a copy of the statement signed when he worked at the state level was included in his file. Upon discovering this omission, the employee was asked to complete the LBSSLC statement as quickly as possible.	
	(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 review of Personal Support Plans for Individual #33, Individual #73, Individual #232, and Individual #239 documented that the parents, primary correspondent, or guardian of these individuals had been provided instructional materials regarding the identification and reporting of unusual incidents, including abuse, neglect, and exploitation. The Personal Support Plan for Individual #61, recently admitted to the Facility, documented that he was provided a copy of a booklet explaining his rights and the reporting of any allegations of abuse, neglect and exploitation. A discussion of individual rights was included in the annual review of the Personal Support Plan. On April 22, 2010, a letter was sent to each guardian and LAR explaining how to identify and report unusual incidents, including abuse, neglect, and exploitation. The Program Compliance Monitor who was directly involved in the mailing of the letter provided the Monitoring Team with a copy of the letter.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	Each living unit and day program site was visited unannounced to determine whether a rights poster was present, accessible, and used for teaching individuals about their rights. A poster was present in each area with the exception of the workshop. The absence of a rights poster was pointed out to the workshop supervisor, and by the next day, two rights posters were placed in visible locations (above the water cooler and on the back of the front door.) The rights poster in 514 S. Cedar Avenue was placed prominently and circled by a colorful purple ring. Thus framed, the poster attracted attention immediately. The QMRP was very animated in describing how the rights poster was used. In 524 N. Cedar Avenue, there were several posters present, but one was placed too high to be seen by an individual in a wheelchair. Staff promptly corrected the placement of the poster. In 528 N. Cedar Avenue, space being used temporarily while renovations were underway, two direct support staff could not locate the rights poster,	Substantial Compliance

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		but the supervisor was able to do so. This poster was placed in a hallway infrequently visited by the individuals living in the residence. Most importantly, each staff person queried during the visits to the living units and day program areas could describe the use of the rights poster as an instructional tool. Several very positive examples were provided as to the use of the rights poster to explain the exercise of rights or the reasons for their restriction. LBSSLC had expanded the discussion of individuals' rights through the development and support of a self-advocacy group. One of the Monitoring Team members had the opportunity to attend the self-advocacy group meeting that was held during the week of the on-site visit. The Human Rights Officer was the group's advisor, and she had taken time to visit individuals at their homes and day/vocational programs both to encourage them to attend the meeting, but also to query them about questions they had about their rights. Part of the agenda was addressing some of the rights questions individuals had raised. For example, some of the individuals had questions about the new cameras that had been installed on campus, and how this affected their right to privacy. The Human Rights Officer used this as an opportunity to provide training on how to protect one's privacy, such as by wearing bathrobes when in common areas. The group also discussed a right of the month, which was money management. This was a very promising initiative, and it was recommended that more individuals be encouraged to participate in the self-advocacy group, and that these self-advocates be provided opportunities to develop their leadership and advocacy skills. For example, some of the individuals in the group had offered ideas about changes they would like to see on campus, such as a television in the break room at the workshop, or ice cream being brought back as an option in the Canteen. While it is positive that the staff advisor was willing to advocate for these changes, it also would be valuable for the individuals to advocate for themselves by bringing these requests to management for consideration with assistance as needed. Participation in state and national self-advocacy conferences also would be invaluable for this purpose. The establishment of the Ombudsman position at the State level and at each SSLC was further evidence that there was a commitment to educating individuals about their rights and helping them to exercise them on a daily basis. It was positive that a Human Rights Officer continued to play a role on campus as well.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The Memorandum of Understanding regarding Investigations of Abuse and Neglect in State Supported Living Centers, dated 5/28/10, mandated that for all allegations reported that the Department of Family and Protective Services (DFPS) notify, within one hour, the local law enforcement agency, if there was cause to believe that criminal activity occurred. The Office of the Inspector General (OIG) must be notified, within one hour, of any allegation of abuse, neglect, or exploitation that may constitute criminal	Substantial Compliance

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		conduct. The 32 investigations reviewed during this monitoring visit indicated that the majority of allegations did not rise to this level of notification. The OIG was notified with regard to six investigations. Law enforcement officials were notified with regard to the investigations alleging physical abuse of Individual #33 and Individual #132. In appropriate cases, however, notification was very prompt, within minutes, after the intake worker recorded the allegations. The investigations involving Individual #33 and Individual #132 resulted in felony indictments against the alleged perpetrators. Individual #33 was kicked in the head by the perpetrator, and was sent to the hospital to determine if she had a closed head injury. The Emergency Room (ER) physician documented a diagnosis of concussion without loss of consciousness. Individual #132 also was physically abused when a staff person struck him in the right eye. The police report was included in the case file for the investigation regarding Individual #33. In the 6/3/10 conference call on this subject, it was noted that the OIG report was sent to the General Counsel for DADS, while the Facility was supposed to receive a summary of the report. Although the results of the OIG investigations sometimes were referenced in email correspondence with the Facility, summaries of their findings had not been included in the investigation records reviewed during this monitoring visit. While this did not affect a finding of substantial compliance, it is recommended that the OIG summaries be placed in the investigation case file.	
	(h) Mechanisms to ensure that any staff person, individual, family member, or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	Informal conversations with staff about the reporting of any allegations of abuse, neglect, or exploitation did not disclose concerns about retaliation. The LBSSLC Policy referenced above regarding "Incident Management, Abuse, Neglect or Exploitation" addressed retaliation. It was prohibited. Instructions were provided for the reporting of retaliatory action. Any employee found to have violated the policy was subject to disciplinary action. In the review of investigation reports and subsequent disciplinary actions, there was no indication of retaliation for reporting an allegation of abuse, neglect, or exploitation. Rather, on occasion, the reporting of an allegation against a co-worker was found to result from an interpersonal conflict. In these instances, employees were counseled.	Substantial Compliance
	(i) Audits, at least semi-annually,	The LBSSLC policies referenced above required the reporting of serious resident injuries.	Noncompliance

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	to determine whether significant resident injuries are reported for investigation.	The Facility investigators were assigned the investigations of serious injuries of known origin. Injuries of unknown origin or serious injuries that might be the result of abuse or neglect were to be investigated by DFPS. LBSSLC prepared a report delineating Unusual Incidents. This report described the type of incident (abuse, choking, and injuries), the name of the individual, and the disposition of the incident (confirmed, unconfirmed, and inconclusive.) The report for 1/1/10 through 7/31/10 was issued on 8/19/10. Although this report was informative, it did not address whether there were significant resident injuries that were unreported. Campus Coordinators were assigned the responsibility of checking shift logs and observation/progress notes to determine whether all injuries were reported. Findings from these reviews were to be discussed at the Incident Management meetings. This protocol was important, but without a summary report and analysis of what was found by the Campus Coordinators, it was difficult to determine whether their auditing is comprehensive, complete, and reliable.	
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.	DADS Policy Number 002.2: Incident Management, dated 6/18/10, governed the investigation of abuse, neglect, exploitation, theft, serious injury, and other serious incidents involving individuals residing in State Supported Living Centers. DADS Policy Number 021: Protection from Harm-Abuse, Neglect and Exploitation, dated 6/18/10 established procedures for the identification, reporting, trending, analysis, and prevention of abuse, neglect, and exploitation at State Supported Living Centers. A draft policy, Number 00.1, dated 8/24/10, was in the process of being finalized, and would direct the actions to be taken upon the death of any individual served at a State Supported Living Center. In order to meet the requirements that were put into place with the passage of Senate Bill 643, an independent organization had been awarded a contract to report data regarding deaths at the State Supported Living Centers. In addition, DADS was re-	Noncompliance

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		examining the internal procedures for the investigation and other reviews that were conducted of deaths. DADS Policy Number 002.2 specified that: "a trained and authorized investigator will investigate all unusual incidents within 24 hours or sooner." The policy stated that all Facility investigators must complete the courses "Comprehensive Investigator Training" and "People with Mental Retardation" within one month of assignment. The course "Fundamentals of Investigation," and a class in Root Cause Analysis must be completed within six months. As discussed in the 6/3/10 conference call with DADS and DFPS, the investigators under the supervision of the Department of Family and Protective Services had mandatory training that included modules regarding working with people with developmental disabilities. The two investigators at LBSSLC had work histories at the Facility that included experience as a direct support staff professional. One of these investigators had experience as a Home Team Leader, and the other had worked eleven years as a direct support professional. Training documentation was reviewed, and it confirmed that both investigators at LBSSLC had completed the Comprehensive Investigator Training and the course titled "People with Mental Retardation." Both investigators had certificates from completion of a course in the "Fundamentals of Investigation." However, there was no documentation submitted that the two investigators had completed a class in root cause analysis, and both had been investigators for more than six months. With regard to the DFPS investigators who conducted investigations, training will need to be reviewed during the next monitoring visit. The Monitoring Team needs to gain a better understanding of the training provided to three of the six investigators to ensure it meets the requirements of the Settlement Agreement. DADS Policy 002.2 required that the investigator not be in the direct line of supervision of the alleged perpetrator. All of the investigations reviewed confirmed that the investigators from DFPS were outside of the line of supervision of the alleged perpetrator. However, although LBSSLC had investigators assigned to conduct investigations who were not within the direct line of supervision of the alleged perpetrators, there were instances in which the investigators relied on others to conduct some of the fact-finding, including, for example, a Unit Director. This is discussed in further detail below with regard to Section D.3.e. Investigations should be objectively conducted without the use of staff within the line of supervision of the alleged perpetrator.	

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	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	There was a Memorandum of Understanding (MOU), dated May 28, 2010, that provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General of Health and Human Services Commission (HHSC). DADS Policy Number 002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." It is recommended that the Policy direct all employees to cooperate with law enforcement or the Office of the Inspector General. Based on a review of 32 investigations, including a small number in which law enforcement or the OIG was involved, it appeared that Facility staff cooperated with the outside entities conducting such investigations.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The interagency Memorandum of Understanding delineated the respective agency roles and responsibilities relating to the investigation of a report of alleged abuse, neglect, or exploitation in the SSLCs and the ICF/MR component of the Rio Grande State Center. When DFPS, the Office of the Inspector General, or a law enforcement agency have any involvement in an investigation concerning abuse, neglect, or exploitation, they take the lead in the investigation. Based on interviews with the staff at the Facility responsible for investigations, they reported following the instructions of law enforcement so as not to interfere with investigations. Also, based on the review of the investigation records for cases in which law enforcement or OIG was involved, the Monitoring Team found no evidence of interference.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	Procedures for the safeguarding of evidence were contained in DADS Policy Number 002.2, Exhibit B. These guidelines referenced the collection, identification, and storage of physical evidence that may be essential to the investigation and disposition of an allegation. DADS Policy Number 042.1: Video Surveillance outlined procedures for documenting an observation of a suspected act of abuse, neglect, and/or exploitation or an incident of alleged criminal activity. There were no investigation reports that indicated the need to collect and store physical evidence. The policy governing investigations provided for the securing of evidence, however, this could not be tested. Photographs of injuries were included in appropriate	Substantial Compliance

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		investigation reports provided to the Monitoring Team. However, the copies were not very clear and it was difficult to discern the actual injury being photographed.	
	(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.	Both the DADS policy and the LBSSLC policy governing the investigation of serious incidents required that each investigation commence within 24 hours or sooner, if necessary, of the incident being reported. In addition, the Settlement Agreement requires that the investigation be completed within 10 days unless a written extension is granted for good cause. Each investigation report is to result in a written report that includes a summary of the investigation, its findings and, as appropriate, recommendations for corrective action. LBSSLC provided 62 investigation reports for review during this monitoring visit. These investigation reports concerned 41 individuals. There were four investigation reports that were completed by the Facility Investigator after referral from DFPS. These investigations did not follow the report format used by DFPS for its reports. Rather, the Facility review was summarized on an Unusual Incident Report (UIR) form. As a result, there were a number of gaps in the investigations. For example, it could not be determined that all witnesses or possible informants were interviewed because witness statements were lacking. In the investigation involving Individual #68 and two other individuals, the staff person assigned to their supervision left the work site without permission, claiming that her wrist was hurting and she needed medical care. Her statement was included in the investigation report, but not that of her supervisor or co-workers. In the investigation alleging neglect of Individual #280, there were no witness statements included in the report and no evidence that the investigator had queried staff about the failure to cut his nails or about the complaint that his diapers were not cleaned properly. The investigator referred these issues to the Unit Director. His response was 12 days late. The alleged neglect of Individual #269 was determined by the Medical Director and the Director of Nursing to be an issue of clinical practice. Although the agency nurse was terminated for failure to administer medication, thus causing the individual to have a seizure and require Emergency Room care, there was no information in the report about the need for additional safeguards on that living unit. As discussed elsewhere in this report, the referral of clinical practice issues to a peer review process had resulted in a lack of information about causation of incidents, and clear definition of corrective action. Finally, in the matter of Individual #202, who ingested a coin, there were no interviews documented with staff assigned to provide him with enhanced supervision. The issue was referred to the Personal Support Team for review and a summary of its recommendations were included in the investigation report. The incident involving the pica behavior of Individual #202 was not reported in a timely manner. The ingested coin was discovered on 5/5/10, but the report was not made until	Noncompliance

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		5/7/10. The incident involving Individual #269 happened on 5/12/10, but was not reported until 5/14/10. These delays were not addressed in the investigation reports. There were other problems with these Facility investigations. The file for the investigation involving Individual #269, included information related to an investigation involving Individual #277. There were a significant number of extraneous or duplicate pages of paper, suggesting that the preparation of the report file was not completed carefully. A sample of 33 investigation reports completed by DFPS (53%) was selected for examination. The sample included investigation reports for 23 of the 41 (56%) individuals, including one unknown male. One investigation report was for Individual #246 who died on 6/20/10. His investigation report consisted of an Unusual Incident Report, sections of his record and statements from the staff present on the night he was taken to the Emergency Room, apparently in pain from a mechanical disruption of the bowel by Percutaneous Endoscopic Gastrostomy (PEG) placement. This abbreviated report did not indicate any abuse or neglect. However, there was no summary of findings included in the investigation report. Apparently, the death was referred to the Medical Director at LBSSLC for further review. For these reasons, this investigation was not referenced in the summary below. A review of the 32 remaining DFPS investigation reports showed that 16 reports (50%) were completed within 10 days, one report was granted a written extension, and one report was late for good cause as police were investigating a felony crime. Completion of the remaining 14 (44%) of the cases did not occur within 10 days. DFPS's internal policies did not require completion of investigations within 10 days until June 2010. Investigations were to be initiated within 24 hours. There were 17 investigations (53%) initiated within that timeframe, and one investigation was delayed for valid extenuating circumstances. (The Facility was investigating an incident involving an altercation between staff. During the course of that investigation, an allegation of neglect was made regarding Individual #199. The investigation then was referred to DFPS.) The initiation of the remaining investigations did not occur within 24 hours. All of the DFPS investigations reviewed resulted in a written report. The findings were summarized and, in some investigations, recommendations were included. For example, it was recommended that all staff be trained in sensitivity about an individual's weight, and that an individual be counseled about unfounded allegations.	

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		The 32 DFPS investigations included seven allegations of physical abuse, seven allegations of verbal abuse, 12 allegations of neglect, and six instances where more than one type of allegation was reported. There were seven allegations that were confirmed: two allegations involving physical abuse; two allegations involving verbal abuse; and two allegations involving neglect. The Facility Director disagreed with the findings in one report. As a result, the conclusion was changed from unconfirmed to inconclusive. The Facility Investigator noted that the presence of security cameras had provided evidence of physical abuse in two recent incidents. The need for a streamlined investigation process was not a significant concern at LBSSLC. Individual #154 was the only person on the list. He was placed on the list in 2006 due to frequent calls alleging verbal abuse. These allegations were unfounded. For him, the streamlined process means that whenever he alleges physical abuse, he is assessed for injury, and a decision is made regarding whether a full investigation will be completed. If DFPS did not conduct an investigation, the Facility would investigate the allegation. (During this monitoring visit, one investigation was reviewed for Individual #154. Despite his label of "chronic caller," his allegation was reviewed by DFPS.) Individual #239 also had a history of unfounded calls. He was not on the list and, in fact, there was documentation that the Unit Director recently assisted him in filing a report even though he was fairly certain that the incident could not have occurred. This is a positive example of the implementation of a policy mandating "zero tolerance of abuse," and an indication that the Facility wants to be certain that all potential abuse and/or neglect is adequately investigated.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person	The standardized format adopted by DADS and utilized at LBSSLC structured the investigation report. The format was uniformly followed. In all DFPS investigations reviewed, the serious incident or allegation was identified, and the names of all witnesses, alleged victims, and alleged perpetrators were recorded, if known. Each person interviewed was named and a brief summary of the substance of the interview was included. Documents reviewed during the course of the investigation were listed. In two investigations, it did not appear that a review of the individual's record was completed. In Case Number 10-07-285, involving a staff altercation and an allegation of emotional/verbal abuse, the record review should have included, at least, Individual # 199's observation notes and Personal Support Plan. This Individual was thought to be disturbed by the altercation, but he was not interviewed nor were any other individuals in this house. In Case Number 10-07-277, the allegation of verbal abuse was deemed to be unfounded. However, there was no review of the individual's Personal Support Plan, or any of the documents related to his psychological assessments	Noncompliance

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	interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	or behavioral health history. However, despite the consistency in formatting, one section of the investigation report requires further development. Although the histories of the alleged victim and the alleged perpetrator were referenced briefly in all but one investigation, there was no analysis or in-depth review of these facts. The previous allegations, if any, were simply recorded without any discussion. If this information is to be useful, it needs to be analyzed, and a summary of the analysis provided. There were concerns regarding the basis for the conclusion of one of the unfounded allegations of physical abuse. Specifically, the investigator determined that an allegation of physical abuse was unconfirmed. Although Individual #254 had reported the abuse, the investigator could not find sufficient proof, as the incident was not witnessed. Yet, this individual had no history of unfounded allegations, and there was no analysis of why the investigator found the staff person to be more credible than the individual who made the allegation. Such analysis would be key to providing the basis for the conclusion. As a result of this missing analysis, it was unclear why the finding was not either "confirmed" or "inconclusive." Furthermore, the Facility Director had expressed reservations about the conclusions in some cases. She had appealed at least two cases for further review. As noted above, one of the appealed cases was returned with the finding changed from unconfirmed to inconclusive. It was positive that the system for appeal resulted in a review by DFPS State Office of the investigation completed by the field office, and a modification made to the findings, as appropriate. Due to concerns regarding the lack of analysis of past allegations, as well as concerns regarding the foundation for some conclusions, the finding is being made that the State is not in compliance with this component of the Settlement Agreement.	
	(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	LBSSLC completed an investigation checklist to ensure that investigation reports were complete and adhered to the requirements of the Settlement Agreement. This document was very useful. It would be helpful to include "timeliness" as one of the checklist items. The Facility Director had strengthened the review of investigations by implementing a protocol that required the consideration of systemic issues at the onset of the investigation and upon receipt of the five-day preliminary report; administrative review of the preliminary findings and the formulation of recommendations to address emerging concerns; examination of the investigation report by the Quality Enhancement staff; and review and sign off of the final investigation report by the Assistant Ombudsman. The investigations were discussed routinely at the Incident Management	Noncompliance

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	shall be addressed promptly.	Review meetings. DFPS investigation reports were signed by the investigator. The supervisor was reported to be signing off electronically, and so there was no shared record of that signature. As was discussed during a meeting between DFPS, DADS, and the Monitoring Teams, a process needs to be devised to allow the Monitoring Teams to assess this component of the SA. This element will not be in substantial compliance until DFPS is able to provide evidence that the supervision of the DFPS investigations is occurring.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility Investigators completed investigations of unusual incidents that did not involve abuse, neglect, or exploitation. These investigations adhered to the standardized format. As cited in the baseline report, the referral of certain allegations or unusual incidents to the protected peer review process leaves the facts and recommendations about certain incidents unknown. Consideration should be given to releasing this information in summary form, at least, so that there is assurance that a comprehensive review has occurred in a timely manner.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The review of 32 DFPS investigations verified that LBSSLC had taken prompt and appropriate disciplinary action when an allegation was confirmed. In certain cases where the allegation was unconfirmed, disciplinary action was taken to address work performance issues identified through the investigation. As a result of investigations conducted since the baseline visit, at least five employees received warnings, one employee was suspended for three days for neglect, and 11 employees were dismissed. In addition, felony charges were filed against two employees found to have physically abused two individuals at LBSSLC. There was documentation that Quality Enhancement staff reviewed the recommendations from investigations and determined whether they had been implemented. They had noted whether victim's counseling was provided, and whether in-service training had been held. This requirement of the Settlement Agreement also focuses on programmatic action. Although LBSSLC has taken appropriate disciplinary action as a result of the investigation process, programmatic actions were not sufficient at this time. The continuing major weakness in the investigation process was the absence of any substantive analysis of Facility-wide constraints or deficiencies that contributed to allegations and/or findings of undesired or unacceptable practices in the residences or day program areas. For example, the crowding in certain residences was not referenced;	Noncompliance

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		the inconsistency of staffing was not highlighted; the lack of active treatment was not cited; and the inappropriate grouping of certain individuals was not questioned. These issues require ongoing attention and corrective action, if there is to be protection from harm and a reduction in risk. Under the leadership of the new Facility Director, these programmatic deficiencies were beginning to be identified, and corrective action was being planned and implemented. For example, the men who lived in 515 S. Cedar Avenue had been relocated, and there were promising signs that this change was beneficial both for the individuals and the staff who worked with them.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The Interim Incident Management and Risk Coordinator confirmed that records of current investigations were secured in the investigators' offices. The records for investigations completed within the last two years were maintained in the files located in the office of the Incident Management Coordinator. Records that were three to five years old were kept in an accessible building at the Facility. Records older than five years were secured in an off-site storage area. She reported that access to investigation records was not a problem. A database was maintained that tracked allegations of abuse, neglect, or exploitation by individual and by employee, and were easily retrievable.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	There was evidence that LBSSLC was attempting to track and trend unusual incidents and the results of investigations. As noted above, a report detailing Unusual Incidents was released in 8/10. The Performance Improvement Committee reviewed this information. There also was a FY 10 Quarterly Report that enumerated the allegations of abuse/neglect and exploitation. These reports were useful and certainly could serve as the foundation for more detailed analysis. However, at the time of the monitoring visit, there was only a very limited narrative summary accompanying the reports that mainly consisted of graphs. This document did not provide an analysis, but rather it provided a brief summary of the number and types of allegations and unusual incidents, and a description of some of them. The reports did not provide sufficient analysis of the facts contained in the investigation reports or the potential trends identified. For example, there was a list of staff alleged to be perpetrators of abuse or neglect. However, there was no attempt to include a narrative that discussed the circumstances involving these alleged perpetrators or the possible factors that led to the allegations. Adequate trending and tracking must also include an analysis of what the underlying causes of the allegations might be, and identification of steps that could be taken to address potential issues that are identified. The Facility Director indicated that one of the issues identified was that alleged perpetrators who were removed from direct contact with individuals were given modified schedules that allowed them to have nights and weekends off. This appeared to	Noncompliance

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		have led to some staff, who wanted time off, calling in allegations on themselves, or having a co-worker do so. To address this, staff who were removed from direct contact due to allegations were required to work their normal shift and days assigned. The need for systemic analysis of available data was identified in the baseline report, and again is being highlighted in this first compliance review. Hopefully, the restructuring of the Performance Improvement Committee will help resolve this critical gap. There is a need to ensure that information gained through the investigation processes is used on an individual as well as systemic level to improve outcomes for individuals, including adequately protecting them from harm, and ensuring that they have access to meaningful opportunities and treatment.	
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.	After discussion with DADS, it was agreed that the rating of compliance with this requirement would be deferred. DADS was working with the Facility to implement a system to summarize the background checks that had been completed on each employee or volunteer. At the time of the Lubbock review, some additional information needed to be added to the spreadsheet before the Monitoring Team could review it thoroughly. Self-reporting of any arrest was mandatory for Facility employees. There also was a statutory requirement that certain components of the background check be conducted annually for each employee. Drug testing was completed at the time of hire, and could be completed randomly or for cause. Once fingerprints were sent in to the Federal Bureau of Investigation, any additional information about new offenses automatically would be sent back to DADS as a "wrap-back." Because self-reporting was required, if a "wrap-back" identified an offense that an employee had not self-reported, this was grounds for immediate termination from employment. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with a criminal history record were discussed on a case-by-case basis. In each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of LBSSLC.	Not Rated

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Based on the success of the relocation of men who lived in 515 S. Cedar, it is recommended that all other living units be reviewed with regard to the number of individuals, the grouping of individuals, and the provision of individualized supports for active treatment. Such actions will be critical to reducing risk in this environment and to promoting the growth and development of the individuals who live at LBSSLC.
2. Facility policy should specifically direct all employees to cooperate with law enforcement or the Office of the Inspector General.

3. The Facility should utilize an investigation report format similar to that used by DFPS. All relevant information, including, for example, summaries of witness statements, descriptions of physical evidence, etc. should be included as part of the report. Reports should clearly reconcile the various evidence collected to justify the conclusions reached.
4. Investigations completed by the Facility should represent objective reviews completed by staff outside of the direct line of supervision of the alleged perpetrator, as required by the Settlement Agreement. For example, relying on a Unit Director to complete part of an investigation should not be considered an acceptable practice.
5. Improvements should continue to be made with regard to the timeliness, the depth of review, and the soundness of the conclusions of investigations. Consideration should be given to including timeliness on the checklist used to evaluate investigations.
6. Within the investigation reports, there should be a summary of the investigator's analysis of the history of the alleged victim and the alleged perpetrator.
7. With regard to serious incidents or allegations that are referred to the peer review process, consideration should be given to releasing this information in summary form. This will provide assurance that a comprehensive review has occurred in a timely manner.
8. There should be more analysis of the information gained through the investigations. The restructuring of the Performance Improvement Committee to the Quality Assurance and Improvement Council should be used as an opportunity to better utilize available data to improve outcomes for individuals, including adequately protecting them from harm, and ensuring that they have access to meaningful opportunities and treatment.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o FY 10 Quality Enhancement Plan, undated; o Inter-rater Reliability for July 2010; o Monitoring review tools for each of the Settlement Agreement sections (blank); o Completed monitoring tools for various months between January 2010 and August 2010; o Results of Consumer Support Observation/Interview Monthly Reviews, for April through July 2010, with emails requesting follow-up; o Supervision Monitoring Forms, Monthly Totals, for April through July 2010; o QE Lifting/Transfer Monthly Analysis Report, for January 2010 and April through July 2010; o LBSSLC Dental X-Ray Checklist, for January and June 2010; o Do Not Resuscitate Monitoring for various months in 2010, with emails regarding needed follow-up; o Memorandum regarding follow-up completed on investigation recommendations, various dates; o Summary data from State Office regarding all SSLCs, 9/1/09 through 6/30/10; o Lubbock State Supported Living Center Monthly Data, including some graphed data, January through July 2010; o LBSSLC Allegations of Abuse, Neglect and Exploitation Trend Reports, from 12/1/09 through 6/30/10; o LBSSLC Trend Analysis Reports for various months; o Safety Committee reports, for various months; o Corrective Action Plans for Various Components of SA, undated o Performance Improvement Council Meeting Notes, January 2010 through July 2010; o Texas Department of Aging and Disability Services, Notice of Accepted Plan of Correction to the 5/21/10 survey from the Department of Health and Human Services, dated 6/25/10; o LBSSLC Policy: Quality Assurance Process, dated 1/13/10; and o DADS Policy Number 021: Protection from Harm-Abuse, Neglect and Exploitation, dated 6/18/10. ▪ **Interviews with**: o Dawn Ripley, Director of Quality Enhancement; and o Bob Robbins, Program Compliance Monitor. ▪ **Observations of**: o Incident Management Review Team Meetings, on 9/13 to 9/16/10; o Performance Improvement Committee Meeting, on 9/14/10; and o Site visits to all living units, the workshop, and day program areas in the Lily and Pines Buildings. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between

	individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees as well as some of the individuals.
	Facility Self-Assessment: The LBSSLC Plan of Improvement did not identify compliance in any of the areas related to Quality Assurance. Although based on review of records and on-site review, it was clear that significant effort was being expended to reach compliance, the lack of compliance identified by the Facility was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: LBSSLC had begun to establish a process for monitoring compliance with the Settlement Agreement. The Facility had begun to customize the review tools, had converted them to an Excel format to make calculations easier, and had begun the process of establishing inter-rater reliability. All of these were positive developments. However, there was still a need for specific instructions/directions, competency-based training of staff responsible for monitoring, and further refinement of the tools and the process of measuring inter-rater reliability. As reported during the baseline review, even though the monitoring and data collection systems needed to be refined, at the time of the review, useful information was being collected, and distributed to decision-making staff. However, it generally did not appear that this raw data was analyzed in any meaningful way, or that responses to these reports, particularly in the form of concrete actions plans, were developed, documented, and implemented. In order for the Facility to have a fully functioning quality enhancement process in place, it is essential that this occur. In addition, trending of some basic quality indicators was being conducted. Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to individuals served by LBSSLC. This is important for a few reasons, including providing the Facility with the ability to identify objectively individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, and to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. Throughout this report, there are references made to data that should be incorporated into such a system. The Performance Improvement Committee met regularly. However, it needed to focus more directly on quality improvement at LBSSLC as a whole and not only on compliance with the Settlement Agreement. Hopefully, this will be remedied with the restructuring of the Performance Improvement Committee as directed by DADS.

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E1	Track data with sufficient	As reported after the baseline review, at LBSSLC, there was significant collection of data	Noncompliance

#	Provision	Assessment of Status	Compliance

	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.	occurring. In the documentation provided to the Monitoring Team and based on interviews with the QE Director, it was clear that the Program Monitors were regularly collecting data through the implementation of multiple monitoring tools, some of which had been in place at the Facility for some time, as well as through the newly adopted Settlement Agreement review tools that the State Office had required all Facilities to use.
		
		At the time of the review, some modifications had been made to these tools. For example, the QE Director indicated that an effort had been made to ensure that each indicator was measuring only one item. The Facility also had converted the tools into an electronic format to make calculations easier. The QE Department, as well as various other departments, had begun to use them, and the Facility had begun to address the question of inter-rater reliability.
		
		It was positive that the Facility was making use of the tools developed by the Monitoring Teams. However, while on site, the Monitoring Team discussed with Facility staff some of the additional modifications and/or enhancements that would be necessary for these tools to be useful to the Facility. These include, but are not limited to:
		▪ The current monitoring tools did not include instruction sheets or guidelines. These would need to be developed to:
		  o Ensure that various Facility staff implementing the tools were using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability;
		  o Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools. These tools were developed by and for the use of Monitoring Team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who have more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts; and
		  o Ensure that quality is being measured, and not just the presence or absence of an item.
		▪ The tools that the Facility had generated electronically included a total compliance score at the end. However, items on the tools had not been weighted, but would need to be if they were going to be used to generate cumulative scores.
		▪ Some of the indicators on the tools were specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Particularly if the Quality Enhancement Department is going to use these tools, such indicators will need to be modified, and more specific methodologies identified	

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		to evaluate such indicators. ▪ At times, it may be beneficial to develop separate scoring sheets to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they very closely track the requirements the Settlement Agreement calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet(s) likely would assist in this process. ▪ Methodologies for monitoring needed to be developed carefully. For example, different samples may need to be drawn to answer all of the questions on one tool. So, for example, a sample of individuals who still live at the Facility and a different sample of individuals who have transitioned would need to be pulled to answer all of the questions for Section T of the SA. It might be beneficial in these situations to separate the questions for these two groups onto different review tools. The monitoring techniques (e.g., interviews, record reviews, and/or observations) that an auditor would be expected to use also should be defined. It appeared that the Facility's Quality Enhancement Plan had begun to define sample sizes. LBSSLC had begun to develop reports to track and trend data. For example, there were reports based on information obtained from the work of the Program Compliance Monitors, the Director of Behavioral Services, the Risk Manager, and the Incident Management Coordinator, as well as others in various departments who had recently become responsible for monitoring. However, these reports were limited in scope and did not analyze the data sufficiently with regard to program areas, living units, work shifts, protections, services and supports, areas of care, individual staff, and/or individuals receiving services and supports. Although data was often broken down along these lines, there was insufficient analysis completed to identify underlying causes or issues to potential trends. The Risk Manager was striving to link data about injuries and safety issues with information about specific individuals and living units. Her work should be continued and discussed in the appropriate forums, such as the newly restructured Performance Improvement Committee/Quality Assurance and Improvement Council. In order for the Facility to be in compliance with this component of the Settlement Agreement, a tracking system needs to be in place to allow identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. Although the Facility had collected a fair amount of data, for example, data related to incidents and allegations, and	

#	Provision	Assessment of Status	Compliance
		data required for submission to the State Office, it had not yet developed a set of key indicators. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, as well as to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. Throughout this report, there are references made to data that should be incorporated into such a system. For example, data needs to be incorporated into the system regarding at-risk individuals; medical, psychiatric, and nursing issues, infection control, physical and nutritional supports, skill acquisition and day/vocational activities, behavioral supports, and outcomes for individuals related to transition to the most integrated setting. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the types of indicators or outcome measures that should be included in such a system.	
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.	As discussed in the baseline report, for some of the data collected, quarterly reports summarized the data across all three months of the applicable quarter, and compared the findings with previous quarters. Quarterly reports were submitted to the Program Improvement Committee (PIC) for review and follow-up action. Reportedly, quarterly reports also were sent to Department heads with the expectation that action plans would be developed and implemented for any indicators falling below 70 percent. As is discussed in further detail in other sections of this report, it generally did not appear that this raw data was analyzed in any meaningful way, or that responses to these reports, particularly in the form of concrete actions plans, were developed, documented, and implemented. In order for the Facility to have a fully functioning quality enhancement process in place, it is essential that this occur. The Director of Behavioral Services had refined his reports regarding the use of restraint at LBSSLC. There was evidence that this data was analyzed and resulted in the development and implementation of corrective action plans. Action plans also had been developed for a number of the Settlement Agreement sections. However, review of these plans showed that they varied in quality, and it did not appear that they all had been approved, and/or that implementation had begun (i.e., they generally were not dated, and signatures were not present). It appeared the Director of QE was playing a role in reviewing these plans, and requesting modifications, as appropriate. As is noted in other sections of this report, a number of the departments had begun to conduct audits using the tools developed by the Monitoring Teams, with some modifications. However, generally, this auditing process was in the initial stages, and	Noncompliance

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		had not yet resulted in the development of corrective action plans. For example: ▪ There were a number of comments on the two audits conducted by the QE Nurse regarding individuals requiring hospitalization that indicated that the auditor was critically reviewing the documentation and identifying problematic issues. Corrective action plans addressing the identified issues had not yet been developed or implemented. ▪ Likewise, audits had been completed related to infection control practices in some of the homes. A number of problematic issues were identified, but corrective action plans had not been developed yet to address them. As reported during the baseline review, with regard to incident reporting Follow-up Recommendations Guidelines were revised in 12/07. Recommendations made during the course of an Unusual Incident investigation were tracked. All recommended actions had to be completed, and documented before the case was closed. A sample of Unusual Incidents was being reviewed every quarter. Based on a review of documentation provided during this most recent review, it appeared that the QE Department continued to be involved in conducting reviews to ensure that recommendations had been implemented. In some cases, the QE Department made additional recommendations to address unresolved or newly identified issues related to the original incident. This is a very positive practice that should continue.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Although as noted above with regard to Section E.2 of the SA, some corrective action plans were being developed and disseminated (e.g., corrective actions required with regard to incident investigations), it did not appear that corrective action plans were consistently developed, and then disseminated to others who would have responsibility for their implementation, or portions of their implementation.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	The Facility's POI indicated that the Quality Assurance Process procedure, dated 1/13/10, needed to be updated to include all of the necessary procedures. However, it did provide general guidance on the monitoring of corrective action plans. The Facility's Quality Enhancement Plan did not provide a description of how corrective action plans would be monitored to ensure they were meeting the desired outcome of remedying or reducing the problems originally identified. In fact, it did not discuss the development of corrective action plans. It referenced recommendations resulting from monitoring activities, but not the conversion of such recommendations into corrective actions plans.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	As noted above, the Facility was in the beginning stages of developing corrective action plans. The Facility's POI indicated that the Quality Assurance Process procedure, dated 1/13/10, needed to be updated to include all of the necessary procedures, but it did provide general guidance on the monitoring of corrective action plans.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. As is detailed above with regard to Section E.1 of the SA, the SA monitoring tools should continue to be revised to better meet the needs of the Facility. This should include, but not be limited to: revisions to indicators as appropriate, the development of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, consideration of weighting indicators, development of scoring sheets, as appropriate, and the definition of the methodologies to be utilized (e.g., definition of samples to be drawn, sample size, and the use of various monitoring techniques, such as interviews, record reviews, etc.).
2. The Facility should develop and implement a tracking system that allows identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. Throughout this report, there are references made to data that should be incorporated into such a system. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the types of indicators or outcome measures that should be included in such a system.
3. The valuable information already being collected through monitoring, trending, and tracking, and other quality enhancement efforts needs to be used more rigorously to actually eliminate potential risk still evident for individuals served by LBSSLC. The information the QE Department gathers needs to be analyzed to identify problematic trends and/or individual issues, and action plans need to be developed and implemented to address issues identified. Such action plans should include actions, person(s) responsible, timeframes for completion, and definition of the desired outcome(s).
4. Once these action plans are developed, they need to be monitored to ensure their completion, as well as to ensure they are effective in addressing issues identified. If they are not, they should be modified appropriately.
5. As particularly complex corrective action plans are developed, the Facility should consider focusing on making substantial changes in one residence or unit at a time. This would ensure that concentrated efforts could be devoted to the change process and ensure success. This would require prioritization of the need for changes to be made, particularly changes that impact the health and/or safety of individuals. It also would require planning to ensure that once the mechanisms for making the changes are established that there be expedient roll-out of the change process to other homes or units.

<table>
<tr><th>SECTION F: Integrated Protections, Services, Treatments, and Supports</th><th></th></tr>
<tr><td rowspan="2">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: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o DADS Policy Number 004: Personal Support Plan Process (Integrated Protections, Services, Treatments and Supports), dated 7/30/10;
o LBSSLC Policies:
▪ Draft Qualified Mental Retardation Professional (QMRP) Role in Coordinating Active Treatment Programs, dated 6/24/10;
▪ Visitation, dated 8/31/10; and
▪ IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring, dated 6/30/10.
o Presentation Book for Section F;
o PowerPoint presentation entitled: Person Directed Planning – Your Role as a New Employee, undated;
o Supporting Visions: Personal Support Planning QMRP Training;
o Supporting Visions: Instructor Certification Training;
o LBSSLC Home Address and PSP Date List; and
o PSPs for the following individuals, including related assessments, Personal Support Plan Addendum (PSPA) meeting documentation, skill acquisition goals/objectives, sign-in sheets, Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) assessment worksheets, and Personal Focus Worksheets (PFWs): Individual #274, Individual #199, Individual #283, Individual #215, Individual #313, Individual #226, Individual #192, Individual #243, Individual #161, Individual #176, Individual #10, Individual #202, Individual #76, Individual #54, Individual #166, Individual #312, Individual #61, and Individual #36.
▪ Interviews with:
o Trent Lewis, Director of Active Treatment, on 9/14/10;
o Marisol Gonazales, ISP Coordinator, on 9/14/10;
o Shelia Powell, Human Rights Officer, on 9/14/10;
o Lola Walker, QMRP Coordinator, on 9/14/10;
▪ Observations of:
o PSP Meeting for Individual #241; and
o PFA Meeting for Individual #107.</td></tr>
<tr><td>Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although it could not be determined how the Facility had reached its conclusions with regard to compliance findings, the Facility's POI for Integrated Protections, Services, Treatments and Supports only identified one subsection for which it believed it was in compliance. The Facility indicated it was in compliance with Section F.1. This was not consistent with the Monitoring Team's findings. Although QMRPs had been identified as the team facilitators, they were not</td></tr>
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	effectively ensuring that assessments were completed, and that the teams worked in an integrated fashion to develop PSPs that adequately met the needs of the individuals at the Facility. As is described below with regard to Section F.2.g of the SA, the Facility appeared to be in the initial stages of refining the tools and developing the processes to complete a thorough self-assessment with regard to Section F. The Facility had adopted the tools developed by the Monitoring Teams, and the Facility had begun to customize them to meet its needs. This process needed to continue, and there needed to be additional training for staff responsible for the audits, implementation of an inter-rater reliability system, and processes developed and implemented to allow aggregation and analysis of the data. All of these activities were necessary to allow the collection and analysis of the data in a meaningful way that resulted in the identification of issues requiring attention, and the development and implementation of corrective action plans to address potential causes of issues identified.
	Summary of Monitor's Assessment: While this Section of the Settlement Agreement is complex and will continue to require the collaboration of all disciplines, there had been progress since the baseline review was conducted. Specifically: ▪ The DADS policy on integrated protections, services, treatments, and supports was issued at the end of July; and ▪ Three LBSSLC staff had been certified as trainers, and all QMRPs at the Facility had undergone the initial training. Training also had begun to be provided to all other PST members. Beginning on 9/1/10, the Facility began using the new process. Some areas that required attention included: ▪ As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning; ▪ Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen; and ▪ The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two	The DADS policy for this section was issued on 7/30/10. LBSSLC had not issued a companion policy as of the monitoring visit.	

#	Provision	Assessment of Status	Compliance
	years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	DADS Policy #004 at II.C.1.b indicated that the QMRP would plan and facilitate the PSP meeting. At the Facility, a draft policy entitled IDT Process Program Development: QMRP role in Coordinating Active Treatment was in the process of being finalized. The QMRP Coordinator confirmed that QMRPs facilitated the teams, including team meetings. During the on-site review, at both the annual planning meeting for Individual #241 and the PFA meeting for Individual #107, the QMRP facilitated the meeting. Although during the meeting for Individual #107, the QMRP attempted to include the individual, and at the same time elicit needed information from team members, she was not completely successful. For example, the team did not develop a prioritized list of needs for Individual #107. Additionally, action plans to correspond with those needs were not developed, obstacles to transition to the community were not identified, and plans to involve Individual #107 more in the community were not discussed. There appeared to be a focus on ensuring that the individual was present for the entire meeting even though his behavior appeared to be indicating that he did not want to be there. Team discussion ended when he left, despite the fact that these important tasks had not been completed. There was no discussion about seeking his permission to finish the meeting in his absence, reconvening, and/or having a series of shorter meetings, whichever would best meet the needs of the individual. The State and the Facility should ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Person-centered planning is not a reason for not having plans that are adequate. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc. It was a positive development that the new DADS policy was in place, and that key Facility staff had completed initial training. Specifically, all QMRPs at LBSSLC had undergone the initial training on the new PSP process and format. This policy clearly identified QMRPs as responsible for facilitating the teams. However, based on review of PSPs as well as during observation of one of the meetings held the week of the on-site review, facilitation of team meetings was not consistently resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. This is a key requirement to achieve compliance with this component of the Settlement Agreement. It is important to mention that during the baseline review, concerns were noted with	Noncompliance

#	Provision	Assessment of Status	Compliance
		regard to the caseloads of the QMRPs, and the potential impact on their ability to facilitate teams. Since the baseline review, positions had been filled, and a floater QMRP had been hired to assist when others were on leave, or otherwise needed assistance. These efforts appeared to have reduced the caseloads to reasonable levels. QMRPs carried caseloads of 13 to 21 individuals. The goal was to maintain a ratio of 1:16. The supervision for QMRPs had been shifted from the Unit Directors to the QMRP Coordinator. Specific in-service training sessions were being offered to QMRPs. Monthly meetings also had begun to be held with the QMRPs. At the meetings, in-service training often was provided regarding processes and procedures, or special topics, such as transition. This appeared to offer QMRPs the opportunity for additional training, as well as to share best practices with one another.	
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.	DADS Policy #004 described the Personal Support Team as including the individual, the LAR, if any, the QMRP, direct support professionals, and persons identified in the Personal Focus Meeting as appropriate, as well as professionals dictated by the individual's strengths, needs, and preferences. As was discussed in the baseline report, teams did not consistently include the participation of professionals as dictated by the strengths, preferences, and needs of the individual. It also was difficult to determine who should be a member of each individual's team. For example, sign-in sheets were provided for many of the PSPs reviewed, but because team membership was not defined clearly, it often could not be determined who should have been present. The discussion and documentation of this in the PFWs should assist in ensuring teams are duly constituted based on the individuals' needs. At times, it was clear that professionals who should have been members of individuals' teams did not participate in annual and other team meetings. For example, as is discussed in further detail with regard to Section O.3 of the SA, therapy staff were often not present at the PSP meetings of individuals with physical and nutritional support needs. This made integration of their Physical and Nutritional Management Plans difficult. Such plans should be integrated across disciplines, but as is also discussed with regard to Section O of the SA, there was little integration of such plans. Examples of meetings at which teams did not include necessary habilitation therapies staff were: ▪ Individual #283's PSP, dated 6/25/10, stated: "continue PNMP." There was no OT, PT, and SLP in attendance to discuss the rationale for the PNMP strategies, and ensure the integration of these strategies across multiple disciplines. ▪ Individual #215's PSP, dated 2/24/10, stated: "continue PNMP." There was no OT, PT, and SLP in attendance to discuss the rationale for the PNMP strategies, and ensure the integration of these strategies across multiple disciplines.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Individual #226's PSP did not have participation by the OT, PT, and/or SLP to address his PNMP and collaborate with PST members in the development of his PNMP. ▪ Individual #176's annual PSP, dated 2/3/10, did not include the expertise of an OT, PT, and/or SLP to collaborate on the development and/or revisions of his PNMP.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences, and needs, as well as recommendations to achieve their goals, and overcome obstacles to community integration. Most of the PSPs reviewed contained assessments of health, residential living [often Positive Adaptive Living Skills (PALS)], behavior including psychological evaluations, speech, OT/PT, nutrition, self-administration of medication, audiological screening, dental, community living options, vocational or day evaluations, and other assessments based on specific needs. However, the timeliness, as well as the quality of these assessments was of concern. With regard to the timeliness, the following summarizes findings that are included below with regard to Section S of the SA. These findings are relevant here as well: ▪ During the baseline review, it was discovered that, for a number of PSPs, Physical/Medical assessments were not available prior to or at the PSP meeting. Upon review of a more current sample of PSPs (N=24), it appeared that this trend had continued. More specifically, the Physical/Medical assessment was unavailable to PSTs at the time of the PSP for several individuals within the sample (i.e., PSP reports for Individual #82, Individual #159, Individual #213, Individual #183, and Individual #237). As previously reported, the absence of this important information was likely to be a significant barrier to the provision of necessary supports and services, as well as limit the overall comprehensiveness of the PSP process. This repeated finding within sampled documentation reflected a consistent trend since the baseline review. Overall, the current review evidenced mixed findings, that is, that the assessments listed in some PSPs appeared to be completed in a timely fashion while other PSPs referenced assessments that were delayed or unavailable. As noted in a number of other sections of this report, the Monitoring Team found the quality of assessments to be an area needing improvement. This is discussed in further detail throughout this report with regard to the sections of the Settlement Agreement that address psychiatric services (Section J), psychology (Section K), medical services (Section L), nursing services (Section M), physical and nutritional supports and OT/PT (Sections O and P), communication (Section R), and habilitation and skill acquisition (Section S). In order for adequate protections, supports, and services to be included in	Noncompliance

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		individuals' PSPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. As part of the baseline review, the Facility submitted its vocational assessment format that included a number of evaluation areas, including work tasks and skills, work attitudes, work-related behaviors, present and future employment options, and work preferences, attendance, and adaptive equipment or accommodations needed. This assessment format included many essential components for evaluating an individual's current skills and work habits, as well as their stated preferences with regard to future work. The instructions for completing the assessment indicated that in order to complete the assessment, the assessor should review information about the individual, such as his or her admission packet, observe the individual performing tasks in the work center on campus, and interview the individual and those who know the individual best. These are all good tools to use in completing a vocational assessment. These basics, however, needed to be expanded upon to create vocational profiles for individuals that will be helpful to teams as they plan for the vocational future of the individual. During this most recent review, the Facility reported that it was in the process of developing a revised vocational assessment. The Facility is encouraged to continue its efforts in this regard. This is discussed further with regard to Section S of the SA. As recommended in the baseline report, vocational evaluations should focus on potential work that is interesting to the individual, and on how that kind of work could be made available to the individual. The evaluation should create a vocational profile based on, for example, objective data, situational assessments, a thorough work history, and/or interest inventories. Often times, for example, an individual might not be able to state what his/her interests are, due to lack of exposure to different jobs available. By using situational assessments, individuals would be provided with opportunities to try out different jobs to determine if they have or could learn the necessary skills and aptitudes, and if they are interested in pursuing such work.	
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.	There appeared to be two major factors negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, a PSP that outlined the protections, services, and supports provided to the individual. These were: 1) there was a lack of consistent interdisciplinary discussion and coordination in the development of PSPs. This limited teams' ability to utilize assessment information to develop integrated protections, supports, and services; and 2) as is noted in other sections of this report, many of the assessments and evaluations being conducted were inadequate. Examples of this include inadequate nursing assessments, vocational assessments, psychiatric assessments, and assessments of individuals' physical and nutritional management support needs. The Facility needs to address these two issues to ensure that appropriate assessment information is available,	Noncompliance

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		and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans required by the SA.	
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).	This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement.	Noncompliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Policy #004 at II.D.4 indicated that Action Plans should be based on prioritized preferences, strengths, and needs. The use of the Personal Focus Worksheet appeared to be helping teams better understand the preferences and strengths of individuals. However, clear prioritization of the individuals' needs or careful delineation of barriers to addressing needs generally was not found. The integration of individuals' preferences to address needs or barriers also was not consistently seen. It was not consistently clear whether or how the goals and objectives were related to individuals' preferences, or were designed to overcome barriers to living in the most integrated setting. For example: ▪ As was mentioned above with regard to the planning meeting that the Monitoring Team attended for Individual #241, there was no discussion of the priority of his needs. ▪ As is discussed below with regard to Section S, it was difficult to determine how skill acquisition goals were decided upon or prioritized based on the various needs of individuals as identified in their assessments. ▪ The following findings are discussed with regard to Section S of the SA, and are also relevant here. Based on the most recent review, of the individual records	Noncompliance

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		sampled (N=12), 50 percent had at least one Specific Program Objective (SPO) identifying the community as the setting or potential setting for training. More specifically, the setting described on several SPOs offered options of both on- and off-campus (e.g., money management SPO for Individual #317 and Individual #183; healthy choice SPO for Individual #82; and, fitness SPO for Individual #268). Other SPOs prescribed the setting as "away from home" (e.g., environmental awareness SPO for Individual # 181) or "community outing" (e.g., money management SPO for Individual #126). As a result, it would appear that greater emphasis was being placed on skill acquisition in the community. However, significant additional work needed to be done to ensure that individuals regularly were provided opportunities to learn skills in natural settings in the community.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	As is discussed in other sections of this report, nursing plans, psychiatric treatment plans, and physical and nutritional support plans were not fully integrated into the PSP. They were generally stand-alone documents that might have been referenced in the PSP. Specific, individualized, measurable goals and objectives were not defined in individuals' PSPs to support the implementation of these essential plans. For example, in order to provide health care supports to individuals served, direct support professionals as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is repositioned every two hours should be specified in measurable ways in individuals' PSPs. Some examples of the ways in which PSPs failed to define measurable objectives included: ▪ Individual #54's 3/30/10 PSP indicated the team agreed that: "Habilitation Therapy will continue skilled speech language services to build and enhance [his] skills utilizing his new speech generating device…" No measurable action plan item was included in the PSP to address this, or to integrate these services with other activities or services. ▪ Individual #166's PSP, dated 4/8/10, indicated in the assessment section that monitoring of his psychotic symptoms should continue. The general discussion record identified his psychotic symptoms as having "hallucinations" and becoming aggressive and leaving campus. Although aggression was defined in an action plan item as a responsibility of the behavioral analyst to track, hallucinations and leaving campus were not included as behaviors needing to be tracked. Direct support professionals' roles in tracking these issues, and/or recognizing and reporting hallucinations were not included as measurable action items. As is discussed below with regard to Section T.1.b.1, teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. The Facility was just at the	Noncompliance

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		beginning stages of this process.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Numerous examples are provided throughout this report regarding how plans, supports and services were not integrated through the PSPs. The following provide a few such examples: ▪ As is discussed in further detail with regard to Section O.3 of the SA, there was a lack of integration of individuals' Physical and Nutritional Management Plans across action plans and disciplines within individuals' PSPs. Examples of individuals for whom this was essential, but did not occur included: o Individual #313's PSP, dated 10/13/09, included an Action Plan that stated: "will receive intervention through a PNMP with a focus to maintain transfer/walking skills with assistance and assistive equipment; to promote independence with self care skills and to improve weight and self feeding with dining plan/equipment." The responsible persons were the PNMP Coordinator and Residential Coordinator. The OT, PT, SLP, and/or PNMP Coordinator did not attend the PSP to discuss the rationale for the PNMP strategies, and to ensure the integration of these strategies across multiple disciplines. o Individual #243's PSP Team meeting, dated 7/20/10, did not have the support of an OT, PT, and/or SLP team members even though she had experienced a significant number of falls over the past year. It would have been important for Habilitation Therapies staff to discuss strategies to prevent and/or minimize her high risk of falling. ▪ As is discussed with regard to Section M, from an outcomes perspective, this lack of integration of services and supports in individuals' PSPs resulted in individuals not being provided with adequate care. For example, based on record review of 16 individuals who had been hospitalized for acute illness, many due to aspiration pneumonia, the medication administration observations and interviews with the nursing staff, there was no collaboration between nursing and the PNMT regarding the individuals who have recurrent pneumonias and aspiration pneumonias. From observations during medication administration, nurses were not assessing safe positioning for individuals when they received medications orally or enterally. Also, the Medication Administration Records (MARs) reviewed did not contain the PNMP and, consequently, nurses were not checking the individuals' position prior to administering medications. This coordination of individuals' supports and services should have begun in their PSPs, but did not. ▪ As is discussed with regard to Section R, while Speech Language Pathologists were completing evaluations that identified the need for augmentative/alternative communication devices, there were not sufficient	Noncompliance

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		resources to provide direct and/or indirect speech therapy supports for individuals with an identified need. To the credit of the SLPs, there were multiple individuals with communication devices on campus (low tech and high tech) as well as many generic devices, but there was not a current framework within the PSP process to integrate these devices into formal, teachable moments, such as integration into skills acquisition programs. For example: o Individual #312's PNMP, dated 8/26/10, documented the following assistive equipment: "remote TV module…, personal radio with switch, Sip 'N' Puff switch, automatic door opener on laptray, call button, grip switch, adapted laptop computer and B table and chin mouse." His Speech Language Update, revised 9/9/10, documented: "Overall, [Individual #312] continues to communicate his wants and needs using complete sentences and requires assistive technology (AT) to access his environment. There are no changes to his assistive technology at this time. His hearing and vision are within functional limits for communication. In view of the above clinical impressions, direct Speech/Language services are not indicated at this time as needs can best be addressed in the context of daily living activities." The Consultation Report, dated 8/27/09, recommended the PST consider activity programming to include community education. Individual #312's PSP Action Plan steps did not incorporate the use of his assistive technology devices, nor did a SLP attend his PSP. o Individual #62's PSP, dated 8/2/10, documented the following communication equipment: Step-by-Step Communicator and Ultimate Switch with 19' Gooseneck. His PSP Action Plans did not integrate the use of his communication equipment into any action steps. o Individual #264 had a Communication/Sensory Visual Schedule and Key Ring, dated 4/15/09, to use in his home to encourage the use of pictures to communicate his sensory needs, and to direct the sequences of sensory activities. This schedule included staff instructions for use. His PSP, dated 1/7/10, did not integrate the use of his communication devices into formal teaching strategies. A SLP did not attend his PSP.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	DADS Policy # 004.II.D.4.d included the required elements. Generally, for the action items identified by teams, timeframes and staff responsible were identified. However, methods for implementation were not always adequate as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement.	Noncompliance

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	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	As is identified in other sections of this report, not all of the interventions, strategies, and supports offered to individuals at LBSSLC effectively addressed individuals' needs, and not all were practical and functional at the Facility and/or in community settings. These are discussed in the sections of this report related to the need to improve the plans that address conditions that place individuals' at-risk, psychiatric treatment plans, nursing care plans, PNMPs, OT/PT treatment plans, and Behavior Support Plans.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. Consistent with the baseline review, for the goals and objectives included in PSPs, generally, the PSPs specified data to be collected and/or documentation to be maintained, and specified a frequency for data collection. It was not always clear who was responsible for reviewing the data, and what that review meant in terms of making changes when there was little or no progress. As is discussed above with regard to Section F.2.a.2, the overarching concern was that many goals and objectives were not specified in individuals' PSPs, or other treatment plans that should have been integrated into the PSP. As a result, appropriate data was not being collected to assist teams in decision-making. As is discussed below with regard to Sections K and S of the Settlement Agreement processes were not yet in place to determine the reliability of the data. There were some indications that the data being collected was not reliable.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted in the baseline review, and based on the current review of PSPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; speech/communication and psychology; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. Review of the PSPs generally showed a multidisciplinary as opposed to interdisciplinary approach.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff	DADS Policy #004.II.D.m required the PSP to be accessible and comprehensible to staff who must implement it. Copies of the PSP were being maintained in the "All About Me" books to which staff working with the individuals had access, as well as the Active Records in the residences. However, the content of the plans was not written in a manner that facilitated direct	Noncompliance

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	responsible for implementing it.	support professionals' understanding. As is discussed below with regard to Section K of the SA, Positive Behavior Support Plans that should be integral parts of the PSP were lengthy and included terminology that was not comprehensible to most direct support professionals. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that PSPs and all of their various components are comprehensible, while still containing the necessary clinical requirements.	
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.	DADS Policy #004 at III addressed personal support plan monitoring including the requirements of the SA. Monthly reviews were requested for a sample of individuals. Although some monthly reviews were submitted, there were very few. It appeared that in some cases, quarterly reviews were being completed, which was not consistent with the requirements of the SA. In addition, data often was not complete. For example: ▪ For Individual #166, a monthly review was completed on 2/25/10 for which no programmatic data was available. The next review occurred on 7/29/10, and was a quarterly review. It did not appear to be a review based on data, but rather a subjective review. For example, the programmatic section read: "No concerns at present time." However, when concerns were noted, such as "[Individual #166] is refusing a lot of his clinics" under the medical section, no action was documented as having been discussed or taken. ▪ Similarly, for Individual #54, no programmatic information was provided in the 2/25/10 monthly review. No other quarterly or monthly reviews were provided for him. ▪ No monthly or quarterly reviews were submitted for Individual #36 who had his PSP meeting on 5/18/10.	Noncompliance
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	DADS Policy #004.IV addressed staff training on the PSP process that comports with the SA requirements. Three staff from LBSSLC had been certified as trainers on the new PSP policy. It was reported that all QMRPs completed the training designed for them. One of the requirements for QMRPs was the ability for them to provide training to team members at the Facility. Members of the workgroup who developed the training observed the QMRPs training staff at LBSSLC. According to the QMRP Coordinator, all of them successfully completed this training requirement. A feedback loop also was being provided to QMRPs, as well as other team members regarding team meetings being conducted using the new format. At the time of the review, the QMRP Coordinator indicated that she had observed approximately four	Noncompliance

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	employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	meetings, and provided feedback to a few teams. In order to meet the Settlement Agreement requirements with regard to competency-based training, QMRPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. At the time of the review, it was reported that not all team members at LBSSLC had attended the initial training. In addition, staff indicated the need for ongoing training and support in implementing this new, but exciting initiative.	
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.	Based on a review of a list provided by the Facility of each individual and the dates of their 2009 and 2010 PSPs, it was found that of the 229 individuals supported by the Facility, 219 (96%) had had timely annual PSPs developed. The larger problem was related to the plans being available and in effect within 30 days. In many cases, a couple of months elapsed before the final document was prepared and filed. As noted in the baseline report, the PSP is the document that should drive the delivery of protections, supports, and services. It is essential that it be available for implementation within 30 days. As noted above, a number of changes had occurred since the baseline review with regard to QMRP staffing and supervision. The Facility should continue to monitor the timeliness in which PSP meetings are held, ensure that the documents are available for timely implementation, and make changes as needed.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	DADS Policy #004.V addressed quality assurance processes to ensure PSPs are developed and implemented consistent with the provisions of the SA. Monitoring tools had been adopted, and were being modified for Facility use as described in Section E of this report. Both the QE Department and the QMRP Coordinator were utilizing the tools to conduct reviews. This process was at the beginning stages. Some corrective action plans had been developed to address issues identified. For example, one was developed to provide better tracking of assessments needed for the annual planning meetings. It appeared that two others were designed to address specific issues with particular individuals' plans. As the process for monitoring this Section of the SA is refined, additional action plans likely will need to be developed and implemented.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Now that the State's policy with regard to interdisciplinary teams and integrated planning has been finalized, LBSSLC should review, and revise, as appropriate, its policies on these topics.
2. The State and the Facility should ensure that person-centered concepts are integrated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.
3. As indicated in other sections of this report, focused efforts should be made to improve the quality and timeliness of assessments used in the development of individuals' PSPs.
4. Barriers to the inclusion and implementation of community-based skill acquisition programs, such as transportation, staffing, and funding, should continue to be investigated and addressed.
5. The LBSSLC vocational assessment should continue to be revised and expanded upon and/or alternatives to the vocational evaluations/assessments should be identified and implemented. Vocational evaluations should focus on potential work that is interesting to the individual, and on how that kind of work could be made available to the individual. The evaluation should create a vocational profile based on, for example, objective data, situational assessments, a thorough work history, and/or interest inventories.
6. PSPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the PSP, rather than stand-alone documents.
7. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that PSPs and all of their various components are comprehensible, while still containing the necessary clinical requirements.
8. QMRPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed.
9. The Facility should monitor to ensure PSPs are completed in a timely manner and prepared to allow implementation to begin within 30 days. Any issues identified should be addressed.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Health Status Meeting (HSM) Minutes for meetings held on 9/2/10, and 9/7/10; o Quarterly Medical Doctor (MD) Progress Notes for HSM for the following individuals: Individual #206 dated 5/6/10, Individual #317 dated 5/6/10, Individual #41 dated 5/6/10, Individual #315 dated 6/8/10, Individual #229 dated 6/8/10, Individual #1 dated 6/8/10, Individual #261 dated 4/15/10, Individual #122 dated 4/15/10, Individual #211 dated 4/15/10, Individual #176 dated 4/15/10, Individual #301 dated 4/15/10, Individual #196 dated 4/15/10, Individual #263 dated 4/15/10, Individual #29 dated 4/15/10, Individual #215 dated 4/1/510, Individual #78 dated 4/15/10, Individual #275 dated 5/27/10, Individual #308 dated 5/27/10, Individual #205 dated 5/27/10, Individual #282 dated 5/27/10, Individual #14 dated 5/27/10, Individual #280 dated 5/27/10, Individual #128 dated 5/27/10, Individual #90 dated 5/27/10, Individual #252 dated 5/27/10, Individual #199 dated 5/27/10, Individual #12 dated 5/27/10, Individual #97 dated 5/13/10, Individual #223 dated 5/13/10, Individual #302 dated 5/13/10, Individual #168 dated 7/13/10, Individual #253 dated 7/13/10, Individual #241 dated 7/13/10, Individual #55 dated 7/13/10, Individual #28 dated 7/13/10, Individual #3 dated 7/13/10, Individual #313 dated 7/13/10, Individual #204 dated 7/13/10, Individual #43 dated 7/13/10, Individual #274 dated 7/1/10, Individual #19 dated 7/1/10, Individual #174 dated 7/1/10, Individual #165 dated 7/1/10, Individual #151 dated 7/1/10, Individual #251 dated 6/29/10, Individual #175 dated 6/10/10, Individual #205 dated 8/26/10, Individual #282 dated 8/26/10, Individual #280 dated 8/26/10, and Individual #311 dated 8/26/10; o Monthly Facility Review – Psychoactive Medication Polypharmacy meeting minutes, dated 10/27/09, 11/17/09, 12/15/09, 1/26/10, 2/23/10, 3/30/10, 4/22/10, 5/25/10, 6/29/10, 7/28/09 (should probably be "2010"), and 8/25/10; o Consultant reports and recommendations and follow-up Primary Care Provider (PCP) Integrated Progress Note (IPN) for the following individuals: Individual #160's Ear, Nose and Throat (ENT) consultation dated 7/12/10, and PCP IPN dated 7/12/10; Individual #127's cardiology consultation dated 7/13/10, and PCP IPN dated 7/13/10; Individual #155's urology consultation dated 7/13/10, and PCP IPN dated 7/13/10; Individual #137's gastroenterology (GI) consultation dated 7/14/10, and PCP IPN dated 7/14/10; Individual #301's wound clinic consultation dated 7/15/10, and PCP IPN dated 7/15/10; Individual #78's ENT consultation dated 7/15/10, and PCP IPN dated 7/15/10, Individual #198's gastroenterology consultation and PCP IPN dated 7/16/10, Individual #313's ophthalmology consultation dated 7/19/10, and PCP IPN dated 7/19/10; Individual #257's gynecology consultation dated 7/19/10, and PCP IPN dated 7/19/10; Individual #214's gastroenterology consultation dated 7/20/10, and PCP IPN dated 7/20/10; Individual #179's gastroenterology consultation dated 7/1/10, and PCP IPN dated

	7/1/10; Individual #50's gastroenterology consultation dated 7/2/10, and PCP IPN dated 7/2/10, Individual #139's gastroenterology consultation dated 7/2/10, and PCP IPN dated 7/2/10, Individual #197's gastroenterology consultation dated 7/7/10, and PCP IPN dated 7/7/10, Individual #290's allergy consultation dated 7/8/10, and PCP IPN dated 7/8/10, Individual #213's sleep study specialist consultation dated 7/19 to 7/20/10, and PCP IPN dated 7/21/10, Individual #68's allergy specialist consultation dated 7/22/10, and PCP IPN dated 7/22/10; o Seizure Committee agenda, dated 9/13/10; o Flow diagram – Process steps seizure management; o Flow diagram – extracted process review - information flow about seizures; o Seizure Committee minutes, dated August 30, 2010; o Old Seizure form: Nursing Observation/Assessment, and page of instructions; o New Seizure Record, dated 6/10; o Lubbock SSLC Plan of Improvement for Section G - Integrated Clinical Services, dated 5/17/10; o Lubbock SSLC Supplemental POI, dated 5/17/10; and o Texas Settlement Agreement Monitoring Instrument for Section G, dated 7/10. ▪ **Interviews with**: o Dr. Glenn Shipley, Medical Director; o Dr. Richard Weddige, Psychiatry Director; o Dr. Russell Reddell, Dental Director; o Billy Bob Beck, Director of Pharmacy; and o John Todd, Clinical Pharmacist. ▪ **Observations of**: o Neurology Clinic, on 9/15/10; o Morning Medical Meetings on 9/14/10, and 9/15/10; o Individuals at 504 East Mesquite Drive, and 504 West Mesquite Drive; and o Rounds with Dr. Rodriguez, PCP.
	Facility Self-Assessment: The Medical Director had oversight of Section G. The summary included in the Facility's POI indicated improvement and/or continued success in several key areas. For example, according to the POI, the psychiatrists attended the neurology clinics. Those individuals with psychiatric diagnoses and requiring medication were discussed with the neurologist treating the individual for seizures. There had been improved documentation in the IPN of dental visits and treatment for other PST members to review. The nurse liaison to the hospital had been successful in updating the Medical and Nursing Departments on the progress of those individuals who were hospitalized. According to Section A.19 of the POI, this was accomplished by "the medical secretary receives input from Nurse Liaison, E-mail from medical secretary showing hospital course, and hospital liaison report showing individual in hospital." The PCPs had begun dictating a review of all consultation reports and provided information as to whether they accepted the recommendations or not. The POI indicated there was not yet compliance with this aspect of integrated care (POI G.2.A.1-20), suggesting that this process had just begun, or there were consultation reports not reviewed, or that non-agreement with the recommendations was not followed by

	alternate options. Although there was progress, the Medical Director also informed the Monitoring Team that there was "still work to do." Based on the Facility's self-assessment as documented in the POI, there were still areas in which progress needed to be made. The Facility indicated it was noncompliant with A.3.3 that required: "individuals receive dental services that are integrated across clinical disciplines," A.5 that required: "Pharmacy services …are integrated across clinical disciplines," A.8 that required: "medical, behavioral services, nursing, therapy, and direct support professionals participated in the positive behavior support planning process," A.20 that required: "there is documentation in the integrated progress notes that the physician was notified timely upon the individual's return," and A.21 that required: "Nursing staff…. communicated all abnormal assessment findings to the PCP and/or appropriate clinical staff."
	Summary of Monitor's Assessment: Although there were some examples of the integration of clinical care at LBSSLC, there remained a number of significant areas in which integration was needed in order to improve the care of the individuals. These included, but were not limited to, Health Status Meetings at which information was presented, but interdisciplinary, integrated discussion did not consistently occur; cooperation between the Dental Department and the QMRP/home manager to resolve refusals of attendance at dental appointments; as well as the Dental Department and the QMRP/psychology department to implement desensitization programs in addition to other strategies to reduce reliance on pre-treatment sedation and/or restraint. There had been improvement in physician documentation of review, and documentation of the physician's agreement or not with consultant recommendations, but it was not clear what percentage was reviewed. There should be a tracking system, and data collection to ensure compliance with this requirement.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	There were some examples at LBSSLC of forums at which there was the opportunity for interdisciplinary discussion, and integration of clinical care. As is described below, some of these forums were functioning at a level that resulted in the integration of care, while others were not. In addition, there were areas where there was a need for integration of care, but there was no process or forum for ensuring that this occurred. The Health Status Meetings were examples of interdisciplinary forums to discuss each individual in the home. As is discussed further in Section I, these teams did not fulfill the intended effect of developing a comprehensive risk assessment, but the teams did include a representative from almost every discipline. However, they were multidisciplinary rather than interdisciplinary in format, with each member contributing their own expertise, with little time for the integration of information due to the number of individuals discussed per session.	Noncompliance

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		From the medical department perspective, the information prepared for use by the HSM was up-to-date and thorough. Several types of documents were submitted for review. The HSM minutes of 9/2/10 and 9/7/10 documented members present, which included a primary care practitioner, psychiatrist, pharmacist, dentist, nursing department representative, dietician, habilitation therapy, and other representatives. Other submissions, entitled Quarterly MD Progress notes for HSM, only included the date of the visit, and no roster or members. The MD progress notes for HSM were reviewed for all homes. From these brief reviews, the notes for a sample of individuals were reviewed in more detail for clinical content. (This sample included: Individual #206 dated 5/6/10, Individual #317 dated 5/6/10, Individual #41 dated 5/6/10, Individual #315 dated 6/8/10, Individual #229 dated 6/8/10, Individual #1 dated 6/8/10, Individual #261 dated 4/15/10, Individual #122 dated 4/15/10, Individual #211 dated 4/15/10, Individual #176 dated 4/15/10, Individual #301 dated 4/15/10, Individual #196 dated 4/15/10, Individual #263 dated 4/15/10, Individual #29 dated 4/15/10, Individual #215 dated 4/1/510, Individual #78 dated 4/15/10, Individual #275 dated 5/27/10, Individual #308 dated 5/27/10, Individual #205 dated 5/27/10, Individual #282 dated 5/27/10, Individual #14 dated 5/27/10, Individual #280 dated 5/27/10, Individual #128 dated 5/27/10, Individual #90 dated 5/27/10, Individual #252 dated 5/27/10, Individual #199 dated 5/27/10, Individual #12 dated 5/27/10, Individual #97 dated 5/13/10, Individual #223 dated 5/13/10, Individual #302 dated 5/13/10, Individual #168 dated 7/13/10, Individual #253 dated 7/13/10, Individual #241 dated 7/13/10, Individual #55 dated 7/13/10, Individual #28 dated 7/13/10, Individual #3 dated 7/13/10, Individual #313 dated 7/13/10, Individual #204 dated 7/13/10, Individual #43 dated 7/13/10, Individual #274 dated 7/1/10, Individual #19 dated 7/1/10, Individual #174 dated 7/1/10, Individual #165 dated 7/1/10, Individual #151 dated 7/1/10, Individual #251 dated 6/29/10, Individual #175 dated 6/10/10, Individual #205 dated 8/26/10, Individual #282 dated 8/26/10, Individual #280 dated 8/26/10, and Individual #311 dated 8/26/10.) Content was thorough, practical, and sufficiently detailed so that the team could make decisions and plans could be updated. The forms were completed with sufficient information so that the team would have the most recent health information available. In reviewing the many forms used to complete this task, it would appear that each building or physician was using different forms. It is recommended that an agreed upon form be used across campus to ensure consistency in presentation. Most of the forms submitted appeared to be worksheets prepared by the PCP for discussion at the HSM. The psychiatry services were integrated with psychology in that the Psychologists had an integral role in the Psychiatric Clinic process. The Psychiatric Clinics were the primary forum for coordinating that aspect of medical care for the individuals who resided at the Lubbock State Supported Living Center (LSSLC). The Psychologists were responsible for	

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		providing the data that influenced and affected the decision-making of the Psychiatrist. However, the review of the individual records described in Section J revealed that behaviors described in the Functional Analysis and Behavior Support Plan as being present on a behavioral basis also were frequently described in the Psychiatric section as "targets" for the psychotropic medication. This would suggest that either the psychotropic medications were being used to suppress behaviors related to environmental and interpersonal factors, or there was a lack of integration between the Psychiatry and Psychology Departments in the development of these plans. Information provided during this on-site visit indicated that the Psychiatrists had begun an active collaboration with members of the Psychology Department to address these issues. The integration between Psychiatry and Medicine was primarily represented by the participation of the Nursing Staff in the Psychiatric Clinic process, as well as the MOSES monitoring for side effects. The interaction with the Primary Care Physicians was usually accomplished by written consultations between disciplines, as well as telephone contacts. The interaction between Pharmacy and Psychiatry was primarily in the form of the detailed Quarterly Reviews of the psychotropic medications by the Pharm. D. In addition, the Pharmacy entered every new medication order through a software system that checked for potential interactions and would notify the prescriber if there was an issue with the medication. The Psychiatrist would be notified if this occurred with a newly prescribed psychotropic medication. The review of records that was carried out in conjunction with the current review indicated that the Quarterly Pharmacy Review Notes were, in fact, completed on a quarterly basis and were reviewed and signed by the Psychiatrist. Further work was needed to ensure that when physicians, including psychiatrists agreed that changes needed to be made, that they were, in fact, made. The Psychoactive Medication Polypharmacy Monthly Facility Review also was an interdisciplinary meeting attended by members of psychiatry, medicine, dentistry, pharmacy, and behavioral services. Minutes of the following meetings were reviewed: 10/27/09, 11/17/09, 12/15/09, 1/26/10, 2/23/10, 3/30/10, 4/22/10, 5/25/10, 6/29/10, 7/28/09 (probably supposed to be "2010"), and 8/25/10. For each individual with polypharmacy, the psychoactive medications were listed, along with a list of diagnoses, and interdisciplinary discussion. The Committee minutes were thorough, and represented a compilation of information that was shared on numerous individuals at any one time. By the amount of detailed information presented, the members came to the meeting well prepared. There were conclusions reached based on the committee's review of the information, suggesting important interdisciplinary discussion, albeit brief for any one individual. From the number of cases reviewed at each meeting, the interdisciplinary approach was limited. Medications were not separately listed as	

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		treating a specific psychiatric diagnosis. For those individuals with more than one psychiatric diagnosis and more than one psychotropic medication, it was not necessarily obvious which medication was being used to treat which diagnosis. This had the potential to limit appropriate integrated discussion of and coordination regarding the use of medication. Neurology Clinic was held on campus at LBSSLC. The neurology consultant saw the individuals, and then discussed each individual. Psychiatry, primary care providers, and nursing were represented. This clinic was a good example of an interdisciplinary forum that integrated the several essential clinical disciplines in optimizing care for those having neurological diagnoses. Morning Medical Report Meetings occurred each business weekday, and included a wide variety of disciplines, including primary care, psychiatry, the Dental Department, and nursing. More information is included about the morning meetings in the section below that addresses L.1 of the Settlement Agreement. The Seizure Committee was in the process of revising the seizure record form, for documentation each time a seizure occurs. The form was being streamlined, which should improve the quality of information provided and assist in ensuring the completeness of information included in the database. It condenses a two-page questionnaire into one page. At the 9/13/10 meeting, the process for seizure management was reviewed using a flow diagram. Different disciplines had contributed to this process of developing an improved seizure management plan and documentation forms, including the pharmacy department, nursing department, medical department, speech pathology department, and QMRPs. This is another example of interdisciplinary cooperation that will ultimately improve the quality of care and life of the individuals at LBSSLC. One example of strength in interdisciplinary cooperation had been the improved communication between habilitation services and the Dental Department concerning positioning to avoid aspiration and choking. The hygienist attended the PNMT meetings, according to the Dental Director. Informally, the dental department had begun to use the habilitation department resource of photographs, which showed optimal positioning while seated. During the on-site review, it was discussed that the Habilitation and Dental Departments would formalize this effort and compile a complete resource catalog of photos demonstrating optimal positioning in the individual's chair in order to ensure health and safety during any dental examinations and procedures. The creation of a nurse position assigned as liaison to the hospital to review, on a daily basis, the individuals who were LBSSLC inpatients had provided improved quality and	

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		completeness of information shared between LBSSLC and the hospital. It also had allowed for improved discharge planning back to LBSSLC. Although there has been progress in a number of the areas discussed above, there was still a critical need for integrated thoughtful discussion and resolution of problems in major areas. For example: ▪ A future opportunity for expanding the interdisciplinary approach to care would be to make the Medical Director a resource to the PNMT. This team will need the expertise of the Medical Director in assisting the Facility to identify and treat problems in the field of physical and nutritional management. The Medical Director could take a leadership role with this team. ▪ During discussions with the Clinical Pharmacist, as well as the Dental Director, there was the perception of need for improved communication with nursing. ▪ The Dental Department also had an unacceptably high rate of "no shows" for appointments (see additional information with regard to Section Q of the SA), but had had difficulty with communication and cooperation from the buildings in assisting to resolve this problem. There was a need for the QMRPs to address the "no show" dental appointments at the PST meetings. ▪ The Dental Department and the QMRP/psychology department need to work together to develop and implement desensitization programs, as well as other strategies to reduce reliance on pre-treatment sedation and/or restraint. ▪ Based on record review of 16 individuals who had been hospitalized for acute illness, many due to aspiration pneumonia, medication administration observations and interviews with the nursing staff, there was no collaboration between nursing and the PNMT regarding individuals who have recurrent pneumonias and aspiration pneumonias. From observations during medication administration, nurses were not assessing safe positioning for individuals when they received medications orally or enterally. In addition, when individuals were coughing, nursing did not have a stethoscope on the medication cart to assess their lung sounds prior to administering medications. Also, the Medication Administration Records (MARs) reviewed did not contain the PNMP and, consequently, nurses were not checking the individuals' position prior to administering medications. ▪ A review of the medical emergency drills found that there continued to be no collaboration between disciplines regarding reviewing the Facility's medical emergency systems. The Competency Training and Development (CTD) Department was solely responsible for conducting the medical emergency drills.	
G2	Commencing within six months of the Effective Date hereof and with	As an improvement to the system, at the time of the review, the PCPs had begun dictating a review of non-facility consultation reports, and indicating whether they were accepting	Noncompliance

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	full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	the recommendations or not. When they were not accepting the recommendation, alternative approaches were included in the note with justification. The following were examples of written entries in the Integrated Progress Notes of the PCP response to external consultant recommendations: ▪ Individual #160 underwent bilateral myringotomy with ventilating tube insertion for chronic serous otitis media on 7/12/10. The PCP summarized the consultant's information and agreed with follow-up orders. ▪ On 7/13/10, Individual #127 completed an echocardiogram, and the PCP summarized the findings and agreed with the follow-up recommendations of the consultant. ▪ On 7/13/10, Individual #155 underwent outpatient urological surgery. The PCP summarized the urological procedure and agreed with the follow-up plan. ▪ Individual #137 had a gastroenterology consultation on 7/14/10. The PCP summarized the findings and agreed with the follow-up plan. ▪ On 7/15/10, Individual #301 was seen in the wound clinic. The PCP summarized the consultant report and agreed with the follow-up plan. ▪ ENT saw Individual #78 on 7/15/10, and the PCP wrote a summary, with follow up to be conducted by ENT. ▪ Individual #198 had a GI consult 7/16/10, and the PCP summarized the consult and agreed with the follow-up plan. ▪ Individual #313 had an ophthalmology consultation on 7/19/10, and the PCP summarized the visit and agreed with the follow-up plan. ▪ Individual #257 had a gynecology consultation on 7/19/10, and the PCP summarized the visit and agreed with the recommendations and plan. ▪ Individual #214 saw a gastroenterologist on 7/20/10. The PCP summarized the visit and agreed with the follow-up plan. ▪ Individual #179 had a gastroenterology consultation on 7/1/10, and the PCP summarized the visit, as well as an alternative follow-up plan including clinical rationale. ▪ Individual #50 had a gastroenterology consultation on 7/2/10, and the PCP summarized the report and agreed with the follow-up plan. ▪ Individual #139 had a gastroenterology consultation on 7/2/10, and the PCP summarized the report as well as an alternative follow-up plan with documented clinical rationale. ▪ Individual #197 had a gastroenterology consultation on 7/7/10, and a PCP summary with agreement of the follow-up plan. ▪ Individual #290 had an allergy consultation on 7/8/10, and the PCP summarized the information, and agreed with the follow-up plan. ▪ Individual #213 saw a sleep study consultant on 7/19 to 7/20/10, and the PCP	

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		summarized the information and documented that the information would be presented at the PST. ▪ Individual #68 saw an allergy consultant on 7/22/10, and the PCP summarized the information and agreed with the follow-up plan. There was 100% compliance with the PCP reviewing the consultant report and findings (17 out of 17 records reviewed), as well as 100% compliance with review of follow-up plans and recommendations, including communicating alternative approaches with justification when disagreeing with the recommendation (17 out of 17 records reviewed). However, LBSSLC had no tracking system to ensure compliance with this component of the SA. There should be a tracking system to ensure all consultant recommendations are reviewed. There was no certainty that the physicians were reviewing all consultations, and/or that this was being completed in a timely manner to ensure there were no lapses in care. The only routine involvement between Psychiatry and a non-facility physician would be with Neurology. There was evidence of integration between the Psychiatry Department at the LSSLC and the Neurology Consultants. Specifically, the Psychiatrists attend the Neurology Clinics and were actively involved in the dialogue with the Neurologist. These interactions were documented in both the Neurology Consultation Notes and the corresponding Psychiatric Progress Notes.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. There should be consistency in the forms used across the campus for HSM reviews, including the worksheet formats that are used for medical department presentations at these meetings.
2. The minutes of the Facility's monthly review of psychoactive medications should identify the diagnosis being treated with each of the medications to ensure that, for those individuals with more than one psychiatric diagnosis and more than one psychotropic medication, it is clear which medication is being used to treat which diagnosis.
3. The Medical Director should take a leadership role as a member of the Physical and Nutritional Management Team, providing needed medical guidance to complex pathophysiologic issues that require interdisciplinary expertise.
4. The Dental Department should track and record attempts to determine the reason for the "no show" appointments. Such tracking should include the date of contact, with whom they spoke and the content of the information. If there is no verbal communication, a written note should be created with space to provide an answer regarding the reason for the individual to have a "no show" in the dental office on that date. The house manager or QMRP should be expected to complete the form, and follow-up with the PST, as appropriate, to address the underlying reason(s) for the "no show."
5. Consideration should be given to providing the Dental Department with a catalog of photos from the OT department demonstrating the best positioning of each individual who may have seating or other positioning challenges while in a dental chair or wheelchair.

6. PCPs should continue to dictate review of consultations, and either agreement with recommendations or a description of alternative approaches with clinical justification. The Medical Director should ensure that all consultation reports are logged in when received, and that a tracking system is maintained indicating the date of PCP review, and the completion of recommendations or completion of alternative recommendation to ensure compliance with this section of the SA.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Medical records for the following individuals: Individual #68, Individual #29, Individual #128, Individual #165, Individual #140, Individual #313, Individual #263, Individual #261, Individual #167, and Individual #78; o "LSS [Lubbock State School] – Health Services Coding Requirements," dated 2/1/08; o LBSSLC Plan of Improvement, Section H, dated 5/17/10; o LBSSLC Supplemental POI, dated 5/17/10; and o Texas Settlement Agreement Monitoring Instrument for Section H, dated 7/10. ▪ **Interviews with**: o Dr. Glenn Shipley, Medical Director; and o Dr. Rodriguez, PCP. ▪ **Observations of**: o Individual #136, Individual #181, Individual #211, Individual #301, Individual #78, Individual #263, Individual #167, Individual #323, Individual #226, and Individual #261.
	Facility Self-Assessment: At LBSSLC, the Medical Director had oversight of Section H. According to the Medical Director and the Facility's POI, the Facility generally was not in compliance with the requirements of Section H of the SA. According to the POI, indicators with which the Facility was in compliance included: a nurse was at every Health Status Meeting and that these were held every 90 days; all diagnoses and all ordered lab work included International Classification of Diseases (ICD) and Diagnostic and Statistical Manual (DSM) diagnoses; and MOSES and DISCUS were completed on all individuals who required these monitoring tests. The Medical Director stated that for Section H, there was "a lot of work to do." Based on the Facility's POI, although the departments were continuing to work on clinical indicators of efficacy of treatment (H.4.A.1), the departments were not compliant with the indicator: "a system is established and maintained to effectively monitor the health status of the individual" (H.5.A.1), or with the indicators: "quarterly psychotropic medication reviews were conducted with input from the pharmacist" and "the PCP has reviewed these reports and addressed recommendations made by the pharmacist in the integrated progress notes" (H.5.A.1.a and b), and/or "the nurse collaborated with other PST members in assessing, planning, implementing and evaluating programs and other activities that impact upon the individual's behavior" (H.5.A.5). The Facility's assessment generally was consistent with that of the Monitoring Team. The Monitoring Team's specific findings are discussed in detail below.
	Summary of Monitor's Assessment: There had been progress in this section, such as ensuring medications had appropriate diagnoses linked to them that were consistent with ICF and DSM criteria.

	MOSES and DISCUS were completed on all individuals (the section of this report that discusses Section N of the SA provides details regarding the Facility's tracking of MOSES and DISCUS). However, the Facility remained in noncompliance in most areas of Section H, including completion of timely annual medical evaluations, as well as inconsistency in approach to the needs of the individuals across the campus. This would be improved through the use of clinical pathways that include timelines so that the same steps are taken at the appropriate time for all individuals with the same diagnosis, unless contraindicated. The medical department had not begun to consider clinical indicators to measure quality of care. A policy and procedure manual for the department should reflect the guidance from the Health Care Guidelines.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Medical assessments were not consistently completed annually. However, there was good documentation of timely assessment by and response from primary care providers for an acute illness and follow-up once returning from the ER or a hospitalization. However, at times, changes in an individual's status had an aggressive response from the health care team, but in other instances there appeared to be lack of critical thinking. Several examples are discussed below with regard to Section L1 of the SA. Three main areas noted included evaluation and treatment of GERD, chronic constipation, and pica. At times GERD was aggressively treated, with some individuals undergoing medical and nursing monitoring and surgical procedures to reduce the risk of GERD and its complications, such as fundoplication, jejunostomy Tube (J-tube) placement, and laryngotracheal diversion. Other individuals were not offered surgical intervention despite repeat aspiration pneumonias, and monitoring at times indicated poor positioning with risk of exacerbating GERD, but there was no systemic resolution to this difficult problem. Some individuals with chronic constipation had frequent reliance on PRN medications, when an increase in routine medication would assist in improving quality of life and decrease symptoms from constipation. There was little consideration for diagnostic work-ups for intestinal hypomotility and interventions based on results of these work ups. When a list of individuals with pica was submitted, few had entries completed concerning the types of articles/objects ingested. The medical staff were not familiar with the individuals with pica or the details of this serious habit, including their target objects for ingesting, suggesting medical staff were not involved in ensuring prevention and treatment of pica behaviors. As mentioned in later sections, there should be clinical guidance from the Medical Director in the form of clinical pathways or guidelines that are uniformly implemented across the campus. There was documentation that monthly interdisciplinary reviews of psychotropic medication were being uniformly carried out, as well as a quarterly direct observation of the individual by the Psychiatrist. However, the review of individual records described in Section J indicated that the quality of the documentation contained in the Psychiatry	Noncompliance

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		Assessments and the Psychiatry Clinic Reviews did not meet the standards set forth in the Settlement Agreement.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Diagnoses on both the active and inactive problem lists were based on the criteria of the International Classification of Disease. There was an excellent relationship with the local university medical center, and work-ups leading to the diagnoses on the active problem list had been thorough and appropriate. Record reviews indicated a variety of test results or procedures that confirmed the diagnoses listed. Additionally, the policy entitled "LSS – Health Services Coding Requirements" documented the steps in assessment or evaluation that were to be performed on a routine basis, and in response to change in an individual's health. According to the policy, the diagnosis was to be in compliance with current ICD and DSM Manuals. The Dental Department was to follow the codes per the American Dental Association (ADA) guidelines. As a feedback mechanism, the Reimbursement Officer notified the PCP if a diagnosis did not have a code that could be used for billing. This ensured all diagnoses were in agreement with the ICD or DSM. The psychiatric diagnoses utilized at the LSSLC were consistent with the nomenclature utilized in the DSM-IV-TR. The current deficiency in this area was incomplete (or missing) documentation in the individual records, which sets forth the specific symptoms that the individual presented in a manner that would support the validity of the psychiatric diagnosis. However, the current review indicated that progress was being made in solving this problem.	Noncompliance
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.	As mentioned above with regard to Section H1 of the SA and discussed in further detail below with regard to Section L.1 of the SA, in order to standardize timely treatment and ensure consistency of interventions, the Medical Director should provide clear guidance as to the expected medical assessments/evaluations and treatment with timelines for such common comorbid conditions as dysphagia, GERD, repeated pneumonias, severe constipation, weight loss, pica, etc. The Medical Director had made a good start with the development of several clinical guidelines, but what was lacking was an expectation of when the next step in the processes, as described in the guidelines should be completed. Timeframes/timelines and/or clinical criteria should be added to these guidelines, as appropriate. For instance, if someone requires three enemas in a month to relieve acute constipation, the guidelines should describe what the next step would be, and when it should be implemented. This might include, for example, increasing maintenance medication doses or adding a new medication, or undergoing radiologic and physiologic bowel hypomotility studies for potential surgical or other medical treatments. The monthly Psychiatric Clinics and Quarterly Assessments of the individuals the	Noncompliance

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		Psychiatrist completed were consistent with the requirements of this provision, in that they were performed in a "timely" manner. As discussed in further detail with regard to Section J of the SA, the deficiencies regarding this provision related to the requirement that these interventions are "clinically appropriate based upon assessments and diagnosis."	
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.	LBSSLC had not developed a quality improvement program in the medical department, which would include identification of clinical indicators to measure treatment efficacy. In reviewing the clinical guidelines already in place and when creating new clinical pathways, there should be sufficient details within the guidelines to allow identification of one or more clinical indicators. For instance, if severe constipation is one of the clinical guidelines, then the guideline should outline the threshold for the next step to be taken. For instance, if a person requires more than three enemas in a month, then there may be an expected response, such as additional dosage of a medication given or a new medication added. A clinical indicator would be three or less enemas per month, which could be tabulated easily across the system to determine the attention and quality of care provided for this problem. One of the main tasks of the Medical Director would be to ensure the clinical pathways or guidelines were understood and followed by the PCPs. Many of the aspects of clinical pathways become practical and meaningful when they are used to demonstrate and measure quality care. The health care team gains a sense of accomplishment when they see measurable indicators have improved. The Medical Director also gains confidence that the health care needs are being met equally across all homes on the campus, and can readily determine if there is a home needing further assistance. The lack of sufficient documentation concerning the efficacy of the psychotropic medication was a significant deficiency in the utilization of these medications at the LSSLC. This subject, as well as potential remedies, is discussed in detail below with regard to Section J of the SA.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	LBSSLC was developing the foundation for a quality improvement program, but the monitoring of health status of individuals remained a future goal. The medical morning report meetings, the database being developed by the medical department, and such tools as drug utilization evaluation results, are all essential components for developing a system that can effectively monitor health status. The current administration at the Facility was appropriately taking steps to develop each of these components, and appeared to understand the need for and the approach necessary to attain this goal. The psychiatric status of each individual receiving psychotropic medication was being discussed on a monthly basis in the format of the Psychiatric Clinics. These meetings also included a discussion by the Nursing Staff of any medical problems, as well as any	Noncompliance

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		apparent side effects of the medications. However, this information was not fully documented in the overall Facility health status assessment process.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	As already mentioned, the Facility had not developed and implemented clinical indicators from clinical guidelines that could be used as measuring tools to identify medical issues and provide interventions. This can be a valuable process for all levels of health care, from preventive, to routine maintenance, to acute care. Such clinical indicators can provide fresh insight into individuals' needs. For instance, episodes of wheezing may be an indicator that is targeted for intervention in attempts to reduce the episodes of bronchospasm. Although there is the understanding that allergies and asthma are causative factors for wheezing, another important cause of wheezing may be severe GERD with aspiration into the lung, setting off an episode of bronchospasm. The appropriate work-up may lead to a new treatment such as implementation of Proton Pump Inhibitors for those that develop wheezing, especially in those with known GERD. With less attacks of bronchospasm, there may be a reduced usage of PRN nebulizer treatments. The number of times PRN nebulizer treatment per week or month is used could be measured, and reviewed for trends to determine improvement. The "clinical indicators" that the psychiatrist responded to were primarily represented by the Behavioral Data presented by the Psychologist in the monthly Psychiatric Clinic. As discussed above, and below with regard to Section J of the SA, a significant deficiency derived from the observation was that the "target behaviors" of the psychotropic medication were also frequently described elsewhere in the record as being present on a learned behavioral basis.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Medical Director had already begun to develop and implement a number of clinical guidelines. Additional guidelines for critical and common concerns such as aspiration pneumonia, and pica should be developed. However, many additional components will be needed to ensure the success of these and other guidelines, such as adding timelines and timeframes to the documents, as well integrating other departments' roles into the guidelines (e.g., consultation by the Dental Department when there is anorexia or aversion to food, the practical steps that should be expected in a nursing assessment for a particular diagnosis to assist the physician in determining the next step in medical care, etc.). The medical staff will need to understand the clinical rationale of the guidelines, the expectations for orders and testing, and timeliness that are built into the guidelines. Medical staff should be provided an opportunity to share their expertise and provide input into each of the guidelines. Recently, the State Office had provided an updated, standardized blueprint of health care guidelines for implementation. The Facility will need to review and prioritize the	Noncompliance

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		guidance provided in this document.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Annual medical assessments should be tracked to ensure timely completion, and each individual should have an annual medical assessment completed.
2. There should be the same intensity of response to changes in individuals' health status across the campus. Guidelines and a monitoring tool should be developed and implemented to ensure all individuals are offered comparable treatment as appropriate to meet their needs throughout the course of their illnesses.
3. For chronic constipation, if there is an increase in the use of PRN medication, there should be a review of the individual's drug regimen, and consideration given to increasing routine or changing medication until the use of PRN medication is unnecessary.
4. The entire medical staff, as well as other clinical departments, should be involved in prevention and treatment of pica behaviors.
5. For a number of clinical guidelines that the Medical Director had developed, there should be timelines/timeframes or clinical indicators added to these guidelines to ensure the PCPs understand expectations regarding when to accomplish the next step.
6. There should be sufficient details within the guidelines to allow identification of one or more clinical indicators for measurement of treatment success.
7. The Medical Director should ensure that the clinical guidelines/pathways are understood and followed by the PCPs.
8. The Medical Director should develop additional guidelines that address critical and common concerns such as aspiration pneumonia and pica.
9. Clinical guidelines should also indicate when to integrate other departments into care of the individual.
10. Medical staff should have the opportunity to share their expertise and provide input into each guideline that is developed.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy Number 006: "At Risk Individuals, including Risk Factor Definitions", dated 9/10; o Database September 2009 – August 2010, causes of injury, with many subcategories listed; o Non-LBSSLC physician review; o Texas Settlement Agreement Monitoring Instrument Sections G, H, I, and L; o SSLC Policy: At Risk Individuals #006, Draft; o SSLC Risk Factor Definitions – Draft 9/2010; and o Lubbock SSLC Plan of Improvement Section I, dated 5/17/10. ▪ **Interviews with**: o Dr. Glenn Shipley, Medical Director; and o Various personnel from the State Office (SO).
	Facility Self-Assessment: The Medical Director had oversight of Section I. In his comments to the Monitoring Team, he stated that the HSM was held every 90 days, that all disciplines attended, and that there was a health status coordinator assigned to monitor and follow up with the PST for areas of elevated risk. As a summary, he stated that there was "much work to do." Based on the POI, the Facility identified several areas in which there was noncompliance, including: ▪ I.1.A.1.c: "the facility has a risk screening, assessment and management system in place and being implemented to identify individuals whose health or well being is at risk that includes a process to ensure appropriate screening and/or assessment when there is a change in an individual's condition;" and ▪ I.2.A.2: "risk screenings are updated in response to changes in individual's condition." In reviewing the Facility's monitoring results, the Facility had identified that preventive interventions to minimize the condition of risk were not integrated into the PSP, and also that for two out of four charts reviewed, the plan was not implemented "within 14 days of being written or immediately when the risk to the individual warrants." Much of the delay in addressing these important requirements of the SA appeared to be that the Facility was waiting for guidance from the State Office, as noted in the Supplemental POI in which the status/comments were "statewide action is required. Facility action will begin after receiving direction from SO." The Facility rated nearly all areas of the POI for Section I of the SA as noncompliant. This is consistent with the Monitoring Team's findings.

	Summary of Monitor's Assessment: The Facility had developed its own risk assessment program, but there were concerns regarding the validity of the risk stratification. In the meantime, the State Office had been actively developing a risk assessment process to be used at all Facilities. At the time of the review, it had not been finalized.

#	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.	DADS Policy Number 006 requires that a "regular risk assessment and management system will be used to identify persons at risk for illness and injury." There was evidence that DADS was working to define risk factors. A draft of definitions of risk factors, dated 9/20/10, was shared for comment with the Monitoring Team. At the Facility, there had been a great deal of energy devoted to developing priority lists of individuals most at risk. The original structure gave the different health status teams in the homes the task of determining the level of risk for each individual on a number of different clinical topics. This has led to different interpretations of the same information across the campus. Further, some of the tools being used did not appear to have been validated, nor did they have face validity. LBSSLC continued using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. As noted from the previous review, this tool was scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. Since the baseline review, the Facility had modified this system so that individuals were no longer given an overall score for risk, but were assigned a risk score for each of the health indicator categories. These indicators were discussed at the HST meetings, at which time the physician or practitioner assigned the risk score for each category: Level 1 was the highest risk, Level 2 represented moderate risk, and Level 3 was low risk. Consistent with the baseline review findings, the risk tools used were not adequate, and the HST meetings did not result in the appropriate identification of individuals at clinical risk. By the next review, there should be a new process in place to identify individuals at risk with the appropriate associated policies and procedures. There appeared to be recognition by the Facility that the at risk identification system was not adequate. During the initial presentation to the Monitoring Team, the Medical Director discussed the concern that the at risk system had not accurately identified those at risk, and in responses to this, he had added recognized tools such as the Braden score and Body Mass Index (BMI). The medical department also attempted to have an increased presence in the homes, and brought in a non-facility physician to conduct record review. The non-facility physician noted that an individual (identified in the	Noncompliance

#	Provision	Assessment of Status	Compliance
		physician's notes as individual #0067) had multiple concerns about aspiration, yet was identified as low risk. Another individual (identified in the physician's notes as individual #30070) had multiple falls and non-serious injuries, but was also categorized as being at low risk. The State Office also refocused efforts on developing a system that was clinically valid and appropriate for this population, as well as reliable and reproducible (i.e., the same level of severity of an issue was identified at the same level of risk across the campus). Various approaches could be used to effectively implement such a system. It may be expecting too much to require the many lay members of the Health Status Team to determine an accurate level of risk. This would require a great deal of in-service training. For health-related risk areas, it might be more expedient to have a core team of nurses and primary care practitioners meet to review all relevant health information related to the individual, and using a standardized process, develop a risk profile of the individual. This profile would be shared with the team, just as other assessments are shared, for the team's review and approval. The team would then be responsible for developing plans to address individual's risk areas. Such a process, as the first step in risk assessment, allows the same criteria and the same interpretation of identified criteria across the campus. As the morning medical meeting is held daily, it would be an excellent forum to discuss changes in risk due to new reported concerns, such as trips to the ER. Since the Health Status Team met only every 90 days, there was no mechanism that drew them all together to discuss the urgent problems that arose between these meetings. Consideration should be given to having the Medical Director take a lead role in assisting in deciding the level of risk. There were several lists that could be used initially to begin to identify individuals who are at risk. While waiting for the State Office policy, the Facility should not delay beginning to address the needs of individuals who clearly present risk factors. The following lists show inherent or face validity: ▪ Emergency Room: Visits by type, from January 1, 2010 to August 16, 2010; ▪ Hospital: Admissions by type, from January 1, 2010 to August 16, 2010; ▪ Individual Diagnosis Report: Constipation from August 1, 2009 to August 31, 2010; ▪ Constipation report, dated 9/13/10; ▪ Client Characteristics Report, dated 8/1/10 to 9/14/10, age 50 to 80, DEXA scan, and results; ▪ Osteoporosis Report, dated 9/13/10; ▪ Individual Diagnosis Report: Fractures, dated January 1, 2010 to August 31, 2010;	

#	Provision	Assessment of Status	Compliance
		▪ GERD Report, dated 9/13/10; ▪ Respiratory Profile Report, from January 1, 2010 to July 31, 2010; ▪ Individual Diagnosis Report Status epilepticus, from April 1, 2009 to August 31, 2010; and ▪ Injuries for the past year (September 2009 through August 2010), and are broken down into subcategories: slip/trip/fall, bite, "bumped into," friction, hit, hit/slap, or push/shove. The SO developed a draft policy for SSLCs entitled: "At Risk Individuals" Policy #006. The strengths included identification of the responsible party for determining a variety of health and wellness categories. Additionally, a table was created with more precise risk factor definitions to guide the teams. This included risk factors such as choking, aspiration, respiratory compromise, weight, cardiovascular disease, constipation/bowel obstruction, diabetes, osteoporosis, seizures, etc. It was a three-page list with three levels of risk for each category, and provided a description or definition for each of those levels of risk. It would be best to pilot this draft policy, and particularly, the table of risk factor definitions. In order to ensure that the needs of those at highest risk are addressed with urgency, it is important to ensure that the criteria used for determining risk levels results in the identification of individuals who truly are at risk. Including many chronic illnesses on the list, that may not require urgent attention, might result in too many people being identified at highest risk. A pilot study might assist in ensuring that the implementation of the risk factor definitions results in individuals at the highest risk being identified. In reviewing the draft policy, the Monitoring Team made a few suggestions. These include: ▪ There should be a mechanism for an individual to be removed from the at risk list or downgraded on the list. The at risk list reflects a dynamic process in which individuals are on the list when their needs are urgent and there is need for close monitoring, but are removed or downgraded to a lower risk level, when the issue is resolved or stabilized. This should be based on objective criteria that is individualized and included in the individual's action plan. ▪ There may be a few individuals at extreme or highest risk, usually two to six individuals for whom both administration and medical/clinical services should conduct a brief daily review of the status. These individuals need resources and collaboration from all departments on campus to be successful. ▪ Concerning the risk factor definition, the category of challenging behaviors may need to be broken down into subcategories, specifically to include such areas as pica, elopement, or suicide attempts. ▪ An adequate risk identification and planning system will require critical thinking	

#	Provision	Assessment of Status	Compliance
		on the part of those responsible for the screening and assessment processes, as well as those responsible for developing plans to address individuals' needs. From a training perspective, there was discussion between State Office staff and the Monitoring Team regarding the need for staff to participate in small group trainings, as well as training sessions at which there is a video presentation or live demonstration of the process. Participants should then have the opportunity to practice the skills they have learned with the trainers present to provide constructive feedback. It was clear that the administration both at LBSSLC and at the SO had a heightened interest in risk assessment. It is hoped that the many resources being utilized and the level of collaboration will result in a successful outcome.	
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 State Office was developing an "at risk" policy at this time in order to provide clear guidance in this area. At LBSSLC, the HST meetings continued every 90 days. At the time of the review, these were not resulting in accurate identification of individuals' risk levels, and, as a result, appropriate interdisciplinary assessments were not being conducted or plans developed consistently. The Physical and Nutritional Management Team initiated their first comprehensive assessment for Individual #301 in July 2010. The PNMT was in the initial stages of implementing a full PNMT process that involved completing comprehensive assessments, developing and implementing action plans, training staff, as well as reviewing and monitoring the efficacy of these interventions for those individuals with complex physical and nutritional management needs as discussed in detail below with regard to Section O of the SA.	Noncompliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take	The SO was developing an "at risk" policy at this time. It was in a draft stage. It is recommended that it be piloted in one facility, or in a cluster of homes in one facility to resolve problems early in the process. Then it can be applied across all SSLCs. Once this system is adequately implemented and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and develop plans to address identified areas of risk. LBSSLC and the State Office recognized that they were not in compliance with this requirement of the SA, which was consistent with the Monitoring Team's findings.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. At risk criteria need to be developed that:
    a. Are easy to interpret by a wide audience of participants;
    b. Represent true and valid risks of the individual at that time;
    c. Have a concrete and measurable component that guides teams as they determine when someone is placed on or taken off an at risk list
    d. Have sufficient specificity to detect the highest risk individuals without creating so many false negatives that those deserving urgent attention are missed;
    e. Have sufficient sensitivity to detect the highest risk individuals without creating so many false positives that it dilutes efforts away from those who need it; and
    f. Provide precise criteria so each unit across the Facility is using the same measurement system.
2. As appropriate, the State should consider identifying and implementing standardized tools to be used by all the Facilities to assess and document clinical indicators of risk. These standardized tools should be selected based on their reliability and validity, as well as their ability to provide a weighted score, and meaningful clinical information to allow teams to identify objectively individuals' level of risk in the appropriate clinical areas.
3. In addition, there is a variety of information available from which to identify individuals who are potentially at risk, such as incident management data. The policies and procedures for a risk management system should draw together the various risk assessment instruments and procedures into one process that can reliably identify individuals whose health or well-being are at risk, and to address their needs.
4. For health related risk areas, consideration should be given to having a core team of nurses and primary care practitioners meet to review all relevant health information related to the individual, and using a standardized process, develop a risk profile of the individual. This profile would be shared with the team, just as other assessments are shared, for the team's review and approval. The team would then be responsible for developing plans to address individuals' risk areas.
5. Consideration should be given to using the daily, morning medical meeting as a forum to discuss changes in risk due to new reported concerns.
6. Given that the HST was not responsive to urgent problems that may arise between these meetings, the Medical Director should take a lead role in assisting in deciding the level of health risk.
7. In reviewing the draft State Office policy, the Monitoring Team offered the following recommendations:
    a. There should be a mechanism for an individual to be removed from the at risk list or downgraded on the list. The at risk list reflects a dynamic process in which individuals are on the list when their needs are urgent and there is need for close monitoring, but are removed or downgraded to a lower risk level, when the issue is resolved or stabilized. This should be based on objective criteria that is individualized and included in the individual's action plan.
    b. There may be a few individuals at extreme or highest risk, usually two to six individuals for whom both administration and medical/clinical services should conduct a brief daily review of the status. These individuals need resources and collaboration from all departments on campus to be successful.
    c. Concerning the risk factor definition, the category of challenging behaviors may need to be broken down into subcategories,

specifically to include such areas as pica, elopement, or suicide attempts.

d. An adequate risk identification and planning system will require critical thinking on the part of those responsible for the screening and assessment processes, as well as those responsible for developing plans to address individuals' needs. From a training perspective, there was discussion between State Office staff and the Monitoring Team regarding the need for staff to participate in small group trainings, as well as training sessions at which there is a video presentation or live demonstration of the process. Participants should then have the opportunity to practice the skills they have learned with the trainers present to provide constructive feedback.

8. Once finalized, the State Office should pilot the "At Risk" policy at one or more Facilities.

Staff of the 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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o The supporting materials and Attendance Sheets from the 9/14/10 Pharmacy and Therapeutics (P&T) Committee Meeting, as well as the minutes, supporting materials/documents and Attendance Sheets from the prior three P&T Committee Meetings, including meetings on 12/15/09, 3/16/10, and 6/22/10; o List of individuals who are receiving Reglan; o Lists of individuals receiving psychotropic medication, inclusive of psychiatric diagnosis and psychotropic medications; o Positive Behavior Support Plan (PBSP) Master List, including the names of individuals, functional assessment date, as well as date of Human Rights Committee approval, and Guardian Consent with expiration dates; o Administration of chemical restraint consultation form: Blank, and two completed examples; o DADS draft policy regarding "at risk" individuals; o Alphabetical list of individuals hospitalized from 1/1/10 through 9/13/10; o List of individuals who are 19 years old or younger; o Reiss Screening instrument spreadsheet provided on 9/14/10; o Reiss Screening instrument; o Completed Reiss Screening Instrument for a random sample of 20% of the individuals screened; o A table entitled, "Comparative on Polypharmacy," which provides frequencies for the following time points: 6/05, 9/08, 9/09, 3/10, and 9/10 with the following categories: ▪ Individuals on one psychotropic medication; ▪ Individuals on two psychotropic medications; ▪ Individuals on three psychotropic medications; ▪ Individuals on four psychotropic medications; ▪ Individuals on five psychotropic medications; ▪ Individuals on six psychotropic medications; ▪ Individuals on two antipsychotic medications; ▪ Individuals on two or more mood stabilizers; ▪ Individuals on two antidepressants; ▪ Individuals receiving benzodiazepines; ▪ Individuals on conventional antipsychotics; ▪ Individuals on Mellaril; and ▪ Individuals on Atarax; o The following documents that were contained in the Presentation Book related to Section J of the Settlement Agreement: ▪ The detailed Facility response to each of the sub-sections (J.1 through J.15) of

	Psychiatry Section J of the initial/baseline report; ▪ The "Psychiatry Progress Record" with entries from 6/6/10 through 8/31/10; ▪ The Compliance Checklist Review prepared by Tammy Marshall, M.Ed., CPM, dated 6/10; ▪ The Compliance Checklist related to Section V: "Consents" prepared by Annette Webster, dated 8/10/10; ▪ The Compliance Checklist Scoring Sheets related to Section J. (Psychiatry), completed by Richard Weddige, M.D., Craig Butler, M.D., John McCollum, Psychiatry Assistant, in 7/10 and 8/10; ▪ The documents contained in the Presentation Book in the section entitled "Derivation of Target Symptoms and Etiology of Target Symptoms," which contained a number of examples of individually specific clinical documentation of the target symptoms of psychotropic medication; and ▪ The sub-section labeled "Risk vs. Benefit" consisted of a number of individually specific clinical examples that illustrate changes in the documentation of the individuals' pharmacological treatment including the assessment of risk vs. benefit; o A spreadsheet entitled "MOSES/DISCUS Monitoring Form for Nursing/Psychiatry/ Pharmacy"; o A blank copy of "Administration of Chemical Restraint" form and two completed examples; o Documentation, in spreadsheet format, entitled "SSLC – Risk Factor Definitions – Draft 9/10"; o List of residents transferred for hospital level of medical care – 2010 – year-to-date through 8/10. o Lubbock State Supported Living Center Summary of Chemical Restraints, from 1/10 through 8/10; o Document entitled "Psychiatry – Section J: Progress Since Monitoring Visit, 3/10"; o Internal QE audit document reviews related to the provision of psychiatric services at LBSSLC; o Policy and procedure addressing dental/medical sedation and restraint, dated 1/14/10 (R); o List of "Clinic Visits with Pre-Sedation" by individual and date for 2010; o List of all individuals receiving psychotropic medication with diagnosis, revised 8/13/10; o Lists of all individuals receiving psychotropic medication with listing of medications and psychiatric diagnosis, dated 8/13/10; o List of individual prescribed benzodiazepines, dated 8/23/10; o List of individuals prescribed anticholinergic medication, dated 8/23/10; o List of individuals prescribed intra-class polypharmacy, dated 8/23/10; o List of individuals monitored for tardive dyskinesia, dated 8/23/10; o Lists of individuals being prescribed an anticonvulsant medication for psychiatric reasons, dated 8/23/10; o List of new admissions since 1/1/10; o List of meeting and rounds attended by the Psychiatrists, dated 8/23/10;

	- Curriculum vitae of Richard Weddige, M.D.; - Curriculum vitae of Gregory Butler, M.D.; - Overview of Psychiatrists' weekly schedule; - Job description of Psychiatry Assistant; - The minutes, supporting documents and attachments for the "Monthly Facility Review of Psychoactive Medication Polypharmacy" Meetings, dated 2/23/10, 3/30/10, 4/22/10, 5/25/10, 6/29/10, and 7/28/09. (Note: Review of the 7/28/09 document suggested that the date is a typographical error and it should read "7/28/10"); and - Selected relevant sections of medical records for the following individuals, which represents 20% of the individuals receiving psychotropic medication: Individual #310, Individual #75, Individual #147, Individual #288, Individual #45, Individual #113, Individual #79, Individual #162, Individual #94, Individual #277, Individual #23, Individual #271, Individual #298, Individual #68, Individual #154, Individual #38, Individual #26, Individual #213, Individual #100, Individual #299, Individual #254, Individual #193, Individual #167, Individual #255, and Individual #33. ▪ **Interviews with**: - Dr. Richard Weddige, Director of Psychiatry, on 9/14/10; - Mr. John McCullen, Psychiatric Assistant, on 9/14/10; - Ms. Martha Castilo, Lead File Clerk, on 9/14/10; - Dr. Gregory Butler, Staff Psychiatrist, on 9/14/10; - Dr. James Forbes, Director of Psychology Services, on 9/15/10; - Ms. Mary Bryant, Administrative Assistant, on 9/15/10; - Dr. Russell Reddell, Director of Dental Services, on 9/15/10 ▪ **Observations of**: - The following individuals were observed in the context of the Neurology Clinic on 9/15/10: Individual #78, Individual #136, Individual #261, Individual #120, Individual #265, Individual #115, Individual #74, Individual #8, Individual #251, Individual #182, Individual #14, and Individual #3; - The Pharmacy & Therapeutics Committee Meeting, on 9/14/10; - The Neurology Clinic with Dr. Daniel Hurst, on 9/15/10; and - During the tour of the residential living units at the LBSSLC, the following individuals were observed: Individual #75, Individual #154, Individual #155, Individual #300, Individual #116, Individual #65, Individual #8, Individual #118, Individual #309, Individual #159, Individual #238, Individual #239, Individual #232, Individual #279, Individual #61, Individual #54, Individual #251, Individual #38, Individual #213, Individual #108, Individual #320, Individual #310, Individual #322, Individual #94, Individual #197, Individual #11, Individual #233, Individual #106, Individual #34, Individual #119, Individual #197, Individual #82, Individual #25, Individual #107, Individual #4, Individual #274, Individual #151, Individual #19, Individual #220, Individual #115, Individual #174, Individual #276, Individual #33, Individual #73, Individual #161, Individual #53, Individual #243, Individual #265, and Individual #257.

	Facility Self-Assessment: The Facility's POI indicated that the Facility remained in noncompliance with most of the subsections and indicators for Section J. Areas in which the Facility indicated there was some level of compliance, included the qualifications of staff, the adequacy of psychiatric hours available, some components of the psychiatric assessment process, processes in place to monitor the use of and side effects of psychotropic medication, and coordination between the psychiatry and neurology departments. As is discussed in further detail below, this was consistent with the Monitoring Team's findings. The documents assembled in the Presentation Book indicated that the Facility had put a great deal of effort into improving the aspects of psychiatric care enumerated in the Settlement Agreement. Although this was not articulated in the Facility's POI, there also had been efforts to utilize internal audit instruments to monitor progress toward meeting the requirements of the SA. The materials in the Presentation Book indicated that the internal auditing tools involved the review of medical records by more than one rater. The progress documented through evidence included in the Presentation Book was also reflected in the Monitoring Team's review of the medical records of 25 (20%) of the residents who were receiving psychotropic medications. As might be expected, the improvements described in the Presentation Book were not fully reflected in the analysis of the random sample, due to the time required for positive changes in the provision of psychiatric services to be fully reflected in practice patterns. The degree to which there was divergence between the results of the internal audits of medical records and the current review, appears to be related to the focus of the internal audit on whether a specific piece of documentation was present or absent, whereas the monitoring review also looks closely for the degree to which this document meets the quality standards set forth in the Settlement Agreement.
	Summary of Monitor's Assessment: The Psychiatry Department at the LBSSLC had a strong foundation. The Medical Director, Dr. Richard Weddige, was certified by the American Board of Psychiatry and Neurology and had had a long career in academic psychiatry at the Texas Tech University Health Sciences Center, Department of Psychiatry. He had worked full-time at the LBSSLC for the last nine years. During the baseline review, Dr. Weddige was optimistic that the LBSSLC would be able to hire another full-time Psychiatrist. Dr. Gregory Butler was subsequently employed by the LBSSLC as a full-time Staff Psychiatrist. He was Board eligible in Psychiatry, having completed an Adult Psychiatry residency at the Texas Tech University Health Sciences Center. He had worked in both the Texas State Correctional Services, and the Mental Health system. Most recently, Dr. Butler was a Staff Psychiatrist at the Big Spring State Hospital. He indicated that during his tenure there he frequently saw individuals with intellectual disabilities/developmental disabilities (ID/DD) who were transferred from the State Supported Living Centers for treatment of an exacerbation of their psychiatric illness. The review of medical records indicated that there was consistent monitoring for the following: psychoactive medication side effects; regular assessment of medication blood levels, when necessary; and electrocardiograms, when indicated. The communication between the Departments of Psychiatry, Medicine, Psychology, and Neurology was impressive. Based on a review of a sample of individuals, the Psychiatrists had assessed every individual receiving psychotropic medication on a monthly and quarterly

	basis. They had the capability of consulting on individuals' daily, or two-to-three times a week, if an individual had been experiencing a psychiatric deterioration. The Facility had made consistent, significant progress in reducing polypharmacy with psychoactive medication since 2005. However, there continued to be a number of individuals who were receiving multiple psychoactive agents. Based on a review of a sample of individuals who were prescribed psychoactive medications, there were concerns about the classification of specific behaviors as being both a symptom of a psychiatric disorder and being present on a learned or operant basis. Additional concerns derived from this analysis related to the degree to which the efficacy of the psychoactive medication had been empirically established, and the observation that most of the narrative sections related to weighing the risks and benefits of psychoactive medications were extremely general in nature, often using terminology that was nearly identical in many of the records. A related issue was the lack of documentation of the specific symptoms that provided confirmation for the psychiatric diagnosis of record. The clinical examples and related materials prepared by the Psychiatry team at the LBSSLC and compiled in the Presentation Book for the current review, documented significant progress toward addressing the issues identified in the baseline report. These examples indicated that the Psychiatry team at the LBSSLC clearly understood the nature of the concerns raised at the initial review, and had been developing strategies to address those issues. The current review was predicated on a randomly selected sample of the medical records of 25 individuals (20% of those receiving psychotropic medication). The changes illustrated in the clinical examples contained in the Presentation Book were not fully reflected in the documents reviewed in the random sample. However, this was to be expected, given the length of time that it takes for systemic changes to be fully reflected in Facility-wide practice patterns.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Dr. Richard Weddige, Director of Psychiatry, was Board Certified in Psychiatry by the American Board of Psychiatry and Neurology. He served on the Faculty of Texas Tech University Health Sciences Center School of Medicine, Department of Psychiatry, full-time for 27 years. He retired in 2001. Following his retirement from the Faculty, he began consulting to LBSSLC on a part-time basis, and had been full-time at the Facility for the last nine years. A second full-time Psychiatrist, Dr. Gregory Butler, had been hired since the last review. Dr. Butler was Board eligible in Psychiatry, having completed an accredited residency in Adult Psychiatry at the Texas Tech University Health Sciences Center School of Medicine. He had extensive experience in both the Texas State Correctional and Mental Health systems, most recently at the Big Springs State Hospital. His experience regarding individuals with ID/DD who also have psychiatric disorders, had primarily been through	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		his work at the Big Springs State Hospital, which frequently provided inpatient psychiatric admissions to residents of the Texas State Supported Living Centers. At the time of the review, the current number of individuals receiving psychotropic medication at the LBSSLC was 120. Drs. Weddige and Butler had divided the caseload equally according to residential units. Thus, at the time of the review, the respective caseload of each Psychiatrist was approximately 60, which was an acceptable number.	
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.	Based on a sample of 20% of individuals who were receiving psychotropic medication, each had been seen and evaluated on a monthly basis by their Psychiatrist. Quarterly Psychiatric Review Notes were also prepared for every individual receiving psychotropic medication in the sample. These were prepared to coincide with the individual's 90-day Quarterly Health Status Committee Meeting, which were conducted in the individual's residence. Based on this random sample of 20% of the records of individuals receiving Psychoactive Medication, an Annual Psychiatric Assessment had been prepared for all individuals in the sample (100%). These Assessments contained the same components as the initial psychiatric assessments. The initial assessments had been carried forward in the record, marked as "not to be removed or purged." The Psychiatrists reported that they received several phone calls a week, and also performed STAT ("immediately or without delay") assessments of individuals having difficulties, either in the residence or the Clinic Building. A separate note was generated for each of these encounters. They had also seen individuals, who were in crisis, on a daily basis, or two-to-three times per week, as necessary. The documentation of these more urgent consultations consisted of a handwritten note in the individual's record, which was followed by a dictated note. There had been occasions when a resident at LBSSLC required psychiatric hospitalization, due to the danger they presented to self or others. These admissions had usually been to the Big Springs State Hospital, or the Crisis Stabilization Unit at Sunrise Canyon. Evidence of the Annual, Quarterly, and Monthly Reviews was found in all of the records reviewed. These were located in the Psychiatry section of the Medical Record. Although substantial improvements had been made since the baseline review with regard to psychiatric assessment, there continued to be concerns regarding: the documentation of the symptoms that support the psychiatric diagnosis; the co-identification of behaviors that were identified as targets of the psychotropic	Noncompliance

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		medication(s); and, for some individuals, the appropriateness of the prescribed psychotropic medication for the identified psychiatric diagnosis. Because these issues raise questions about the clinical justification for the diagnoses and the medications prescribed, the Facility remains out of compliance with Section J.2 of the SA. These issues are discussed in more detail in below with regard to Sections J.9 and J.13 of the SA.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	This provision primarily relates to the non-specific use of psychotropic medication to manage aberrant disruptive behaviors in the absence of an active Behavioral Support Plan, or as punishment. All of the records reviewed indicated that individuals receiving psychotropic medication had an active Behavioral Support Plan. There was no indication that psychotropic medication was being used as a punishment at the LBSSLC. As discussed in more detail below, the description of a behavior listed as a target of psychotropic medication and also present on a learned or behavioral basis was problematic, because it could give the impression that the medication was being used to suppress a learned behavior. However, it is also conceivable that such a behavior could be derived from both biological and psychological factors. During this review, both the Director of Psychiatry and the Director of Psychological Services indicated that they had spent several days reviewing the profiles of a number of individuals for whom this was an issue. Thus, the Facility was in the initial stages of developing a plan to address this matter. Until this issue is addressed, compliance will not be attained with the requirement that psychotropic medication not be used as a substitute for programming or in the absence of a clinically justified psychiatric diagnosis.	Noncompliance
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	The LBSSLC interdisciplinary teams had developed some strategies to replace the routine use of pre-treatment sedation medication prior to dental procedures. However, as is discussed in greater detail with regard to Section Q.2 of the SA, it did not appear that these were being routinely implemented, and/or updated. Psychology staff were reportedly becoming more involved in the process. Documentation could not be located which would suggest that efforts were being made with regard to desensitization for medical procedures. During an initial interview with the Director of Dental Services, he provided an overview of the desensitization protocol as follows: 1. The individual visits the Dental Office until they feel comfortable with coming to the office. 2. The next step involves entering into the Dental Exam Room until it no longer produces anxiety. 3. Once the individual is comfortable in the Exam Room, they are asked to sit in the dental examination chair. 4. After the individual is comfortable in the dental chair, the next step is to have the	Noncompliance

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	effects.	dental hygienist stand over them. 5. The final steps in the process involve the dentist also standing over the individual in the chair, and then beginning to gently probe into their mouth. The Director of Dental Services indicated that after he became the Facility dentist, he organized a major remodeling of the Dental Clinic, to make it seem less intimidating. This remodeling included a lighted, overhead, translucent painting of a relaxing outdoor scene, which was strategically placed over the dental chair in an effort to distract and comfort the individual. The Director of Dental Service indicated that he did not use mechanical restraints. However, as is discussed below with regard to Section Q.2 of the SA, it appeared at times, restraint had been used. During the interview with the Director of Dental Services, he indicated that only a few individuals had progressed to the point that they were able to come to the Dental Office. However, he believed the "tooth-brushing protocols" that were being utilized in the living units, to begin the desensitization process, were widely in use. As is discussed in further detail with regard to Section Q.2 of the SA, specific data was not being shared with the Dental Department regarding the implementation of desensitization plans, or other strategies designed to reduce the need for pre-treatment sedation. The Director of Psychology Services indicated, during the 9/14/10 interview, that the responsibility for the overall coordination, implementation, and monitoring of these desensitization plans will be transitioned from the QMRPs to the Psychology Department. This transition should take place by the time of the next review. It was difficult to locate a description of the current Behavioral Desensitization Plans. The Director of Dental Services indicated that they might reside on the individual's living unit and not in the integrated medical records. During this review, the existence of both a plan for pre-treatment sedation medication prior to medical and/or dental appointments, as well as a general reference to the existence of a Desensitization Plan (for dental appointments), could be verified in the Rights section of the record. The review of the random sample of the medical records for 25 (20%) of the individuals receiving psychotropic medication revealed a reference to a Dental Desensitization Plan for 16 individuals (64%) in the sample, but the actual plan was not included. There was also a reference to a pre-treatment sedation order for medical/dental appointments in 12 (48%) of the records reviewed. Three of these individuals required the intravenous anesthesia protocol while the others were prescribed Ativan in a dosage range of one to three mg, which are reasonably safe dosages. One individual required 1000mg of Chloral Hydrate, which appeared to be safe for this individual. The information obtained during the interviews with the Psychiatrists indicated that they did	

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		not routinely have any direct input into the construction of the pre-treatment sedation protocols, and that the primary care physicians wrote these orders. However a psychiatrist might be contacted if an individual was refractory to the medications that were usually used for pre-treatment sedation. This review did not find any examples of that type of communication. Ten individuals did not have a Desensitization Plan. However, nine of these (90%) also did not require a pre-treatment sedation medication, which suggested that they were able to attend and participate in dental and medical appointments without difficulty. Based on interviews and document review, and as is discussed in further detail with regard to Section Q.2 of the SA, although it appeared that desensitization plans had been developed for some individuals at some point in time, it did not appear that they had been implemented consistently, or updated and integrated into the overall PSP. It is positive that the Psychology Department will be playing a stronger role in the development, implementation, and monitoring of such plans and other strategies to minimize the need for pre-treatment sedation. This is an area that the Monitoring Team will continue to review during upcoming visits.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	There were approximately 120 individuals receiving psychotropic medication according to a list of such individuals, dated 8/13/10. As indicated above with regard to Section J.1 of the SA, at the time of the review, LBSSLC employed two full-time Psychiatrists. Between them, they had evenly divided the caseload according to residential units. The resultant caseloads of approximately 60 individuals per Psychiatrist were consistent with accepted guidelines, and appeared adequate to allow LBSSLC to meet the requirements included in Section J of the SA.	Substantial Compliance
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.	At the time of the most recent review, LBSSLC relied upon the psychiatrists' assessment, diagnosis, and case formulation. However, they did consult with Psychology. The baseline review, in March of 2010, indicated that for many individuals, the psychiatric diagnosis of record was not supported by a description of the specific symptoms, which substantiated the validity of the diagnosis. The Case Examples that were contained in the Presentation Book, which LBSSLC prepared prior to the current review, indicated that the psychiatric staff of the LBSSLC was actively addressing this issue. The degree to which this effort contributed to the improvement in documentation in the medical records of individuals who were receiving psychotropic medication was determined by conducting a review of the medical records of the random sample of 25 (20%) of the individuals receiving psychotropic medication.	Noncompliance

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		This review indicated that symptoms that were congruent with the psychiatric diagnosis of record could be identified in 18 of the 25 records (72%). The individuals for whom the symptoms of the psychiatric diagnosis could not be identified were as follows: Individual #45, Individual #271, Individual #298, Individual #68, Individual #213, and Individual #167. However, in many cases, the description of these symptoms was not found in a proximal location to the actual psychiatric diagnosis, and could only be located in other sections of the record (usually the narrative descriptions of behavior status), historical sections (such as those related to prior psychiatric hospitalization(s), and/or the mental status exam). As required by Appendix B of the SA, the psychiatric assessments need to contain diagnostic assessments and case formulations that clearly set forth the individual's current symptoms and that clinically justify the diagnosis. Although it was positive that the Facility had taken steps to address the quality of the psychiatric assessments/evaluations, additional work is needed to ensure that this change is systemic.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Reiss Screen was designed to identify individuals for whom a formal psychiatric assessment should be considered, based on the results. It was not intended to replace a formal psychiatric assessment. In conducting a review of this requirement, a sample was drawn of individuals who had not had a psychiatric assessment completed. A spreadsheet generated on 9/14/10 entitled, "Reiss Screen for Maladaptive Behaviors" listed individuals who had been administered the Reiss Screen beginning in 2008. There were 120 individuals receiving psychotropic medications at the time of the current review, and the REISS Screen for Maladaptive Behavior Spreadsheet, that was revised 8/5/10, indicated that as of that date, 101 individuals who had not received a Psychiatric Evaluation, had been administered the Reiss Screening Instrument. The census of LSSLC as of 9/14/10 was 229. The combined number of individuals who had received either a Psychiatric Evaluation or had been administered the REISS Screening instrument was 221. The number of individuals who had received a formal Psychiatric Evaluation (120) is based on the finding that 100 percent of the individuals contained in the random sample of 25 (20% of individuals receiving psychoactive medication) had undergone a psychiatric evaluation. Thus 96.5% of the total population had either had a Psychiatric Evaluation or had been administered the REISS Screening Instrument. In order to assess the validity of the information contained in the spreadsheet, a random sample of 20% (every fifth individual) was selected and the copy of the actual Reiss Screening Protocol was requested. Documentation was submitted and verified for 100% of the random sample derived from the spreadsheet. The individuals for whom this information was requested, and the date the Reiss Screen was administered was as follows:	Noncompliance

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		REISS – RANDOM SAMPLE Individual # Date Completed Individual #181 7/9/08 Individual #176 1/22/09 Individual #215 1/21/09 Individual #37 12/19/08 Individual #17 6/25/08 Individual #139 12/23/08 Individual #74 6/23/08 Individual #112 11/5/08 Individual #120 11/8/09 Individual #43 4/24/09 Individual #80 11/8/08 Individual #253 2/4/09 Individual #296 4/24/09 Individual #19 4/23/08 Individual #135 4/23/08 Individual #48 10/2/08 Individual #203 4/24/09 Individual #252 4/29/09 Individual #308 12/30/08 Individual #128 2/2/09 The Facility did not utilize the commercial screening program to score the Reiss Screening Protocols, but had developed an internal system to ensure that there was an appropriate clinical response to the individuals who were identified by the Reiss Screening Instrument as requiring additional psychiatric assessment. Documentation of this follow-up process was not provided for review. However, the lack of this information may well be due to a miscommunication between the Monitoring Team and the Facility. The follow-up process will be further assessed during the next review. Confirmation that the follow-up assessments have occurred would mean the Facility is meeting this requirement of the Settlement Agreement.	
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	Interviews with the two psychiatrists and the Director of Behavior Services indicated that there was a close working relationship between the Departments of Psychiatry and Psychology. The psychiatrists had relied on the Psychology Staff for both data that related to the behaviors that were thought to be responsive to psychotropic medication, as well as the impact of environmental and interpersonal factors that might be effecting the individuals' behavioral presentation.	Noncompliance

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	other interventions through combined assessment and case formulation.	Examples were identified that indicated there were ongoing problems with the co-identification of behaviors being present both on a learned/operant basis, and as target behaviors for the psychotropic medication. This is discussed in more detail below with regard to Section J.9 of the SA. The existence of this co-description of the function of the aberrant behaviors in the absence of a reasonable rationale indicated a lack of thorough integration of pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The co-identification of target behaviors for the prescribed psychotropic medications as also being present on a learned basis and/or related to environmental factors was identified in the baseline review. At the time of the most recent review, this issue continued to be problematic and directly related to deficiencies in the collaboration between the Psychiatry and Psychology Departments in determining the least intrusive intervention to address the individual's aberrant behaviors. The rationale for this assessment is that if the identified behavior is a symptom of an established Axis I psychiatric disorder, it would most likely not be amenable to behavior modification techniques. Conversely, those behaviors that are identified in the functional analysis as being present on an operant basis would be inappropriate targets for psychotropic medication. The existence of the same behavior in both categories should prompt a discussion as to the rationale for its appearance in both categories. During the current review, the Director of Psychiatry indicated that he and the Director of the Psychology Department had allocated time to review the records of several individuals in an attempt to develop strategies to address this problem. There were also clinical examples in the Presentation Book that indicated that the Psychiatry and Psychology staff were actively addressing this issue. The co-existence of the same behavior in both categories was identified in 16 (64%) of the records that were reviewed in detail. The records in which this overlap was not found were as follows: Individual #75, Individual #147, Individual #113, Individual #79, Individual #154, Individual #26, Individual #299, Individual #254, and Individual #167. A statistical analysis was not performed to investigate which individual factors characterize the individuals for whom aberrant behaviors are designated as both target behaviors of psychotropic medication and identified in the functional analysis as being present on a behavioral-operant basis. However, gross inspection of the data sheets suggested that this overlap was more apt to occur in individuals who were functioning in the Severe to Profound Range of intellectual disability and who also had a diagnosis of an Autism Spectrum Disorder, such as Pervasive Developmental Disorder. Those individuals, for whom this overlap in the categorization of their overt behaviors did not occur, were much more likely to function in the Mild-to-Borderline Range of intellectual	Noncompliance

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		disability and to have a discreet Axis I psychiatric disorder (such as Schizophrenia or Bipolar Disorder), and there were clear examples of recorded behaviors related to the underlying psychiatric disorder. An example of an individual for whom this overlap in etiology of the identified behaviors still existed was found in this excerpt from the document entitled "Structural and Functional Assessment Report," dated 1/4/10, regarding Individual #162: *Psychiatric* *[Individual #162's] most recent available psychiatric consult in her file was dated 12/1/09. The 30-day psychoactive medication review states that she is monitored for SIB. Her Haldol was recently decreased from 6 mg to 5 mg daily. She continues on Naltrexone 100 mg daily. Her diagnosis is Stereotypic Movement disorder with self-injurious behavior (SIB). Past trials of Zyprexa or Risperdal were not helpful in reducing challenging behaviors. Other medication tried to treat her behavioral difficulties are Trazodone, Zoloft, and Mellaril.* *Current Positive Behavior Support Plan (PBSP)* *The current PBSP #DT1325C dated 2/27/09 targets self-injurious behavior. Self-injurious behavior is defined as slapping, scratching, hitting her face or ears, flicking her ear with her finger, pulling or tugging on her ear, pulling her hair out. Antecedent interventions were conducting periodic checks with [Individual #162] to determine her needs or wants; if uncooperative with a request, give her a few minutes before returning to make the request again; giving verbal praise for communication, participation, and cooperation; offer her choices rather than directives. Consequent interventions were noted to be asking her to stop the behavior, several times if necessary; asking her what she wants or needs; and if injury noted, contact the nurse. Data collection methods were ABC [antecedent-behavior-consequence] recording per event or episode.* *Medications used at this time to address behavioral difficulties are Naltrexone (trichotillomania), and Haldol (SIB).* Later in this document, the rationale for the behavioral aspects of Individual #162's program were described as follows: *Rationale for Treatment Approach:* *The current structural and functional assessment identified tangibles as a primary motivation of [Individual #162's] engagement in self-injurious behavior, along with attention to some degree. Consequently, this plan builds on her strength of gestures,*	

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		vocalizations, and facial expressions often being able to be interpreted as need for assistance or a tangible. In this regard, it has been demonstrated that challenging behavior and communicative acts can be equivalent in function and that strengthening functional communication through differential reinforcement can weaken challenging behavior (Carr, et al., 1985). Teaching alternative assistance-seeking and attention-getting communication has reduced challenging behavior and generalized (Durand, et al., 1991). *Escape/avoidance also appears to be involved to some degree. Escape extinction has been shown to reduce or eliminate self-injurious behavior and increase cooperation with instructions (Iwata et al., 1990). Presentation of a high-probability command sequence prior to a low-probability sequence has increased the likelihood of cooperation with the low-probability sequence (Mace et al., 1988).* *It has been demonstrated that choice making reduced levels of problem behaviors when opportunities for choices among instructional tasks and reinforcers were provided (Dyer et al., 1990).* *This plan consequently incorporates functional communication, behavior momentum, offering choices, and escape extinction as interventions. Response blocking is included as a safety measure to reduce the potential for injury.* In summary, the self-injurious behavior was clearly described as being related to behavioral factors and the rationale for the concomitant use of the Haldol was not clearly delineated. A similar process occurred with regard to the use of Depakote (Valproic Acid) for Individual #45, as illustrated by the following excerpt from the "Positive Behavior Support Plan," dated 12/3/09. *Reason for Review*: *This PBSP was prepared in conjunction with [Individual #45's] annual PSP meeting in November. His prior PBSP targeted two behaviors that were not identified* [in] *this review period as challenging and will not be continued, including inappropriate sexual stimulation and sleeplessness. Sleeplessness is ruled out based on his having had only one sleepless night documented in the last 8 months. Regarding inappropriate sexual stimulation, it was not identified as a target behavior during assessment, and data indicate that he had no incidents during the year from October 2008 through September 2009. There are some modifications to the target behavior definitions to update current behavioral topographies. There is emphasis placed on provision of a body pillow to help him calm when agitated. This PBSP also supports the use of the medication Valproic Acid. This plan is seeking a 1-year approval; however, if modifications need to be made, they will be addressed in a timely fashion as the data warrants.*	

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		<u>*Relationship of Plan and Fundamental Outcomes*</u>*:* *This plan is intended to increase appropriate means of escape through increased functional communication and decrease his target behaviors through appropriate staff interventions, and the use of a body pillow for self-calming. The goal of assisting him in the use of functional communication is that it will serve as a pivotal behavior for self-help, socialization, and vocational behaviors. This should lead to an overall better quality of life, and ultimately increase his ability to benefit from higher levels of community integration.* <u>*Replacement Behavior*</u>*:* *The behavior targeted for acquisition is functional communication of sign language to escape unwanted situations (the sign "STOP"), used as a replacement behavior to agitation, aggression, and self-injurious behavior.* <u>*Behaviors Targeted for Reduction*</u>*:* *AGGRESSION: hitting, grasping, or scratching others.* *AGITATION: groaning, yelling, jumping up and down in his wheelchair, tearing his clothes or brief, hitting/pushing tables and chairs.* *SELF-INJURIOUS BEHAVIOR (SIB): throwing himself out of his wheelchair onto the floor, banging his head against the floor or wheelchair, or hitting or pinching himself.* The rationale for the use of the Depakote for Individual #45 was also described in similar terms in the Informed Consent document dated 11/3/09. *LEGAL STATUS* *Adult, Court-committed/Guardian of Person & Estate* *Explanation of the proposed treatment/procedure as listed below includes:* <u>*Treatment/Procedure and Purposes*</u>*:* *BSP #LJ1364B(1) targets self-injurious behavior, agitation, and aggression. The BSP employs positive reinforcement and environmental changes to reduce the occurrence of those behaviors. There is more emphasis placed on provision of a body pillow to help him calm when agitated. The targeted replacement behavior is the functional communication of using sign language to communicate wants and needs, particularly his desire to leave a*	

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		situation, instead of engaging in challenging behaviors. The program authorizes the use of Depakote (Valproic Acid) to treat target behaviors. *<u>Benefit versus Risk, and Risk versus Risk Analysis</u>:* *Risks/Discomfort: There is no known risk associated with the behavioral procedures in this plan. The possible side effects (listed in order from frequent to occasional) to the psychoactive medications authorized in this plan are as follows:* *Valproic Acid – hair loss, low platelet count (platelets clot the blood, when low, may see increased tendency to bleed, and bruising easily), weight gain, sedation, nausea, vomiting, indigestion.* *<u>Benefits</u>: This plan is intended to decrease [Individual #45's] target behaviors through appropriate staff interventions, the use of calming techniques, and appropriate means of escape through increased functional communication. Success in assisting him in the use of functional communication will increase his ability to learn new functional skills in the areas of self help, socialization, and vocational, provide him with an overall better quality of life, and ultimately increase his ability to benefit from higher levels of community integration.* *<u>Risks of Not Providing this Treatment</u>: The risks of not providing the procedures in this plan may include an increase in challenging behaviors, physical injury or more restrictive handling of challenging behaviors, with significant negative impact on his quality of life. Procedures would not be clearly defined to encourage him to use his identified replacement behaviors, which could greatly reduce his potential to be served in a less restrictive environment.* *If you do not wish to consent to the above treatments, the alternatives are no treatment, behavioral measures alone, or behavioral measures in combination with other psychoactive medications.* A specific rationale for the use of Depakote (Valproic Acid) could not be located in the description of the Behavioral Plan for Individual #45, although it was consistently referred to as an essential component of the Plan. Thus, this Plan gave the impression that the Depakote was being used to address and/or suppress behaviors that were present on a learned or operant basis. An example of an individual's record that provided clear delineation of the behaviors thought to be present on a biological basis, as opposed to being present on a learned basis, was contained in the following excerpt from the record of Individual #79 taken from the Informed Consent document, dated 5/4/09:	

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		<u>*Treatment/Procedure and Purpose*</u>: *This PBSP was prepared as a result of [Individual #79's] most recent psychiatric appointment on 4/16/09. This appointment was requested by the PST members to discuss an increase in agitation. During this time it was determined that she is in a manic phase. The psychiatrist ordered Abilify and Buspar to help alleviate the agitation and other symptoms related to her bipolar disorder.* Thus, this Behavior Plan delineated the aspects of the individual's behavioral presentation for which the psychotropic medications were prescribed, as well as the link between behaviors and the psychiatric diagnosis. These distinctions were also further discussed in the following excerpt: *Overall, this PBSP is designed to track agitation as it related to [Individual #79's] diagnosis of Bipolar I Disorder in order to determine effective medication usage. If successful with medication management, she could experience less "cycles" in relation to her disorder. In addition, this PBSP will define procedures to decrease inappropriate oral stimulation and increase the use of a more appropriate means to satisfy the need to chew. Staff will be instructed to block her from putting her shirt or hands in her mouth and offer the chewy tube as a replacement. Response blocking has been shown to decrease hand mouthing or inappropriate oral stimulation. An increase in the use of her replacement behavior (using a chewy tube) will decrease the need to chew on clothing causing her clothing to become wet and getting holes. This will provide a better appearance in the area of grooming. In the future, transitioning will take place from the chewy tube to a more socially appropriate item that can offer the same sensory input.* The differentiation between behaviors that were thought to be present on a biological basis, as opposed to being present on a behavioral basis also appeared in the record of Individual #26. The Psychiatric Consultation Note that was signed and dated 7/27/10 indicated that: *Additionally he is on a PBSP which includes replacement behavior and other techniques. It appears that the etiology of his target symptom may be both on a biological basis as related to his psychiatric diagnosis, that is pervasive developmental disorder as well as on a behavioral or functional basis in that at time*[s] *I suspect he is able to avoid or escape programming or gain desired items when he manifest*[s] *this behavior. He will continue to be monitored for the same target symptoms and we will adjust his psychoactive medication depending on his progress. If the continued incidents of target symptoms remain low we will consider a taper of the Zyprexa.*	

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		The following excerpt from the Human Rights Committee Review of PBSP for Individual #26 further illustrated this differentiation: *PBSP Information: (to be completed by Psychologist)* *The plan is being reviewed based on completion of a new functional assessment. [Individual #26] was on a Positive Behavior Support Plan (PBSP) targeting agitation, for which he was also receiving Seroquel. He was seen in psychiatric clinic on 5/20/09, at which time it was noted that he had shown an increase in agitation since he was started on Seroquel. In the past, he had been on Risperdal but this medication was discontinued because of increased prolactin level. [The psychiatrist] suggested starting him on Zyprexa and discontinuing the use of Seroquel. His program was updated at the time the Zyprexa was begun on 6/12/09, and approved pending completion of the new functional assessment. Results of the functional assessment indicated his behaviors most in need of reduction revolve around food seeking behavior and property destruction displayed when seeking food and when riding in the van. Agitation was not identified during functional assessment as a challenging behavior. However, it will be tracked as a marker to maintain optimum dose of Zyprexa.*	
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.	Risk-benefit analysis as it relates to the use of psychotropic medication in individuals with developmental disabilities involves a number of interrelated steps. The first of these steps is to assess the *severity* of the behavioral symptoms of the psychiatric disorder in terms of physical harm to the individual or others, quality of life issues, overt emotional distress, and related functional limitations. Second, this risk is then weighed against the side effect profile of the proposed psychotropic medication. This discussion includes not only the potential side effects, but also the probability of the occurrence of those side effects. The third element in this assessment relates to the likelihood that the proposed medication will be effective in diminishing the harm produced by the behavioral symptoms of the psychiatric disorder that the medication is intended to address. In the LBSSLC records, the risk-benefit considerations with regard to the use of psychotropic medication primarily appeared in the Human Rights section of the record. The results of the current review of randomly selected records of individuals receiving psychotropic medication was similar to the initial baseline review, in that the risks of the psychotropic medications were usually put forth in very general terms, and the benefits were described as decreasing the maladaptive behaviors. The risk-benefit discussion of the psychotropic medications accompanied a similar discussion related to the Behavioral Treatment Plan, and the approval for both psychotropic medications and the Behavior Plan were, to a certain extent, combined.	Noncompliance

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		The side effect listing of the medications were generic in nature and did not provide any information with regard to the frequency with which those side effects have been reported to occur in large populations. In addition, the benefits of the medications were usually described simply as a reduction of the identified target behaviors of the medication. The overall construction of the discussion was formulaic in nature, and suggestive of the use of templates. Thus, it was not possible to use this information to render an empirical or reasonably informed opinion as to the relative risk versus benefit of the psychotropic medication(s) that were currently being utilized or were being proposed. An example of this appeared in the record of Individual #310, who was receiving four psychotropic medications, as indicated in the following excerpt from the "HRC Review of BSP," dated 5/10. The following example was representative of what was found in the other records reviewed: *RISK VS. RISK AND BENEFIT VS. RISK ANALYSIS* *The risks and benefits of the procedures of this plan have been analyzed by the personal support team in order that this approach has the highest potential for improving quality of life while minimizing risks to the greatest extent possible.* *<u>Potential Risks/Discomfort</u>: There are no risks or discomfort associated with the behavioral aspects of this plan. The side effects of medications mentioned in this plan are as follows:* *KLONOPIN (clonazepam) – drowsiness, abnormal muscle coordination, increased salivation (drooling), constipation, abdominal pain, low white blood cells (causes problems fighting infections), low breathing rate, and rash;* *LITHIUM (eskalith, lithium carbonate, lithobid) – drowsiness, headache, confusion, restlessness, dizziness, impaired speech, abnormal muscle coordination, muscle weakness, blurred vision, dry mouth, metallic taste, nausea, vomiting, poor appetite, diarrhea, thirst, abdominal pain, gas, indigestion, itching, rash, increased blood sugars, low thyroid;* *HALDOL (haloperidol) – involuntary muscle movement, sedation, blurred vision, dry mouth, skin rash, urinary retention, allergic reactions (fever, increased heart or breathing rate, and sweating) or tardive dyskinesia caused by long term use of antipsychotic medication. Repetitive and involuntary movements characterize tardive dyskinesia (e.g., grimacing, tongue protrusion, lip smacking, puckering and rapid eye blinking, rapid movements of the arms, legs, and trunk may occur); and*	

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		SEROQUEL (quetiapine fumarate) – dizziness, headache, prolonged drowsiness, low white blood count (causing high risk for infections), weight gain or tardive dyskinesia caused by long term use of antipsychotic medication. Repetitive and involuntary movements characterize tardive dyskinesia (e.g., grimacing, tongue protrusion, lip smacking, puckering and rapid eye blinking, rapid movements of the arms, legs and trunk may occur). *BENEFITS: Benefits of this Plan are reflected in the Relationship of Plan and Fundamental Objectives section.* *RISKS OF NOT PROVIDING THIS TREATMENT: The risks of not providing the medication treatment as outlined by the staff psychiatrist would be the risk of extreme mania and episodic depression. [Individual #310] would potentially become suicidal and aggressive, as has occurred in the past without those medications. This may lead to psychiatric hospitalizations and serious harm to self or others. Without this plan she would continue to engage in fictitious conversations which are socially unacceptable within our society and community.* *DETERMINATION BY PERSONAL SUPPORT TEAM: The risks and benefits of the components of this plan have been reviewed by the personal support team (PST). The PST has determined that the possible risks of not providing the treatment outweigh the potential risks associated with the behavioral and psychopharmacological interventions that were selected. The PST, in conjunction with the psychiatrist, has concluded that a behavioral approach in combination with a pharmacological approach will best serve [Individual #310]. Of the alternative interventions considered, the behavioral and pharmacological components of the plan appear to be the most positive and least intrusive available to achieve desired fundamental outcomes and to reduce targeted challenging behavior. One treatment goal is for the behavioral strategies to minimize the need for psychotropic medication to the lowest degree possible. In regard to Lithium specifically, it has been determined that the risks associated with manic behavior are higher than the risk of any influence the Lithium may have regarding increased thirst, which may have resulted in a fluid restriction.* As noted above, the risk of discontinuing treatment with these psychotropic medications was identified only as the "risk of extreme mania and episodic depression." The probability of the occurrence of these outcomes was not discussed. In addition, analysis of the document indicated that all four of the diagnoses were essentially combined into one (for the purposes of the Consent), and there was no attempt to differentiate the relative risk versus benefit considerations for each individual psychotropic medication.	
J11	Commencing within six months of the Effective Date hereof and with	This provision relates to the degree of inter-class and intra-class polypharmacy, as well as the attempts to reduce polypharmacy.	Noncompliance

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	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.	During the initial baseline tour, the Monitoring Team was provided with a chart that illustrated the yearly reductions in the rates of polypharmacy, dating back to 2005. This data clearly illustrated a consistent, marked reduction in the rates of polypharmacy. An updated version of this document was requested during the most recent review. The current version of this document illustrated further progress in reducing the frequency of polypharmacy with psychotropic medication. A review of this document indicated that the number of individuals receiving six or more psychotropic medications had been maintained at zero since 2008, and the number receiving five psychotropic medications decreased from one in 9/08 and 3/10 to zero in 9/10. The number receiving four psychotropic medications had remained in the same range over the past year: seven in 9/09, six in 3/10, and seven in 9/10. The number of individuals receiving three psychotropic medications had gradually decreased to 14 as of 9/10, from 44 in June of 2005, when monitoring began. The most significant decline in this subcategory of polypharmacy occurred in the early years of the initiative with more modest incremental changes in recent years (6/05 - 44; 9/08 - 27; 9/09 - 18; 3/10 - 21; and 9/10 - 14). This pattern was also seen with the effort to reduce polypharmacy in general, and it would be expected that the most obvious cases of suspected unnecessary polypharmacy would be addressed first. The number of individuals receiving two psychotropic medications, (56 as of 9/10), was in the same range as the prior three reporting periods (53 to 56). The data for individuals receiving one psychotropic medication indicated an initial decline, from 57 in 6/05, and 52 in 9/08, to the lower range of 38 in 9/09, 40 in 3/10, and most recently 44 in 9/10. The data also substantiated improvement with regard to intra-class polypharmacy. Six individuals were receiving two antipsychotic agents as of 6/05, and this has stabilized at three for the most recent three reporting periods. The most significant decline with regard to intra-class polypharmacy had been for the use of two mood stabilizers, which had decreased from 20 in 6/05 to two in 9/09. The number of individuals receiving two antidepressants had also gradually declined from six in 6/05 to zero as of 9/10. The review of documentation from the "Monthly Facility Review of Psychoactive Medication Polypharmacy Meetings," dated 2/23/10, 3/30/10, 4/22/10, 5/25/10, 6/29/10, and 7/28/09 (the document dated 7/28/09, contained recent contemporary information from 2010 and, thus, likely should have been dated "10" rather than "09") indicated that a thorough review of multiple individuals who were receiving polypharmacy with psychotropic medications took place each month. The format of these meetings, as reflected in the minutes, was a detailed review of each individual's medications, as well as their psychiatric status. The length of the minutes ranged from	

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		18 to 26 single spaced pages. This detailed monthly review process had likely played a major role in the Facility's ability to continuously reduce the rates of polypharmacy on a year after year basis, although as noted above, the rate of change had decreased in recent years as more individuals had been successfully removed from medication regimens that would constitute polypharmacy. The primary difficulty with the current process related to the observation that the Polypharmacy Meeting Minutes often concluded that an individual's treatment with multiple Psychoactive medications was justified based on subjective impressions that multiple medications were necessary for their continued stability rather than an empirical determination of efficacy (see also the discussion of this issue with regard to Section J.13 of the SA). The terminology in this section of the Settlement Agreement is clear in stating that treatment with multiple psychoactive medications must be "clinically justified," which would suggest an independent assessment of the utility of each medication in a complex regimen of medications. The members of the professional staff who routinely attended these meetings were as follows: Gregory Butler, M.D., Staff Psychiatrist, Glen Shipley, DO, MPH (Medical Director), John Todd, Clinical Pharmacist, Dr. Russell Reddell, Director of Dental Services, and Dr. Richard Weddige, Director of Psychiatry. Thus, the Facility continued to make consistent progress toward meeting this requirement of the Settlement Agreement.	
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.	The Director of Psychiatry indicated that nursing staff performed the MOSES, and the Psychiatric Assistant performed the DISCUS. It was reported that the Psychiatric Assistant had completed specific training regarding the proper administration of the DISCUS. A review of the random sample of 25 individual medical records (20% of those individuals receiving psychotropic medication) indicated that a current DISCUS (within the last three months) could be identified for each of the individuals, and that the reviews had been performed on a quarterly basis for the last two years. The DISCUS was also performed on those individuals who were receiving Reglan for gastro-esophageal reflux, as the pharmacological profile of this agent has dopamine-blocking properties, which are somewhat similar to those produced by antipsychotic agents. In order to assess the completion of these exams, a spreadsheet dated 8/24/10 was obtained that listed all individuals who were prescribed Reglan. This list was then cross-referenced with the list of individuals who were receiving psychotropic medication as well, and those individuals who were receiving both Reglan and psychotropic medications were then deleted. The compilation of names that resulted from this process contained only individuals who were receiving Reglan for GERD. A random	Noncompliance

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		sample of this list (20%) included the following individuals: Individual #199, Individual #301, Individual #139, Individual #312, and Individual #136. Copies of the current DISCUS, as well as those for the last year, were then requested for these individuals. A review of these documents indicated that the DISCUS had been performed for all individuals within the most recent three months, and quarterly for the prior year, with the exception of Individual #312, for whom only two completed DISCUS forms were produced (dated 7/12/10 and 6/8/10). Thus, 80% of this sub-sample had the DISCUS administered as per the protocol. The review of the random sample of 25 records also indicated that the MOSES was completed on a periodic basis. The frequency with which the MOSES was routinely administered was every six months for these individuals, which was consistent with the Health Care Guidelines.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric 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.	This provision of the Settlement Agreement addresses three extremely important points. The first of these is the validity of the psychiatric diagnosis, as it relates to the identified behaviors that are thought to derive from that diagnosis. The second point is the degree to which the prescribed medications are appropriate for that diagnosis. The third issue is the degree to which the medication can be empirically demonstrated to be effective in decreasing the frequency and intensity of the behavioral symptoms of the disorder. In order to assess compliance with this provision, a tripartite analysis was conducted of the 25 records, which comprised the random sample (20%) of those receiving psychotropic medication. The degree to which a description of the specific symptoms that justified the psychiatric diagnosis of record could be identified is discussed above with regard to Section J.6 of the SA. As discussed above, there is a strong need for psychiatric assessments to include information related to the symptoms that provide clinical justification for the diagnoses. Many of the records reviewed did not include this clear justification in the psychiatric assessment/evaluation, but were only identified by the Monitoring Team searching through other components of the records. The review of the random sample of records also assessed the degree to which the psychotropic medications prescribed for the individuals were found to be appropriate, and/or a rational hypothesis was provided. The results of this analysis indicated that the medications were appropriate for 19 individuals (76%) of the random sample. Those individuals for whom the correlation between the psychotropic medication and the diagnosis could not be established were as follows: Individual #45, Individual #271, Individual #298, Individual #68, Individual #213, and Individual #167.	Noncompliance

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		Examples of individuals for whom a rationale for the psychoactive medication could not be derived from the psychiatric diagnosis were: ▪ Individual #298 whose psychiatric diagnosis was "Impulse Control Disorder with SIB" (8/13/10 list of psychiatric diagnosis by individual), and who was being prescribed the antipsychotic agent Abilify 30 mg per day (8/13/10 medication profile); and ▪ Individual #213 whose diagnosis was "Intermittent Explosive Disorder" (8/13/10 list of psychiatric diagnoses), and who was prescribed the antipsychotic agent Seroquel 400 mg at a.m. and noon, the anticonvulsant mood stabilizer Valproic Acid 750 mg twice a day, and the antihypertensive agent (which is often used for impulsive behavior) Clonidine 0.2 mg a.m. and noon and 0.1 mg in the p.m. (8/13/10 medication profile). The final analysis related to the section of this provision regarding the determination that the prescribed psychoactive medications had been effective in decreasing the frequency and/or intensity of the behavioral symptoms, which were described as being related to the primary psychiatric diagnosis. This analysis was accomplished by examining the longitudinal behavioral data that appeared in the Psychological section of the records. However, this data was compromised somewhat by the routine purging of records, so that data was only available for the last few years. Thus, baseline data for a medication that was begun five or more years ago was generally not present. This analysis indicated that empirical evidence that the prescribed psychotropic medication was effective in diminishing the identified behavioral symptoms of the psychiatric disorder could be identified in eight out of the 25 (32%) records reviewed. Those individuals for whom it was determined that there was sufficient evidence to suggest that the medications were effective were as follows: Individual #147, Individual #113, Individual #277, Individual #38, Individual #100, Individual #254, Individual #193, and Individual #255.	
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	Documentation that the individual had a legal guardian was located in 14 out of the 25 (56%) individual records reviewed. LBSSLC had a number of individuals whose teams had identified that they were not competent to make an informed decision relating to the inherent risks and benefits of the proposed psychotropic medication, and who did not have a Legally Authorized Representative (LAR). For these individuals, the Director made the decision, and signed the necessary consent form. The documentation available in the records would suggest that this individual had signed off on the necessary documentation. However, the consent process at the LBSSLC raised concerns similar to those related to the risk-benefit analysis described above with regard to Section J.10 of the SA. The	Noncompliance

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	limitations on the use of the medications or restrictive procedures and shall identify associated risks.	specific concerns related to the generic listing of the medication side effects, which did not include any indication of frequency or delineation of the most severe side effects. In addition, the consents for multiple psychotropic medications were collectively addressed as if they represented one intervention. The consents also did not indicate a specific dosage range that was appropriate for the medication. In fact, the dosage range was not discussed at all. These issues result in the finding that the information provided to the LAR and/or Facility Director was not adequate to ensure that the consent obtained was informed consent.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	In addition to the neurologist, the two staff psychiatrists, the Medical Director, two primary care physicians, and the physician assistant attended the Neurology Clinic on 9/15/10. The format was consistent with that observed at the time of the baseline review. A nurse from their Residential Unit accompanied the individuals reviewed. The nurse presented the relevant history, and their clinical files were also available to the neurologist. A discussion followed the review of each case presentation. These discussions were quite detailed, involved the Psychiatrists and PCPs and, where appropriate, there was a discussion of the relevant published literature. The presence of the psychiatrists was documented in the Neurologist's Note and was also documented in a corresponding Progress Note from the Psychiatrist. The consistency of this process was verified by a review of the Neurology section of the medical records of the 13 individuals within the random sample who required and received neurological consultation. The only note in all of these records that did not mention the presence of the Psychiatrist at the Neurology Clinic was the Neurology Consult dated 9/25/10, for Individual #23. The format described above, which was consistently documented, confirmed the direct collaboration between the Neurologist and Psychiatrists, as set forth in this provision of the Settlement Agreement.	Substantial Compliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The work started by the Directors of Psychiatry and Psychology should continue to ensure that for each individual prescribed psychotropic medication, if a specific behavior is listed as both being present on a behavioral basis and also as a target behavior of psychotropic medication, the rationale is identified and documented.
2. Consideration should be given to integrating the Treatment Plans for the use of psychotropic medications with the Behavioral Support Plan, so

that it is clear which of the identified behaviors are directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies.

3. The Facility should continue its efforts to provide adequate documentation of the symptoms that confirm the psychiatric diagnosis for each individual.
4. The responsibility for the development, implementation, and monitoring of the behavioral desensitization programs and other strategies to assist individuals in tolerating medical and dental appointments should be delineated clearly.
5. An interdisciplinary review should be conducted of the Human Rights/Consent process with regard to the approvals for psychotropic medications with the goals of:
    a. Ensuring that approval is sought and obtained for each psychotropic medication, when more than one is prescribed;
    b. Improving the adequacy of the current listing of medication side effects to include the probability of their occurrence;
    c. Defining the potential that a psychotropic medication will be (or has been) effective in treating the identified target behavior; and
    d. Including analysis of the potential side effects of the psychotropic medication(s) as they relate to the potential harm posed by the symptoms to be addressed by the medication.
6. The Facility should ensure that side effect monitoring occurs for each individual receiving psychotropic medications on at least a quarterly basis, as required by the SA.
7. For those individuals who are receiving multiple psychoactive medications, it would be useful to provide the rationale for each medication.
8. Potential mechanisms for retaining the longitudinal, historical behavioral data in the individual records to facilitate the determination of the efficacy of psychotropic medication(s), which may have been started multiple years ago should be investigated and implemented.
9. The internal auditing process for Psychiatry Services should be modified to ensure that the individual items identified on the checklist are not only present, but also meet the quality standards contained in the Settlement Agreement as well as the Health Care Guidelines.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Plan to Demonstrate Competence of Psychologists, updated 8/6/09 (TX-LB-1009-PH.17.2); o Packet of information including copies of diplomas, educational, training and/or conference certificate of attendance, online quiz summaries, and Behavior Analyst Certification Board certificates, and field and practicum experience supervision forms for behavioral services staff (TX-LB-1009-PH.17.2); o Curriculum vitae of Jim Forbes, M.Ed., BCBA, Director of Behavioral Services (TX-LB-1009-VIII.10); o Summary document of title, position, and credentials (or development of credentials) of Behavioral Services Staff, as of 8/16/10 (TX-LB-1009-VIII.9); o LBSSLC Summary document of budgeted positions, staff, contractors, unfilled positions, current FTE, current staff-to-individual ratio, including current census, as of 8/23/10 (TX-LB-1009.I.13.F); o LBSSLC Policy – Positive Behavior Support: Positive Behavior Support Practices, dated 8/31/10; o LBSSLC – Positive Behavior Support: Psychological Evaluations, revised 8/31/10; o Human Rights Committee (HRC) meeting minutes, from 3/3/10 to 8/25/10; o Behavior Support Peer Review Committee (BSC) meeting minutes, from 2/5/10 to 8/13/10; o LBSSLC Behavioral Services Tracking Grid of BSC, HRC and Consent Expiration for Positive Behavior Support Plans, dated 9/18/10; o LBSSLC Behavioral Services Tracking Grid of BSC, HRC and Consent Expiration for Safety Plans, dated 9/13/10; o Positive Behavior Support Plans (PBSPs) for: Individual #213, Individual #317, Individual #126, Individual #99, Individual #237, Individual #298 , Individual #320, Individual #134, Individual #2, Individual #33, Individual #107, Individual #167, Individual #114, and Individual #190; o Safety Plans for: Individual # 33, Individual #82, Individual #239, Individual #213, and Individual #134; o Safety Plans Progress Notes, for at least three or more months, as available for: Individual #33, Individual #82, Individual #239, Individual #213, and Individual #134; o Integrated Progress Notes for at least three or more months, as available, for: Individual #154, Individual #264, Individual #36, Individual #159, Individual #213, Individual #107, Individual #183, Individual #317, Individual #268, and Individual #60; o Psychological Assessments, including Inventory for Client and Agency Planning (ICAP) Evaluations, when available for: Individual #264, Individual #36, Individual #213, Individual #183, Individual #181, Individual #317, Individual #235, Individual #82,

	Individual #126, Individual #108, Individual #99, Individual #66, Individual #237, Individual #190, Individual #135, Individual #167, Individual #298, Individual #106, Individual #320, Individual #134, Individual #33, and Individual #2; o Structural and Functional Assessment Report (SFAR) for: Individual #264, Individual #36, Individual #213, Individual #183, Individual #181, Individual #317, Individual #235, Individual #82, Individual #126, Individual #108, Individual #99, Individual #66, Individual #237, Individual #190, Individual #135, Individual #167, Individual #298, Individual #106, Individual #320, Individual #134, Individual #33, and Individual #2; o Case notes and Treatment Plans, as available, from external counseling center for: Individual #36, Individual #159, and Individual #82 (TX-LB-1009-VIII.8); o Listing of Recipients of Individual Psychotherapy by Outside Counselor, based on July 2010 Billing Statements (TX-LB-1009-VIII.8); o Behavioral Services Work Completion Plans (TX –LB-1009-PH-15.1.d); o PBSP Assessment-Guided Staff Training rubric; o PBSP Observation-Guided Staff Training rubric; o Responses to PBSP Assessment-Guided and Observation-Guided Staff Instructions, including data from 8/8/10 to 8/28/10 (TX –LB-1009-PH-15.1.c); o PBSP Survey Report, developed by Jim Forbes and Blake Perez (TX –LB-1009-PH-15.1.c); o Positive Behavior Support Plan Checklist (TX –LB-1009-PH-15.1.f); o LBSSLC Competency-Based Training - first draft, undated (TX –LB-1009-PH-15.1.f); and o Plan Regarding PBSP Competency Assessments (TX –LB-1009-PH-15.1.f). ▪ **Interviews and Meetings with the following**: o Lola Walker, QMRP Coordinator, Marisol Gonzales, ISP Coordinator, and Trent Lewis, Director of Active Treatment, on 9/14/10; o Jim Forbes, Director of Behavioral Services on 9/13/10 and 9/15/10; o Bob Robbins, Program Compliance Monitor, on 9/14/10; o Trent Lewis, Director of Active Treatment, on 9/15/10; o Laura Anciso, Director of Vocational and Day Programs, Paul Thomas, Recreation Supervisor, and Rodshadi Moore, Active Treatment Supervisor, on 9/15/10; and o Psychologists and Psychology Assistants, including: Carolyn Milton, Philip Kite, Melissa Moore, Nicole Johnson, Joanna Mollica, Anna Shackelford, Amber Flores, Krista Leubner, Lamexxa Abduljaomi, Valerie Martinez, Lynette Frantzen, Christina Sosa, Ronald Flint, Blake Perez, Dustin Collums, Raul Trevino, and Beckie Dobbins, on 9/15/10. ▪ **Observations Conducted**: o Observation and discussion with Dr. Weddige, Christina Sosa, and other staff members at Psychiatric Clinic for Individual #235, on 9/13/10; o Incident Management Meeting, on 9/14/10; o Integrated Treatment Meeting, on 9/15/10; o Behavior Support Committee Peer Review Meeting, on 9/16/10; o Restraint Reduction Committee, on 9/16/10; o Onsite direct observation, including interaction with direct support professionals, and other professionals including Residence Coordinators, Psychologists, Psychology

	Assistants, Home Team Leaders and Assistant Home Team Leaders, Active Treatment Staff, and/or QMRPs were conducted throughout the morning, day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Quail (504 E), on 9/13/10; ▪ Sparrow (504 W), on 9/13/10; ▪ Maple (517), on 9/15/10; ▪ Oak (518), on 9/15/10; ▪ Zinna (528), on 9/16/10; ▪ Fir (516), on 9/15/10; ▪ Canna (521), on 9/16/10; ▪ Rose (525), on 9/16/10; ▪ Tulip (526), on 9/16/10; ▪ Violet (523), on 9/16/10; ▪ Aspen (513), on 9/13/10; ▪ Birch (514), on 9/15/10; ▪ Elm (515), on 9/15/10; ▪ Willow (520), on 9/15/10 and 9/16/10; ▪ Estacado Industries Residential Services (EIRS), on 9/15/10; ▪ Estacado Industries Workshop (EIWS), on 9/16/10; and ▪ Educational Building on 9/15/10.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for LBSSLC did not include this component, the POI did contain action steps, evidence, Facility target dates, full SA implementation dates, judgment on current noncompliance (N) or substantial compliance (S), and additional comments. The majority of dates on the POI were for at least six months or more from the current review, and assessment of many of the sections were dependent upon development or revisions of policies or the need for corrective action plans. Subsequently, this process was a work in progress. According to the POI, LBSSLC did not indicate substantial compliance with any subsections of Section K of the SA. With one exception, this finding was consistent with the Monitoring Team's findings. More specifically, based on the Monitoring Team's review, the Facility was in substantial compliance with Section K.2.
	Summary of Monitor's Assessment: Progress had been made with Psychological Services since the previous baseline visit. For example, LBSSLC had been successful in attracting a new BCBA into a full-time position, as well as a BCBA-D within a consulting, external peer review position. At the time of the review, all of their Associate Psychologists were enrolled in online graduate coursework in pursuit of BCBA credentialing. In addition, the Director of Behavioral Services demonstrated substantial education and clinical competence within his position. The inclusion of additional LBSSLC staff as well as an external BCBA-D consultant within the behavioral

	services peer review committee had enhanced the membership's ability to provide critical peer review. Similarly, additions of individuals not employed by the Facility to the HRC also supported more independence in review of programming. Progress also had been made in the area of data collection and monitoring of PBSPs, and skill acquisition programs. However, concerns regarding the adequacy and timeliness of data collection remained. Improvements included new standardized formats. The effectiveness of this new standardized data collection format will need to be examined at the next review. Although inter-observer data collection had not yet started, plans were underway to identify an acceptable system. In addition, new methods of monitoring treatment integrity were soon to be initiated. Structural and Functional Behavior Assessment (SFBA) continued to be an area of strength within psychological services. These comprehensive reports appeared to be successful in identifying underlying function(s) of target behaviors, as well as evidenced-based interventions. Challenges remained with regard to identifying and defining specific replacement behaviors, as well as prescribing detailed teaching strategies necessary to promote effective skill acquisition. Psychological assessments were updated annually for current residents and completed in a timely fashion for new residents. However, many of these assessments relied on intelligence testing that had occurred 10 to 20 years ago. Slight improvement in the treatment plans and monthly monitoring notes for individuals receiving counseling services was also observed. Active efforts to maintain and improve the quality of PBSPs were noted. For example, feedback from direct support professionals was obtained to assist in determining effective formats of PBSPs. Also, a new rubric to ensure a consistent format was soon to be implemented. Areas for improvement included ensuring adequate operational definitions for replacement behaviors, prescribing specific teaching strategies, and the integration of sufficient reinforcement. Systems examining the treatment integrity of PBSPs had been developed, but not systematically implemented. Once in place, staff should be able to more systematically examine the effectiveness of staff training. Indeed, competency-based training continued to be an area of significant concern.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who	As reported after the baseline visit and as more recently observed during the compliance visit, the professionals within Behavioral Services were a group of dedicated, hardworking, and thoughtful professionals committed to improving the lives of the individuals they serve at LBSSLC. This was a group with a diverse range of educational backgrounds as well as training in Applied Behavior Analysis (ABA). The Director of Behavioral Services, as well as the Psychologist I and all Associate Psychologists (N=9), had at least a Master's degree. At the time of the review, two of the psychology staff (i.e., the Director and Psychologist I) were Board Certified Behavior Analysts (BCBAs).	Noncompliance

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	have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Progress certainly had been made in supporting staff to pursue credentialing. All nine of the Associate Psychologists were pursuing BCBA credentialing. That is, they were all enrolled in online coursework through the University of North Texas. Indeed, six of the nine had already completed multiple courses toward certification. Recent verbal reports from a number of these staff indicated that the financial assistance the Facility offered (in supporting coursework, certification, and supervision) removed a significant financial barrier, thus enabling them to pursue (or continue to pursue) certification. The importance and value of adequate onsite field supervision cannot be underestimated, and will be critical to the development of competencies necessary for certification. The provision of this supervision to behavioral services staff, at no cost, is a substantial benefit, and will continue to enhance the Facility's ability to retain staff. Other financial benefits, such as supporting state and local conference attendance and related training, also appeared to increase the likelihood of staff retention and professional development. Many of the Associate Psychologists had obtained supplemental training in the last year. This included attendance and continuing education opportunities at an ABA state conference, as well as other ABA trainings facilitated by experts in the field. In addition, six of the Associate Psychologists had started receiving the necessary supervision toward certification. As reported following the baseline review, a written plan addressing the recruitment, training, and retention of BCBAs was developed and implemented. This plan appeared to have been successful in recruiting and training BCBA-level professionals. That is, a new BCBA-level psychologist was hired recently. This new hire replaced the previously hired BCBA who resigned following the baseline visit. In addition, an external BCBA consultant was also engaged recently (i.e., at less than 16 hours a month) to assist with peer review (discussed below with regard to Section K.3 of the Settlement Agreement). At the time of the review, there was one BCBA position (Psychologist 1) still open. At the time of this review, there were eight Psychological Assistants compared to the five that were employed at the time of the baseline visit. Recent changes reflected a higher percentage of psychology assistants with bachelor degrees. That is, from baseline to the current visit, the number of staff with bachelor degrees changed from one to five. At the time of the review, there was one open Psychological Assistant position. This provision item was rated as noncompliance because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9	

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		of the SA.	
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.	As reported during baseline, Jim Forbes, M.Ed., BCBA, was the current Director of Behavioral Services. He had a Master's degree in School Psychology, and received his BCBA in March 2009. He had been employed in his current position for over seven years, and had extensive experience (over 31 years) supporting individuals with intellectual, mental, and physical disabilities. He had taken the lead in the development of statewide policies and procedures for behavioral assessment, positive behavior support, and limiting the use of restraint. Verbal reports during the baseline review evidenced very positive evaluations of Mr. Forbes' job performance. This included strong endorsements from behavioral services staff, including Associate Psychologists and Psychological Assistants, as well as staff and professionals from other disciplines. Verbal reports received during the more recent compliance visit were consistent with those initially voiced during baseline reviews. Based on these reports, it is obvious that staff at LBSSLC had very high regard for Mr. Forbes, and valued his skills, leadership, support, and dedication. Following the baseline review, the Facility made a change in the administrative structure from a unit-based model to a discipline-based model. This change allowed the Director of Behavioral Services to directly supervise all staff within behavioral services. Based on verbal reports from behavioral services staff, this change was very positively received, and appeared to have facilitated more consistent adherence to the clinical responsibilities of behavioral services staff.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	At the baseline review, it was established that LBSSLC supported a rigorous internal peer review system, the Behavior Support/Peer Review Committee. As found during the most recent visit, this system continued to be quite rigorous, and had improved since the baseline visit. For example, specific process criteria related to the peer review process were added to existing policy. More specifically, procedures regarding both internal (i.e., BSC) and external peer review had been added. The new information outlined included the designated members of each review process (including the authors of the plans), the expected frequency of meetings, the purposes of the meeting/review, the targets or content of the reviews, and the frequency with which documents (PBSPs or Safety Plans) were to be reviewed. Other noted improvements since baseline included greater diversity within the BSC. That is, additional staff included a QMRP, Psychological Assistants, and an external BCBA consultant. The inclusion of Psychological Assistants was a welcome change since the baseline visit. The QMRP currently attended as a representative for those who are responsible for carrying out the plans.	Noncompliance

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		Review of sampled meeting minutes from the BSC suggested that the committee continued to meet approximately once a week. In addition to those members listed above, attendance by other LBSSLC staff members continued to make this committee a very diverse group of professionals. For example, meetings typically continued to be attended by a speech-language pathologist, human rights officer, medical staff (Psychiatrist or RN), and quality enhancement staff. Direct observation of the BSC during the recent onsite visit continued to evidence very active participation of committee members, presentation of plans by their authors, and the utilization of data when reviewing assessments or when making decisions. It was noted on the POI that authors of plans might not always be in attendance when the plans were reviewed (i.e., K.3.A.5). It is difficult to estimate, given the available documentation, how often this might occur. In addition, the POI indicated that not all decisions were data based given that the data in some cases was incomplete (i.e., K.3.A.7). This Facility report was consistent with the Monitoring Team's current findings related to inconsistent data collection (see more information below with regard to Section K.4 of the SA). It is expected that as changes and improvements are made in data collection systems, the increasing availability of data will likely facilitate more informed decision-making. In addition to internal peer review, progress had been made in improving external peer review. As briefly described above, one significant change since the baseline review had involved the hiring of an independent consultant to assist with external peer review. This consultant, a Doctoral-level Board Certified Behavior Analyst (BCBA-D) from Texas Tech University with expertise in Special Education and Applied Behavior Analysis, had attended the Behavior Support Peer Review Committee on a monthly basis since 5/12/10, and had also provided more in-depth case review on selected individuals. His involvement in program review, in general, at these meetings as well as in more comprehensive case reviews, at the individual level, was expected to continue. This established partnership was a very positive improvement, and appeared to set the foundation for other mutually beneficial interactions and outcomes. A review of the Behavioral Services summary grids that included the dates of PBSP approval by BSC and Human Rights Committee, dated 9/18/10, as well as dates of Safety Plan approval by BSC and Human Rights Committee, dated 9/13/10, was completed to estimate whether or not PBSPs and Safety Plans were reviewed at least annually. According to this documentation, it appeared that 7% (10 out of 132) of PBSPs and 12% (one out of 8) of Safety Plans were out-of-date (i.e., their BSC and/or HRC approval date was prior to 9/18/10.	

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		Issues related to authors of the plans not being consistently present at BSC meetings, as well as decisions not being data-driven due to a lack of reliable data, need to be addressed for the Facility to be found in substantial compliance with this component of the SA.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	As reported following the baseline review, a high percentage of PBSPs and Safety Plans contained data on target and replacement behaviors in a variety of formats, including within tables and/or graphic display. These documents were reviewed to estimate the current nature of data collection and display of data related to these programs. Twenty sampled Positive Behavior Support Plans, representing 15% of the total number of PBSPs currently in place (N=132), were reviewed to estimate what data was collected and how it was displayed. Based on this review: ▪ All of the PBSPs reviewed identified and defined target and replacement behaviors, with one exception (i.e., Individual #167). Several PBSPs identified and defined behaviors for monitoring in an attempt to measure supplemental behaviors reflective of an underlying psychiatric diagnosis (i.e., Individual #154, Individual # 107, Individual #317, Individual #109, Individual #237, and Individual #190). ▪ Baseline data was displayed in table format in 95% of sampled PBSPs (i.e., a table was not included for Individual #167). Tables typically displayed baseline data on target and replacement behaviors as well as dosages of medication(s). However, baseline data on replacement behaviors was not included within these tables for seven (35%) of the reviewed PBSPs. ▪ In addition, graphic (line or bar) display of target and replacements behavior was found in 75% of sampled PBSPs. Graphic display was not included in the PBSPs for five individuals (i.e., Individual #264, Individual #66, Individual #167, Individual #33, and Individual #298). Within line graphs, data displayed typically included target and replacement behaviors. However, one sampled PBSP included a line graph that did not include replacement behaviors (i.e., Individual #183). ▪ When utilized, bar graphs typically displayed information on medication dosages. However, not all sampled PBSPs contained bar graphs (Individual #108, Individual #268, and Individual #107). There were several graphs where legends were not adequately described or labeled, leading to confusion regarding what they represented (i.e., Individual #159 and Individual #268). In addition, some graphs illustrated a target behavior (e.g., reflecting levels of depression) that was not adequately defined (i.e., Individual #213). As found during baseline and again more recently during the compliance visit, when PBSPs included the graphic or tabular illustration of data, only a single replacement	Noncompliance

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		behavior was displayed (typically labeled "replacement"), even in cases where multiple replacement behaviors were identified and defined within the PBSP. It was unclear, in these cases, which of the replacement behaviors (as identified and defined in the PBSP) were represented by the data in the table or graph (i.e., Individual #154, Individual #36, Individual #159, Individual #235, and Individual #82). Five sampled Safety Plans for Crisis Intervention (SPCI), representing 63% of the total SPCIs currently in place, were reviewed to estimate how data related to restraint was collected and displayed. The frequency of restraint, total duration of restraint, and average duration of restraint, per month, was displayed. Four of the sampled SPCI displayed the data both in Table and Graph (line graph) format. A unique integration of table and graphic format was utilized for Individual #82. The fifth SPCI only displayed data using a table (i.e., Individual #33). One of the five sampled SPCIs included data on the use of chemical restraint. Lastly, all five SPCIs presented data on the occurrence of injuries related to restraint. Safety Plan Progress Notes for the five individuals reviewed above were also reviewed to determine the adequacy of data collected, displayed, and summarized. All of the monthly progress notes contained tables and line graphs illustrating data on frequency of restraints, total duration of restraints, average duration of restraint, and number of injuries related to restraint per month. Review of this information did not evidence any missing raw data. However, some of the reports reviewed provided inadequate summary information in the discussion sections when restraints were documented. Consequently, when restraint is utilized, consideration should be given to providing more descriptive information in the discussion section related to the use of restraint. For example: ▪ Individual #239 was "restraint free" for 10 consecutive months and, when a restraint was required in the subsequent month, the only information provided was "… (Individual #23) has only been in a physical restraint 1 time this month. The restraint occurred for 2 minutes." This information was redundant as it was already available in the table and on the graph. Instead of repeating known data, it may be more valuable to describe why the restraint was necessary, including the behaviors leading to the restraint and the interventions that were unsuccessful in avoiding the restraint. This information could be extremely helpful in the future when attempting to assess why target behaviors occur and what strategies are most helpful in avoiding restraint. ▪ A similar opportunity was missed when Individual #213 experienced a significant increase in restraints in March 2010, and only information regarding resultant pharmacological intervention was described. ▪ A good example of providing potentially helpful descriptive information was found in notes (April, May and August) completed for Individual #82.	

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		Data collection, as observed during baseline and more recently during compliance visits, continued to be inconsistent. During the baseline visit, data was collected in a variety of ways that differed across residential programs. More specifically, data on target, replacement, or other behaviors were recorded on data cards, on an Antecedent-Behavior-Consequence (ABC) behavior record, and/or in observation notes. Methods of data collection appeared to vary as well, and were noted to include frequency, partial interval, and duration data. During the current compliance visit, brief record reviews reflected continued inconsistency in data collection within these various formats across settings. Discussion with staff also reflected inconsistencies about where and when data should be collected. Behavioral services staff recognized the inadequacy of the data collection system during the baseline review. At that time, their comments reflected a strong desire to improve the quality of their data. Since the baseline visit, efforts had been made in developing a new standardized data sheet called the "Daily Summary of Target Behavior." This new standardized format was expected to utilize frequency recording and would allow staff to record data for all individuals on a single sheet. Reports from staff indicated that this new system was not in place across all settings yet. The Monitoring Team recognizes the rationale for a consistent and standard format to "simplify" data collections across sites. However, the system would still need to be flexible enough to allow individualized data collection systems when warranted. In addition, this new format prescribed data collection across shifts. This system might continue to inadvertently support the collection of data at the end of the shift rather than recording the behavior following its occurrence (which might be more likely if staff are required to complete data recording more frequently). Consideration should be given to how the new format will support or increase timely data collection. As found during baseline and more recently during the compliance visit, inter-observer agreement (IOA) data was not collected. Behavioral services staff, including the Director of Behavioral Services, continued to acknowledge that the confidence they had in the accuracy of their data, and their ability to make data-based decisions was substantially limited by the lack of IOA data collection. Reports indicated that a plan was in place to start collection of IOA in November of 2010 on a small scale utilizing psychology assistants as independent observers of selected individuals. As found during baseline, PBSP data was typically collected and summarized on a monthly basis. At the time, Associate Psychologists completed the monthly PBSP data summary on a document called the Integrated Progress Note. At the time of the most recent review, this system was still in place. Current review of a sample (N=10) of requested Integrated Progress Notes indicated that text within the report was often	

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		inconsistent or contradictory to the data presented. For example: ▪ Comments under "replacement behavior(s)/alternative behaviors(s) data" section for Individual #159 included "… doing really well in monitoring her behavior and appropriately seeking attention from preferred persons." This statement did not appear to be data-based as no replacement behavior data was provided within the table or graph for March 2010. The data that was provided on this graph was especially difficult to interpret as multiple abbreviations, that were not readily identified or defined, were used across data markers on the legend. In addition, three of the seven abbreviations did not appear to be related to target behaviors identified and defined on the PBSP. ▪ Comments under the same section for Individual #60 (July 2010 Integrated Progress Note) also did not appear to be consistent with data included on the table or graph. More specifically, comments indicated that "… [Individual #60] engaged in replacement behavior 15 times this month, compared to 15 last month, representing progress toward criteria, which he did not yet meet." It was unclear, given that the current and previous month each evidenced 34 incidents of the replacement behavior, which data was correct, and whether or not progress was being made. ▪ The Integrated Progress Note from February 2010 for Individual #183 appeared to contain multiple errors. For example, information under the "objective criteria" and "objective met" was not consistent with data provided on the table, and comments made by the Associate Psychologist. In addition, the description of data in text was inconsistent with the data displayed in the table. This was especially worrisome when the text indicated "… no incidents of pica for 12 months," when data displayed clearly indicated one incident in October 2009. In addition, it was unclear why this individual did not meet the criteria for his targeted behavior of "pica attempts," when it appeared that he evidenced four consecutive months of zero attempts. Lastly, it seemed unlikely that this individual would exhibit the exact same number of replacement behaviors for three of the last four months (i.e., 18, 18, 0, and 18 in November, December, January and February, respectively). Lastly, the text in the February 2010 note indicated that "… used his functional communication skills 27 times during the month of October …," but neither the month nor number of responses matched those displayed in the table and line graph. ▪ In some of the sampled integrated progress notes, data on replacement behaviors was not reported, often for consecutive months. For example, replacement behavior data was unavailable for at least six months for Individual #268 (March-August 2010). Similar instances of missing replacement behavior data were found for other sampled documentation (e.g., Individual #264, Individual 159, and Individual #317).	

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		Review of graphs (line and bar) on Integrated Progress Notes also evidenced inaccuracies as well as other problematic issues. For example: ▪ In general, the Y-axis of both line and bar graphs were seldom labeled. ▪ Line graphs did not always accurately reflect the raw data (i.e., data from the table). For example, a data path for Verbal Outbursts was not included in the line graph for Individual #268 (i.e., March 2010). ▪ In general, bar graphs displaying medication dosages on integrated progress notes may be unnecessary if the dosages are also listed in provided tables. That is, the same data was displayed in both table and bar graphs within Integrated Progress Notes. ▪ In some cases, the extreme range in doses of medication made interpretation difficult. For example, the 30% increase in Geodon (from 80 to 120) is imperceptible when displayed concurrently with Depakote that had a range up to 1750 (i.e., Individual #60). ▪ Also, if bar graphs continue to be used, consideration should be given to the difficulty in discriminating between different colors of bars when viewing copies of the original graphs. When this occurs, it is challenging to discriminate between the shades of gray on multiple bars. To facilitate interpretation, perhaps different patterns within the area of the bar could be utilized in place of different colors. ▪ Often, comments placed on graphs were unnecessary and should be avoided if the data was readily available elsewhere. For example, comments were included on the line graph to indicate changes in medication when the same information was readily available in the table and bar graph on the same page (i.e., March 2010 Integrated Progress Note for Individual #213). The inclusion of this additional information was redundant and, as more information is included on graphs, might lead to a higher probability of inaccuracies (e.g., the text on the line graph "Zoloft increased to 150" in October 2009 was inconsistent with other data on medication dosage provided. Consideration should be given to only including narrative text on graphs when that information is not readily apparent or already displayed in provided tables or graphs. Recent reports from the Director of Behavioral Services indicated that a new format for the Integrated Progress Note was currently under development. Future compliance visits will need to examine this new format and determine if it addresses the above concerns.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and	At the baseline review, it was determined that the underlying expectation by behavioral services staff was that each individual residing at LBSSLC was required to have a current psychological evaluation. That is, discussions indicated that a psychological assessment would be completed, updated, and/or reviewed at least annually for each individual	Noncompliance

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	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.	served. This included reviewing and including summary data from previous Inventory for Client and Agency Planning (ICAP) evaluation on an annual basis, with the requirement of conducting a re-evaluation using the ICAP at least once every three years or sooner if significant events appeared to impact adaptive functioning. As of the most recent compliance visit, this expectation for the completion of an annual psychological evaluation or update had not changed. Indeed, as outlined in LBSSLC policy, revised 8/31/10, each resident must have a current psychological evaluation. For the most recent review, a sample of psychological assessments (N=22) was selected for review. This sample reflected approximately 10% of the total number of individuals with psychological assessments. Within this sample, 100% had a psychological assessment that was updated within the last 12 months. Also, 100% of the psychological assessments included summary scores from an ICAP evaluation completed within the last three years. Although this was challenging to verify as some of the dates on provided documentation (ICAP booklets and scoring summaries) were not consistent with cross-referenced information found within psychological assessments or PSPs (see below). Of the psychological assessments reviewed, 86% (i.e., 19 out of 22) contained results of previously completed standardized tests of intelligence. These tests included the use of the Wechsler, Slosson, Kaufmann, TONI, and/or Leiter and were completed, on average, approximately 13 years ago (range of completion dates from one to 23 years). The majority (74%) of these IQ tests were conducted over 10 years ago (i.e., 42% and 32% completed with the last 10 to 20 years and over 21 years ago, respectively). Only three individuals sampled had standardized intelligence quotient tests (IQ) completed within the last five years (e.g., Individual #320, Individual #235, and Individual #36). The three sampled psychological assessments that did not provide summary information on standardized tests of intelligence including the following statements: ▪ Psychological Assessment for Individual #181 indicated that: "… due to profound … deficits in adaptive functioning and sensory impairments, standardized formal intelligence tests was not appropriate." ▪ Psychological Assessment for Individual #2 indicated that: "… [Individual #2's] sensory deficits preclude intelligence testing using the available instruments." ▪ Psychological Assessment for Individual #264 indicated that: "… an adaptive behavior tool was used to assess his IQ, as [Individual #264] would not attend to any other standard IQ test." It was unclear from the above statements, as well as associated psychological assessments, which standardized assessments were utilized without success. In addition, it was unclear how many attempts were made to complete an assessment, and whether or not alternative tests were attempted. In consideration of current LBSSLC psychological evaluation policy, these reports should have indicated which individual	

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		factors were considered when selecting the test (i.e., how it was most applicable to the person) or, given the above situations, a full description of the individual factors that "ruled out" the use of a specific test or testing in general. In addition, it would have been important to describe the modifications that were attempted (and their potential effect on the validity of the results) in response to individual limitations that did not allow prescribed testing procedures. The Facility should examine the current policy and consider if additional guidance should be included within this policy to: 1) address cases where examiners are limited in their selection of available or appropriate tests; 2) assist examiners in determining when testing is not appropriate; and 3) determine if and/or when standardized assessments of adaptive behavior may replace the utilization of standardized tests of intelligence. Of the psychological assessments currently reviewed (N=22), 64% contained results of previously completed standardized tests of adaptive behavior, specifically utilizing either the Vineland Adaptive Behavior Scale or the AAMD Adaptive Behavior Scales. The remaining psychological assessments (36%) included the use of the ICAP as the initial measure of adaptive behavior. The differentiation in description here is based on the apparent differentiation of these two assessments within current LBSSLC policy. Overall, 100% of psychological assessments included scores from standardized assessments of adaptive behavior. Some of the psychological assessments did not include the most recently obtained assessment results that appeared to be available. In addition, the completion dates of assessments, typically the ICAP evaluation dates, were inconsistently recorded across reports. For example: ▪ The ICAP and the psychological assessment for Individual #183 were completed on the same day. However, the findings from the completed ICAP were not included in the psychological assessment, even though they were completed concurrently. In addition, it appeared that the date on the ICAP worksheet had been changed (written over). ▪ In addition, although the date in the psychological assessment matched the date on the ICAP, the date did not match the one found in the PSP (Individual #181). ▪ The date on the ICAP scoring sheet did not match the date listed in the PSP or the Psychological Assessment (Individual #317 and Individual #126). ▪ The date on the ICAP scoring summary sheet (11/3/09) did not match the date listed on the ICAP booklet (11/25/09), and neither date was included in the Psychological Assessment that was updated one month later (Individual #99). One might assume that the effort required to complete a more current ICAP, just weeks prior to revising the psychological assessment, would lead to the inclusion of that new date and data into the revised assessment. In addition, it appeared that the date on the ICAP booklet was changed (i.e., perhaps the use of	

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		"white–out," and then written over). ▪ An ICAP was completed six days after a 30-day evaluation. It was unclear why the ICAP was not completed a week sooner, and the new date and data included into the revised assessment (Individual # 190). ▪ The date on the ICAP booklet (8/11/08) matched the date in the psychological assessment, but not the date indicated on the ICAP scoring summary (Individual #298). As detailed during the baseline review, additional screenings for psychopathology, behavioral, and emotional issues, in addition to the above assessments, were completed using the Reiss Screen for Maladaptive Behavior. The Reiss was utilized to screen individuals who were not receiving psychiatric services. According to discussions with psychology staff, these assessments were completed in the past as part of a system-wide supplemental screening process. According to the Director of Behavioral Services, these assessments were completed and submitted to the psychiatry department. In addition to the annual Psychological Assessment, individuals who received behavioral and psychopharmacological interventions were required, according to current policy, to have a Structural and Functional Assessment Report (SFAR). Of the individuals sampled (N=22), 86% had a SFAR that was updated within the past 12 months. For the three remaining individuals without SFARs, one was not dated (i.e., Individual #36), requested documentation was not provided for one (i.e., Individual #181), and one was outdated by a few days (i.e., Individual #298). Overall, review of LBSSLC Summary Listing of Individuals for whom an SFAR had been completed within the last year revealed that 116 SFARs were completed between 8/1/09 and 7/31/10. According to the behavioral services grid, revised 9/18/10, approximately 14 percent of the total SFARs were currently out-of-date. This was an improvement from the baseline review where it was estimated that 20 percent of all SFARs were out-of-date. As found during the baseline review, the sampled SFBAs (N=22) were comprehensive and primarily adhered to a standard format. The assessment methodology or processes that were the basis of these reports were widely accepted and viewed as standard practice within the field of ABA, including structured interview formats (e.g., Functional Assessment Interview Form, The Problem Centered Interview), rating scales [e.g., Motivation Assessment Scale (MAS), Functional Analysis Screening Tool (FAST)], event recording and permanent product review (e.g., ABC behavior recording, scatter plot, etc.), and direct observation. These findings were consistent with the findings from the recent compliance visit. As previously reported during baseline review, these reports typically: 1) provided background information; 2) identified target behaviors, including operational	

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		definitions; 3) described findings from indirect (interviews, rating scales, review of observation notes, etc.) and direct (direct observation) assessment methods; 4) summarized medical and psychiatric status; 5) displayed previous data, including target and replacement behaviors, as well as medication and doses; 6) identified potential setting events, motivating operations, antecedents, and consequences; 7) indentified potential function(s) and related hypotheses; 8) identified potential replacement behaviors; 9) described related research; and 10) identified individual preferences/potential reinforcers. Overall, sampled plans were consistent with this format and provided substantial information relevant to providing effective behavioral supports. There were, however, areas in need of improvement that were noted. These included: ▪ The plans contained very comprehensive raw data produced from multiple interviews, rating scales, observation notes, and direct observations. In some cases, this information included data from previous years. The amount of information was considerable, and made reading and understanding the report challenging. Consideration should be given to summarizing the raw data associated with each of these methods and highlighting how each supports (or does not support) the hypothesized underlying function(s). ▪ Although plans typically identified potential functions and provided general ideas for replacement behaviors based on research, no SFAR appeared to identify and operationally define a specific replacement behavior. In the current sample, it was challenging at times to find the proposed replacement behavior(s). Indeed, in some reports, the Monitoring Team could not identify a specific replacement behavior (e.g., Individual #183, Individual #213, and Individual #108). This was consistent with the baseline review as well. Consideration should be given to standardizing a section in the SFAR, already found in some reports (e.g., Individual #126, Individual #235, and Individual #213), devoted to identifying and defining one or more replacement behaviors. Creating this section, will undoubtedly assist readers and reviewers of these reports as they attempt to identify one of the most crucial outcomes of the entire assessment. ▪ In rare cases, assessment methods appeared not to be helpful. In this situation, authors of the SFAR should qualify their results. For example, as described in the SFAR for Individual #135, interviews, direct observation, and rating scales did not offer substantial data. It appeared, then, that the hypothesized function was based solely on limited information from three observation notes. In this case, authors should highlight the potential limitation and implications of such restricted data. Since this did not occur, it was unclear how the function of pica, as well as other important variables (setting events, antecedents, etc.) were identified. ▪ A common concern evident across SFARs included the lack of data on	

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		replacement behaviors. For example, of the sampled SFARs, 50% either did not provide data on replacement behavior(s), or the data presented was inconsistent or partially unavailable. In addition, some plans appeared to utilize replacement behaviors that had a restricted range, that is, the variable could only increase within a prescribed range of responding (i.e., Individual #298 and Individual #126). For example: o The replacement behavior for Individual #298 was measured through the use of a rating scale. The scale used a Likert type rating from one to three, with a lower score reflecting "…better responses to replacement behavior training." There was no way a viewer would know this from just looking at the data in the table or graph. In addition, the individual's PBSP identified two replacement behaviors, and it was unclear which behavior was measured using this scale. As a result, including this data with other target behaviors on a line graph appeared problematic. The best score the individual could receive was a "1," which is counterintuitive. A viewer might assume that higher scores reflected improved responding. Even if the scale was reversed, the best the individual could score would be a "3." Displayed this way, the information was likely to be misinterpreted, especially if the range of responding of the other targets were to be very large (e.g., zero to 28 for SIB). ▪ Consideration should be given to the link between intervention and assessment. It was positive that research was provided to demonstrate the evidence underlying the recommended treatment. However, staff should be aware that the intervention, although seemingly appropriate and worthwhile, might not be functionally equivalent to the identified target behavior. For example, the recommended treatment to address the skin picking of Individual #183, holding preferred objects, might not functionally address one of the hypothesized functions of attention. Consequently, reinforcing a competing alternative activity (holding a preferred object) might reduce the SIB, but it might not provide an opportunity to learn a new response that is effective in producing attention. ▪ Review of sampled reports indicated that some authors struggled with identifying setting events, establishing operations, behaviors, antecedents and/or consequences, as well as how these related to potential interventions (e.g., Individual #235, Individual #213, Individual #82, and Individual #298). Additional training should be provided on these concepts, how they relate to the development of hypothesis, and their implication on identifying appropriate intervention strategies. ▪ Lastly, consideration should be given to identifying specific "threshold criteria" to help psychology staff (or reviewers) determine if an assessment is adequate	

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		or not. The SFAR for Individual #135, dated 8/13/10, was clearly insufficient given the severity of the target behavior of pica.	
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.	As described earlier with regard to Section K.5 of the SA, 100% of the individuals sampled (N=22; 10% of total number) had a psychological assessment that was updated within the past 12 months. This finding was consistent with estimates based on the previous baseline sample. Closer inspection of these assessments revealed that the majority (74%) of standardized intelligence tests were conducted over 10 years ago (i.e., 42% and 32% completed with the last 10 to 20 years and over 21 years ago, respectively). And, only three individuals sampled had these tests completed within the last five years (e.g., Individual #320, Individual #235, and Individual #36). Overall, review of LBSSLC Summary Grid/Tracking data (revised 9/17/10) indicated that according to the Facility's data, four percent (i.e., nine out of 229) of psychological assessments are currently out-of-date. As described earlier with regard to Section K.5 of the SA, 86% of the individuals sampled (N=22) had a SFAR that was updated within the past 12 months. Regarding the SFARs for the three remaining individuals, one was not dated (i.e., Individual #36), one was not provided with the requested documentation (i.e., Individual #181), and one was outdated by a few days (i.e., Individual #298). Overall, review of LBSSLC Summary Listing of Individuals for whom an SFAR had been completed within the last year revealed that 116 SFARs were completed between 8/1/09 and 7/31/09. According to the behavioral services grid (revised 9/18/10), approximately 14% of the total SFARs were currently out-of-date. This was an improvement from the baseline review where it was estimated that 20% of all SFARs were out-of-date. Sampled Psychological Assessments as well as Structural and Functional Assessment Reports (SFAR) were examined to estimate the availability of current behavioral data. Of the individuals sampled (N=22), 73% of the psychological assessments contained data within tables and/or graphs. Of the remaining psychological assessments, three did not include data because they were for individuals who had been admitted recently (Individual #36, Individual #235, and Individual #190), as well as one individual (Individual # 181) who did not have a PBSP. Surprisingly, no data was displayed for two individuals even though each had a PBSP (Individual #317 and Individual #135). This finding was very concerning given that Individual #135 displayed significant pica behavior. Review of remaining documentation revealed considerable diversity in the type of data collected as well as the format used to display collected data. For example, 39% contained both tables and graphs (line and/or bar graphs) with the remaining assessments containing only data displayed in tables. The data displayed continued to	Noncompliance

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		vary across individuals with some plans including data on replacement behaviors and some not (i.e., Individual #264, Individual #183, Individual #167, and Individual #33). In addition, some plans included bar graphs illustrating medication and associated dosages (i.e., Individual #213, Individual #183, Individual #126, Individual #99, Individual #167, and Individual #298). The same diversity in data collection and display was evident with SFARs as well. Of the SFARs sampled (N=22), 78% contained data within tables and/or graphs. The remaining SFARs contained only data tables (i.e., Individual #264, Individual #82, Individual #106, and Individual #330). SFARs with line graphs were also likely to have provided bar graphs displaying data on medication and associated dosages (with the exceptions of Individual #235, Individual #82, Individual #135, and Individual #33). In addition, some of the SFARs displayed restraint data (i.e., Individual #82 and Individual #33). The Facility should consider examining the type of data collected and displayed within the Psychological Assessment and SFARs. It appeared that some of the data was redundant and might not need to be equally displayed across each document and, at times, repeatedly displayed within the same document. Specific graphs on target and replacement behaviors, for example, might be more informative within the context of the SFAR, compared to the psychological assessment. In this situation, a more concise summary of behavioral progress (over the year) might be more appropriate. In addition, as found upon review, some documents included bar graphs displaying data on medication and/or line graphs illustrating restraint data. The Facility should consider providing guidelines to staff regarding when and where to include certain types and formats of data.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	As described earlier with regard to Section K.5 and K.6 of the SA, 100% of the individuals sampled (N=22; 10% of total number) had a psychological assessment that was updated within the past 12 months. This finding was consistent with estimates based on the previous baseline sample. Closer inspection of these assessments revealed that the majority (74%) of standardized intelligence tests were conducted over 10 years ago (i.e., 42% and 32% completed with the last 10 to 20 years and over 21 years ago, respectively). And, only three individuals sampled had these tests completed within the last five years (e.g., Individual #320, Individual #235, and Individual #36). Overall, review of LBSSLC Summary Grid/Tracking data (revised 9/17/10) indicated that according to the Facility's data, four % (i.e., nine out of 229) of psychological assessments were out-of-date. As described earlier with regard to Section K.5 and K.6 of the SA, 86% of the individuals sampled (N=22) had a SFAR that was updated within the past 12 months. Regarding the SFARs for the three remaining individuals, one was not dated (i.e., Individual #36), one	Noncompliance

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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.	At the time of the baseline review, LBSSLC contracted with a community agency to provide counseling services to 14 individuals. After the baseline review, the Monitoring Team reported that counseling services were not typically identified within psychological assessments or consistently documented in PSPs, that services did not have measurable goals or objectives, and descriptions of interventions often lacked enough detail to determine if interventions were based on evidenced-based practice. Since the baseline review, behavioral services staff had approached the community counseling providers to improve the nature of their services and, according to recent verbal reports, it appeared that the contracted agency had been responsive to identified concerns. In an effort to examine these efforts, a sample of progress notes and treatment plans were reviewed to determine if concerns had been addressed adequately. According to provided documentation (i.e., July 2010 billing statements), there were 15 individuals receiving individual psychotherapy. A sample of three individuals, representing approximately 20% of the total number of individuals receiving counseling, was chosen for review. These included Individual #36, Individual #159, and Individual #82. The following summarizes the findings of these reviews:	Noncompliance

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		▪ Based on July 2010 documentation, Individual #36 was scheduled to attend counseling services four times per month (attended twice). Counseling services were not specifically recommended within the psychological assessment, but it was identified in his PSP. His current treatment plan included reasons for treatment; descriptions of treatment, including therapy modalities as well as primary therapeutic orientation; and treatment goals. Treatment goals appeared to include measureable objectives. However, monthly goals might be more helpful in responding more efficiently to changes (or lack of change) in performance. The primary therapeutic orientation was described as "enhanced cognitive behavioral therapy" and "family systems therapy." In addition, a monthly progress note (for August 2010) was generated to provide a summary of treatment progress. In the note, the therapist attempted to measure weekly performance against the stated treatment goals. ▪ Based on July 2010 documentation, Individual #159 was scheduled to attend counseling sessions five times in July (attended three sessions). Counseling services were specifically recommended within the psychological assessment and included within the PSP. Her current treatment plan included long- and short-term goals and objectives, as well as identified therapeutic interventions. Many of the stated goals/objectives were subjective and did not appear easily or readily measureable. In addition, it was difficult to identify the underlying therapeutic orientation or approach. A monthly progress note (for August 2010) was generated to provide treatment progress. However, the identified goals were rather global and subjective, and it was unclear from the description how progress on objectives (other than teaching calming techniques) was proceeding. ▪ Based on July 2010 documentation, Individual #82 was scheduled to attend counseling services four times per month (she attended all four). Counseling services did not appear to be specifically identified or recommended within the psychological assessment or the PSP. Indeed, there was no specific reason(s) for treatment identified. Her current treatment plan included long- and short-term goals and objectives, as well as identified therapeutic interventions. Although the short-term goals were objective, the long-term goal was not objective or measureable. In addition, it was difficult to identify the underlying therapeutic orientation or approach. For example, it was unclear how the therapist was going to "teach," "instruct," or help "consolidate" new skills to the individual. A monthly progress note (for August 2010) was generated to provide treatment progress. However, the identified therapy goals continue to be subjective and difficult to measure. In general, the identified goals were certainly an improvement over what was found during the baseline review. Based on current findings, therapists should continue to	

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		define short- and long-term goals objectively and ensure that these are measureable. In addition, they should consider writing goals that might be measured weekly or monthly and, thus, offer an opportunity to be more responsive to changes (or lack of changes) in performance. In addition, "fail criteria" should be used to identify a level of performance (e.g., lack of progress, failure to attend appointments) that would trigger review and revision of interventions. In addition, if data from July was representative of other months, it appeared that most individuals missed one or more appointments per month. Attending counseling could be identified as a goal in PSPs for individuals that miss one or more appointments per month. Lastly, it would seem beneficial to integrate therapeutic objectives and skills into skill acquisition programs within the residential program through collaboration with associate psychologists. In addition to the counseling services, several other types of therapeutic services were identified and observed during the baseline visit. These supports and services included, for example, sensory activities, sensory diets, and access to multi-sensory rooms where individuals were offered opportunities to experience different sensory stimulation across various modalities. The use of these activities was observed during the recent compliance visit as well. In general, it appeared that these experiences were utilized primarily for leisure activities, recreation, and/or relaxation. However, these also appeared to be recommended as part of ongoing therapy. For example: ▪ Often sensory items or sensory diets were recommended, for example, as part of therapeutic recommendations provided by the Habilitation Therapy Department (e.g., OT evaluation in PSP for Individual #264). These recommendations, at times, appeared to result in specific objectives in skill acquisition programs (i.e., sensory objective for Individual #126) ▪ The PST team agreed to encourage the use of a sensory room in response to the aggressive behavior exhibited by an individual with "… sensory problems" when he was touched by a peer (i.e., PSP Addendum dated 3/8/10 for Individual #107). At a subsequent meeting in response to significant SIB, the PST subsequently recommended contacting "HT for an evaluation for a sensory diet." ▪ Recommendations for sensory stimulation activities were also found in psychological assessments (e.g., Individual #183). Recent onsite observations during meetings also evidenced multiple incidents where team discussions included, for example, reference to sensory diets and sensory integration. These strategies were described as potentially beneficial when individuals were "agitated" or demonstrating "behaviors," as well as effective in helping with communication. As previously recommended, if such strategies are identified as therapeutic and implemented as part of an individual's therapy, then specific outcomes should be identified for each individual, and data collected and reviewed to determine the therapy's effectiveness on an individualized basis. It is important that the	

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		interventions identified and recommended within PSPs have empirical support. The Monitoring Team's concern is that popular treatments without empirical support will be utilized in place of, or will undermine, other less common, but potentially more effective evidence-based practices. At the time of the review, the Director of Behavioral Services had developed a plan to identify and assess non-evidenced based interventions that were currently utilized at the Facility as therapeutic or therapy. This plan appeared to be in the development phase, although, it listed action items to be completed by June 2011. This timeline appeared too limited, as it is likely to take more time to identify and evaluate these interventions. In addition, the integration of behavioral services within other LBSSLC disciplines and settings (e.g., vocational, habilitation, and other day programming) had been assigned to a senior Psychologist. This is discussed in further detail with regard to Section K.12 of the SA. Future reviews will be required to examine progress in this area.	
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 written extension based on extraordinary circumstances.	Progress had been made since the baseline visit in regard to the development of PBSPs. A sample of PBSPs were reviewed (N=14; 11% of total number of PBSPs) to assess compliance with the SA. Overall, as found during the baseline review, the PBSPs were comprehensive and adhered to a standard format. The sampled documents typically provided a description of why the plan was being revised. However, as discussed below, information on earlier updates/revisions or previously attempted interventions (and related outcomes) was not typically available. Plans also included brief information on an individual's preferences as well as how the plans related to overall goals or outcomes listed within the PSP. Areas where the PBSPs continued to meet the requirements of the Settlement Agreement included: 1) the treatment rationale, including references of evidenced-based practices; 2) identification and definitions of target behaviors; 3) descriptions of potential functions of behavior; 4) identification of reinforcers; 5) identification of preventative (antecedent) and reactive (consequence) strategies; 6) display of data and description of data collection procedures; and 7) expected treatment outcomes. As previously observed, in general, the PBSPs reflected thoughtful interventions that appeared to be based on empirically supported treatments, as well as results of current structural and functional assessments. There were still areas within sampled PBSPs that were somewhat limited or insufficient, and did not meet the requirements of the Settlement Agreement. These included: 1) descriptions of previously attempted interventions; 2) the identification of multiple replacement behaviors, including their operational definition, when appropriate (although this was evident in a few sampled plans); 3) the description of specific teaching strategies targeting replacement behaviors; 4) detailed procedures for how/when to use (or not use) reinforcers; and 5) general background information, including relevant medical or health care issues (there were exceptions, however, for example, the plan for	Noncompliance

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		Individual #33) and information about previously attempted interventions. Examples of these are described below: ▪ An improvement since baseline was observed in the emphasis on integrating replacement behaviors within PBSPs. Although these were now typically included, there were examples of where they are not well defined (e.g., Individual #237 and Individual #107). Good examples were also evident (e.g., Individual #2). The Facility should ensure that replacement behaviors are as objectively and precisely defined as target behaviors. In addition, data collection procedures typically described the collection of target behaviors, but often not the replacement behaviors (e.g., Individual #317). ▪ Although information on psychiatric status and use of psychotropic medication was found in PBSPs, other relevant medical or healthcare considerations were not consistently obvious across plans. Relevant issues should be made more apparent in PBSPs or at least, there should be an indication that there are no relevant issues of concern. ▪ Often PBSPs included additional descriptions when evaluating previous data (e.g., Individual #213 and Individual #126). This was helpful as it might provide qualitative information that would assist in understanding the variability within the data. Indeed, explanations of variability within the data was often more helpful than describing the data (e.g., Individual#298). Prior interventions that were not successful should be described as well. ▪ Improvement was noted since the baseline review in the amount of descriptive information included under "reason for review" (e.g., Individual #126). This additional information was helpful in attempting to understand the "larger picture." For example, description of changes in the definition of a target behavior as well as in the selected topography of a replacement behavior was useful information (e.g., Individual #317). Providing a brief description of why this change was necessary would also add meaningful background information. ▪ The Facility should ensure that definitions only include objective descriptions of the specific response(s). Definitions that included intent or referenced competing responses tended to be ambiguous and subjective. For example, changing the stated definition of "functional communication" from "…waving to obtain a break rather than exhibiting aggression to escape an undesired activity or escape from others" to "waving her hand back and forth independently" reduces the ambiguity and enhances accurate data collection (e.g., Individual #317). Eliminating "… to escape from demands or gain attention" from a definition of "malingering" removes the required inference making the response easier to accurately measure (e.g., Individual #237). Simplified, objective and descriptive definitions of "eat," "drink," and "stop" would likely assist staff in prompting, reinforcing, and measuring "communication" (e.g., Individual #99). ▪ Often, the use of reinforcement in PBSPs as well as the use of reinforcers within	

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		specific teaching strategies was not evident (e.g., Individual #317). In some cases, reinforcers were identified, but clear direction in when (or how often) to use them was lacking (e.g., Individual #320). However, there were examples where strategies emphasized reinforcement within specific teaching strategies (e.g., Individual #99 and Individual #2). ▪ Often, strategies within PBSPs might inadvertently reinforce target behaviors. For example, prompting some one to sign for a "break" following an aggressive response, and then immediately providing a break once "break" is signed is likely to reinforce an unwanted behavioral chain (e.g., Individual #317). In this and similar situations, where prompting and reinforcing alternative responding was desired, strategies prompting calm behavior prior to reinforcing the alternative response would tend to be more desired (e.g., Individual #126). In addition, providing someone whose behavior functions to obtain escape or attention an opportunity to go to a quiet area or talk about concerns following an aggressive response (and before required calming) is counterproductive and is likely to maintain aggressive responding (e.g., Individual #237). ▪ An objective written for a response should be independent from other identified replacement or target behaviors (e.g., Individual #99). In addition, objectives summarizing data monthly should indicate "per month" when describing goals (e.g., "… no more than 2 incidents of aggression per month for 10 of 12 months". ▪ Consideration should be given to attempting to streamline the current PBSPs. There might be areas of the plans that contain redundant information or information that might not be necessary. For example, repeated descriptions of data collection methodology (on page 2 and within staff instructions) and full research citations could be removed (e.g., Individual #99). There was evidence that brief and concise staff instructions were being developed (e.g., Individual #114 and Individual #190). ▪ As similarly found during the baseline review, the current review found that compared to behaviors targeted for decrease, operational definitions for replacement behaviors appeared to be less objective, precise, and obvious (i.e., especially within staff instructions). The strategies outlined to teach desired replacement behaviors also seemed less detailed and rigorous compared to antecedent or consequence-based procedures for target behaviors. ▪ Lastly, data collection on replacement behaviors continued to be inconsistent and overlooked. Several authors had found ways to highlight the replacement behavior on the staff instruction pages of the PBSP. These included creating a section entitled "Replacement Behavior" (e.g., Individual #126) or "Training of Replacement Behavior" (e.g., Individual #99). These sections allowed authors to emphasize the new skill and how to teach it, which ultimately was intended to replace the target behavior(s). This was an improvement over other staff instructions within plans where the replacement behavior was either not found	

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		or clearly defined (e.g., Individual #33, Individual #317, Individual #298, and Individual #237). One example where potentially effective teaching strategies (e.g., Differential Reinforcement of Other Behavior and discrete trial teaching procedures) were being used, but not yet integrated into staffing instructions was evidenced for Individual #2. However, staff instructions did not include a definition of this individual's behavior or guidance in how to collect data on it. As found during the baseline visit, a rubric entitled the "Positive Behavior Support Plan Self-Monitoring Guide and Quality Assessment Rating Scale" was created by the Director of Behavioral Services, and utilized by psychology staff and BSC members to ensure that the format, and ultimately the quality, of PBSPs remained consistent. Since the baseline review, modifications to the form had been made and it was now called the "PBSP Checklist." According to the Director of Behavioral Services, starting in October 2010, staff would be required to complete the checklist prior to submitting plans to the behavior support peer review committee. Sampled plans demonstrated good adherence to the format with some of the older plans showing the greatest divergence (e.g., Individual #167). As reported following the baseline review, an additional committee, had responsibility for reviewing PBSPs, and restrictions. The LBSSLC Human Rights Committee (HRC) met weekly and was comprised of LBSSLC staff (i.e., QMRPs, psychologists, QE staff, RN, etc.), as well as individuals external from the Facility (e.g., Ombudsman parents, and community volunteers/representatives). In addition, at that time, there was representation by an individual served occasionally reflected in the minutes. However, despite the fact that multiple community volunteers and/or parents attended HRC meetings, the majority of HRC members at each meeting appeared to be employed by LBSSLC. Review of recent sampled HRC meeting minutes reflected regular weekly scheduling, and more participation by individuals not employed by LBSSLC. More specifically, review of a five-week sample (meetings from 7/28 to 8/25/10), reflected a range of 25-50% of attending members who were not employed by the Facility. A recent report, dated 9/7/10, also indicated that the Facility's Human Rights Officer had identified two new community members for potential inclusion on the HRC. Lastly, the behavioral services tracking grid was examined to estimate the number of PBSPs where approvals and/or consents had expired (i.e., labeled "out of date") as of the most recent revision date of 9/18/10. According to dates displayed on this grid, the BSC, HRC, and/or guardian consent had expired in approximately 10% of the total number of PBSPs.	
K10	Commencing within six months of the Effective Date hereof and with	As previously discussed with regard to Section K.4 of the SA, collection of inter-observer agreement (IOA) on PBSP data had not been initiated. As found during baseline and	Noncompliance

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	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.	more recently during the compliance visit, the Director of Behavioral Services acknowledged the value and importance of collecting this data and demonstrated a sincere desire to develop an effective campus-wide system. Facility staff recognized that the confidence they had in the accuracy of their data and their ability to make data-based decisions was substantially limited by the lack of IOA data collection. Reports indicated that a plan was in place to start collection of IOA in November of 2010 on a small scale utilizing psychology assistants as independent observers of selected individuals. It appeared that behavioral services staff were still exploring specific methods to collect this data. As found during baseline and more recently during the compliance visit, PBSP data was typically collected and summarized on a monthly basis. Associate Psychologists, with the assistance of Psychological Assistants, completed the monthly PBSP data summary on a document called the Integrated Progress Note. This report typically displayed data on target behaviors, replacement behaviors, behaviors for monitoring, and medication (including dosages) within tables and/or graphs (line and/or bar). For individuals with SPCIs, monthly data was summarized on a document called the Safety Plan Progress Notes. This report typically displayed data on frequency of restraints, total and average duration of restraints, and injuries related to restraint. As previously presented with regard to Section K.4 and K.6 of the SA, not every table or graph contained all the data identified in the PBSP. In many cases, for example, replacement behaviors were still not included in some data displays. Replacement behaviors might be included in a table, but not the graph (or vice versa) in the same document (e.g., Integrated Progress Notes for Individual #36, Individual #159, and Individual #183). In addition, a general finding across all tables and graphs sampled included the display of only a single replacement behavior when, at times, multiple replacement behaviors were identified, defined, measured, and collected. The opposite was true, at times, for the target behaviors. That is, multiple target behaviors would be included in a graph despite the fact that the behaviors were never defined within the PBSP (i.e., line graphs for Individual #159). As found during baseline and again with the more recent compliance review, the consistent collection of replacement behavior data continued to be problematic. More specifically, monthly reports missing consecutive months of replacement behavior data were often found within sampled documentation (e.g., Integrated Progress Notes for Individual #126, Individual #108, Individual #99, Individual #317, Individual #268, Individual #159, and Individual #264 as well as Psychological Assessments for Individual #106 and Individual #187). Missing data on target behaviors, although seemingly less troublesome overall, was still evident (e.g., Psychological Assessment and SFAR for Individual #135). Overall, graphs appeared to have improved since the baseline visit. For example, many	

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		more graphs included data on replacement behaviors than previously observed. Based on recently sampled documents, however, most graphs could still be improved. More specifically, there were some graphs that did not adequately label the Y axis, did not clearly identify markers within the legend, or contained too much information on the X axis, that is, provided comments that were already self evident (i.e., Integrated Progress Notes for Individual #159). The vertical positioning of multiple graphs in some documents often allowed easy examination and comparison of changes in behavioral data concurrent with changes in medication regimen (e.g., Individual #167). However, at times, the graphs were "shrunk" to fit the page making interpretation somewhat challenging (e.g., psychological assessment for Individual #99, Individual #190, and Individual #237). The use of the graphic display should be to aid visual analysis and promote more accurate interpretation. Lastly, the range of medication dosages that were graphed often had a negative impact in ease of interpretation. That is, when one medication had an extreme range, it made it harder to perceive changes in other medications with more limited ranges, especially in bar graphs (i.e., Integrated Progress Notes for Individual #36 and Individual #60). The Facility should consider examining the type of data collected and displayed within assessments (Psychological Assessments and SFARs) as well as plans (PBSPs and SPCIs). As discussed earlier, it appears that some of the data presented was redundant. That is, the same data was presented in multiple documents and, at times, repeatedly displayed within the same document (e.g., psychological assessment for Individual #298). Specific graphs on target and replacement behaviors, for example, might be more informative within the context of the SFAR, compared to the psychological assessment. In this situation, a more concise summary of behavioral progress (over the year) might be more appropriate. In addition, as found upon review, some documents included bar graphs displaying data on medication and/or line graphs illustrating restraint data. The Facility should consider providing guidelines to staff regarding when and where to include certain types and formats of data.	
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.	The previous baseline and current compliance visits evidenced similar findings regarding staff knowledge of and ability to implement PBSPs. Overall, verbal reports from direct support professionals and direct observations during program visits produced mixed results. During some interactions, staff members were able to provide accurate information about a selected individual's PBSP (e.g., site visit to Tulip on 9/16/10). In other interactions, however, staff had difficulty in accurately describing important components of a PBSP (e.g., site visit to Maple on 9/15/10). The same mixed findings were evident following direct observation of target behaviors. That is, direct support professionals did not follow prescribed consequence-based strategies, for example, following the aggressive responses of a resident (e.g., site visit to Willow on 9/16/10). Observations also evidenced inconsistencies across settings regarding access to Specific	Noncompliance

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		Program Objectives (SPOs), and completion of timely and complete data collection. Efforts at examining the format of PBSPs and considering potential changes of the report rubric had occurred since the previous baseline visit. This process included surveying direct support professionals (N=100) using a five-item (open-ended) survey developed to obtain feedback from direct support professionals. Results of the survey indicated that: 1) approximately a third of respondents did not view the PBSPs as making their job easier; 2) staff were more likely to emphasize consequence-based than antecedent-based strategies; and 3) staff who found the PBSP difficult to read indicated that it was due to the language, length, and difficulty in finding salient information. Feedback regarding potential solutions included shortening the plans and using simpler language. The results also indicated that, if staff found the plans effective, they would be more willing to read them. As found during the baseline review, PBSPs were rather lengthy. In recognition, the last few pages of PBSPs, labeled "staff instructions," contained a structured and condensed version of the overall plan that highlighted the function of challenging behaviors, fundamental outcomes of the plan, antecedent strategies for prevention of each target behavior, consequence strategies for each target behavior, information on psychoactive medications, and documentation. These pages, typically between two to four pages long, were designed to promote effective training and to be accessible to direct support professionals. Recent discussions with behavioral staff indicated that efforts would continue to include simpler language, avoid technological jargon, and reduce length, when possible, within these staff instructions. This process was reported to be occurring as PBSPs were revised. Efforts at systematically measuring treatment integrity had been ongoing and attempts to improve the system had been initiated since baseline. According to the Director of Behavior Services, a new spreadsheet had been developed to assist in the management of treatment integrity data. This spreadsheet was now used in conjunction with the previously developed assessment-guided and observation-guided forms that estimated staff knowledge of and competencies in implementing PBSPs. Data displayed within this new spreadsheet indicated that data was collected for three weeks (from 8/8/10 to 8/28/10), and estimated staff knowledge of target PBSPs between 72 to 84%. Observation data estimating staff's ability to implement PBSP strategies, however, had not yet been initiated. Subsequent review of these new procedures, including examination of treatment integrity summary data, will need to be completed at the next compliance visit.	
K12	Commencing within six months of the Effective Date hereof and with	Progress in the area of competency-based training had been observed since the baseline visit. At that time, behavioral services staff reported using a variety of teaching methods	Noncompliance

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	full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	(e.g., typically including didactic instruction and, to a lesser extent, modeling and role-playing) to improve the effectiveness of staff training. It appeared that these methods differed across settings and over time. This diversity was likely due to constraints on trainer and staff availability, as well as limits on the time available for training. Following staff training, each staff member was given a written quiz, entitled the Competency Assessment, to assess his/her knowledge of behavioral programming. As reported during baseline, there appeared to be a number of limitations associated with this quiz. Since baseline, the decision was made to discontinue the use of these written tests. The baseline review also revealed the development of two rubrics designed to facilitate staff training and, ultimately, improve the treatment integrity of PBSPs. More specifically, the PBSP Assessment-Guided Staff Training form was developed to assist with measurement and improvement of staff competency, and involved asking direct support professionals to show or report information relevant to the PBSP. The PBSP Observation-Guided Staff Training rubric was designed to measure and increase treatment integrity of PBSPs, and involved observing direct support professionals and recording whether or not they implemented strategies, including data collection, as written. Data associated with the use of these assessments was not available at the baseline review. However, as presented earlier with regard to Section K.11 of the SA, data had begun to be collected, at least using the assessment-guided staff training form. Since baseline, progress also had been made in developing a policy that would incorporate all of the above procedures and standardize expectations regarding staff training and measurement of treatment integrity. At the time of the review, this policy, "Competency Based Training", was in draft form, and many sections appeared to contain incomplete information. Subsequent compliance visits will be needed to examine the completed policy, as well as evaluate the changes in competency-based training. Based on discussions with behavioral services staff and review of the draft policy, it was unclear if other concerns related to the adequacy of staff training had been resolved. For example, it was unknown if more time was being allocated so that new staff could attend sufficient training. Observations and interactions with staff members suggested that, at least in some cases, adequate training was not provided. For example, discussion with a "pulled" staff from another residence, who was unexpectedly assigned to provide an enhanced level of supervision, revealed that she received only minimal training consisting of a few minute discussion with the home team leader prior to being assigned to work one-on-one with an individual she had never met on her first day working in the residence (i.e., observation at Tulip on 9/16/10). In addition, it was unclear if changes were made to ensure adequate staff attendance at staff training sessions.	

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		Lastly, as reported during baseline review, the limited integration or collaboration of behavioral services staff with onsite and community-based day programming and employment services appeared to impact negatively the success of individuals served at LBSSLC. At that time of the baseline review, staff reported that behavioral concerns (e.g., job refusal) limited individuals' attendance and participation at campus-based day and vocational services, as well as their involvement in employment in community settings. Without behavioral staff being regularly available to ensure that vocational/day program staff were trained and competent in the implementation of individuals' behavior support plans, this success likely will continue to be limited. At the time of the most recent review, verbal reports from the Director of Vocational and Day Programming as well as behavioral services staff indicated greater collaboration between psychology staff and other vocational and day programming staff. In an effort to promote the integration of behavioral services across disciplines and settings (e.g., vocational, habilitation, and other day programming), a senior Psychologist had been assigned these direct responsibilities. Future reviews will be required to examine progress in this area.	
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.	Progress had been made in the composition of staff within psychological services. At the time of the baseline review, in addition to the Director of Behavioral Services, LBSSLC employed nine Associate Psychologists, and five Psychological Assistants. At the time of the most recent compliance visit, LBSSLC employed, in addition to the Director of Behavioral Services, nine Associate Psychologists, one Psychologist, and seven Psychology Assistants. Since the baseline visit, one additional Psychologist and four additional Psychological Assistants had been hired. In addition, there were currently two positions (i.e., a Psychologist I and Psychological Assistant) that remained open. Recent documentation, as of 8/23/10, indicated that LBSSLC currently served 229 individuals. Based on this census and the recognition that the Director of Behavioral Services did not carry a caseload, an approximate average ratio of 1:23 psychologist-to-individual served was determined. With seven psychological assistants currently employed, the Facility exceeded the ratio of one psychological assistant for every two associate psychologists. This provision item was rated as noncompliance because the professionals within Behavioral Services were not yet demonstrably competent in applied behavior analysis as required by this provision item as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should continue to support BCBA certification for all behavioral services staff by providing tuition reimbursement and necessary

supervision. This should include ensuring adequate supervision, especially now that interest has increased.

2. Monitoring of and follow-up on the behavioral services tracking grid should be continued to ensure closer adherence to the completion of necessary consents and approvals prior to their expiration.
3. Data collection systems should continue to be evaluated and improved. New systems should be somewhat standardized to decrease confusion, but should still support timely data collection to ensure that data are reliable and valid. Measures should reflect the frequency, duration, and/or intensity of problem behavior, and its corresponding replacement behavior. The system should be flexible enough to allow individualization, when necessary.
4. Training on the new data collection systems should be sufficient to ensure that staff understand the operational definitions of all targeted behaviors, that staff are able to identify the presence and absence of the same, and that they collect measures that provide an accurate reflection of the frequency and severity of the problem.
5. Inter-observer agreement should be assessed regularly, but no less than once each month.
6. Facility staff should collect, summarize, and graph data on at least a monthly basis, or more frequently, if necessary. This should include the identification, collection, summary, and display of all target, monitoring, and replacement behaviors.
7. The Facility should consider examining the type of data collected and displayed within assessments (Psychological Assessments and SFARs), as well as plans (PBSPs and SPCIs). The Facility should consider providing guidelines to staff regarding when and where to include certain types and formats of data.
8. The Facility should consider the following as it revises its graphing procedures:
    a. Given the difficulty in discriminating between different colors of bars when viewing copies of the original graphs, to facilitate interpretation, perhaps different patterns within the area of the bar could be utilized in place of different colors;
    b. Only including narrative text on graphs when that information is not readily apparent or already displayed in provided tables or graphs;
    c. Adequately label the Y axis;
    d. Clearly identify markers within the legend;
    e. Limit the information on the X axis; and
    f. Ensure that the ranges of medication dosages that are graphed can be easily interpreted. That is, when one medication has an extreme range, changes in other medications, with more limited ranges are harder to distinguish, especially in bar graphs.
9. Continued emphasis should be placed on the identification, training, and monitoring of one or more functionally equivalent replacement behaviors in PBSPs.
10. If not already completed, policies should be established and implemented regarding the identification of at risk individuals and the development and implementation of appropriate behavioral supports.
11. Clear behavioral objectives should be identified whenever a person receives therapy or support services in addition to their Behavior Support Plan, and these should be integrated with the individual's PSP. Objective measures of anticipated behavior change should be collected with accompanying data analysis to determine the effectiveness or lack thereof of the recommended practice.
12. Similar to behavioral programming, data should be collected on the use of any intervention (e.g., Sensory Diet) conceptualized, described, or utilized as therapeutic or therapy. This data should include goals with measureable objectives and treatment expectations. This would allow teams to determine if the therapies are effective or not, and ensure the more efficient utilization of limited resources.
13. The Facility should continue to emphasize competency-based training and the ongoing monitoring of treatment integrity. This includes the utilization of PBSP Assessment-Guided and Observation-Guided Staff Training rubrics, and summary data systems.
14. A system should be developed to ensure adequate oversight and appropriate assignment of pulled staff to ensure that they are adequately trained to support the individuals to whom they are assigned to work.
15. The initial training in Positive Behavior Support that is provided to staff should be greatly expanded. A more in-depth review of all of the following areas should be provided: possible functions of problem behavior, identification and teaching of replacement behavior, identification

and application of reinforcement, antecedent strategies, and interventions that can be applied contingent upon the target behavior.

16. Training on individual Behavior Support Plans should occur across all shifts as these plans are developed and revised. A policy that describes competency-based training for all staff implementing Behavior Support Plans should be completed and implemented as soon as possible. This policy should include competency-based assessment that measures staff actually demonstrating competence in the implementation of PBSPs. Time should be arranged for adequate initial training for staff on all plans, with follow-up conducted on-the-job.
17. Additional needed areas of training should be identified, developed, and implemented. This might include training on the development, implementation, and monitoring of skill acquisition programs (including chaining, task analysis, etc.); assessment methods for measuring IOA and treatment integrity; and/or a review of empirically validated treatments for individuals with autism. Attendance and participation by selected staff should be required and monitored.
18. The Facility should continue to promote the integration of behavioral services within day vocational/employment or habilitation services.
19. The Facility should examine the current policy and consider if additional guidance should be included within this policy to: 1) address cases where examiners are limited in their selection of available or appropriate tests; 2) assist examiners in determining when testing is not appropriate; and 3) determine if and/or when standardized assessments of adaptive behavior may replace the utilization of standardized tests of intelligence.
20. Consideration should be given to summarizing the raw data associated with each of these methods and highlighting how each supports (or does not support) the hypothesized underlying function(s).
21. Consideration should be given to standardizing a section in the SFAR, already found in some reports (e.g., Individual #126, Individual #235, and Individual #213), devoted to identifying and defining one or more replacement behaviors.
22. Additional training should be provided on basic concepts (setting events, establishing operations, antecedents, behavior, consequences), and how they relate to the development of hypothesis, and their implication on identifying appropriate intervention strategies.
23. Lastly, consideration should be given to identifying specific "threshold criteria" to help psychology staff (or reviewers) determine if an assessment is adequate or not. The SFAR for Individual #135, dated 8/13/10, was clearly insufficient given the severity of the target behavior of pica.
24. With regard to PBSPs, the Facility should ensure that replacement behaviors are as objectively and precisely defined as target behaviors. In addition, relevant issues related to biological or healthcare issues should be made more apparent in PBSPs or at least, there should be an indication that there are no relevant issues of concern. Prior interventions that were not successful should be described and if changes in PBSP procedures or strategies have changed, a brief description of why this change was necessary would also add meaningful background information.
25. When writing definitions, the Facility should ensure that definitions only include objective descriptions of the specific response(s).
26. The Facility should continue to pursue the addition of other BCBA professionals to assist with external peer review.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Continuing Medical Education (CME) certificates and CME tracking information for PCPs, dentist, and psychiatry; o Medical Records for the following individuals: Individual #159, Individual #106, Individual #108, Individual #320, Individual #15, Individual #151, Individual #267, Individual #251, Individual #302, Individual #210, Individual #138, Individual #322, Individual #125, Individual #205, Individual #211, Individual #265, Individual #195, Individual #304, Individual #62, Individual #175, Individual #165, Individual #217, Individual #68, Individual #176, Individual #29, Individual #140, Individual #293, Individual #72, Individual #135, Individual #229, Individual #128, Individual #130, Individual #6, Individual #301, Individual #111, Individual #313, Individual #299, Individual #199, Individual #283, Individual #161, Individual #323, Individual #312, Individual #226, Individual #228, Individual #17, Individual #180, Individual #246, Individual #208, and Individual #286; o Emergency Room Packet, including: Consultation Report, LBSSLC Transfer Record, Hospital Admission Form for University Medical Center, Patient Profile Report, Client Identifying Data Sheet, Active Problem List and Significant Medical Events/Findings, Admission/Annual Medical Summary, and Physical Examination. o Medical department clinical care guidelines, including: Guidelines for the Treatment of Urinary Tract infections in Females, Guidelines for the Treatment of Urinary Tract Infections in Males, Guidelines for the Treatment of GERD (Gastroesophageal Reflux Disease), Guidelines for the Treatment of Pressure Ulcers, Guidelines for the Treatment of Acute Bronchitis, Guidelines for the Treatment of Cellulitis, Guidelines for the Treatment of Chronic Bronchitis, Guidelines for the Treatment of Acute Conjunctivitis, Constipation in Adults, Guidelines for the Treatment of Viral Gastroenteritis, Guidelines for the Treatment of Essential Hypertension, Guidelines for the Treatment of Otitis Media, Guidelines for the Treatment of Community Acquired Pneumonia, Guidelines for the Treatment of Sinusitis, Guidelines for the Treatment of Type 2 Diabetes Mellitus, and Guidelines for the Treatment of Type 1 Diabetes Mellitus; o Medical Department document: Number of Individuals and Homes Doctors Assigned; o Client characteristics report, age 50 thru 90, history of colonoscopy; o Client characteristics report, female, age 40 thru 90, history of mammogram; o Pneumonia Profile Report for August 1, 2009 to August 31, 2010; o Home Population Report/Roster: Individuals who received H1N1 vaccine; o Home Population Report/Roster: Individuals who received seasonal flu vaccine; o Do Not Resuscitate (DNR) list, updated 9/14/10; o Most recent BSPs and subsequent addendums for the following individuals: Individual #23, Individual #127, Individual #34, Individual #170, and Individual #77; o Pica/Inedible ingestion list - 2010, updated 9/15/10;

	- Pica List for 2010; - Pica Report, dated 9/13/10; - Pica incidence from October 2009 through July 2010; - GI Profile Report, from 8/1/09 to 8/21/10; - Enteral Feeding and Frequency Report for September 2010; - Medication Patient orders run date 9/15/10 for: Individual #261, Individual #7, Individual #301, and Individual #176; - Physician follow-up list of 9/13/10, 9/14/10, and 9/15/10; - Untitled list of campus coordinator and unusual incident reports for: 9/13/10, 9/14/10, and 9/15/10; - Daily clinic report for: 9/13/10, 9/14/10, and 9/15/10; - Document entitled "Rounds with Dr. Rodriguez on 9/15/10"; - Texas Settlement Agreement Monitoring Instrument, for Sections G, H, I, and L completed by Dr. Kubala; - LSS – Health Services: Death of an Individual Protocol, revised 10/8/08; - Death Review Investigation: Death Review Nursing Services; - Emergency Room: Visits by Type January 1, 2010 to August 16, 2010; - Hospital: Admissions by Type January 1, 2010 to August 16, 2010; - Respiratory Profile Report January 1, 2010 to July 31, 2010; - Client characteristics report dated 8/1/10 to 9/14/10, age 50 to 80, most recent thyroid tests; - GERD Report, dated 9/13/10; - Client characteristics report dated 8/1/10 to 9/14/10, age 50 to 80, Dual Energy X-ray Absorptiometry (DEXA) scan and results; - Individual Diagnosis Report from January 1, 2010 to August 31, 2010: fractures; - Osteoporosis Report, dated 9/13/10; - Constipation Report, dated 9/13/10; - Individual Diagnosis Report: Constipation from August 1, 2009 to August 31, 2010; - Individual Diagnosis Report: Status epilepticus from April 1, 2009 to August 31, 2010; - State Office (SO) Policy #007; SSLC Policy: Psychiatry Services, dated 7/20/10; - Policy: LSS – Health Services: Clinical Care, revised 12/1/09; - Policy: LSS – Health Services: Medical Care, dated 8/2/10 Draft; - Policy: LSS – Health Services: Management of Acute Illnesses and Injuries, revised 12/1/09; - Policy: LBSSLC – Health Services: At Risk Individuals – Health Status Team Meetings, dated 1/22/10; - Policy: LSS- General Clinical Care: At-Risk Individuals – Health Status Meetings, dated 4/22/09; - Policy: LSS – Health Services: Preventive Medicine, revised 12/1/09; - Policy: LSS – Health Services: Medical Review System, revised 4/13/09; - Policy: LSS – Health Services: Coding Requirements, dated 2/1/08; - Policy: LSS – Health Services: Tracking System for Lab/Radiology Department, dated

	7/12/08; o Policy: LSS – Health Services: Tracking System for Physician/Dentist/PA Licensure, dated 7/12/08; o Policy: LSS – Health Services: Tracking System for Consultations, dated 7/12/08; o Policy: LBSSLC – Risk Management and Infection Control: Needlestick/Bloodborne Pathogen Protocol, dated 9/21/09; o Policy: LSS – Health Services: Convulsive Seizure Management, dated 2/9/09; o SO SSLC Policy # 00.1 Death of an Individual, dated 8/24/10 Draft; o Lubbock State School Pandemic Respiratory Infectious Disease Readiness Plan, revised 10/08; o LBSSLC census; o LBSSLC staff roster receiving H1N1 vaccination; o LBSSLC staff roster receiving annual influenza vaccination; o Lubbock SSLC Plan of Improvement for Section L, dated 5/17/10; and o Lubbock SSLC Supplemental POI, dated 5/17/10. ▪ **Interviews with**: o Dr. Glenn Shipley, Medical Director; and o Dr. Ricardo Rodriguez, PCP. ▪ **Observations of**: o Daily medical meeting, on 9/14/10, and 9/15/10; o Rounds with Dr. Rodriguez, on 9/15/10; o Neurology clinic, on 9/15/10; and o Individual #136, Individual #181, Individual #211, Individual #301, Individual #78, Individual #263, Individual #167, Individual #323, Individual #226, Individual #324, Individual #304, Individual #185, Individual #89, Individual #293, Individual #261, and Individual #120.
	Facility Self-Assessment: During the on-site review, the Medical Director provided an overview of compliance. According to the Medical Director, advances and successes included the development and implementation of a transfer packet that accompanied individuals being sent to the Emergency Room (ER), verbal communication between the hospital physician and the Facility physician upon discharge of the individual from the hospital, IPN notes written by the physician upon return from the ER or hospital, a non-facility physician review of medical records, and the beginning of a medical database to track ER visits, hospitalizations, clinic visits, and common diagnoses. According to the Medical Director, there was "much work to do." The Facility's POI indicated noncompliance with almost all action steps, suggesting agreement with the Medical Director's global comments, which were generally consistent with the Monitoring Team's findings. The exception was L.2 of the POI that indicated the Facility was in compliance because a medical peer review system by a non-facility physician was being implemented. As is discussed below with regard to Section L.2 of the SA, a physician from Denton SSLC had conducted a limited review of six individuals' records. No report had been written summarizing the findings of this review, and the Medical Director indicated that no follow-up had yet been completed with regard to the recommendations included on the individual monitoring forms.

	Summary of Monitor's Assessment: Although the medical department had made some progress, the main area that needed improvement was with regard to the critical thinking used by medical staff. Critical thinking needed to occur to determine, for example, why someone had recurrent aspiration, a fracture, abdominal pain and vomiting, etc. PCPs as a group should have been familiar with all individuals with pica on campus, yet there seemed little awareness of what specific individuals ingested, and/or whether adequate plans were in place to prevent this potentially life-threatening behavior. The morning medical team meetings had great potential. However, at the time of the review, they consisted of rapidly reading a few lists concerning individuals with urgent needs in the ER or hospital, or those attending clinics that day, without critical review of medical issues. Efforts had been made to have a non-Facility physician review completed. However, a physician from Denton SSLC conducted the review without any involvement from a "non-Facility" physician. The sample size was small (less than three percent of the population), and the review did not result in a cumulative report that identified any systemic issues. In addition, there was no action plan based on this visit. The contents of the individual reports were helpful, and should have been used as an opportunity for additional medical system improvements at LBSSLC. Many clinical guidelines had been created, and this was an important step. However, some of the more pressing medical issues did not have a clinical guideline. In addition, there was little in the way of timelines to ensure physicians completed the next step in the process in a timely manner, and to ensure care was consistent across the campus. There was no quality assurance program, and no clinical tools were being used to measure the quality of care provided. There were a number of data sources available, such as reports related to individuals being hospitalized and/or sent to the Emergency Room. It would be a natural next step to analyze this data to identify areas in which improvements could be made.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sub-sections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, routine care, preventative and emergency care, mortality reviews, Do Not Resuscitate Orders, and emergency medical drills. Additional information regarding medical care is found below in the sections addressing Section L.4 of the SA. <u>Staffing</u> The Facility had a full complement of primary care practitioners. This included the Medical Director, two other physicians, and one physician assistant (PA). The Medical	Noncompliance

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	the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Director was assigned a caseload of 14 individuals. One of the other physicians had a caseload of 67 individuals, and the third physician had a caseload of 69 individuals. The physician assistant had a caseload of 81 individuals. As part of the caseload, one of the physicians was assigned the two homes with individuals who had complex medical needs. This assignment was for a census of 229 individuals. At the time of the review, there were two full-time psychiatrists on staff. There were also two full-time x-ray technicians, one of whom also served as a phlebotomist. One measure of the quality of the health professional staff is the continuing education that they complete. Documentation of this was provided for the medical, dental and psychiatry staff. One member of the medical staff had no submissions of proof of CME, which was of concern. CME topics covered a wide range of subjects important to the respective disciplines. <u>Routine Care</u> Morning reports were being conducted each business day. Three documents were reviewed, including: the daily clinic report, a physician follow-up list, and an untitled list by shift of unusual incident reports and campus coordinator visits. All the primary care practitioners, the psychiatrists, dentists, and various members of the nursing department attended the meetings. The purpose was to inform all present of the health issues being confronted for the day. Based on the observations of the Monitoring Team during the week of the on-site review, the meetings were relatively brief, with little discussion of any case or concern. Rather, the meetings consisted of a reading of identified concerns from various lists. Given that these meetings are well attended, there is opportunity to expand the potential for the morning meetings. With the small caseloads of the primary care practitioners, the Medical Director should set the expectation that the PCPs know each individual on his/her caseload well. For individuals on the lists reviewed during morning meeting, the PCP should be able to provide a quick update regarding the concerns of the day, providing background information, and tests to be ordered or results that are pending, as well as a description of current and future treatment. An example of how this would be helpful included: ▪ At the morning meetings on 9/14/10 and 9/15/10, Individual #280's medical concerns of nausea and vomiting arose. There was little information available and critical questions were not asked. For instance, it was learned he had constipation, that treatment had been given at the ER, and he had returned to LBSSLC. However, there was no information from his BM log available, and there was no information about whether the treatment in the ER had produced results. Both of these questions should have been answered at the morning	

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		meeting. Further, because of the vomiting and abdominal pain, another critical question that was not asked was whether there was a history of pica. Based on the Monitoring Team's review of this individual's record, there happened to have been a history of pica, but there was little information about the types of ingestion. The PCP and other members of the health care team should readily know the history of ingestions for all those with a pica habit. Considering this individual ate latex gloves in the past, and latex gloves are dangerous once ingested, the entire medical department should be aware of such individuals with high-risk pica behavior. There was information that LBSSLC no longer uses latex gloves, but with this individual's trip(s) to the ER, no one was certain if the Emergency Medical Services (EMS) and ER facilities provided access to latex gloves. Individuals with abdominal pain and complaints with a history of pica should be evaluated and monitored for potential pica ingestion unless the cause is obvious. In many cases where the ingested material is not radiopaque, the diagnosis is difficult and challenging. The lack of critical questions at the morning meeting, and lack of critical information shared regarding those individuals in the hospital or those returning from the ER indicated a need to raise the expectations of what is required from the primary care practitioners, as well as nursing staff attending these meetings. These meetings also provide forums for the Medical Director to provide teaching and expectations of standards of care for diagnosis and treatment on campus. The Medical Director needs to be informed of all serious medical problems on campus, and needs to be confident that appropriate and timely care is given in all cases. In this way, the morning meeting has the potential to be a valuable tool for the Medical Director in ensuring consistent quality care each 24-hour period. Medical rounds were made with one of the PCPs assigned the most medically complex individuals. Medical records were available for review, and an active problem list was readily available for each of the individuals. The PCP was able to provide important clinical history for each individual presented. Based on observation of rounds and review of records, there was wide variation in the surgical treatments of dysphagia, GERD, and aspiration, from Gastrostomy Tube (G-tube) to J-tube to laryngeal tracheal diversion. Some individuals appeared to have had appropriate aggressive care, but that same intensity did not seem to occur with the care of all individuals. It is recommended that clear guidelines be developed and implemented that indicate the steps to be considered for each individual with severe dysphagia, and severe GERD, so that each individual is considered for all available options at the appropriate time in the clinical course. The following are examples of individuals for whom it was unclear why certain procedures or treatments were not considered: ▪ Individual #301 had a long and complicated medical history that included	

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		dysphagia, GERD, G-tube placement and J-tube placement. He had continued to have aspiration pneumonias (in 10/09 and 5/10), and was noted to have formula coming from his mouth (on 11/8/09). He had a DNR (Level II) in place. There was no information regarding whether a fundoplication was considered for this individual, a procedure that may have been lifesaving and improved quality of life, or whether there were reasons not to consider this procedure. ▪ In 2009, Individual #211 had three aspiration pneumonias, yet there was no critical next step, such as a fundoplication and/or J-tube placement. The individual had a G-tube dating from 1993. The following describes appropriate follow-up to address ongoing medical concerns: ▪ Individual #130 experienced weight loss beginning in April 2010. The physician ordered a battery of tests and an EGD was completed indicating gastritis. His labs were considered normal. He was placed on an appetite stimulant, weighed twice weekly, and had a high calorie diet with supplements. A home team leader participated in his PSP Addendum of 8/4/10, and brought information about his purchasing snacks at the canteen that were not part of his correct food texture, and this change to unhealthy food practices was believed to have contributed to his weight loss (e.g., not eating his regular meal, because of eating the less healthy snacks). An earlier PSP addendum, dated 7/14/10, considered psychiatric evaluation once his medical concerns were resolved. His weight stabilized and the PNMT recommended moving him back to weekly weights. This multidisciplinary and timely approach to meeting the individual's needs and preventing further complications represents excellent teamwork from a diverse number of departments. Generally, direct support professionals identified individuals as having healthcare concerns and needs. They notified the nurse, and an assessment was completed. Individuals needing the attention of the PCP were scheduled for a clinic visit. As was discussed in the report from the baseline review, there was concern that the direct support professionals were the initiators of the need for physician care. Direct support professionals were not clinically trained to identify health care needs, and had not had adequate in-service training on recognizing signs and symptoms of illness or changes in status. According to the Medical Director, since the last review, there had been little in-service training on changes in health status that would assist the direct support professionals to identify health issues. There seemed to have been no advance in development of a formalized curriculum covering the main aspects of health in this population, which increases the risks that significant health issues are missed or not noticed until they are in an advanced stage of development. There were questions related to the routine care that was provided at LBSSLC, because	

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		due to the fact that in only 14 out of 20 records reviewed (70%) demonstrated had timely annual medical summary and that physical examinations had been completed. The following reviews were in compliance: for Individual #159, annual exams on 7/15/09, and 7/28/10; for Individual #106 annual exams had been completed on 7/21/09, and 7/27/10; for Individual #108, annual exams had been completed on 8/19/09, and 8/17/10; for Individual #320, annual exams on 8/19/09, and 8/4/10; for Individual #15, annual exams completed on 7/7/09, and 7/7/10; for Individual #15, annual exams on 8/19/09, and 7/15/10; for Individual #251, annual exams on 8/19/09, and 7/8/10; for Individual #302, annual exams on 7/8/09, and 7/15/10; for Individual #125, annual exams on 7/8/09, and 7/13/10; for Individual #205, annual exams on 7/24/09, and 7/30/10; for Individual #265, annual exams on 8/17/09, and 7/27/10; for Individual #195, annual exams on 7/31/09, and 7/23/10; for Individual #175, annual exams on 7/15/09, and 7/22/10; for Individual #322, annual exams on 7/21/09, and 7/14/10. Although there was an updated annual medical summary and physical examination for the following individuals, the most recent report was completed more than 12 months from the previous report. Anytime within the calendar month of the due month was considered acceptable. The following reports were completed beyond this guideline: for Individual #267, annual exams on 6/9/09, and 7/22/10; for Individual #210, annual exams on 6/16/09, and 7/6/10; for Individual #138, annual exams on 6/2/09, and 7/23/10; for Individual #211, annual exams on 5/29/09, and 7/23/10; for Individual #304, annual exams on 5/29/09, and 7/22/10; and for Individual #62, annual exams on 5/29/09, and 7/22/10. Other records being reviewed for acute care reasons were noted to have the following annual medical summary and physical examinations completed in a timely manner: Individual #165's exam was dated 11/30/09, Individual #217's was on 6/24/10, Individual #68's was on 4/8/10, Individual #176's was dated 2/11/10, Individual #29's was on 12/22/09, Individual #140's was dated 9/16/09, Individual #72's was completed on 6/24/10, Individual #128's was completed on 9/3/09, Individual #130's was completed on 10/8/09, Individual #6's was dated 12/9/09, Individual #301's was dated 2/11/10, Individual #111's was dated 9/1/09, and Individual #313's was completed on 9/1/09. For these records 13 out of 15 (87%) were compliant. Most individuals were scheduled and seen in the clinic setting. For those unable to be transported to the clinic, or for which there would be significant reasons to keep them in the home, the physician made a home visit. There was an attempt, based on the recommendation of the last Monitoring Team visit, to make rounds in the buildings in order to see the environment and to recognize early illness of those in the home not yet referred for a clinic visit. However, this had been logistically difficult, as most individuals	

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		were not in the home during the day, but at programming activities. The PCP could not see a number of individuals when this system change was attempted. The medical department had continued to find the clinic system the most efficient and effective approach to primary health care at LBSSLC. Preventative, Acute, and Emergency Care There was demonstration of some basic preventive care at LBSSLC. However, there were some concerns raised regarding potential lapses in the provision of preventative care at LBSSLC, such as in the provision of colonoscopies and mammograms. Examples of good preventative care included: ▪ As part of medical care and surveillance, there was an aggressive approach to flu prevention and containment during the year. According to a review of available data, there was only one case of H1N1 confirmed in the Facility and no deaths attributed to H1N1. H1N1 vaccination was administered to individuals in 2009. Of those currently residing at LBSSLC, 227 individuals had received H1N1 vaccination. There were only two individuals that were currently residing at LBSSLC at the time of the monitoring visit who had not received the H1N1 vaccination from the Facility, and neither lived at LBSSLC at the time the H1N1 vaccination was administered. This included Individual #235 and Individual #61, both of whom were admitted in the spring of 2010. Staff were offered both the routine influenza vaccine and the H1N1 vaccine. However, from the data submitted from LBSSLC, there were approximately 767 employees on 10/1/09, of which 16.5% received the H1N1 vaccination and 45% received the annual flu vaccine. A readiness plan will require immune and healthy employees, and it is recommended that the Medical Director assist in promoting voluntary vaccination compliance during annual vaccination campaigns. ▪ Similarly, of the 229 individuals currently residing at LBSSLC, 227 individuals had received the influenza vaccination in 2009. Only the two individuals already mentioned, who moved to LBSSLC in 2010, did not receive the vaccination from the Facility. Concerns noted with regard to preventative care included, for example: ▪ At LBSSLC, 44 individuals were identified as age 50 or greater. A number of health care agencies recommend colonoscopies every ten years beginning at age 50, including the HCGs. There are other recommendation options, such as air contrast barium enema, and more frequent sigmoidoscopies. Although all of them require cooperation with preparation, the colonoscopy has been perhaps the most successfully completed in the Intellectual Disability/Developmental	

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		Disability (ID/DD) population. It is also completed for symptomatic gastrointestinal complaints, but those cases are not considered preventive tests. A list of individuals having a colonoscopy completed was provided. This document did not differentiate preventive reasons from acute illness evaluations. The report indicated that of the 44 individuals over age 50, 19 had completed a colonoscopy (during a time span of 2005 to 2010). If all were considered preventive tests, then 43% completed this test. Six individuals had to either be rescheduled, or had been scheduled at the time of inquiry, representing 14% of this population. Two did not complete the test due to guardian requests, suggesting this test was offered to the individual. Twelve individuals (27%) did not have this test completed, nor scheduled, suggesting it had not been offered. There are various reasons not to offer a colonoscopy, such as the rigorous preparation, the conscious sedation required, the position required for examination, and the fragile health condition of the individual, as well as those with a short life expectancy. Of most concern was the 27% who had not completed a test. No additional information was available for review, but it is recommended that as required by the HCGs, the medical department review these cases to determine if there are contraindications or the risk outweighs the benefits in those individuals, and to document the results. Each individual over 50 should have a colonoscopy or other colon cancer screening procedure completed, or have a clearly identified reason documented for not ordering the test as part of the standard of preventive care. ▪ Forty-two women were identified over the age of 40. Of these, 31 (74%) completed a mammogram between 2004 and 2010. Nine individuals were unable to tolerate the procedure for behavioral or physical reasons, or were simply listed as not having one completed. One was scheduled (Individual #175) for the near future and one was canceled due to hospitalization in 2/10 (Individual #66), but not rescheduled. Of the 31 individuals that had completed a mammogram, 16 (38%) had them completed in either 2009 or 2010. Fifteen had their last mammogram in 2008 or earlier, suggesting a need to review these individuals (Individual #261 completed in 2007, Individual #184 completed in 2007, Individual #281 completed in 2008, Individual #53 completed in 2008, Individual #309 completed in 2007, Individual #138 completed in 2008, Individual #116 completed in 2005, Individual #277 completed in 2008, Individual #179 completed in 2007, Individual #283 completed in 2004, Individual #269 completed in 2004, Individual #8 completed in 2004, Individual #13 completed in 2007, Individual #14 completed in 2007, and Individual #310 completed in 2008), and develop a system to ensure appropriate frequency of preventive screening. There may be clear clinical reasons for not pursuing mammograms for these individuals. The medical department needs to ensure each individual is reviewed and mammograms are ordered at appropriate	

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		intervals or that documentation for not ordering this preventive test is included in the individual's record. Additionally, there were two individuals who had no history of having completed a mammogram with no reason given (Individual #228 and Individual #119). The records should be reviewed to ensure documentation as to the reason for not completing this test or such testing should be completed. Care prior to individuals being hospitalized and after hospitalization was also reviewed. All of the record entries reviewed indicated that the physicians were available to respond to acute care needs. There were written entries for many individual prior to their transfer to the hospital, unless it was after hours, and there was a prompt readmission note. Lab and x-ray reports were also reviewed and interpreted. Response to the acute care of the individuals was appropriate in 100% of the records reviewed, which involved 12 acute events for 11 individuals. For example: ▪ On 8/9/09, Individual #299 refused meals and supplements. On 8/10/09, the PCP examined him in the clinic, his exam was unremarkable, and the assessment was behavior due to bipolar disorder. Medications were to be continued, including Valproic Acid (VPA) and Lamictal for his bipolar disorder and Tegretol for his seizure disorder. Later in the day, he refused his medication. On 8/12/09, he developed an unsteady gait and emesis, and complained of a headache. He was monitored closely with repeated vomiting, and an on-call PCP arrived at the scene. EMS was called, and he was sent to the hospital and admitted. His diagnosis was carbamazepine toxicity. ▪ Individual #135 ingested a foreign body, possibly a battery. The PCP followed his clinical course closely. An x-ray report from 4/8/10 was received on 4/14/10 and suggested battery ingestion. An x-ray of the abdomen was then completed 4/14/10, and the interpretation was received on 4/16/10, confirming the foreign body. With continued presence of the battery in the colon, he was sent to the ER, but it passed on its own without surgical intervention. Clinically, he had no noticeable symptoms. ▪ Individual #199 was noted to have increased tube-feeding residuals on 7/14/10. Nursing followed him closely and this resolved on 7/16/10, and then recurred briefly on 7/21/10 with resolution. Then on 7/24/10, he vomited, and had increased residuals. The PCP evaluated the individual. He was noted to be less active and his bowel sounds were absent in the lower quadrants. He was sent to the ER. ▪ The PCP saw Individual #283 on 2/12/10 for chronic chest congestion. A lengthy note detailed the exam, with the lungs having good air movement with scattered rhonchi that cleared with coughing. Plans were to continue the Mucomyst and Albuterol nebulizer treatments, and add Claritin. She did well for about 24 hours, but the following evening developed worsening congestion, and	

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		she was sent to the ER for evaluation. ▪ Individual #283 also began to have lower oxygen saturation readings on 5/21/10 despite suctioning, repositioning, a breathing treatment, and oxygen supplementation. The PCP was notified and EMS was called. She returned on 6/1/10 after being treated in the hospital for pneumonia. The PCP wrote a readmission note at the time of readmission. ▪ Individual #161 returned from the hospital on 1/8/10, after being treated for acute renal failure and dehydration. A PEG was placed. The PCP completed an initial exam and wrote a readmission note. A Speech Language Pathologist (SLP) note also was entered the same day, with comments that the PNMP was current and the dining plan was modified. The PEG tube was noted to be leaking, and on 1/9/10, the PCP examined the individual, made the diagnosis that the PEG tube was dislodged, and she was sent to the ER. At the hospital, she received a new PEG tube on 1/10/10 via an open gastrostomy. She returned from the hospital on 1/12/10. The physician reviewed her clinically on 1/13/10, and she was considered stable. On 1/14/10, a PCP entry indicated that she again was having leaking from the G-tube. She was returned to the ER. She returned to LBSSLC on 1/18/10, with another feeding tube having been placed at a different location. A PCP wrote a readmission note summarizing the important clinical history. A follow-up PCP note was written on 1/20/10 and 1/22/10, and she was considered stable. Then, she developed leaking at the G-tube site on 1/23/10, and she again was sent to the hospital on that date. On 1/29/10, the physician wrote a readmission note that a Mickey button had been placed. ▪ Individual #323 developed vomiting and fever on 11/7/09. The PCP examined him and the diagnosis was viral gastritis. He was placed on Pedialyte for that day. He initially tolerated the Pedialyte, and then there was the report of a self-induced episode of a small amount of emesis. He then developed shaking and increased respiratory rate, and he was sent to the hospital. ▪ Individual #312 was taking Coumadin, and a physician note indicated a therapeutic international normalized ratio (INR) was recorded on 3/11/10. On 3/13/10, he developed congestion and lowered oxygen (O2) saturations. On 3/14/10, the PCP saw him, and ordered a chest x-ray, complete blood count (CBC), Comprehensive Metabolic Panel (CMP), and antibiotics. On 3/15/10, there was a follow-up PCP note and clinically he had improved. However, lab results were returned indicating a low platelet count and he was transferred to the hospital for further evaluation. ▪ Individual #226 returned from the hospital following a probable upper GI bleed on 2/22/10. The PCP reviewed the hospital record and examined the individual at the time of return. Then on 2/24/10, the PCP saw him for vomiting and possible aspiration. His oxygen saturation was down to 80% and he was placed on oxygen supplementation with improvement to 92 to 93%. However, he was	

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		still having difficulty breathing with an increased respiratory rate, and the physician decided to send him to the ER for evaluation. He returned from the hospital on 3/3/10, and there was a physician readmission note. ▪ Several months later, Individual #226 returned from the hospital on 8/23/10, in the evening, and a physician reviewed and examined the individual and wrote an IPN on 8/24/10. He had been treated for a urinary tract infection (UTI). The physician wrote another IPN on 8/26/10 reviewing his recent lab results. ▪ Individual #228 received routine inhalation therapy. On 8/10/10, she was seen by the PCP for increased nasal discharge, which made her gag and caused her to vomit. The ENT had followed her regularly for chronic maxillary sinusitis and nasal polyposis. Exam by the PCP was not remarkable and plans were to refer her to the allergy clinic. ▪ Individual #17 developed a fever on 10/3/09. A urine sample was obtained by catheterization. His oxygen saturation then dropped and the PCP evaluated the individual. The PCP transferred the individual to the ER and he was admitted to the hospital with pneumonia. As part of quality medical care, the information provided to an emergency room during transport is critical to the accurate and timely diagnosis and treatment of the individual. A sample of a blank emergency room packet was submitted. This included a form for completion by a consultant (form returned to LBSSLC at end of visit); and a LBSSLC Transfer Record sheet with basic information such as the attending physician's name at LBSSLC, reason for the transfer, primary diagnosis, relevant labs, the name of the physician/nurse to whom the report was given at the ER, the last medications received prior to the transfer, and a list of potential attachments for further information (PNMP plan, physician orders for the last 24 hours, allergy list, Identification Profile sheet, and lab results), hospital admission form for billing information, a patient profile report computer generated information sheet with similar information such as birth date, diagnoses, active medication list, and medication allergies, a client identifying data sheet that included information already mentioned in prior forms, but also information concerning legal guardian name and contact information, a page recording the active problem list and significant medical events/findings, and the most recent copy of the admission/annual medical summary and physical examination evaluation form. This latter form included additional information such as resuscitation status, an inactive problem list, labs, immunizations, preventive health care tests, prophylaxis treatment, psychoactive medication, physical examination at time of annual evaluation, other significant consultations completed, discussion of all active problem list diagnoses, general condition in past year, plans and recommendations at time of annual evaluation, and a section concerning understanding rights, administration of medication, and training recommendations.	

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		There appeared to be good communication between the hospital and the PCP at the time of discharge from the hospital. According to the Medical Director, there was routinely a verbal discussion with acceptance back to LBSSLC. This allowed for a rapid up-to-the-minute update, and an opportunity for the PCP to ask questions of the hospital physician. Emergent health care was also reviewed. A profile report was submitted for those who were diagnosed with pneumonia/aspiration pneumonia from August 1, 2009 to August 31, 2010. Forty individuals developed pneumonia during this time. Based on a census of 229 individuals, this represented 17% of the population. Of these, 24 individuals were documented as having one bout of pneumonia, 13 individuals had two episodes of pneumonia, two individuals had three pneumonias during that time period, and one individual was recorded as having four pneumonias during this time period. It is recommended that the Medical Director review these individuals, and develop a clinical pathway or guideline for preventive measures, with emphasis on early diagnosis and intervention with clear directives for diagnostic work-up, potential procedures or medications to reduce future pneumonias, and an interface with the Physical and Nutritional Management Team (PNMT), etc. Although the Medical Director had provided a number of protocols, pneumonia/aspiration pneumonia had not been one of them. Given that 17% of the population had this severe illness (many requiring hospitalization), this is an urgent recommendation. The following provide examples of individuals who had experienced pneumonia: ▪ Individual #68 had a diagnosis of aspiration pneumonia in 9/09. His modified barium swallow test indicated the need for a PEG tube, which was placed on 9/9/09. He did well for several months until 3/10 when there was concern about possible aspiration, but the exam by the PCP was normal. On 4/5/10, he had the G-tube replaced in the ER. On 4/8/10, it was noted he had gained 16 pounds since the insertion of the G-tube in 9/09. The G-tube was replaced on 4/20/10, and on 4/21/10, he had a large emesis with concern for aspiration. He was sent to the ER and returned, but on 4/22/10, he was found to be hypoxic, and returned to the ER. He was found to have obstipation, aspiration pneumonia, and a wound infection at his G-tube site. He returned to LBSSLC on 4/27/10. On 4/30/10, he self-induced vomiting. The tube feeding was turned off, and the gastric residual removed, but again he vomited a large amount within a short period of time. He was returned to the hospital and treated for ileus. He returned to LBSSLC on 5/3/10, and by 5/5/10, his G-tube site infection, ileus, and pneumonia had resolved. On 7/13/10, it was noted that he had not had a bowel movement in three days and an enema was given, but was not effective. Magnesium citrate was then administered. His G-tube was changed on 8/26/10, and also on 9/6/10, both considered routine changes. On 9/8/10, he was noted to be constipated and an enema was given. Another enema was given on 9/11/10. His most recent routine medication included	

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		Miralax once a day and an additional recent medication Fiberstat daily. This case represents an individual who continued to need hospitalization after a G-tube was placed for severe dysphagia/aspiration/GERD. However, the integrated progress notes did not indicate a review of his repeat hospitalizations to determine potentially treatable causes. His obstipation/constipation could have contributed to his nausea with vomiting, but the reliance on enemas and magnesium citrate was maintained, with Fiberstat being added 9/9/10. There was the concern that the vomiting may be in part due to or exacerbated by severe reflux, but there was no mention of the need to ensure upright position around the clock, including while being bathed, and the potential for other surgical procedures to reduce reflux, and changing the intermittent tube feeding to a continuous low rate to reduce gastric volume. There was also the concern that his feeding tube was changed frequently, but no reason was given. These areas need further exploration by the PCP. ▪ Individual #176 had a complicated history, with both a J-tube with a Roux-en-Y procedure, and a G-tube, which is drained at routine intervals to decompress the stomach and remove residual. He continued to be diagnosed with aspiration pneumonias/pneumonias (1/13/10, 5/24/10, 7/28/10, and 8/4/10). He was allergic to Rocephin and had usually responded to intravenous (IV) Levaquin. Once discharged, he had been placed on Levaquin through the J-tube. However, fluoroquinolones have been associated with decreased absorption through a J-tube with decreased blood levels and alternatives often are recommended. With his frequent need for antibiotics, he developed C. difficile colitis in July through August 2010. Despite his J-tube and G-tube surgical treatments, he had continued with pneumonias, and may be a candidate for other procedures (e.g., laryngeal-tracheal diversion) as a potential resolution to what is considered continued aspiration pneumonias in a complex case. The Facility had provided adequate care, but the frequent pneumonias contribute to poor quality of life, and a pulmonary consult or surgical opinion from an ENT may provide insight into other steps that may be taken to improve his health, given the limitations of choice and complications from antibiotics in his history. Four individuals at LBSSLC had J-tube placements, including Individual #176, Individual #301, Individual #261, and Individual #7. According to a patient order list, each had received Levofloxacin or other Fluoroquinolone. This family of antibiotics has been demonstrated to reduce blood levels in those individuals receiving this medication through a J-tube. If administration of this family of antibiotics is occurring through J-tubes at LBSSLC, it is recommended the pharmacy provide an alternative list of medications or routes of medications to ensure therapeutic blood levels. For those individuals who return from the hospital following a course of IV Levofloxacin with a recommendation to	

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		continue it in tablet or liquid form, there should be a review and discussion with the physicians and pharmacy staff at the hospital to ensure the most appropriate medication and best option of treatment is provided to the individuals upon their return to LBSSLC. When using this family of antibiotics in individuals with J-tubes, the physicians should be alert for early signs of relapse, recurrence, or bacterial resistance. ▪ At the time of the review, Individual #29 had a G-tube, but had continued to have pulmonary events requiring hospitalization (asthma with acute exacerbation on 5/18/10, 7/9/10, and 7/13/10, and pneumonia on 8/18/10). He was known to have reflux, which can trigger and aggravate bronchospasm. Given his frequent hospitalizations, J-tube placement (which had been suggested during his 8/10 hospitalization), as well as a Nissen fundoplication, may assist in reducing his acute respiratory events. He was also on intermittent feeding, and his reflux may benefit from a reduction in feeding rate and changing the feeding to continuous. Frequent monitoring of his positioning on all shifts to ensure he is not allowed to lie flat, even when bathing, may assist in reducing his bouts of pneumonia and bronchospasm. ▪ Individual #128 had a G-tube. She was hospitalized for aspiration pneumonia on 10/10/09, 11/26/09, and 1/22/10. She was bolus fed, and due to her GERD and aspiration, this should have been reviewed. For example, she may improve with intermittent or continuous feedings. The most problematic concern was referenced in an RN note on 3/19/10 that read: "I entered changing room looking for [Individual #128]. She was lying flat on the changing table. I told DCS [Direct Care Staff] they needed to put a wedge under head for elevation. They continued with what they were doing and I did not see them put a wedge under her head. …" This reflected a lack of training or understanding that could seriously impact the health of this individual. Additionally, there was no further information as to whether the supervisor of the direct support professional was contacted, or the PNMT was notified to provide training. Individuals with G-tubes and GERD are at risk for aspiration pneumonia, and lying flat increases the risk of this occurring, and such poor positioning should be corrected and not tolerated. ▪ At the time of the review, Individual #6 had had a G-tube placed recently. He already had a Nissen fundoplication. He was admitted to the hospital from 1/8/10 to 1/20/10 for sepsis, from 4/19/10 to 4/29/10 with open cholecystectomy, on 4/21/10, and 6/12/10 for G-tube placement, from 6/19/10 to 6/24/10 for an UTI, hypernatremia and aspiration pneumonia, as well as C. difficile colitis, sent to the ER on 6/28/10 for a fever, and hospitalized on 7/1/10 for a fever. This individual represented a complex case. Because this individual continued to have hospitalizations after his G-tube placement and despite a fundoplication, it might be appropriate to consider a second or even third	

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		opinion for J-tube placement or a laryngeal tracheal diversion. There was also the potential that the Nissen fundoplication may have become unwrapped at some point, given the history of recurrent vomiting and rumination, and may need evaluation. Certain medical problems were common and remained unresolved. Constipation is a well-known problem in this population, and can have serious consequences. The following are examples of how this problem remained unresolved for individuals at LBSSLC: ▪ Individual #165 had an annual physical summary completed on 11/30/09. There was a referral to a gastroenterologist for progressive weight loss. There was no mention of constipation in this note. However, he underwent a successful colonoscopy on 12/4/09 (previous attempts on 3/29/09, 5/15/09, 7/17/09, and 9/28/09 were unsatisfactory due to poor preparation). There was stool in all areas of the large colon, despite the preparation that he received. At that time it was recommended he be placed on Amitiza 24 micrograms (mcg) BID (twice a day), Colace 200 milligrams (mg) daily, Benefiber six capsules TID (three times a day), and Miralax 17 grams (gm) in eight ounces of water QID (four times a day) indefinitely. The PA summarized a follow-up GI consultant report on 2/17/10, continuing to confirm the diagnosis of reflux and constipation, and the plan to continue medications previously prescribed. The integrated progress notes did not indicate a problem of constipation from the time of the colonoscopy for several months forward. Then, on 3/30/10, the Miralax was changed from QID back to BID, and the reason was not clearly defined in the progress note. The hand written order may have read that the constipation was better (due to legibility, one could not be certain of the word that was written). On 5/28/10, it was recorded he did not have a bowel movement (BM) for three days, and his abdomen was slightly distended. An enema was given. Again on 6/17/10, an enema was given for constipation. On 6/25/10, an x-ray of the abdomen indicated fecal impaction, and his bowel movement record did not indicate any bowel movement in three days. Again, a fleets enema was given. On 7/1/10, it was discovered he had had no BM since 6/25/10. An enema was given. On 7/3/10, another enema was required to relieve the constipation. Other enemas were administered on 7/13/10, 7/18/10, 7/26/10, 7/27/10, 8/8/10, and 8/19/10. On 8/23/10, the PNMT discussed his constipation, and initiated a plan to increase fluid intake and monitoring. He was given enemas on 8/24/10, 8/27/10, 9/6/10, and 9/10/10. The record was somewhat confusing as there was not always documentation of standing orders on the dates of the enemas. The earlier order of Miralax was effective and once reduced to BID, there was no written documentation of consideration to increase this medication, despite numerous administrations of	

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		enemas. There seemed to be no review on the part of the medical staff, which would have revealed that he had no difficulties for months while on QID Miralax, and developed worsening constipation a few weeks after reducing the dosage. It would have seemed a reasonable choice to increase the dosage of Miralax soon after enema use began, but this was not done. ▪ Individual #140 had had several bouts of constipation (on 11/12/09, and 12/31/09 given mag citrate and 10 days of Bisacodyl, on 1/20/10 given mag citrate, on 1/25/10 mag citrate for 2 days). A colonoscopy was completed on 2/4/10, and the assessment was regional enteritis, reflux, and constipation. On 6/28/10, he was given prune juice and docusate. He was noted to be on Miralax, Milk of Magnesia (MOM) three times a week, Fiber Stat, and Activia. On 8/24/10, and 8/25/10 he was given mag citrate, on 9/2/10, he was given Lactulose, and on 9/3/10, the PCP discontinued Lactulose. He was to be given 3.5 liters of fluid daily. He had significant symptoms of screaming and straining when producing stool on some of these occasions. The continued episodes of constipation and additional short-term medications suggested the need to review his history and regimen, and increase his daily medication to prevent and minimize constipation rather than reacting to constipation once it occurred. ▪ Individual #313, as of 9/1/09, was taking Milk of Magnesia daily, and Miralax twice a day, as well as being ordered a high fiber diet. A colonoscopy was completed in 8/07, and there were no abnormal findings. He was found to have constipation and required treatment on the following dates: 9/9/09, 9/11/09, 9/21/09, 9/24/09, 10/5/09, 10/8/09, 10/16/09, 1/6/10, 1/15/10, 1/16/10, 3/10/10, 3/11/09, 3/19/10 (sent to ER for impaction), 5/26/10, 6/8/10, 6/18/10, 7/6/10, 7/11/10, 7/14/10, 8/6/10, 8/17/10, and 8/24/10. Bisacodyl was increased from 5 mg to 10 mg every morning (QAM) starting on 4/22/10. Thereafter, there was no further PCP intervention. With the continuing number of episodes of constipation, one would expect a review of the trend and increase in maintenance medication to prevent future episodes. The following provides an example in which it appeared constipation was addressed appropriately: ▪ Individual #111 had a Nissen fundoplication in September 2008 for symptomatic GERD (emesis). The GERD symptoms decreased. On 9/6/10, he developed constipation requiring an enema. On 9/14/10, Miralax was added to his orders. Both of these issues, treatment for GERD, and treatment for constipation, represent timely interventions, which reduce long-term complications from these concerns and also improves the quality of life of the individual. Pica events were reported 17 times at LBSSLC from October 2009 through July 2010.	

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		BSPs and any subsequent addendums were requested on several individuals with a history of pica. It was not clear from review of the records that adequate steps were taken to ensure that individuals did not access inedible objects, and/or that the medical staff were involved in reviewing BSPs and working in an integrated fashion with other team members to prevent pica from occurring. The following concerns were noted with regard to pica, a potentially life-threatening behavior: ▪ Individual #135 had a history of pica. On 2/16/10, a KUB (x-ray of the abdomen) showed several staples. On 3/15/10, he had a colonoscopy to remove six coke tabs, three coins, and a "bunch" of plastic paper. On 4/18/10, he had a colonoscopy to remove a dime and a penny. There also was a history of his swallowing a battery. On 7/13/10, his BSP was revised. He was to have routine pica sweeps of his home. Areas were to be observed before this individual entered the home. He was not allowed to handle coins except during a brief transaction. His wardrobe was to be searched daily. He was to have one-to-one staff supervision. Despite these measures, he again was able to ingest an inedible object. On 8/6/10, on x-ray, he was noted to have a coin-like foreign body in his colon. In this case, the one-to-one staff went to a vehicle to retrieve something, and did not have a direct line of vision of Individual #135 at all times. Although reportedly a campus-wide review of pica was undertaken at LBSSLC, staff may not understand the imperative that an individual with a history of pica not be provided any opportunity, even briefly, to obtain an inedible object. A further series/review of in-services concerning pica is recommended. ▪ Individual #23 had an incident of latex glove ingestion on 2/25/10. The BSP was dated 2/19/10, and the baseline data was through October 2009. There was no further addendum submitted. Latex glove ingestion can lead to serious and life threatening complications, and, at a minimum, there should have been a review of the BSP, as well as staff's implementation of it. ▪ Individual #127 had two recent pica incidents on 8/6/10 and 8/13/10, in which cigarette butts were ingested. Also, he had an earlier incident of ingesting twigs in 4/10. The BSP was dated 7/9/10 and reflected baseline data through March 2010. Despite two events in August 2010, no additional addendum to the BSP was provided to show that team discussion had occurred and consideration given to the possible need to modify the BSP to address the ongoing pica issue. ▪ Individual #34 swallowed a hearing aid battery on 11/2/09 and on 3/5/10. Her BSP was dated 1/20/10, and there were two implementation dates 2/18/10, and 5/12/10. Pica was mentioned as a behavior for monitoring, but there was little else in the document to address this issue. One would expect an addendum to show team discussion regarding her swallowing a battery, but none was submitted.	

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		Mortality Reviews The death review process was completed in two steps. Initially, the physicians met to review the case. This included the QE nurse, and also might have included the physician on staff at the hospital who was a liaison to the medical department at LBSSLC. The DADS SSLC Medical Services Coordinator was on a conference call during the meeting, when this can be arranged. The second step included the Medical Director, the Director of the Facility, the QE director, the Chief Nurse Executive (CNE), and a layperson from the community. There were delays if an autopsy was completed, but results had not been received. As an estimate, according to Facility staff, autopsies were completed on 60 to 70% of those individuals that had a fatal outcome while under the care of LBSSLC. The Medical Department followed the policy entitled "LSS-Health Services: Death of an Individual Protocol," and the Nursing Department followed the death review investigation entitled "Death Review Nursing Services." The Monitoring Team reviewed deaths for five individuals who died within the last six months of the on-site visit. This evaluation consisted of a review of the entire medical record, and these findings were compared with the Facility's summary of findings. Generally, it appeared that when death reviews had been conducted, the review team had considered appropriate information, and had made recommendations that were appropriate. The following specific comments are offered: ▪ According to his record, Individual #180 had an active problem list that included stereotypic movement disorder with self-injurious behavior (SIB), Barrett's esophagus, hiatal hernia, GERD, cholelithiasis without cholecystitis, speech defect, osteopenia of the lumbar spine, osteoporosis of the femoral neck, cardiomegaly, constipation, and type 2 diabetes mellitus (diet controlled). In January 2010, this individual completed a modified barium swallow study (MBSS) followed by an Electroencephalogram (EGD) that indicated an esophageal stricture. The modified barium swallow study demonstrated dysfunctional swallowing, and he was no longer safe to take nutrition, fluids, or medications by mouth. His level of supervision had been increased to protect him from pulling at the G-tube that had been placed on 1/14/10. An abdominal binder was placed and he adjusted well, showing no inclination to pull at the G-tube. It was also noted in his record that Zyprexa was being weaned, as he had not demonstrated agitation or SIB. This individual had a routine G-tube replacement on 4/12/10, and then had diarrhea for two days. It was thought this was due to an antibiotic he had been taking for an abscessed tooth. He finished the antibiotics on 4/16/10. He also	

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		attended the neurology clinic on 4/16/10, with normal monitoring results. On 4/18/10 at 1:53 a.m., as oral care was begun, a dried brown substance was noted on this individual's mouth. The Licensed Vocational Nurse (LVN) was paged. The on-call physician was contacted on 4/18/10 at 4:30 a.m. due to a greenish brown emesis and due to the tachycardia and history of emesis. The physician ordered transfer to the hospital. The emesis had no odor. His oxygenation was 100%, and his temperature was 97.2 degrees (°) Fahrenheit (F), and pulse was 112, with respirations 20, systolic blood pressure (BP) was 92. He was described as whimpering with watery eyes. Bowel sounds were present. He was pale. The Registered Nurse (RN) assessed the individual, and because the individual was acting more his normal self with increased activity over a short period of time, believed the individual should be seen in the home. The nurse called the on-call physician again and it was decided the individual would be seen later that day in the home. The nurse instructed that additional water be given and to notify the physician for any vital signs outside of normal parameters. In summary, at first the physician gave an order to transfer to the ER because of the emesis and tachycardia, but the nurse suggested increased vital sign monitoring as an option, and transport was cancelled by the on-call physician. Individual #180 had his 6:00 a.m. tube feeding without problems. He appeared to have recovered and was sitting up during the day. The physician visited the home later that day and ordered monitoring with pulse oximetry. On 4/18/10 at 5:30 p.m., this individual was noted to be pale and barely responsive. The nurse was called, and he was assisted to the floor. A medical emergency was called and 911 was contacted. CPR was started. An Automatic External Defibrillator (AED) was placed with three to four shocks given. He was stabilized by EMS, transported to the hospital, and admitted to the Medical Intensive Care Unit (MICU). He subsequently died. An autopsy indicated he had a lethal electrolyte imbalance and dehydration due to an elevated Sodium (Na) level of 174, blood urea nitrogen (BUN) of 122 with creatinine of 3.3. It was discovered that the G-tube was improperly positioned in the transverse colon, and there was a fistula (abnormal connection between two parts inside of the body) between the stomach and the transverse colon. There was the comment that the fistula was likely from a prior G-tube placement. The death review covered a number of topics and appeared to be comprehensive, reviewing critical areas such as monitoring for dehydration, post-operative care placement at specific homes at LBSSLC to allow for more intensive nurse monitoring and observation, the use of the most up-to-date AED	

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		documentation logs, and expansion of GI consultations available to the population at LBSSLC. The autopsy findings were unexpected. Because he was being tube fed at the time, it seemed unlikely that an individual would develop dehydration. The staff at LBSSLC appeared to have provided appropriate care. ▪ According to his record, Individual #246 had an active problem list that included insomnia, legal blindness, G-tube placement (from 12/17/08), speech defect, constipation, urinary incontinence, a partial colectomy due to a sigmoid volvulus on 11/19/08, and a history of fecal impactions in 5/09. Most recently, on 6/18/10, he pulled out the G-tube Mickey button and he was sent to the ER. When he returned on 6/19/10, he appeared calm, but when medication was given through the G-tube, he laid on the floor, agitated, pulling at the binder, with some blood noted at the G-tube site. There were several entries during a brief period of time, and if interpretation is correct, the record indicated that he underwent further evaluation at the ER later on 6/19/10, including a computed tomography (CT) scan, and that there were no abnormalities found. On return, he continued to have signs and symptoms of pain late on 6/19/10 and 6/20/10. His pain and discomfort worsened, unrelieved by Lortab and subsequently Ativan. Due to continued agitation and symptoms of pain, he again returned to the ER. Initial exam was recorded as alert with no acute distress. The abdomen was not distended. Laboratory tests and CT were ordered, and while waiting for completion of the results, he coded. The autopsy report was still pending at the time of review. However, it appeared that this was a clinical enigma, despite all the tests and monitoring completed. Based on review of the last days of his life, LBSSLC staff provided adequate care in attempting to monitor and provide control of pain and transported him to the ER at appropriate intervals. ▪ Individual #208 had an active problem list that included a speech defect, scoliosis, spastic cerebral palsy, generalized spasticity, swallowing dysfunction, constipation, weight loss, and osteopenia. On 6/10/10, this individual was found in bed moaning and he was constipated, which was relieved by an enema. He also was noted to not be eating well for the prior three days. He refused his meals that day. He was described as alert with no signs of distress, but he was agitated and refused vitals signs. His pulse and temperature were obtained at some point and were normal. He was able to consume water and supplements, and took his medications in the evening, but then had some emesis. He appeared uncomfortable and had a large emesis, at which time 911 was called. He became cyanotic with no vital signs. He was resuscitated and taken to the ER. He had an acute abdomen due to ischemic bowel and he was taken to surgery, but did not survive. The internal death review was considered complete, determining appropriate clinical concerns and providing suggestions. ▪ Individual #286 was under hospice care at the time of death. His terminal	

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		diagnosis was bladder adenocarcinoma. His active problem list included congenital cranial abnormalities, macrocephaly, meningomyelocele, seizures, cerebral palsy, a permanent vesicostomy, paraplegia, osteoporosis, and constipation. He had a Percutaneous Endoscopic Gastrostomy (PEG) tube placed on 1/13/08. Urology was consulted on 10/6/08 for a mass, and the mass was found to be an adenocarcinoma. He was presented at the hospital Tumor Board. Death review was complete and suggested ways to improve oversight and monitoring of individuals on hospice. There were no clinical concerns noted in the death review. ▪ Individual #229 had an active problem list including seizures, hyperlipidemia, and gastritis. His seizures were well controlled, and he had been seizure free since October 2009. His PNMP/dining plan indicated that he was to be encouraged to eat slowly. His diet was an 1800-calorie, low cholesterol chopped diet. The family had taken him on a picnic on campus, when he collapsed, unresponsive and not breathing. CPR was initiated upon staff arrival and EMS was called. EMS found a large chunk of tortilla in his throat. There may have been a language barrier with the family, and there was no indication of training of the family on his PNMP/dining plan from the record reviewed. An autopsy was completed. Death was reported as due to anoxic brain injury secondary to aspiration. This was a tragic and unexpected event, and the direct support professionals initially on the scene started CPR until help arrived. It is recommended that the Facility review its policy regarding training families or others on dining plans before they are allowed to assume responsibility for an individual on or off-site for a meal. When logistically possible, the family member should show competency in preparation of the meal, as well as the ability to carry out the dining plan. A final administrative review had not yet been completed at the time of the Monitoring Team's visit. <u>Do Not Resuscitate (DNR) Orders</u> A "Do Not Resuscitate list," updated 9/14/10, was provided. It listed 14 individuals for whom an out-of-hospital DNR order has been placed. Three of these individuals were on hospice. Based on the medical rounds that the Monitoring Team observed, there were two individuals, Individual #261 and Individual #263, who had complicated histories, during which time their code statuses were made DNR. It is positive that they regained health and quality of life, however, it may be time to reconsider the DNR order for these two individuals, because the circumstances of their health had changed. What was an appropriate choice at one time should be reviewed to determine if the order should still be kept. At some point, if their clinical condition deteriorates and the DNR has been removed, it can be discussed again with the family/guardian with the current medical information at that time, rather than based on clinical information from a prior historical	

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		event. <u>Emergency Medical Drills</u> Concerning "code blue" drills at the Facility, the Medical Director stated that none of the primary care physicians were involved in these drills. He also was not aware that they were being conducted, suggesting a lack of communication between the medical and nursing departments. It is recommended that a schedule of "code blue" drills and other mock emergency drills be shared with the Medical Director, and that the primary care practitioners be required to participate in these drills when they are on campus at LBSSLC.	
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.	LBSSLC arranged for Dr. Kubala from the Denton SSLC to complete a physician case review. He was at LBSSLC from August 9 through 12, 2010. Reportedly, Dr. Kubala was expected to complete a physician medical review yearly. He reviewed six medical records and completed a review on each record using the Plan of Implementation for Sections G, H, I, and L. There were many comments, indicating significant time was given to reviewing each record, and there were a number of concerns noted. Concerns related to this process included: ▪ The reviewer was a "Facility" physician, because he worked for Denton SSLC. This does not appear to meet the intent of this requirement of the Settlement Agreement that requires the review to be conducted by "non-Facility" physicians. At a minimum, if physicians from other facilities are going to assist in conducting such reviews, a physician external to the SSLC system should participate as a member of the team to provide a further objectivity to the review. ▪ The sample reviewed was not large enough to allow generalizations to be drawn from the review. The sample consisted of six records, representing less than three percent of the census of 229 individuals. ▪ There was no submission of a formal summary document of the review, but only hand written comments and completion of the Texas monitoring tool for the medical department. To assist in the facilitation of quality medical care and medical quality improvement, a formal report should be provided that identifies individual as well as any systemic issues identified, and provides recommendations. There were a wide range of observations, such as overdue BSPs and PSPs, no dental representation at an HST, PT and OT that were not addressed at an HST, no discussion of communication skills at an HST, need for work-up of increased liver function tests, need to address lack of mobility at an HST, a psychiatric diagnosis not listed in the acute problem list, need for better control of lipids in a high-risk individual, and the need for follow up cardiology recommendations. The range of comments was impressive. The	Noncompliance

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		Medical Director acknowledged the report, but stated that the recommendations had not been reviewed, nor had follow-up been completed. His overall interpretation was that there were no large problems identified. However, as noted above, no report had been provided analyzing the results of the review. It is recommended that the Medical Director review the findings to identify potential systemic concerns, as well as the need for systemic improvement to begin to ensure similar findings are not repeatedly found in future reviews. In addition to concerns related to the methodology used and the objectivity of the review, the Facility had not yet addressed the second part of this SA section, in which the results of the review are used to facilitate the quality of medical care and performance improvement. As a result, the Facility remains in noncompliance with this sub-section of the SA.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	At the time of the review, a medical database was being developed and included tracking of emergency room visits, deaths, hospitalizations, chemical restraints, and pre-treatment sedation. Pre-treatment sedation was tracked per individual, with the pre-treatment sedation ordered, the reason for the order, when Human Rights Committee (HRC) approval was obtained, the legal representative that signed for consent, and the date the chemical restraint was given. The most common diagnoses from the clinic were also tracked. The Facility had not begun to review trends, but reported that in the future, the information would be reviewed for any trends. Preliminary information suggested that trends for constipation were stable (i.e., they were not worsening). The rate of ER use was steady at about 30 visits per month. There were a number of databases available for review, interpretation, and next steps in quality improvement. The following reports were generated from existing databases: ▪ Individual Diagnosis Report: Constipation from August 1, 2009 to August 31, 2010; ▪ Constipation report, dated 9/13/10; ▪ Client Characteristics Report, dated 8/1/10 to 9/14/10, age 50 to 80, DEXA scan, and results; ▪ Osteoporosis Report, dated 9/13/10; ▪ Individual Diagnosis Report: Fractures, dated January 1, 2010 to August 31, 2010; ▪ GERD Report, dated 9/13/10; ▪ Client Characteristics Report, dated 8/1/10 to 9/14/10, age 50 to 80, date of most recent thyroid test; ▪ Emergency Room: Visits by type, from January 1, 2010 to August 16, 2010; ▪ Hospital: Admissions by type, from January 1, 2010 to August 16, 2010; ▪ Respiratory Profile Report, from January 1, 2010 to July 31, 2010; and	Noncompliance

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		▪ Individual Diagnosis Report Status epilepticus, from April 1, 2009 to August 31, 2010. As one example, the Emergency and Hospital visits by type from January to August 2010, was reviewed. There were 138 ER visits. Of those, 48 individuals had a diagnosis in the category of soft tissue and bony injury, 12 visits were initiated due to a respiratory problem, and 22 visits were due to a gastrointestinal problem. There were 117 hospitalizations, of which 28 were due to respiratory problems and 20 were due to gastrointestinal diagnoses. This basic information should provide a framework for prioritization of where to begin to devote time and energy to making the most improvement in the health of the population at LBSSLC. The information would need to be further analyzed and plans developed to address any potentially contributing factors to ER visits and hospitalizations.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility was not yet in compliance with this sub-section of the Settlement Agreement. It had begun to develop clinical care guidelines, and was in the process of incorporating State Office policies and the Health Care Guidelines into existing policies, and/or developing new policies. This activity is summarized below. The Medical Director had developed a number of Clinical Care Guidelines for common health issues, which included such aspects as key factors of the history and exam, diagnostic tests, and treatment options. They were presented in a succinct bullet format to allow other primary care providers easy review. Topics included: ▪ Guidelines for the Treatment of Urinary Tract Infections in Females; ▪ Guidelines for the Treatment of Urinary Tract Infections in Males; ▪ Guidelines for the Treatment of GERD (Gastroesophageal Reflux Disease); ▪ Guidelines for the Treatment of Pressure Ulcers; ▪ Guidelines for the Treatment of Acute Bronchitis; ▪ Guidelines for the Treatment of Cellulitis; ▪ Guidelines for the Treatment of Chronic Bronchitis; ▪ Guidelines for the Treatment of Acute Conjunctivitis; ▪ Constipation in Adults; ▪ Guidelines for the Treatment of Viral Gastroenteritis; ▪ Guidelines for the Treatment of Essential Hypertension; ▪ Guidelines for the Treatment of Otitis Media; ▪ Guidelines for the Treatment of Community Acquired Pneumonia; ▪ Guidelines for the Treatment of Sinusitis; ▪ Guidelines for the Treatment of Type 2 Diabetes Mellitus; and ▪ Guidelines for the Treatment of Type 1 Diabetes Mellitus.	Noncompliance

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		These guidelines provided the framework for standardization of care and set forth the expectations for care and treatment across the campus. However, it did not appear that they were completely consistent with the HCGs. In addition to reviewing them to ensure their compliance with the SA and HCG, the following recommendations are based on the review of these documents: ▪ Several important topics such as acute aspiration, aspiration pneumonia, and pica were not included. These life threatening conditions should have guidelines developed and implemented. ▪ For acute care issues such as aspiration pneumonia, GERD, severe constipation, etc., there should also be a timeline for when a further next step diagnostically or therapeutically is expected. This will further promote similar expectations across the campus. ▪ The documents were not dated, and there should be a routine review and updating of information to ensure they remain current. Placing the initial date of the policy and follow-up dates of reviews is recommended. There was a policy for "convulsive seizure management," dated 2/9/09. In the content, it states "treatment should be instituted if the individual has been seizing 10 minutes." It is probable that seizures are being treated before the 10-minute time interval, and it is suggested that this be changed to five minutes in the policy. This would be consistent with the HCGs that define status epilepticus as a seizure lasting more than five minutes, unless otherwise defined by the PCP or neurologist. The policy should indicate that status epilepticus must be treated as a potentially life-threatening emergency. For those preparing to move to the community and needing a PRN medication for seizure control, Diastat is usually given, as families and community providers quickly learn how to use this medication. It is usually prepared thee minutes into the seizure and administered five minutes into the seizure. For alternative medication, it would be fairly typical to provide treatment five minutes into the seizure, if Ativan injection or other medication is given. Diastat should be considered for those beginning the transition process, to ensure that it is effective in controlling seizures while still at LBSSLC and then can be taught to the receiving family or agency. There were also other policies developed and in place (or in draft form) related to the Medical Department. Many of these needed to be updated to ensure consistency with the Settlement Agreement and Health Care Guidelines. The following policies were currently in place at the Facility: ▪ LSS – Health Services: Clinical Care, dated 12/1/09 (R); ▪ LSS – Health Services: Management of Acute Illnesses and Injuries, dated 12/1/09 (R);	

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		▪ LBSSLC – Health Services: At Risk Individuals - Health Status Team Meetings, dated 1/22/10 (R); ▪ LSS – General Clinical Care - At Risk Individuals – Health Status Meetings, dated 4/22/09 (R); ▪ LSS – Health Services: Coding Requirements, dated 2/1/08; ▪ LSS – Health Services: Preventive Medicine, dated 12/1/09 (R); ▪ LSS – Health Services: Medical Review System, dated 4/13/09 (R); ▪ LBSSLC – Risk Management and Infection Control: Needlestick/Bloodborne Pathogen Protocol, dated 9/21/09; ▪ LSS – Health Services: Tracking System for Lab/Radiology Department, dated 7/12/08; ▪ LSS - Health Services: Tracking System for Physician/Dentist/PA Licensure, dated 7/12/08; ▪ LSS – Health Services: Tracking System for Consultations, dated 7/12/08; ▪ LSS – Health Services: Medical Care, dated 8/2/10 Draft; and ▪ LSS - Health Services: Death of an Individual Protocol, dated 10/8/08 (R). The SO had also developed a SSLC Policy for Psychiatry Services, dated 7/20/10, and many sections were important to the medical, pharmacy, and Dental Departments. These sections needed to be incorporated into the Facility's policies.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The medical department should maintain information on all CME activities for all PCPs, psychiatrists, and dentists, and should ensure that all medical staff and consultants regularly complete CME in areas relevant to the healthcare of individuals at the Facility.
2. At the morning medical meeting:
    a. The Medical Director should ask critical questions and gather detailed information to ensure appropriate and efficient health care is being provided for any and every individual on the list that is reviewed;
    b. Critical information should be shared concerning updates for those hospitalized and those returning from the ER; and
    c. Presentation of follow-up next steps should be precise and complete.
3. The entire medical department should be aware of individuals at high-risk of pica.
4. Individuals with abdominal pain and complaints (nausea/vomiting) with a history of pica should be evaluated and monitored for potential pica ingestion unless the cause is obvious.
5. Direct support professionals need a formalized educational program focusing on changes in health status (how to identify, what to look for, what to articulate/describe to the nursing staff or physicians, etc.).
6. For those over the age of 50 who have not completed a preventive colonoscopy screening, the Medical Department should review each individual's case to determine if there are contraindications or if the risks outweigh the benefits in those individuals. Justification for not completing a colonoscopy should be documented. For those individuals for whom no reason can be found, a colonoscopy should be completed.
7. The Medical Department should ensure that each woman receives a mammogram according to the standards set forth in the Health Care Guidelines.

8. Consideration should be given to developing and implementing a database management system to ensure the timely completion for all individuals served by LBSSLC of:
    a. Annual medical summaries and physical examinations; and
    b. Preventive screenings.
9. The Medical Director should urgently review the individuals who have had cases of pneumonias to develop a clinical guideline/pathway for preventive measures and early diagnosis and intervention, including diagnostic work-up, and potential procedures and medications to reduce future pneumonias. There also should be a clear role for the PNMT in preventive care of pneumonias.
10. When there are serial hospitalizations/ER visits over several months, the integrated progress notes should include a physician note reviewing these events to determine any trend or consistent reason for recurrence, asking the critical "why" questions and not simply treating each acute event separately.
11. The Medical Director with the Chief Nursing Executive should review the frequent routine feeding tube changes that are documented. The routine replacement schedule for feeding tubes should meet the needs of the individual. This might require individualization of the schedule for routine tube replacement. For example, if an individual has had a need for a tube replacement (e.g., due to clogging, etc.), then the regularly scheduled tube replacement might not need to be completed, and the schedule recalibrated for that individual.
12. There is medical literature to suggest fluoroquinolones may not be well absorbed through a J-tube, and provide lowered blood levels when given through this route. This issue should be discussed with the hospital attending physician and hospital pharmacy when an individual is returning from the hospital after IV Levaquin is provided, as well as discussing with the Facility PharmD to determine the best antibiotic at the best dosage strength.
13. Clinical pathways/guidelines should identify further steps to be taken once aspiration or GERD begins to reoccur in an individual with G-tube placement. Additional steps should continue to occur as long as episodes of aspiration pneumonia persist. Clinical pathways should be designed to ensure all available options are considered for each individual at the appropriate time in the clinical course. Clinical guidelines also should address recurrent hospitalizations to ensure that critical thinking occurs about ways to prevent such hospitalizations.
14. Consideration should be given to the fact that bronchospasm may be an indication of severe GERD with aspiration in this population and may respond with aggressive treatment of GERD either medically or surgically.
15. For those with recurrent aspiration pneumonia with prior G-tube placement, it is recommended that a clinical pathway include review of feeding rate (to reduce bolus feedings). It also should include a component of monitoring in the home to ensure proper position at all times, including mealtimes, during medication administration, when bathing, and when sleeping.
16. It is recommended that episodes of similar pathological events (constipation as an example) should be looked at as an opportunity to consider providing an increase in routine medication, to prevent further constipation and to reduce the PRN use of medication. On a regular basis pro re nata (PRN, or as needed) usage of constipation medications should be reviewed to determine the next addition or change in the routine medication regimen prescribed. Reduced need for PRN constipation medication should be one of the clinical indicators used to measure successful prevention of constipation.
17. A further series or review of in-service training sessions concerning pica should be conducted campus-wide for all departments.
18. For those individuals who exhibit pica behavior, when pica occurs, the individual's team should meet to review the BSP, and determine the need for either additional staff training and supervision to ensure the implementation of the BSP, and/or to develop and quickly implement an addendum to the BSP.
19. A system should be in place to ensure that when direct support professionals do not follow the guidelines set forth to ensure the health and safety of individuals that such issues are reported to supervisory staff, and, as necessary and appropriate, staff are retrained.
20. The Facility should review and revise as appropriate its policy regarding training families or others on dining plans before they are allowed to assume responsibility for an individual on or off-site for a meal. When logistically possible, the family member should show competency in preparation of the meal, as well as the ability to carry out the dining plan.
21. There are individuals with DNR orders that may have been appropriate during a time of critical illness, but with excellent recovery may no

longer apply due to their improved health. What was an appropriate choice at one time should be reviewed to determine if the order should be maintained. If a DNR order is removed, it can be reconsidered, using current information, if the health status of the individual deteriorates. A DNR order should not be based on a remote historical event.

22. The Medical Director should be made aware on a regular basis of the "code blue" or other emergency drills that are scheduled to occur at the Facility. Physicians available during emergency drills should also be expected to participate in the drills to ensure they remain familiar with the equipment and the running of a code, as they would be expected to be in charge if they were in the proximity to the code until EMS arrives.
23. With regard to the non-Facility physician review:
    a. At a minimum, if physicians from other facilities are going to assist in conducting such reviews, there should be participation by a physician external to the SSLC system as a member of the team to provide further objectivity to the review;
    b. An adequate sample of records should be selected and reviewed to ensure that the results of the review can be considered representative of the entire population at LBSSC. Generally, to accomplish this, at least a 20% sample would need to be drawn; and
    c. When a non-facility physician reviews the medical charts at LBSSLC, a formal narrative summary of the review with findings and recommendations should be submitted to the Medical Director.
24. The Medical Director should create an internal medical department corrective action plan based on a review of the findings of any non-facility physician review. Such action plans should address individual as well as systemic findings, and should identify person(s) responsible, dates of expected completion, and anticipated outcomes. Such action plans should be reviewed regularly, and modified if the anticipated outcomes are not achieved.
25. The State Office should identify non-facility physician(s) from outside the SSLC system to conduct the non-Facility physician reviews to ensure objectivity and allow a fresh perspective on areas needing improvement.
26. The Medical Director should begin to analyze the current information available in the medical department database. Clinical indicators need to be determined to begin to monitor quality care from a variety of perspectives (timeliness of treatment, lab tests completed, medications chosen, documentation, consents, outcomes for individuals, etc.). Priority should be on those clinical issues that lead to ER visits, hospitalization, and poor quality of life.
27. Clinical guidelines should continue to be developed. The guidelines should be dated and periodically reviewed with dates of updates also documented, to ensure that the standard of care remains current. Clinical guidelines for future development should focus on pathophysiology and disease that are frequent and lead to critical illness, such as aspiration pneumonia. Timelines also should be included in the clinical guidelines to ensure all medical staff adhere to an appropriately aggressive approach to resolution of medical illness and diagnoses.
28. The policy for "convulsive seizure management" should be reviewed to ensure it is consistent with the HCGs and specifically that medical treatment of seizures begins at the five-minute interval, unless the PCP or neurologist have otherwise defined status epilepticus.
29. For individuals preparing to move to the community with a seizure disorder, Diastat should be considered for those needing PRN seizure control. It should first be used while at LBSSLC to ensure its effectiveness, then taught to the receiving agency or family members who will be supporting the individual.
30. As part of a voluntary vaccination campaign, consideration should be given to the Medical Director actively promoting vaccination among employees in order to protect the individuals living at LBSSLC, and to ensure healthy staff are available for work during any potential outbreak.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o LBSSLC's POI, dated 5/17/10; o LBSSLC's Nursing Supplemental POI, dated 5/17/10; o LBSSLC's Nursing Department Presentation Book; o Advertisements for Nursing positions; o Invoices for publications, television, and radio advertisements for Nursing positions; o Television commercial for Nursing positions; o Job descriptions for additional full-time positions for Infection Control and Nursing Education; o LBSSLC Nurse Mangers monitoring data since July 2010: six Acute Illness and Injury audits, three Prevention audits, seven Urgent Care and Hospitalization audits, and four Medication Administration and Documentation audits; o QE monitoring data since July 2010: two Urgent Care and Hospitalization audits; o Thirty-eight Standard Precautions Monitoring Tool for Infection Control; o Monthly Residential Round data; o Seven Hand Washing spot check audits; o The new Infection Control Monitoring tool and data; o Current Active Nursing Projects and Workgroups provided by the State Office Nursing Coordinator; o Infection Control policies; Limited Access, Multidrug-Resistance Organisms and Isolation, and a draft of Deep Cleaning; o LBSSLC's Work Restrictions Guidelines and Management of Infectious Illness; o Seventeen Infection Control Surveillance Rounds Monitoring Tools; o Administrative Review Team Meeting minutes, dated 4/28/10 and 7/29/10; o Infection Control Committee meeting minutes, dated 2/25/10, 3/23/10, 4/29/10, 5/27/10, and 7/6/10; o LBSSLC's nursing staffing vacancies; o Pharmacy and Therapeutic Committee minutes, dated 3/16/10, and 6/22/10; o Infection Control course description for new employee orientation; o LBSSLC's Life Threatening Emergency Drills, from 3/10 through 7/10; o The medical records for the following individuals: Individual #226, Individual #261, Individual #41, Individual #193, Individual #109, Individual #176, Individual #73, Individual #283, Individual #280, Individual #118, Individual #197, Individual #241, Individual #253, Individual #301, Individual # 265, Individual #151, Individual #204, Individual #213, Individual #209, Individual #160, Individual #267, Individual #175, Individual #74, Individual #59, Individual #34, Individual #314, Individual #65, Individual #23, Individual #322, Individual #254, Individual #109, Individual #211, Individual #270, Individual #161, Individual #111, Individual #45, Individual #176, Individual #73, Individual #265, Individual #68, Individual #8, Individual #282, Individual #106,

	Individual #174, Individual #25, Individual #134, Individual #4, Individual #310, Individual #58, Individual #242, Individual #255, Individual #229, Individual #274, Individual #130, Individual #75, Individual #215, Individual #146, Individual #267, Individual #250, Individual #213, Individual #1, Individual #184, Individual #82, Individual #268, Individual #147, Individual #322, Individual #237, Individual #50, Individual #155, Individual #86, Individual #125, Individual #134, Individual #254, Individual #154, Individual #97, Individual #301, Individual #282, Individual #175, Individual #257, Individual #33, Individual #260, Individual #205, Individual #237, Individual #300, Individual #112, Individual #159, Individual #82, Individual #275, Individual #268, Individual #34, Individual #322, Individual #94, Individual #8, Individual #213, Individual #125, Individual #109, Individual #120, Individual #16, Individual #73, Individual #314, Individual #76, Individual #233, Individual #127, Individual #23, Individual #199, Individual #6, Individual #66, Individual #68, Individual #232, Individual #310, Individual #280, Individual #162, Individual #134, Individual #190, Individual #36, Individual #274, Individual #216, Individual #235, Individual #61, Individual #201, and Individual #321; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o LBSSLC's lists of individuals who were seen in the emergency room, and hospital; o LBSSLC's Risk lists for health indicators; o Revised Medical Emergency Response policy, dated 7/21/10; o Revised Medical Emergency Drill Checklist; o LBSSLC's nursing training rosters; o Minutes of the Medication Error Committee, dated 2/9/10, 4/29/10, and 6/30/10; o Medication Observation audits from February through August 2010; o Medication Observation Schedule and database; o The revised Comprehensive Nursing Assessment form, and Guidelines; and o One hundred and eight one Medication Administration Observation forms. ▪ **Interviews with**: o Don Minnis, RN, BSN, Chief Nurse Executive; o Jeremy Ellis, RN, QE Nurse; o Michelle McElroy, RN, Infection Control; o Ruth Clark, RN, Nurse Educator; o Irma Curry, Training Specialist, Competency Training and Development; o Valerie Kiepfer, RN, State Office Nursing Coordinator; and o John Todd, R.Ph. ▪ **Observations of**: o Medication Administration in buildings Sparrow and Quail; o Emergency equipment demonstrations in Maple; and o Life Threatening Emergency Medical drill in Maple.

	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps it was taking to assess compliance with regard to the specific sections of the Settlement Agreement related to nursing care. Although the POI for LBSSLC did not include this component, the POI highlighted the commitment the State and the Facility had to the thoughtful implementation of the processes and systems needed to provide quality services. LBSSLC indicated that it was not in compliance with Section M of the SA, which was consistent with the findings of the Monitoring Team. In order to move into a position of substantial compliance, there are a number of foundational systems and required competency in Nursing that have to be solidly built before additional needed systems are constructed. This will affect the determination of substantial compliance in many areas. Also, quality, not just completion is the determining factor in appropriately assessing substantial compliance in most areas. After these foundational systems are built and the monitoring systems include the quality piece, to substantiate compliance it will necessary to provide data validating substantial compliance that includes the total population being reviewed (N), and the sample of that population audited (n) to yield a percent sample to indicate the relevance of the compliance scores. An adequate sample size also needs to be reviewed to ensure that the findings can be applied to the total population. Without this information, the Facility's data cannot be accurately interpreted, analyzed, or accepted as a valid reflection of the practices being measured.
	Summary of Monitor's Assessment: Since the baseline review, LBSSLC had invested considerable effort into securing consistent nursing staff at the Facility. The Facility had placed a number of nursing employment advertisements in both local and regional publications, advertised open nursing positions on local radio stations, and developed a thoughtful television commercial advertisement for vacant nursing positions using actual Facility nursing staff, as well as some individuals from the Facility. Appropriate guardian consents had been obtained for these individuals. The Facility went from having only 57% filled nursing positions to 88% filled nursing positions. Clearly, the Facility's efforts and strategies were effective in securing a significant number of nursing staff that should facilitate positive clinical outcomes for the individuals at LBSSLC. The Facility's QE Nurse and Nursing Department had begun using some of the new monitoring tools. This system was in the initial stages of implementation, and the data generated from the auditing was not yet addressing the quality of the areas audited. Once the Facility has more experience with these tools, instructions will need to be developed for each monitoring tool. As these are developed, the Facility will also need to develop and implement a procedure for establishing inter-rater reliability. In addition, the Facility will need to ensure that auditors are competent in the areas that they are auditing to ensure the data is an accurate reflection of the Facility's practices. Consistent with the findings from the baseline review, there continued to be a significant number of problematic issues regarding the fact that nursing documentation lacked complete and adequate nursing assessments of symptoms for acute changes in status. There were problems noted regarding the lack of adequate documentation when an individual began showing symptoms of a change in status and of insufficient assessments prior to the transfer to an off-site medical center, as well as upon return to the

	Facility. The Nursing Department was in the early stages of beginning to audit individuals with acute illness and those requiring hospitalization, which should lead to the implementation of plans of correction to address the identified deficiencies. The State Office had approved the use of the Health Care Protocols: A handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and nursing care plans. Consistent with the baseline findings, there were significant problems found regarding the quality of the Nursing Assessments and Nursing Care Plans. Since the baseline review, the State Office had modified the procedure Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. The Facility had implemented the modified Comprehensive Assessment form and the new Nursing Care Plan templates at the time of the review. However, no competency-based training was provided prior to implementation. Consequently, there was no improvement found in the quality of the assessments or care plans. Since the baseline review, the Nursing Department was in the process of implementing some interventions associated with the medication administration system. The Medication Observation tool was appropriately revised to include all the basic elements of medication administration (orally, by injection or via tube), and the frequency of the medication observations for nurses was changed from annually to quarterly. The Facility had already completed a round of medication observations for most of the nurses. However, competency of the auditors will have to be determined for this area to ensure accurate data is generated from the observations. Although many of the systems needed to address the requirements of the SA to meet substantial compliance were not in place, the Facility's Nursing Department demonstrated its commitment to moving forward. Many of the systems implemented should assist the Facility in moving towards compliance and these are detailed further in the sections that address each of the requirements of Section M of the SA.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of sub-sections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found in the sections addressing Sections M.2 and M.3 of the SA. Staffing Since the baseline review, LBSSLC had invested considerable effort into securing consistent nursing staff at the Facility. The Facility placed nursing employment ads in	Noncompliance

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		both local and regional publications and also advertised nursing positions on local radio stations. In addition, the Facility developed a thoughtful television commercial advertisement for vacant nursing positions using actual Facility nursing staff, as well as some individuals from the Facility. Appropriate guardian consents had been obtained for these individuals. The Chief Nurse Executive (CNE) described the importance of the content in the advertisements, which he felt needed to indirectly address the past reputation of the Facility. The CNE felt that the Facility's poor reputation, as had been reported during the baseline review, was a barrier to filling nursing positions. The basic catch phrase that was developed for all the advertisements was: "It's a new day at Lubbock State Supported Living Center." At the time of the baseline review, LBSSLC had a total of 105 nursing positions with 50 vacancies; 30 for RNs and 20 for LVNs. At that time, in order to meet minimum nursing staffing ratios, the Facility used the services of seven agencies. Since the baseline review, LBSSLC had a total of 102 nursing positions, due to position conversions and the fact that the Clinic Nurse position was placed under the Medical Department, with only 13 total vacancies. The Facility went from having only 57% filled nursing positions to 88% filled nursing positions. Clearly, the Facility's efforts and strategies were effective in securing a significant number of nursing staff that should facilitate positive clinical outcomes for the Individuals at LBSSLC. In addition, since the previous review, the Facility had added one full-time LVN position to Infection Control (IC) and one full-time position as a Nurse Educator Assistant to support the Nurse Educator in providing competency-based training and skills assessments. In addition, the CNE had requested a Nurse Auditor position dedicated to the Nursing Department. This position had not yet been approved at the time of the review. The Facility had developed job descriptions/job duties for the IC LVN, and the Nurse Educator Assistant positions. Policies, procedures, and/or protocols should be modified or developed to address the integration of these positions into the Nursing Department. At the time of the review, LBSSLC had a census of 229 individuals. The structure of the Facility's nursing services remained the same since the previous review: ▪ Three of the residential buildings had 24-hour nursing care, specifically buildings Sparrow, Quail, and Maple. ▪ The Facility did not have an infirmary. ▪ During the day, nurses were assigned to each building. During the night shift, the Facility utilized a Campus Nurse who made rounds, and covered the portions of the Facility that did not have 24-hour nursing. ▪ The Facility's nursing staffing assignments included eight RN4 positions, 23 RN3 positions, 13 RN2 positions, and 44 LVN3 positions. Since the baseline review,	

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		the five LVN2 positions were reallocated to LVN3 positions ▪ The Chief Nurse Executive continued to directly supervise the Hospital Nurse Liaison, Nurse Educators, the Infection Control Nurses, the Nurse Operations Officer, the Nurse Recruiter, and an Administrative Assistant. ▪ The minimum nursing staffing requirements were based on a fixed number of nursing staff (RN and LVN) per specific Unit, but could be modified based on census, acuity, and staff workload related to individual or staff activities. Discussions with the CNE indicated that his goal was to staff the three buildings, with the most medically compromised individuals, Sparrow, Quail, and Maple, with RNs. Although at the time of the review there was no set plan in place for this transition, the findings of the baseline review and the current review supported the need for an increase in the clinical skill level of staff working with this population. The Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Quality Enhancement Efforts Since the baseline review, the QE Nurse, Nurse Managers, and the Hospital Liaison Nurse had recently begun using some of the Monitoring Teams' review/monitoring tools for Nursing in the areas of Acute Illness and Injury, Prevention, Medication Administration and Documentation, and Urgent Care and Hospitalizations. A review of six Acute Illness and Injury audits, three Prevention audits, seven Urgent Care and Hospitalization audits, four Medication Administration and Documentation audits, and two Urgent Care and Hospitalizations audits conducted by QE found that the Facility was in the initial stages of becoming familiar with the monitoring tools. The QE Nurse and CNE reported that thus far, the audits did not adequately address the quality of the documentation reviewed by the auditors and were basically a first attempt in using the tools. In order to adequately and consistently monitor all of the areas required by the SA, instructions should be developed for each of the monitoring instruments. Once these are in place, the Facility should develop and implement a procedure for establishing inter-rater reliability. In addition, the auditors scoring the monitoring tools must be clinically competent in the areas they are reviewing in order for the data generated to be an accurate reflection of the current practices. Clearly, the Facility was at the beginning stages of piloting and implementing a number of new monitoring systems. Continued efforts are needed to develop the processes necessary for generating data that can be accurately interpreted, analyzed, and reflect the practices being measured. These include: ▪ Having tool instructions; ▪ Providing the total population being reviewed (N), and the sample of that population audited (n) to yield an adequate percent sample to indicate the	

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		relevance of the compliance scores; ▪ Having an adequate sample size, usually 20%; ▪ Ensuring auditors are competent in the areas they review; and ▪ Assessing for quality. As the Facility implements its monitoring systems, staff assigned monitoring duties will need to be trained and complete inter-rater reliability assessments. LBSSLC's Supplemental POI indicated that the inter-rater reliability process would be completed by 7/2011. However, in order for inter-rater reliability to be established, monitoring instructions for the tools must be developed and implemented. These processes should assist departments in ensuring that staff who are assigned monitoring duties are competent in the areas that they are reviewing. Auditor competency is essential to ensure the Facility's data accurately reflects the quality of care being provided, and to quickly identify problematic trends and implement timely plans of correction. In addition, the data generated from the monitoring tools needs to be regularly reviewed and addressed by the appropriate disciplines and integrated into the Facility's Quality Management and Risk Management systems. The Facility's initial audits did not accurately identify the quality of the documentation and overall compliance. The audits the Nurse Managers conducted identified only a very few problems. However, there were a number of comments on the two audits conducted by the QE Nurse that indicated that the auditor was critically reviewing the documentation and identifying problematic issues. Some of these issues included: ▪ Lack of a transfer sheet or transfer packet in the active records for individuals sent to the community hospital; ▪ Lack of documentation of a complete assessment upon return to the Facility; ▪ Lack of nursing documentation on the second day following return from emergency room (ER) visit; ▪ Lack of documentation of dressing changes as ordered; ▪ Lack of documentation by direct care nurses as required by the Acute Care Plan; ▪ No documentation of resolution of an injury; ▪ No documentation of time or method individual was transferred to hospital; ▪ Lack of documentation of skin assessments; ▪ Hospital discharge summary not found in record; ▪ Lack of documentation of communication with PSTs and direct support professionals ; ▪ Physician recommendation not addressed by team; ▪ Error found in the transcription of an order for Tylenol; ▪ Format for documentation not consistently followed; and ▪ Frequency of interventions not included in the Nursing Care Plan.	

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		Since the Facility had initiated the new monitoring tools in July 2010, they had not yet developed any Corrective Action Plans addressing any of the problems identified from the monitoring data. Interviews with the CNE, the QE Nurse, and the nursing staff reviewing medical records with the Monitoring Team while on site, verified that the department was invested and committed to implementing monitoring systems that accurately identified the strengths and weaknesses in nursing practices. LBSSLC's Nursing Department should continue their efforts in implementing monitoring systems that generate accurate clinical data focused on the quality of nursing services and not just the completion of the required documentation. In order to execute this type of system, the Nursing Department has to ensure that all nurses conducting monitoring activities are clinically competent and critically auditing their assigned areas. This issue is crucial in ensuring reliable data so that the department can easily identify problematic trends, so that timely and appropriate plans of correction can be implemented. Once the Quality Enhancement systems are in place, this data should be integrated into the Facility's Quality Management and Risk Management systems. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> As noted above, the Nursing Department and the QE Nurse had conducted some initial audits for individuals who experienced an acute illness and hospitalization. The CNE acknowledged that the monitoring conducted thus far had not yet resulted in any measurable changes regarding clinical outcomes. This was consistent with the Monitoring Team's findings for this population. A review of medical records for 16 individuals (Individual #226, Individual #6, Individual #261, Individual #41, Individual #193, Individual #109, Individual #176, Individual #73, Individual #283, Individual #280, Individual #118, Individual #197, Individual #241, Individual #253, Individual #301, and Individual #265), who had been transferred to a community hospital, or emergency room found that, consistent with the findings documented in the baseline report, in every case reviewed (100%) there continued to be significant problems regarding the nurses' documentation in the following areas: ▪ A lack of documentation regarding the status and appropriate assessment of the individual at the time of onset of the symptoms; ▪ A lack of assessments in response to changes in vital signs, oxygen saturations, eating habits, or mental status; ▪ Significant gaps in nursing documentation when nurses' notes stated "will monitor"; ▪ The type of temperatures taken was not consistently documented; ▪ Discrepancies in bowel movement data found in the nurses' notes; ▪ A lack of follow-up from issues noted in previous nurses' progress notes; ▪ A lack of follow-up for symptoms related to the reasons for the hospitalizations; ▪ A lack of specific description regarding size and location of injuries, bruises or rashes;	

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		▪ Administration and follow-up for PRNs (as needed medications) not adequately documented; ▪ Inadequate assessments and follow-up addressing pain; ▪ A lack of mental status assessments documented during status changes; ▪ A lack of lung sounds assessed and documented for respiratory issues; ▪ A lack of assessment of bowel sounds and abdomen for individuals with constipation; ▪ Physician/Practitioner not timely notified of change in status due to nurses' inadequate follow-up; ▪ No documentation of communication with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ Nurses writing essentially the same progress note without assessments or adequate objective data; ▪ The lack of specific descriptions of the individuals' behaviors and mental status, assuming that all staff reading the progress notes were familiar with the individuals; ▪ Lack of analysis of contributing problematic issues affecting changes in status; ▪ Inappropriate abbreviations; ▪ A lack of documentation regarding the individual's status and assessment at the time of transfer to hospital or emergency room; ▪ No documentation indicating that an information packet was sent to the receiving hospital at the time the individual was transferred; ▪ Inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ Inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes; ▪ Lack of a complete nursing assessment upon return to the Facility, especially addressing the same symptoms that precipitated the transfer; ▪ The lack of modifications to the Nursing Care Plans when interventions were not effective; ▪ Dates and times not consistently documented for progress notes; ▪ Inconsistent use of format for progress notes [Description, Assessment, and Plan (DAP), Data, Action, Response, and Treatment (DART)]; ▪ Lack of an adequate, updated Nursing Care Plan to reflect changes in status and new interventions; and ▪ Many nursing progress notes and signatures were illegible. Similar to the findings from the baseline review, there were a number of significant, problematic issues found regarding complete, timely, and adequate nursing documentation and assessments of symptoms for acute changes in status for individuals. Below are examples of some of the problems noted.	

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		▪ In the case of Individual #41, the documentation indicated that she had received another individual's psychotropic medication. The nursing documentation did not indicate the time frame regarding when the individual received the wrong medication and when it was actually discovered, despite the fact that this is crucial information for evaluating symptoms associated with the medication ingested and its properties. Although a set of vital signs and the oxygen saturation were documented, there was no way to determine how quickly these were taken once the error was discovered. A review of previous notes indicated that the individual's blood pressure was significantly lower than it had been in the past few weeks. However, there was no assessment of the individual's mental status or level of consciousness documented as would be clinically appropriate for this situation. In addition, there was no indication from the integrated progress notes regarding when the error was discovered, and if it was at or around the time the medication was administered or whether it was due to changes in the individual's status. The notes indicated that the individual was sent to the emergency room for an evaluation. However, there was no note indicating what time the individual was sent to the ER, how the individual was transported, an assessment of the individual prior to leaving the Facility, what information was sent to the hospital, or any communication from nursing or medical with the receiving hospital staff. The documentation from the Hospital Liaison Nurse indicated that the individual was admitted to the hospital's Intensive Care Unit, placed on a ventilator, and given a number of medications through a triple lumen intrajugular catheter on the right side of the neck. Three days later the individual was moved to a regular hospital room after her blood pressure was stabilized and she was able to breathe on her own. She was discharged from the hospital after four days and returned to the Facility. A review of the integrated progress notes found no nursing note indicating what time she actually returned to the Facility, an assessment of her status upon return, any changes in her medications or treatments, a summary of the hospitalization, or Nursing Care Plans modified to ensure this situation does not reoccur. ▪ In the case of Individual #253 who was enterally fed with a G-Tube and had his right lung removed in the past, the documentation indicated that he had been hospitalized for eight days due to acute rectal bleeding secondary to internal hemorrhoids found during a colonoscopy. While in the hospital, a renal mass was discovered from an abdominal Computed Tomography (CT) Scan with follow-up scheduled for a consult and possible Magnetic Resonance Imaging (MRI). A review of the integrated progress notes since the individual's return from the hospital found that there were no nursing notes addressing the presence or absence of any rectal bleeding or the status of his bowel movements. There was no summary of the hospitalization found except a note from the	

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		physician indicating that the rectal bleeding had been resolved. However, there was no indication as to whether or not the hemorrhoids had been removed. In addition, there was no assessment of the individual's mental status since his hospitalization. The nurses' notes for the six days following the hospitalization only included a set of vital signs and oxygen saturations. The type of temperatures, such as oral, rectal, temporal, or auxiliary, were not included in notes and it was therefore difficult to determine the accuracy of the temperatures taken. In addition, the notes indicated that he was having some variations in his oxygen saturations; from 97% to 93% on room air. However, no lung sounds were assessed and documented in response to these variations. Three days after his hospitalization the notes indicated that his G-Tube was replaced without documentation addressing why it needed to be replaced, and/or the procedure used to replace it. On the sixth day after his hospital discharge, the nurse's note indicated that he had a temperature of 100.1, pulse rate of 99, and oxygen saturation of 94% on room air. No further assessment was found. In fact, most of the nurse's notes during this period of time only noted the vital signs, oxygen saturations, and stated "no distress noted. Continue to monitor and document." There were no integrated progress notes found for the next four days. When the documentation resumed, the nurse's notes for the next two weeks only noted the vital signs, oxygen saturations, and stated "no distress noted. Continue to monitor and document." A month after the individual returned from the hospital the nurse's note indicated that the individual had vomited and that there was possible faint wheezing noted to the left lung, however, the nurse documented "unable to assess client due to client making noise." The documentation indicated that five minutes later the nurse was still unable to accurately assess the lung sounds and called an RN supervisor "to assess clients lung sounds." There was no documentation found that the RN supervisor had assessed the individual. The next nurse's note was documented for the following day and noted that the individual had a non-productive cough, included a set of vital signs and oxygen saturation, and stated "no distress noted." The individual was seen at the Clinic that morning and the physician's note indicated that the individual had a "croupy cough x unknown number of days. Staff and nurse accompanying patient to medical clinic unable to give any history. Patient's chart not available." A second note from the physician that morning stated: "Went to home and reviewed patient's chart. Apparently had an episode of emesis on (date). Probably aspiration pneumonia." Although subsequent physicians' notes indicated that the individual was sent and admitted to the hospital for two days, no nurse's notes were found documenting the individual's transfer to the hospital. From the 16 records reviewed, all had significant problematic issues indicating deficits in	

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		the clinical competency of the nursing staff, the lack of nursing protocols in place, a lack of clinical judgment to guide frequency of assessments and documentation, poor communication between nurses and other clinical disciplines, a lack of reporting protocols addressing when it was necessary to notify the physician of changes in status, and an inability to analyze clinical data. It is imperative that the Nursing Department establish appropriate criteria and competency testing for the entire nursing staff in order to have any meaningful and lasting effect on the clinical outcomes for the Individuals at LBSSLC, and ensure that care is provided in accordance with the SA and Health Care Guidelines. In addition, a review of the 16 cases of individuals listed above found that the documentation from the Hospital Liaison Nurse was present in only one (for Individual #41) of the 16 records reviewed. LBSSLC's Supplemental POI indicated that the hospital liaison would be documenting daily progress notes for individuals in the hospital and that these notes would be placed in a shared drive and printed by the Case Managers and submitted for filing by 12/30/10. Clearly, this documentation is important for continuity of care and to keep the individuals' PSTs apprised of their status and enable the team to coordinate the needed services in preparation for the individuals' return to the Facility. Regarding the monitoring of this area, the CNE reported that the Hospital Liaison Nurse would be responsible for auditing this area since she followed the individuals while they were hospitalized. While on site, two cases were reviewed with the various nursing staff that included the Hospital Liaison Nurse, the QE Nurse, Case Managers, and the Nurse Educator. Initially, the Facility nurses did not accurately identify the deficits in the integrated progress notes. However, when questioned regarding the quality of the documentation and specific components that were missing from the notes, the nurses began to critically audit the notes for clinical quality. In order to generate accurate monitoring data, it is recommended that the auditing staff first read the "clinical story" included in the integrated progress notes from the start of the change of status to the individuals' return to their home unit, and then score the monitoring tools. This method would assist the auditing staff to ensure that they are evaluating the quality of the documentation related to clinical care and the completeness and appropriateness of assessments, rather than just looking for the completion of notes. As mentioned previously, LBSSLC had begun the initial stage of auditing individuals who had required hospitalizations and ER visits. This initial step was an appropriate decision by the Nursing Department due to the significant problematic clinical issues found during the baseline and current reviews. By the next review, the department should have generated data for a number of months, and developed and implemented plans of correction addressing a number of the problematic issues related to urgent care and	

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		acute changes of status. As noted from the baseline review, LBSSLC had a policy addressing "Management of Acute Illness/Serious Injury LBSSLC Health Services, Revised January 21, 2010." However, the policy did not address the assessment and documentation criteria that should be completed prior to an individual being sent to the hospital/ER, and upon return. LBSSLC's Supplemental POI indicated that the policy would be rewritten by 9/1/10. At the time of the review, this issue had not yet been addressed. Since the baseline review, the Nursing Department had acquired the Lippincott Manual of Nurse Practice, 9th Edition, and the Health Care Protocols: A handbook for DD Nurses that the State Office had approved to use for nursing policies, protocols, and care plans. From discussion with the State's Nursing Coordinator while at LBSSLC, she indicated that the Nursing Departments were to use the books as a reference to develop their policies, procedures, and protocols. However, they needed to individualize these materials to align them with the systems in the Facilities. The Lippincott Manual does not include a set of policies, and the Facilities would need to develop and/or amend existing policies to be in alignment with the procedures and protocols contained in the Manual, as well as with State and Facility practice, the Health Care Guidelines, and SA. For example, there might be procedures included in the Lippincott Manual that would not be allowed at LBSSLC due to its licensing, or only certain staff might be able to perform specific duties due to their credentialing or State regulations. This needs to be defined in facility-specific policies. The CNE reported that binders of policies and procedures from these resource books had been placed in each building the Friday prior to the Monitoring Team's visit. He reported that they had not been individualized in alignment with the Facility's systems, nor had any training been provided to staff prior to distribution to the buildings. In addition, at the time of the review, the CNE did not have a set plan for when these materials would be individualized to the Facility, when training would be conducted for the newly developed policies, procedures and/or protocols, and when implementation of these would occur. Based on the number of medically compromised individuals who had been admitted to the hospital or seen in the emergency room, and the significant problematic issues found from the baseline and current reviews regarding acute status changes, this area should be considered a priority for the development, training, and implementation of nursing policies, procedures, and protocols. Although not a requirement of the SA, it would be extremely beneficial to the Nursing Department to modify or develop a separate policy from the State's policy addressing Nursing Peer Review, which is an investigational process rather than an educational process. As defined by the American Nurses Association (ANA) in 1988, peer review is	

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		an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. Again, although not a requirement of the Settlement Agreement, the introductory section of the HCG highlights the value of nursing peer review. The Nursing Department is encouraged to utilize an educational process for regularly reviewing cases and to identify the strengths and weaknesses of the Facility's nursing practices. This should include a critical analysis of nursing practices, identification of problematic trends and implementation of plans of correction for areas found, and continual monitoring to improve clinical outcomes. These activities will certainly contribute to the Facility's movement toward compliance with Section M of the SA, and will facilitate a clinical dialogue among nurses and assist with the Facility's efforts with regard to self-assessment. Based on the POI, the Facility reported that they were not in substantial compliance with items specific to urgent and acute care. This was consistent with the findings of the Monitoring Team. <u>Availability of Pertinent Medical Records</u> At the time of the review and based on information provided at the entrance meeting, as of July 2010, one Medical Records Clerk and five File Clerks were assigned to the Quality Enhancement division. In August 2010, the Facility had implemented the new Unified Record Guidelines and, at the time of the review, had converted the records in alignment with the Guidelines in all but three homes (525 N Cedar, 526 N Cedar, and 518 N Cedar). However, in reviewing records onsite, it was noted that a number of documents were not in the medical records, and had to be obtained from the units. This was consistent with findings during the baseline review. A number of Nursing Quarterly Assessments, Nursing Annual Assessments, Nursing Care Plans, and Hospital Liaison Nurse's notes were not found in the records. However, all integrated progress notes were found in the medical records from the Monitoring Team's sample. Interviews with the CNE, QE Nurse, and other nursing staff indicated that the Facility had locked "chart boxes" in each building where information was placed for filing in the medical records. However, all nursing staff interviewed reported that filing was often not completed in a timely manner, and that when the staff needed a document that had been placed in one of the chart box, they had to flip the box over and shake the contents out to retrieve the needed information. Although consistency regarding where the contents of the medical records are kept is essential, having all the appropriate documents timely filed in the medical records is crucial. The Facility needs to ensure that documents are filed in a timely manner in the individuals' records, so that pertinent	

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		clinical information is readily available to clinicians who need this information to make decisions regarding treatments and health care services. <u>Infection Control</u> Based on the POI, the Facility reported that they were not in substantial compliance with any of the items specific to Infection Control. This was consistent with the findings of the Monitoring Team. At the time of the review, the Facility continued to have one full-time registered nurse as the IC Coordinator and this staff member had some infection control experience in an acute care hospital. The part-time IC position, which was filled with an LVN with no IC experience, and who assisted the IC Coordinator with monthly environmental surveys at the time of the baseline review, had been increased to a full-time position in August 2010. The same LVN had remained in the new full-time position and her additional duties included updating the employee health database, administering PPDs, participating in the Hepatitis B clinic, and conducting spot checks in the buildings along with some monitoring responsibilities. A job description had been developed for this position. There continued to be no clerical employees assigned to work specifically with the IC staff. Consistent with baseline review, the IC Coordinator had no documentation to verify that the LVN was competent in the area of Infection Control, and/or the duties assigned to her. Validation of clinical competency for staff working in a specialized area such as infection control is essential to ensure that they are knowledgeable about all facets of infectious and communicable diseases and practices. The IC Coordinator should ensure that all IC staff is competent in the area of Infection Control and maintain documentation for verification. Also consistent with the findings from the baseline review, LBSSLC's IC staff continued to track the basic areas regarding the surveillance of MRSA; Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); HIV; Syphilis; current immunizations; current vaccines; and antibiotic use. However, an interview with the Infection Control Coordinator indicated that there continued to be no formalized system in place to ensure the reliability of the Facility's IC data. She candidly reported that she did not consistently receive accurate information from the buildings regarding infections, and used a number of other reports to identify issues related to infection control. When asked what other systems she reviewed to gather this information, she cited the Supervisor report, the antibiotic report, the Clinic report, the providers meeting every morning, lab and culture reports, and the Case Managers' Acute Care plans. Highlighting the need for a formalized system to ensure the reliability of the IC data, the	

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		list of individuals, who had an infectious or communicable disease, which was provided to the Monitoring Team during the review, was not accurate. When a member of the Monitoring Team asked the IC Coordinator to check the list because it contained so few names, additional names were added for MRSA and C-Diff. The Facility should develop and implement formal procedures regarding how different systems are used to ensure data reliability. The procedures need to address specific information such as when data are collected from each system, how discrepancies between the systems are tracked, where unit reporting falls into the data collection system, and how system discrepancies are to be addressed. Without assurance that the IC data is reliable, the Facility cannot accurately identify trends or problematic changes in trends requiring timely corrective interventions. Also, without reliable data, the Facility cannot ensure that treatments and treatment plans are clinically sound, or that timely and appropriate training is being provided, or that proactive interventions from analyses of past data trends are initiated. Ensuring reliability of the IC data is a fundamental step that must be taken in order for the activities of the IC staff to be meaningful. It is troubling that a year has passed since the initial implementation of the SA, it has been six months since the baseline review, and yet data reliability has not been established for the clinical area of infection control. Since the baseline review, competency-based training was provided to the Residential Coordinators in April 2010 regarding hand washing, so that they could begin to monitor one staff per shift each month using the Facility's Standard Precautions Monitoring Tool for Infection Control. Although the Monthly Residential Round document indicated that audits were not completed for many of the homes, a review of 38 audits completed between April through August 2010 looked promising in terms of generating valuable data. Some of the issues identified included the following: ▪ Side bathrooms smelled strongly of urine; ▪ Staff needed reminding to sanitize training materials after each use; ▪ Staff needed reminding to clean up office; ▪ Soap disperser empty; ▪ Front bathroom out of towels; ▪ Observed staff not scrubbing under fingernails when washing hands; ▪ Staff was noted to be wearing the same pair of gloves for over an hour; ▪ Linen cart not covered; ▪ A new staff noted not washing his hands between assisting individuals; ▪ Staff not washing their hands upon reporting for duty; ▪ Soiled brief placed on the floor; ▪ Wheelchairs needed cleaning; and ▪ Sinks were messy with toothpaste smears. Some of the audits noted when corrective actions were taken, however, this was not consistently documented. At the time of the review, there had been no analysis	

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		conducted on the data generated from the audits to identify problematic trends. This type of analysis should be implemented, so that problematic trends can be identified and plans of correction timely implemented. In addition, the lack of completed audits for several of the homes and day/vocational areas should be addressed. As noted previously, this appeared to be a promising monitoring process to ensure that staff in the homes are using standard precautions, sanitizing equipment, and are not putting individuals and other staff at risk from cross contamination. In addition, the IC Coordinator had recently implemented spot check monitoring for hand washing in the homes. However, at the time of the review there had been no formal system or structure developed for when and how frequently these spot checks would occur. The current system was informal and only conducted on a voluntary basis without any regularity. At the time of the review, seven hand-washing spot checks had been conducted with three noting a deficiency. Again, these spot check audits have significant potential for generating valuable data regarding hand-washing practices at the Facility. The Facility should consider formalizing this system to ensure regular spot checks are conducted in different areas to generate additional data regarding staff hand-washing practices. At the time of the review, the Facility had not begun to review the immunization status of the individuals in accordance with the HCGs. In addition, there had not yet been a schedule developed regarding when the individuals were going to be reviewed. A schedule addressing these issues should be developed to ensure individuals are appropriately prioritized and that no one is overlooked. Regarding the new Infection Control Monitoring tool, the IC Nurse had recently implemented the tool and had completed two audits at the time of the review. However, a review of the tools and data found that individual records were used to answer audit items that reflected the operations of the department, which resulted in erroneous data. Without instructions for the monitoring instruments, efforts and energy expended on completing the audits yielding data that cannot be interpreted is wasted. Consistent with the baseline findings, there were no IC audits being conducted to ensure that appropriate treatment practices were being implemented regarding infection control issues. For example, there was no formal monitoring system in place to ensure that individuals with MRSA were audited regarding treatment with the appropriate antibiotic in line with the culture and sensitivity results. In addition, there was no indication that individuals with Hepatitis C were screened as to their immunization status for Hepatitis A and B, and, if needed, had timely received these vaccines. During the review, the State Office Nursing Coordinator reported that a number of	

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		workgroups comprised of staff from the various Facilities had been organized. This group had been meeting to address the development of standardized processes and procedures in several areas of nursing. In the area of Infection Control, a workgroup was in the process of addressing education and monitoring; policy and procedure; as well as data collection, trend analysis, and Infection Control Meetings. The workgroups were scheduled to present the drafts of their assigned projects at the CNE meeting in November 2010. The standardization of these areas in Infection Control is a very positive forward movement towards compliance with the SA. However, significant attention needs to be paid to building a solid infrastructure, with formal operational procedures, that drives the activities for Infection Control. For Infection Control staff who have inherited the systems within which they currently work, having to build a new infrastructure can easily exceed any nurses' expertise and divert clinical energy towards building a framework without any type of blueprint. Although the Facility's Supplemental POI for Infection Control indicted that: "State Office has ruled that sufficient knowledge and skills exist at each facility," the findings from the baseline and current review suggest otherwise. Consideration should be given to securing the services of an expert in the area of Infection Control to provide consultation to the State and the Facilities. As noted above, a workgroup was developing standardized policies and procedure for use at all SSLCs. However, according to the State Office Nursing Coordinator, until these were completed, reviewed, and approved, it was the Facility's responsibility to have and maintain appropriate and adequate policies and procedures regarding Infection Control. The Facility's Supplemental POI addressing Infection Control policies and procedures indicated that a State Office policy was required and that: "Facility action would begin after receipt of new/amended policy and direction from the State." However, the Facility's action step indicated that it would create new policies when necessary, and by 4/29/11, evaluate if existing policies needed revision. Since the last review, the Facility had developed two new policies: Limited Access and Multidrug-Resistance Organisms and Isolation. In addition, a third policy was in draft form: Deep Cleaning. There was no indication that any existing Infection Control policies/procedures had been reviewed or revised. Consistent with the baseline review, the IC Nurse reported that documentation of IC staff activity was contained in both the IC Committee Meeting minutes and in the Pharmacy and Therapeutics Committee Meeting minutes. The Facility used the IC Committee to address issues that pertained mainly to the homes and the direct support professionals, while the Pharmacy and Therapeutics Committee was used to address other clinical IC issues such as antibiotic use. Review of the Pharmacy and Therapeutic Committee meeting minutes dated 3/16/10,	

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		and 6/22/10, found that they included data regarding the number of antibiotics used and an issue related to the community hospital prescribing individuals an antibiotic to which they had been resistant. The minutes noted that the Medical Director was to discuss this issue with the Liaison Physician. However, in the June meeting minutes, there was no mention as to whether or not this had been done. The Pharmacy and Therapeutics Committee meeting held in June 2010 indicated that the IC Nurse reported that the antibiotics prescribed were sensitive to the organisms found on the cultures "or if an antibiotic was prescribed initially that was resistant, it was changed to one that was sensitive once the culture results were obtained." This appeared to be an initial report on the treatment practices regarding infections, which is very positive. However, formal monitoring data needs to be documented to support these findings and was not available and/or being reported at the time of the review. Review of the IC Committee Meeting minutes for 2/25/10, 3/23/10, 4/29/10, 5/27/10, and 7/6/10, indicated that the structure and format of the minutes were modified beginning with the April 2010 minutes. Unfortunately, the content of the minutes had gone from containing very little information to including a nearly verbatim recording of the narrative discussions in which the Committee engaged, which then made any pertinent information difficult to extrapolate. The current format of the minutes lacks structure, and the documents did not designate the agenda topic, facts, discussion, action steps agreed upon with the responsible party identified, and the status of action steps agreed upon in previous meetings. In addition, it was impossible to determine if the lengthy discussions resulted in plans of correction with designated outcomes. Although very difficult to follow topically, there was good information included regarding the findings from the Residential Coordinators' monitoring data linked to units with higher infection rates. There were several attempts made to identify trends and some associated corrective actions. However, addressing trends is more than just looking at the numbers of how many times an event occurred. It also includes an analysis of the numbers, and variables that may be associated with those events. For example, throughout the Infection Control Meeting minutes there were a number of references to 504 West Mesquite regarding urinary tract infections (UTIs). In fact, the minutes noted that UTIs were "pretty rampant." The minutes noted that an in-service was done regarding hydration and proper specimen collection in that particular building. However, there had been no analysis conducted of the individuals' actual fluid intake or what fluid intake had been recommended for the individuals who had the UTIs. Similarly, the Pharmacy and Therapeutics Committee Meeting minutes indicated that there had been a number of individuals who had been hospitalized for dehydration. In an attempt to prevent similar hospitalizations in the future, a pharmacist conducted a review to determine if the individuals had been receiving the recommended amount of	

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		fluids. Although the minutes did not reflect whether or not the individuals had received adequate fluids, there could have been a crosswalk between Infection Control and the Pharmacy and Therapeutics committee to determine if some of these individuals were the same as those with UTIs, and the variables analyzed. From this information, plans of correction and additional monitoring activities could be implemented. Action plans could specifically define what type of monitoring was to be conducted, how often it would occur, who was assigned to do it, and who would review the monitoring data. In addition, the Infection Control meeting minutes indicted that MRSA and Oxacillin Resistant Staph aureus (ORSA) were "pretty rampant." However, there was no analysis found regarding this issue. The minutes noted an increase in the occurrence of this issue and stated: "we are working on that," without citing the specific steps and strategies that were being implemented. In addition, the minutes stated that there were six individuals who had been diagnosed with MRSA/ORSA. However, the Infection Control list that the Facility provided from the IC database to the Monitoring Team only listed four individuals. Additionally, the Infection Control Committee minutes noted several issues that were not clearly identified or addressed. For example, the minutes stated that: "eye infections went down a couple," without any further information provided. In addition, the minutes stated: "we did have more gastroenteritis going around," again, without any specific information provided. Also, the minutes stated the following under a discussion section: *There was an incident were [sic] a person came over to the clinic and we transferred him out of his wheelchair and there was formula spilled all over the chair and it stunk really bad. I don't know if that was an infection control concern but can we add something in there about that. The home was notified and they cleaned it up but I wouldn't want to be sitting in it.* This documented lack of action on the part of professionals to address identified issues and conduct meaningful analysis resulting in improved outcomes for individuals was of significant concern. The Infection Control Committee meeting minutes should include a comprehensive analysis of identified trends in the IC data, the inquires made into problematic trends, the corrective actions implemented addressing any problematic trends, and the process for monitoring outcomes in relation to the activities and interventions of the Infection Control staff in conjunction with the practices on the units. Also, conducting a root cause analysis on events such as outbreaks would be extremely valuable in providing direction and identifying systemic issues that contributed to both positive and negative outcomes. As noted from the baseline review, the IC staff developed a number of graphs regarding the Facility's surveillance data. However, as previously mentioned, there was no	

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		documentation found that included an analysis of the meaning of the data related to trends, clinical practice, and outcomes. Consequently, the data only represented raw numbers, rather than clinical outcome indicators for the Facility's infection control practices. Similar to the baseline findings, a review of 17 Infection Control Surveillance Rounds Monitoring Tools addressing the environment from 4/10 through 8/10 found that they did not comport with the Monitoring Team's observations while on-site. A review of the audits found that they did not accurately reflect the lack of cleanliness observed at the Facility. There were very few problematic issues noted on the audits and no indication that the problems identified had been corrected. In order to generate accurate data, the Facility might want to consider rotating the auditor for these audits to bring a "fresh set of eyes" to the process. Also, consistent with the baseline findings, there were no reports found that addressed or analyzed the environmental data generated from the audits, or action plans to address trends identified. The Infection Control Nurse reported that she had begun reviewing Nursing Care Plans addressing infectious diseases, but was not auditing the records with a monitoring tool to collect data. The current process for this review was that the Nursing Case Managers initiated and individualized the care plan, and sent it via email to the IC Nurse who would email back any recommendations for modifications. The Infection Control Nurse reported that she found that all of the Nursing Care Plans she reviewed were adequate. However, as discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, of the 53 Nursing Care Plans the Monitoring Team reviewed addressing infectious diseases, all were found to be inadequate, which was consistent with the baseline findings in this area. In addition, the Facility had not yet begun to address systems regarding individuals who refused treatments, such as immunizations or TSTs, to ensure that that their treatment teams were addressing the refusals and implementing interventions. A review of the Facility's Infection Control curriculum for orientation and annual classes demonstrated that hand-washing and Standard Precautions were included in the curriculum and in the post-test. However, from review of the curriculum and the post-test for Infection Control, the content did not include information regarding the spread of specific infections and the post-test did not adequately measure competency regarding Infection Control issues. As noted previously, the State had implemented a workgroup to address and standardize the area of education for infection control issues. However, until the IC curriculum is standardized, the Facility should modify the IC curriculum and post-test so that they are reflective of comprehensive, yet basic infection control information to ensure competency in this area. In addition, consistent with findings during the baseline review, the lack of adequate Nursing Care Plans addressing infectious	

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		diseases warrants additional and on-going competency-based training for the nursing staff. LBSSLC's staff responsible for Infection Control had inherited most of the systems in place, which clearly had significant deficits. It was evident that the IC staff had put a considerable amount of energy to take steps and move forward so as to meet some of the requirements of the SA. Clear direction needs to be provided so that the efforts and actions of the IC staff are not wasted on building systems that are not adequate to produce sustainable compliance. Additional expertise in Infection Control is needed to assist the staff in defining and implementing systems to effectively meet IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement. Code Blue Drills Since the baseline review, LBSSLC had received the statewide policy addressing Medical Emergency Response and the Medical Emergency Drill Checklist. The policy indicted that drills were to be conducted monthly in each of the homes on every shift. From the minutes of the Administrative Review Team Meeting minutes dated 7/29/10, it appeared that the Facility was going to keep their current policy in place and only change the title when it next came up for review. In addition, the minutes indicated that the Facility was not going to implement the new form for the drills since the State Office's form did not include the same information. From review of the attendance at the ART, there was no representation from medical, nursing or the CTD Department participating in the decision regarding the policy and drill forms for this area. The Facility should ensure that there is collaboration between medical, the CTD Department, and nursing regarding the policies and procedures for the Life Threatening Emergency Drills to ensure that the policy and forms are clinically appropriate. From review of LBSSLC's Life Threatening Emergency Drill documentation from 3/10 through 7/10, the Facility had been consistently conducting emergency drills on a monthly basis on different shifts. An interview with a Training Specialist from the CTD Department indicated that the CTD Department conducted all the emergency drills at the Facility, and that all of the drills conducted consisted of CPR, and scenarios for either seizures or choking. No other scenarios were included in the drills such as heat stroke, bee stings with anaphylactic shock, head injuries, or scenarios addressing first aid issues. Although observations of a drill while on site conducted by the CTD Department found it to be very thorough and professionally conducted, the Facility should expand its emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions other than CPR. As mentioned previously, the Facility had the Administrative Review Team (ART) in place to review the Life Threatening Emergency Drill data. Based on review of the	

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		minutes from 4/28/10 and 7/29/10, consistent with the baseline findings, no actual analysis was found regarding the content and quality of the drills, trends identified, or plans generated to implement corrective actions, or progress measured on anticipated outcomes. The ART minutes reflected the Pass Rates for each quarter and the implementation of "cheat sheets" posted by the after-hour's emergency telephone, but did not address issues found noted on the Drill forms. Some of the issues included: ▪ A staff had no pager. When asked how long they had not had a pager, the answer was a month; ▪ Staff member refused to complete the drill; ▪ Nurses did not show up for drill; ▪ Nurses at Quail could not get page through, even after trying four times; ▪ CTD received no page; ▪ Documentation for drill not completed; ▪ Direct support professional unable to conduct the CPR steps properly; and ▪ Nurses did not follow the proper protocol when entering drill, and did not use Ambu bag properly. From review of the documentation, there was no indication that these issues were addressed. Although the CNE was noted to participate in one of the ART meetings, there was no joint medical and nursing review of the emergency systems in the Facility. In addition, consistent with the baseline review, from the drills reviewed, there was no indication that the physicians participated in the drills. The purpose of conducting regular medical emergency drills is to identify strengths and weaknesses of the Facility's response to emergencies by continuously assessing the process, as well as staff knowledge and competency in executing emergency procedures. There should be interdisciplinary collaboration with the CTD Department regarding medical emergency drills and the Facility's emergency systems. It is essential that the physicians practice their role in a medical emergency, know the Facility's emergency systems, and be familiar with staff knowledge of emergency procedures. Based on an observation of a medical emergency drill, the staff only used the Automated External Defibrillator (AED) and Ambu bags during the drills. In fact, the CTD staff brought the AEDs to the drill, rather than having staff demonstrate that they knew where the units were. As the Facility expands the scenarios for medical emergencies, the use of the emergency equipment should be incorporated into this process. Since the baseline review, the CNE reported that the Facility had decided to have an AED for every home, and had already acquired nine devices and expected to receive five more. In addition, the CNE reported that during the quarterly medication observations, nurses were being asked to demonstrate the emergency equipment. The training rosters indicated that the Nurse Educator completed the first round of competency- based	

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		training, regarding the use of the emergency equipment, on 8/1/10. While on-site during the review, the nurses who were asked to demonstrate the emergency equipment were able to do so. However, there were a number of backup oxygen tanks and suction machines that were not being checked to ensure that they were in good working condition, and relevant documentation maintained. In fact, one of the suction machines did not work until it was adjusted by the CNE. The Facility should continue to implement the system in which nurses are regularly observed checking the emergency equipment to ensure they are familiar with the use of the equipment. In addition, there should be documentation that all emergency equipment is being checked regularly and that it is in good working condition. As noted during the baseline review, it is essential that the Facility incorporate the actual use of the emergency equipment in medical emergency drills. This is necessary to ensure that when an emergency arises, the nurses will be familiar with the operation of the emergency equipment and avoid delays in treatment during an actual medical emergency.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Since the baseline review, in July 2010, the procedure for Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form were modified by the State Office. The CNE reported that the Facility began using the modified assessment forms in July, but did not provide any competency -based training prior to their implementation. At the time of the review, there was no plan to initiate competency- based training. In addition, the competency- based training curriculum for the Comprehensive Nursing Assessment had not yet been developed. The CNE reported that a workgroup of Nursing Educators from the Facilities were to meet in October to discuss training needs for the nurses. Building competency regarding nursing assessments is essential. The nursing summary section of the assessment should provide a clinical analysis of all data from the previous sections regarding the individual's progress related to their health and behavioral goals. The competency- based training for the Comprehensive Nursing Assessment needs to adequately measure nurses' capability in producing a quality comprehensive nursing assessment. The records of 42 individuals who had quarterly or annual nursing assessments completed since the modified guidelines and assessments forms were implemented were reviewed, including: Individual #151, Individual #204, Individual #213, Individual #209, Individual #160, Individual #267, Individual #175, Individual #74, Individual #59, Individual #34, Individual #314, Individual #65, Individual #23, Individual #322, Individual #254, Individual #109, Individual #211, Individual #270, Individual #161, Individual #111, Individual #45, Individual #176, Individual #73, Individual #265,	Noncompliance

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		Individual #68, Individual #8, Individual #282, Individual #120, Individual #106, Individual #174, Individual #25, Individual #134, Individual #4, Individual #310, Individual #58, Individual #242, Individual #255, Individual #229, Individual #274, Individual #130, Individual #75, and Individual #215. The quality of all 42 quarterly/annual assessments was very poor, which is consistent with the findings during the baseline review. The narrative summary section for all of the 42 assessments reviewed continued to lack any type of assessment of the individuals' status related to their health or behavioral issues. Although some of the summaries in the assessments were noted to be lengthier than previous assessments, the content included consisted of more historical information or merely more raw data, rather than an analysis of the data. In many cases, the summary section of the assessments contained pieces of the Nursing Care Plans with a few interventions cited. However, there was no mention regarding how the individual was progressing related to the health issue. Clearly there had been no improvement in the Nursing Assessments since the baseline review. The following provide some examples of the concerns noted: ▪ The Quarterly Nursing Assessment Summary, dated 7/1/10, for Individual #109 stated the following: *[Individual #109] is a 46 year old male residing at 515 S Cedar at the Lubbock State Supported Living Center. He has resided here since 1971. This past quarter [Individual #109's] health has not seen any serious setbacks. He continues to receive his medications and cyclical feedings via peg tube. His appetite during meals remains unchanged and his weight is 10 lbs above the DWR [desired weight range]. He has remained unharmed from any PICA episodes during the past quarter as well. Had one incidence of vomiting on 5/21/2010 and was sent to the [hospital] on 5/22/2010 with projectile vomiting. Diagnosis intestinal obstruction. Was sent back to Elm on 5/26/2010. We will continue to monitor [Individual #109] for any issues that need to be referred to the physician.* Clearly, the individual had experienced a serious health setback during the quarter. However, many of the summary sections of the nursing assessments contained superficial introductions that were not reviewed from quarter to quarter and in many cases contradicted the information added into the summaries. Obviously, nurses did not routinely read the entire summary sections that they had written. In addition, this summary did not contain an adequate assessment of the individual's health status as compared to the previous quarter with an associated analysis indicating progress or the lack of progress. ▪ The Annual Nursing Assessment Summary for Individual #111 stated the following:	

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		[Individual #111] is a 54 year old white male with profound mental retardation secondary to complications of prematurity and blindness who resides at 517 S Cedar. He is independent and walks around the home without difficulty. Individual has had no hospitalizations or ER visits during the past year. He has had several SIB behaviors, but his Seroquel dose has been adjusted and this seems to have improved as well as his sleeping. Will continue to monitor client for any changes in his health and report to the physician. We will continue the plans of care as outlined above as he remains at risk. This annual nursing assessment summary made no mention of the individual's chronic problem with constipation, his diagnosis of GERD, his problems accepting dental treatments, his low Vitamin D levels, his movements related to his diagnosis of Tardive Dyskinesia, his elevated cholesterol levels, his rapid rate of eating, the osteoarthritis of his hips, his overall sleep patterns, how his behaviors affected his functioning, or his episodes of incontinence. The assessment provided essentially no information or analysis that indicated how this individual was progressing from the previous year. ▪ In the case of Individual #23, the Quarterly Nursing Assessment summary, dated 8/4/10, included the following: *[Individual #23] is a 41 year old male residing at 515 S Cedar (elm), at the Lubbock State Supported Living Center. He has resided here since 1971. He is on a Level 1, Moses is updated as of 7/7/10. [Individual #23] continues to remove his clothing from time to time, and want to lay on cold surfaces, despite his thyroid level being WNL [within normal limits]. [Individual #23] is a Level 2 for Medical concerns, and Level 2 Risk for choking, all other areas he remains a Risk Level 3. See summary areas for detailed data. Will continue to monitor [Individual #23] for any changes in condition and report them to the Physician.* As noted for the previous examples, there was no analysis of the individual in regard to his health status included in the quarterly nursing assessment. The inclusion of the risks levels was meaningless without an analysis of supporting data that described the rationale for the risk levels. ▪ The Annual Nursing Assessment summary for Individual #229, dated 7/28/10, included the following: *In June, 2010 [Individual #229] had a fall with a laceration to his right eyebrow. He was give Keflex as a preventative and Vicodin for pain control. Individual wore an arm sling to right arm s/p [status post] fractured clavicle and required assistance with toileting after this fall. [Individual #229] did not have any acute illnesses in the past year. He was*	

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		healthy. [Individual #229] was only about 10 lbs above his desired DWR. In the past 6 months, [Individual #229] lost weight to the point that he was in the upper rage of his DWR. With the exception of the fall noted above, [Individual #229] did not have any other serious injuries. On July 18, 2010, [Individual#229] passed away at UMC after an episode of choking. It was unclear why a quarterly nursing assessment was completed after an individual died. However, if the purpose was to summarize the health issues of the individual, the assessment failed to address a number of issues related to the individual's diagnoses such as GERD, Reflux, Seizure Disorder, Hyponatremia (low sodium), and Hyperlipidemia (high lipid levels). The lack of competency based training that should have been provided prior to the Facility implementing the modified Nursing Assessment form and Guidelines clearly resulted in extremely poor nursing assessments similar to those found during the baseline review. Without the appropriate training, the nurses transferred poor nursing practices regarding assessments onto new forms. The Facility should provide adequate competency- based training to ensure that nursing assessments reflect clinically appropriate information. The records of 17 individuals who were seen by psychiatry and/or prescribed psychotropic medications were reviewed, including: Individual #146, Individual #267, Individual #250, Individual #213, Individual #6, Individual #1, Individual #184, Individual #82, Individual #268, Individual #147, Individual #322, Individual #237, Individual #50, Individual #155, Individual #86, Individual #125, and Individual #134. A review of the past two quarterly nursing assessments found that 12 of the individuals (71%) had quarterly nursing assessments that were timely completed. The other five individuals had two nursing quarterlies completed, but the second quarterly was completed one to two months early without explanation. In the case of Individual #213, the dates of the past two Nursing Quarterlies were only one month apart. The CNE reported that the dates Nursing Quarterlies and Annual Assessments were due was inconsistent and based on the dates of the PSP, which could also change. He reported that the Facility was in the process of changing this so that the date of an individual's annual assessment was based on their admission date, which would then become consistent. Consistent with the findings during the baseline review, the quality of all 34 of the most recent quarterly assessments (100%) was extremely poor and required significant improvement. The summary narrative section for all of the 34 quarterly assessments reviewed continued to contain either superficial information, which was carried over	

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		from each quarterly assessment, or raw data without analysis regarding the individual's health status. There were essentially no comparisons of the individuals' health data between the current and the previous quarters, to assess if the individual was doing better or worse regarding their health issues, and/or if there was progress or lack thereof on measurable objectives, services and/or supports that were included in the Nursing Care Plans. In addition, there was little to no mention of behavior or mental issues for individuals prescribed psychotropic medications. For example: ▪ The nursing assessment, dated 5/27/10, for Individual #86 indicated that she had high cholesterol from recent lab work and was on a low cholesterol, lactose restricted bland diet with ground texture. In addition, she was to receive Ensure if she refused any meals. The assessment noted that she had a two-pound weight loss, but was still within her desired weight range. She also had GERD and a hiatal hernia. She had a transverse loop colostomy and ileostomy since 2005. The assessment also noted that she had a diagnosis of Major Depressive Disorder, recurrent. The only two Nursing Diagnoses listed on the assessment included risk for impaired skin integrity around stoma, related to irritation from bowel contents due to ileostomy, and ineffective health maintenance related to deficient knowledge regarding care of stoma as evidenced by severe mental retardation. The nursing summary section included the following: *[Individual #86] has been healthy over the quarter. [Individual #86] was placed on Diphenhydramine 25 mg for stomal puritis [itching]. Over the next quarter will continue to follow [Individual #86] with care plans for risk for impaired skin integrity around stoma related to her ileostomy and ineffective health maintenance related to deficient knowledge regarding care of her stoma. Will continue to follow up on [Individual #86] weight and closely monitor all other health concerns.* The Nursing Assessment contained no assessment of this individual's status from last quarter. There was no assessment and analysis addressing her appetite or meal refusals since she had experienced some weight loss. There was also no comparison of her recent cholesterol level to previous levels to indicate if her values were getting better or worse. In addition, there was no description of the stoma site since the assessment noted she had been placed on medication for itching at the stoma site and was at risk for skin breakdown around the stoma. In addition, there was no assessment of the status of her moods related to her diagnosis of depression. The assessment provided no information that indicated how this individual was doing since the previous quarter. In addition, the records of 40 individuals who were identified by the Facility as being at	

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		risk for specific health indicators were reviewed, including: Individual #254, and Individual #154 for Diabetes; Individual #97, and Individual #301 for skin integrity; Individual #282, Individual #175, Individual #257, Individual #33, Individual #260, and Individual #205 for constipation; Individual #237, Individual #300, Individual #112, Individual #159, Individual #82, Individual #275, Individual #268, Individual #34, Individual #322, Individual #94, and Individual #8 for weight issues; Individual #213, and Individual #125 for behaviors; Individual #109 for gastrointestinal issues; Individual #120, and Individual #16 for urinary tract infections; Individual #73, Individual #314, and Individual #76 for seizures; Individual #233, and Individual #127 for cardiac; Individual #23 for dehydration; Individual #199, Individual #6, Individual #66, and Individual #68 for aspiration; and Individual #232, Individual #310, Individual #280, and Individual #162 for medical concerns. A review of the past two quarterly nursing assessments found that 36 of the individuals (90%) had quarterly nursing assessments that were timely completed. Again, consistent with the findings during the baseline review, the quality of all 80 of the most recent assessments was exceedingly poor. The overall issues that were found from these Quarterly Nursing Assessments were the same as found in the reviews of the above Quarterly Nursing Assessments. Some of the problematic issues included: ▪ Significant discrepancies in the assessments and/or in the nursing summaries due to information being clearly cut and pasted from the previous assessments; ▪ Information found in the comment/summary sections had not been updated to reflect the individual's current status; ▪ Frequent clinical contradictions were found in the assessment summaries noting that the individual had good health during the quarter and reporting information that did not support the concept of "good health;" ▪ Lack of an analysis of the health and behavioral data indicating whether or not the individual was progressing in their health goals; ▪ Nursing Care Plans being inserted into the summary section that provided no update regarding the individuals' health status; and ▪ Significant lack of information regarding the high-risk health indicators identified by the Facility for the individuals. Also, the records were reviewed for nine individuals who were admitted to the Facility since the last review, including: Individual #134, Individual #190, Individual #36, Individual #274, Individual #216, Individual #235, Individual #61, Individual #201, and Individual #321. A review of the Quarterly Nursing Assessments found that all were inadequate and contained the same problematic issues as noted in the above reviews. The consistent problems found in the Nursing Assessments reinforce the importance for	

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		the Nursing Department to ensure that it is providing clinically appropriate, competency -based training regarding Comprehensive Nursing Assessments. In addition, as the Facility develops and implements the monitoring process for this area, the Facility should ensure that the staff auditing this area is clinically competent in determining compliance ratings addressing the quality of nursing assessments.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Since the baseline review, the State Office had approved the use of the Health Care Protocols: A handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition as a resource for nursing policies, protocols and nursing care plans. The CNE reported that the Facility had obtained these resource books. The CNE reported that the new Nursing Care Plans had been implemented on 7/1/10. However, there had been no competency-based training provided prior to their implementation. At the time of the review, there had been no developed curriculum for competency-based training regarding Nursing Care Plans. A clinically sound competency-based training curriculum should be developed and implemented to ensure nurses are appropriately trained and can demonstrate the ability to develop clinically adequate nursing care plans. The records of 17 individuals who were see by psychiatry and/or prescribed psychotropic medications were reviewed, including: Individual #146, Individual #267, Individual #250, Individual #213, Individual #6, Individual #1, Individual #184, Individual #82, Individual #268, Individual #147, Individual #322, Individual #237, Individual #50, Individual #155, Individual #86, Individual #125, and Individual #134. Consistent with the baseline findings, there were no Nursing Care Plans found addressing the mental health diagnoses that should have included interventions related to any behavior plans and/or strategies the individuals had, as well as the psychotropic medications prescribed for the individuals. Some of the individuals had nursing care plans addressing risks of injuries related to their challenging behaviors. However, these were essentially templates that contained little to no individualization. In addition, none of the interventions listed on the care plans addressed ways to prevent injuries from behaviors; only what to do when an injury occurred. For example: ▪ Individual #213 was noted to have aggressive behaviors with frequent attacks on others. He was prescribed psychotropic medication, and had been given five emergency medications since March 2010, as well as having several episodes of restraint. The only Nursing Care Plans found in his record were for Gastroparesis, intermittent positive pressure breathing due to severe obstructive sleep apnea, and low weights. There was no Nursing Care Plan found addressing the risks related to his behaviors or the use of psychotropic medications.	Noncompliance

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		In addition, the records of 40 individuals who were identified by the Facility as being at risk for specific health indicators were reviewed, including: Individual #254, and Individual #154 for Diabetes; Individual #97, and Individual #301 for skin integrity; Individual #282, Individual #175, Individual #257, Individual #33, Individual #260, and Individual #205 for constipation; Individual #237, Individual #300, Individual #112, Individual #159, Individual #82, Individual #275, Individual #268, Individual #34, Individual #322, Individual #94, and Individual #8 for weight issues; Individual #213, and Individual #125 for behaviors; Individual #109 for gastrointestinal issues; Individual #120, and Individual #16 for urinary tract infections; Individual #73, Individual #314, and Individual #76 for seizures; Individual #233, and Individual #127 for cardiac; Individual #23 for dehydration; Individual #199, Individual #6, Individual #66, and Individual #68 for aspiration; and Individual #232, Individual #310, Individual #280, and Individual #162 for medical concerns. Consistent with the baseline findings, the Nursing Care Plans for all 40 individuals were inadequate. The Nursing Care Plans found were a mixture of the old formats as well as some of the new templates. The interventions contained in the old Nursing Care Plans consisted of service provisions, such as "administer medication as ordered," "vital sign monitoring," and "monitor for effectiveness of prescribed medications and treatments." The new Nursing Care Plans were merely copies of the templates. The lack of individual-specific interventions in either type of Nursing Care Plan provided little to no direction for caring for individuals who were identified as being at risk. In addition, there were no appropriate objectives listed for measuring individuals' progress toward their goals. Consistent with the baseline findings, the interventions contained in both the old and new Nursing Care Plans did not address any type of preventative interventions or interventions that would minimize the individual's' identified health risks. The resource book the Facility was using consisted of nursing protocols and not nursing care plans. In order to develop appropriate nursing care plans, the information from the protocols needs to be specific to the individual the nursing care plan is addressing. Simply using generic templates as nursing care plans renders them meaningless in providing appropriate direction to staff caring for the individual. Nursing care plans need to accurately reflect what nursing is doing for prevention, health maintenance, and health promotion for the individuals. The new Health Care Protocols the Facility had implemented should be modified to include appropriate goals and significant individualization to become quality Health Care Plans. An additional sample of 53 Nursing Care Plans for 38 individuals' records was reviewed to determine if individuals who were diagnosed with a variety of infections and infectious diseases had appropriate care plans to address their needs. These individuals included: Individual #208, Individual #170, Individual #97, Individual #290, Individual #59, Individual #160, Individual #223, Individual #302, Individual #50, Individual #54,	

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		Individual #41, Individual #48, Individual #164, Individual #303, Individual #36, Individual #213, Individual #121, Individual #193, Individual #116, Individual #276, Individual #107, Individual #23, Individual #284, Individual #151, Individual #109, Individual #174, Individual #115, Individual #263, Individual #56, Individual #127, Individual #2, Individual #132, Individual #76, Individual #14, Individual #16, Individual #147, Individual #3 and Individual #180. Of the 53 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. Some of the deficiencies included: ▪ The lack of individualization of the Nursing Care Plan template; ▪ The lack of clinically appropriate goals and objectives; ▪ The lack of designation on the subject of documentation regarding who was to document, how often, where the documentation was to be done, who was to review the documentation, and how often it would be reviewed; ▪ The lack of interventions addressing teaching and education for staff and individuals; ▪ The lack of proactive interventions; and ▪ The lack of documentation demonstrating that interventions were actually being implemented. As discussed in detail in with regard to Section M.1 of the SA, this area requires significant attention due to the clinical relevance of infectious and communicable diseases. Consistent with the findings during the baseline review, there was no system in place to ensure that individuals with infectious diseases were actually being provided the appropriate infection control measures, or that clinically appropriate interventions to prevent the spread of infection were being consistently implemented. Nursing Care Plans should be documents that nurses review to plan and prioritize the activities they need to do during their shifts. These documents are basically a blueprint for guiding staff in providing the needed care and supports for the individuals in their care. However, as was demonstrated with the Nursing Assessments, implementing the new Nursing Care Plans without first providing competency-based training to the staff resulted in the same ineffective system as was previously in place. Consequently, the Nursing Care Plans continued to be seen as a task to complete rather than a clinical guide for care. The State and the Facility might want to consider pursuing the use of integrated care plans that would incorporate all clinical disciplines' interventions into one treatment plan. This process facilitates collaboration with other disciplines regarding care plans so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated, as required by Sections G and F of the SA.	

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		Regardless of what system is preferred, the consistent problems since the baseline review found in the Nursing Care Plans demonstrate that it is essential for the Nursing Department to ensure it is providing clinically appropriate, competency-based training regarding Nursing Care Plans. In addition, as the Facility develops and implements the monitoring process for this area, the Facility needs to ensure that the staff auditing Nursing Care Plans are clinically competent to determine compliance ratings addressing the quality of the plans.	
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.	As reported previously, the State Office had approved the use of the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols, and would need to develop and/or amend existing policies in alignment with the elements contained in the Manual. At the time of the review, the Facility had obtained this resource and binders of policies and procedures from this resource book had been placed in each building the Friday prior to the Monitoring Team's visit. The Lippincott Manual does not include a set of policies, and the Facilities would need to develop and/or amend existing policies to be in alignment with the procedures and protocols contained in the Manual, as well as with State and Facility practice, the Health Care Guidelines, and SA. For example, there might be procedures included in the Lippincott Manual that would not be allowed at LBSSLC due to its licensing, or only certain staff might be able to perform specific duties due to their credentialing or State regulations. This needs to be defined in facility-specific policies. However, they had not been individualized in alignment with the Facility's systems, nor had any training been provided to staff prior to distribution. At the time of the review, the Facility did not have a plan for when training would be conducted for the newly developed policies, procedures or protocols or when the implementation would occur. As is discussed in detail above with regard to Section M.2 and M.3 of the SA, at the time of the review, the Facility did not have an adequate assessment process in place, nor did it develop appropriate nursing care plans. As a result, LBSSLC was failing to adequately address the health care needs of the individuals it served.	Noncompliance
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health	At the time of the review, the State was in the process of reviewing and revising the system addressing indicators of risk. However, since this system was not revised, LBSSLC continued using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. As noted from the previous review, this tool was scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. Since the baseline review, the Facility had modified this system so that individuals were no longer given an overall score for risk, but were assigned a risk score for each of the health indicator categories. These indicators were discussed at the	Noncompliance

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	status of the individual.	HST meeting at which time the physician or practitioner assigned the risk score for each category: Level 1 was the highest risk, Level 2 represented moderate risk, and Level 3 was low risk. Consistent with the baseline review findings, the risk tools used were not adequate, and the HST meetings did not result in the appropriate identification of individuals at clinical risk. By the next review, there should be a new process in place to identify individuals at risk, along with the appropriate associated policies and procedures. In addition, once this system is adequately implemented and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and develop plans to address identified areas of risk. LBSSLC and the State Office recognized that they were not in compliance with this requirement of the SA, which was consistent with the Monitoring Team's findings.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the baseline review, the Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection, or via tube. Medication Pass Observations forms verified that the Facility had implemented the new form, and had conducted the first round of observations on most of the nurses. In addition, Nursing Education had a database and schedule established to ensure all nurses were being observed every quarter. The CNE reported that the Facility had appropriately modified the frequency of the medication observations for nurses from annually to quarterly. However, at the time of the review, the policy regarding medication observations stated that all nurses that routinely administer medications will be observed at least every six months rather than quarterly. The policy should be reconciled with the practice. In addition, the Facility should ensure that the auditors for medication observations are competent in the practice. Also, as the system continues to be developed, the department should establish inter-rater reliability among auditors in order to produce reliable data to accurately identify areas of strength and weakness in this system, and to be able to implement targeted plans of correction for deficient areas. The Facility should develop and implement a procedure addressing establishing inter-rater reliability since a number of monitoring systems are being implemented by several disciplines. At the time of the review, there was no formal report summarizing the issues found from medication observations that were conducted since the baseline review. However, from review of the Medication Error Committee meetings, information regarding which nurses were observed was discussed. Since the frequency of the observations had increased, the data needed to be analyzed to identify trends and generate plans of correction. The Facility should develop a system for aggregating this data so it becomes usable to	Noncompliance

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		facilitate corrective actions. In addition, it was difficult to identify the issues and outcomes from the format of the Medication Error Committee meetings. The format was a narrative dialogue that had no structure regarding the identification of the issue, analysis of the issue, plan of correction including who was responsible for its implementation and when it would be implemented, outcomes, and plans for further monitoring. Although difficult to extrapolate information, the minutes indicated that the Facility was discussing medication errors, mainly focusing on why the nurse made the error. However, there was little discussion regarding what system issues could have contributed to the error, such as issues related to having only one nurse giving several individuals medications while trying to stay within the time parameters. The minutes did indicate that interruptions were a major issue for the medication nurses, and the Committee was exploring ways to deal with this problem. When observing medication administration while on site for individuals living in Quail and Sparrow, the following significant issues were identified, many of which placed the individuals involved at risk. Specifically, the nurse did not: ▪ Pour liquids at eye level to ensure the correct dosage; ▪ Wash her hands consistently between individuals receiving medication; ▪ Speak to individuals as they were adults and not children; ▪ Use privacy screens consistently; ▪ Wash her hands after putting an individual's shoe on before giving them their medications; ▪ Have a stethoscope on the medication cart to listen to lung sounds for individuals coughing before or after receiving medications; ▪ Use gloves when manipulating tubes; ▪ Tell individuals what she was doing and what medications she was administering; and ▪ Ensure the individual was in the proper positioning prior to medication administration. During the observation, one of the individuals began having jerking movements to his body. When this was pointed out to the medication nurse and the Facility nurse conducting a medication observation audit, both stated that the individual "always does that," and returned to setting the medications up. When asked if the individual had a seizure disorder, they reported he did, but had not had any seizures for months. Neither nurse initiated an assessment of the individual until asked to do so by the Monitoring Team. In addition, the nurse proceeded to administer the medications to the individual while he was not yet awake and alert. The nurse was asked by the Monitoring Team to	

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		wait until the individual was alert to administer the medications, and was reminded to document and notify the physician regarding the activity that just had been observed. Although the Facility nurse conducting the medication observation audit provided some appropriate prompting and feedback to the staff nurse who was being observed, she did not intervene while the individual was having seizure-like movements. Based on a conversation with a different nurse being observed, when reminded to talk to the individuals and tell them what medications were being administered, she reported that the individuals did not understand what she was saying. From these observations and observations conducted during the baseline review, nurses were viewing medication administration as a task that had to be completed, rather than as a time to assess and interact with the individuals. The process had become so task-driven that the medication nurses were not seeing signs and symptoms that needed to be assessed before administering medication. These issues should be addressed so that medications are administered appropriately and safely to individuals. From 181 Medication Observations reviewed, only four had noted some problematic issue. This data did not comport with the Monitoring Team's findings from the past two reviews. From conversations with the CNE, the auditors for Medication Observations had not been tested for competency in this area, nor had inter-rater reliability been established. The Facility should ensure that nurses who are auditing this area are competent in the process to ensure the Facility is receiving accurate data on the medication practices of the nursing staff. A review of the minutes of the Medication Error Committee noted that the medication errors by month were as follows: ▪ February 2010 – one medication error; ▪ March 2010 - 15 medication errors; ▪ April 2010 - 12 medication errors; and ▪ May 2010 - 15 medication errors. However, there was no formal report of medication errors found in the documents provided by the Facility. As noted from the baseline review, these numbers strongly suggest that LBSSLC had a significant issue with the underreporting of medication errors. From conversations with the CNE and the Pharmacist, the Facility recognized this issue and was in the process of findings ways to address the reliability of the medication error data. As stated in the baseline report, having a medication variance system would expand the scope of the review of the medication system. The medication error system the Facility currently had in place only reviewed errors addressing the wrong individual, wrong time, wrong dose, wrong route, wrong drug, wrong technique, and omitted medications. There are many additional systems issues that can contribute to	

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		medication variances other than a breach of one of the "six rights" for medication administration. In fact, only using these limited indicators as a measure of the Facility's variances limits the analysis of the system. Section N.8 of the SA references medication variances as opposed to medication errors. The Facility should continue its efforts to include medication nurses in the Medication Error Committee and/or assessments of the medication administration system, because their perspectives, with regard to the realities of medication administration, are invaluable.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. LBSSLC should continue its efforts in recruiting, maintaining, and evaluating possible reallocations of nursing positions to meet the requirements of the Settlement Agreement.
2. Policies, procedures, and/or protocols should be modified or developed addressing the integration of the IC LVN, and the Assistant Nurse Educator positions into the Nursing Department.
3. The Facility should continue its efforts to develop the processes necessary to generate data that can be accurately interpreted, analyzed, and are reflective of the practices being measured. These include:
    a. Develop review tool instructions. The Facility, in conjunction with the State Office, should develop instructions for each monitoring tool to ensure that all auditors are using the same documentation and criteria to determine compliance with each item, which will assist in establishing inter-rater reliability;
    b. Provide the total of the population being reviewed (N) and the sample of that population audited (n) to yield an adequate percent sample that indicates the relevance of the compliance scores;
    c. Establish and reviewing an adequate sample size;
    d. Assess for quality;
    e. Develop and implement a procedure for establishing inter-rater reliability at 85% or above;
    f. Ensure that all nurses conducting monitoring activities are clinically competent in the areas they monitor; and
    g. Ensure that audits consist of a critical review of nursing practices, which focus on the quality of nursing services and documentation and not just the completion of the required documentation.
4. Data generated from the monitoring tools should be regularly reviewed and addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems.
5. The Nursing Department should establish appropriate criteria and testing for competency for the entire nursing staff in order to have meaningful and lasting effect on the clinical outcomes for the individuals at LBSSLC.
6. The Facility should ensure that the documentation from the Hospital Liaison Nurse is timely filed in the individuals' medical records.
7. To generate accurate data regarding acute illness and urgent care, it is recommended that the auditing staff first read the "story" included in the progress notes from the start of the change of status to the individuals' return to their home unit, and then score the tools. This method would help to ensure recognition of the quality issues related to clinical care and the completeness and appropriateness of assessments, rather than just the completion of notes.
8. As the Facility begins to generate data from the monitoring systems, plans of correction addressing identified problematic issues should be developed and implemented.
9. LBSSLC's policy addressing "Management of Acute Illness/Serious Injury LBSSLC Health Services, Revised January 21, 2010" should be revised to include issues related to the assessment and documentation criteria that should be completed prior to an individual being sent to the

hospital/ER, and upon return to the Facility.

10. Using the Lippincott Manual of Nurse Practice, 9th Edition, and the Health Care Protocols: A handbook for DD Nurses was approved by the State Office to use for nursing policies, protocols and care plans. The Facility should individualize the content in alignment with the Facility's systems and provide training to staff prior to distribution to the buildings.
11. The Facility should develop and implement a schedule for training on the newly developed nursing care protocols, based on priority of need, as well as when implementation will occur.
12. The Facility should continue its efforts to ensure that documents are filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information to make decisions regarding treatments and health care services.
13. Although not required by the SA or HCG, the Facility is encouraged to implement the peer review process in alignment with the American Nurses Association definition that states: peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. Such efforts should substantially assist the Facility in meeting other requirement of the SA, as well as meeting the goal of adequate self-assessment.
14. The IC Coordinator should ensure that all IC staff are competent in the area of Infection Control and maintain documentation for verification. Validation of clinical competency for staff working in a specialized area such as infection control is essential to ensure that they are knowledgeable about all facets of infectious and communicable diseases and practices.
15. Discussions with the State Office Nursing Coordinator indicated that there was a workgroup that was in the process of developing standardized policies and procedures. However, until these are completed, reviewed, and approved, the Facility should have and maintain appropriate and adequate policies and procedures regarding Infection Control.
16. The Infection Control Committee meeting minutes should include a comprehensive analysis of the infection control data, including trends identified, inquires into problematic trends, corrective actions addressing any problematic trends, and the process for monitoring outcomes in relation to the activities and interventions of the Infection Control staff in conjunction with the practices on the units.
17. The Facility should develop a procedure outlining the specific process to ensure data reliability for infection control, including how discrepancies in the data are reconciled and tracked.
18. The Facility should continue to implement the process for reviewing and updating, if necessary, individuals' immunizations, and develop a schedule addressing when individuals will be reviewed based on priority needs so that no one is overlooked.
19. In order to generate accurate data from the Environmental audits, the Facility might want to consider rotating the auditor for these audits to bring a "fresh set of eyes" to the process. In addition, the Facility should implement a process to review the findings from the audits and document the actions taken regarding any problematic issues identified.
20. The Infection Control staff should consider conducting root cause analyses on events such as outbreaks or post exposures to provide a framework and structure for completing a comprehensive analysis and identifying systemic issues that contributed to both positive and negative outcomes.
21. The Facility should modify the Infection Control training curriculum and post-test so that it is reflective of comprehensive, yet basic infection control information to ensure competency in this area.
22. The Facility should provide on-going competency-based training to staff related to infection control issues.
23. Using data collected from the audits completed using the Standard Precautions Monitoring Tool for Infection Control, an analysis should be completed to identify problematic trends, and to develop and implement timely plans of correction. In addition, the Facility should ensure that all designated areas are completing these audits.
24. The Facility should consider formalizing this system to ensure regular spot checks are conducted in different areas to generate additional data regarding hand washing practices of the staff.
25. The Monitoring Team continues to recommend that the State consider securing the services of an expert in the areas of Infection Control and

Nursing to provide consultation and onsite assistance to the State and Facilities.

26. The Facility should ensure that there is collaboration between medical, the CTD Department, and nursing regarding the policies and procedures for the Life Threatening Emergency Drills, to ensure that the policy and forms are clinically appropriate.
27. The Facility should expand emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions other than CPR.
28. There should be interdisciplinary collaboration with the CTD Department regarding medical emergency drills and the Facility's emergency systems.
29. The physicians should participate in the Medical Emergency drills to be familiar with their role in a medical emergency, know the Facility's emergency systems, and be aware of staff knowledge of emergency procedures.
30. The Facility should ensure that all emergency equipment, including back-up equipment, is being regularly checked to ensure it is in good working condition with supporting documentation.
31. The Facility should incorporate the actual use of the emergency equipment in medical emergency drills. This is necessary to ensure that when an emergency arises, the nurses will be familiar with the operation of the emergency equipment and avoid delays in treatment during an actual medical emergency.
32. The Facility should develop and implement clinically sound competency-based training curricula for Nursing Assessments and Nursing Care Plans ensuring that it adequately measures nurses' competency in producing quality assessments and plans.
33. The Facility should ensure that the new Health Care Protocols the Facility is implementing include appropriate goals with significant individualization.
34. As required by Sections G and F of the SA, the Nursing Department should collaborate with other disciplines regarding care so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all treatment plans. The State and the Facilities might want to consider pursuing the use of integrated care plans that would incorporate all clinical disciplines' interventions into one treatment plan. This process facilitates collaboration with other disciplines regarding care plans so that an interdisciplinary team approach is used consistently.
35. The State and the Facility should continue to develop and implement the system addressing risk indicators based on standardized risk assessments with established reliability and validity, and these should be used by all the Facilities in assessing and documenting clinical indicators of risk.
36. Once this system is implemented and individuals' risks are appropriately identified, teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.
37. The Facility should reconcile the current requirements with regard to the frequency of the Medication Observations with what is listed in the Facility's policy.
38. Data from the Medication Observations audits should be analyzed to identify trends and generate plans of correction. The Facility should develop a system for aggregating this data so it becomes usable to facilitate corrective actions.
39. The Facility should continue to include medication nurses in the Medication Error Committee, and/or assessments of the medication administration system.
40. Using the Lippincott Manual as a resource, the Facility should develop and/or modify nursing policies, procedures, and protocols to be consistent with the manual, State and Facility practice, and the SA and Health Care Guidelines. Once policies are developed, nursing staff should be provided with competency-based training on their implementation.
41. The Facility should continue to address issues regarding the medication administration system so that medications are administered appropriately and safely to individuals.
42. To be consistent with Section N.8 of the SA, a medication variance system should be developed and implemented that would expand the scope of the review of the Facility's medication systems.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Single Patient Intervention Reports for the following individuals: Individual #302, dated 6/11/10; Individual #260, dated 7/9/10; Individual #2, dated 6/1/10; Individual #33, dated 7/9/10; Individual #143, dated 6/14/10; Individual #127, dated 6/9/10; Individual #204, dated 6/23/10; Individual #312, dated 6/23/10; Individual #70, dated 6/2/10; Individual #323, dated 6/2/10; Individual #242, dated 6/15/10; Individual #299, dated 7/21/10; Individual #136, dated 7/21/10; Individual #271, dated 7/13/10; Individual #143, dated 7/8/10; Individual #205, dated 7/22/10; Individual #205, dated 7/1/10; Individual #190, dated 7/1/10; Individual #237, dated 9/1/10; Individual #50, dated 9/1/10; Individual #29, dated 8/20/10; Individual #304, dated 8/17/10; Individual #138, dated 8/26/10; Individual #261, dated 8/23/10; Individual #226, dated 8/23/10; Individual #149, dated 8/18/10; Individual #162, dated 8/2/07(10?); Individual #271, dated 7/13/10; Individual #279, dated 8/24/10; Individual #299, dated 8/31/10; Individual #323, dated 7/26/10; Individual #191, dated 7/12/10; Individual #193, dated 7/20/10; Individual #74, dated 7/27/10; Individual #267, dated 7/30/10; Individual #160, dated 7/23/10; Individual #79, dated 7/12/10; Individual #253, dated 8/11/10; Individual #51, dated 8/11/10; Individual #147, dated 8/16/10; Individual #193, dated 8/12/10; Individual #302, dated 7/16/10; Individual #44, dated 7/20/10; Individual #322, dated 7/9/10; Individual #290, dated 7/9/10; Individual #197, dated 8/23/10; Individual #160, dated 8/11/10; Individual #176, dated 8/3/10; and Individual #128, dated 8/13/10; o Quarterly Drug Regimen Reviews (QDRRs) for the following individuals: Individual #241, dated 8/25/10; Individual #313, dated 8/25/10; Individual #204, dated 8/25/10; Individual #43, dated 8/25/10; Individual #16, dated 8/25/10; Individual #147, dated 8/25/10; Individual #111, dated 8/25/10; Individual #171, dated 8/25/10; Individual #182, dated 8/25/10; Individual #259, dated 8/25/10; Individual #80, dated 8/25/10; Individual #55, dated 8/25/10; Individual #28, dated 8/25/10; Individual #146, dated 8/25/10; Individual #70, dated 8/17/10; Individual #318, dated 8/17/10; Individual #183, dated 8/17/10; Individual #26, dated 8/17/10; Individual #222, dated 8/17/10; Individual #299, dated 8/17/10; Individual #203, dated 8/17/10; Individual #99, dated 8/17/10; Individual #238, dated 8/17/10; Individual #1, dated 8/20/10; Individual #35, dated 8/20/10; Individual #306, dated 8/20/10; Individual #170, dated 8/20/10; Individual #45, dated 8/24/10; Individual #245, dated 8/20/10; Individual #194, dated 8/20/10; Individual #95, dated 8/20/10; Individual #143, dated 8/20/10; Individual #271, dated 8/20/10; Individual #266, dated 8/20/10; Individual #132, dated 8/20/10; Individual #315, dated 8/20/10; Individual #202, dated 8/20/10; Individual #25, dated 8/16/10; Individual #323, dated 8/9/10; Individual #63, dated 8/9/10; Individual #258, dated 8/9/10; Individual #37, dated 8/9/10; Individual #312, dated 8/9/10; Individual

	#226, dated 8/9/10; Individual #217, dated 8/9/10; Individual #228, dated 8/9/10; Individual #17, dated 8/9/10; Individual #104, dated 8/9/10; Individual #321, dated 8/9/10; and Individual #270, dated 8/25/10; o Adverse Drug Reaction (ADR) Form with instructions: Med Watch, the FDA Safety Information and Adverse Event Reporting Program, Form FDA 3500A, dated 1/09; o Medication Error Committee Meeting Minutes for: February 9, 2010; April 29, 2010; June 30, 2010; August 25, 2010; and September 7, 2010; o LBSSLC Policy: Health Services: Medication Errors and Reporting Short Version, dated 5/7/08 (R) o Medication Error Information Report (TX-LB-1009-WZ-16.8); o LBSSLC Policy - Health Services: Medication-Administration; Nursing, dated 5/5/08; o LBSSLC Policy - Health Services: Administration of Oral Medications, dated 2/9/10 (R); o Pharmacy and Therapeutics Committee meeting minutes for the following dates: September 22, 2009, December 15, 2009, March 16, 2010, and June 22, 2010; o Pharmacy and Therapeutics Committee meeting agenda for September 14, 2010; o Monthly Facility Review – Psychoactive Medication Polypharmacy Meeting minutes for the following dates: 10/27/09, 11/17/09, 12/15/09, 1/26/10, 2/23/10, 3/30/10, 4/22/10, 5/25/10, 6/29/10, 7/28/09 (10?), and 8/25/10; o Drug Utilization Evaluation (DUE) Calendar Fiscal Year 2010-2011; o Adjunct Study to Phenytoin DUE, Phenytoin Administration with enteral feedings, August 2010 o DUE Form, Drug Audited: Clozapine (regular and extended release forms), Summary of Findings; o Planning Calendar Drug Utilization Evaluation: Most recent DUE Calendar [March 2009-September 2010]; o Restraint Checklist/Face-to-face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint on the following individuals: Individual #213, dated 3/10/10; Individual #317, dated 3/25/10 at 10:40 a.m.; Individual #317, dated 3/25/10 at 2:45 p.m.; Individual #33, dated 7/9/10; Individual #235, dated 7/21/10; Individual #288, dated 8/4/10; and Individual #288, dated 8/6/10; o Flow diagram: Drug Interaction Alerts – New Order Processing; o Flow diagram: Drug Interaction Alerts – Monthly Activities; o Monitoring of Side Effects Scale (MOSES)/ Dyskinesia Identification System: Condensed User Scale (DISCUS) Monitoring Form for Nursing/Psychiatry/Pharmacy; o DISCUS Evaluations on the following individuals: Individual #288, dated 5/26/10, and 8/31/10; Individual #240, dated 5/26/10, and 8/30/10; Individual #147, dated 5/25/10, and 8/31/10; Individual #111, dated 5/25/10, and 8/31/10; Individual #259, dated 5/25/10, and 8/31/10; Individual #241, dated 5/25/10, and 8/31/10; Individual #264, dated 5/28/10, and 8/30/10; Individual #276, dated 5/25/10, and 8/30/10; Individual #107, dated 5/25/10, and 8/30/10; Individual #65, dated 5/25/10, and 8/30/10; Individual #61, dated 6/21/10, and 8/30/10; Individual #237, dated 5/26/10, and 8/31/10; Individual #50, dated 5/25/10, and 8/31/10; Individual #235, dated 5/26/10,

	and 8/31/10; Individual #166, dated 5/25/10, and 8/30/10; Individual #140, dated 5/26/10, and 8/30/10; Individual #300, dated 5/25/10, and 8/30/10; Individual #155, dated 5/25/10, and 8/31/10; Individual #232, dated 5/25/10, and 8/30/10; Individual #60, dated 5/25/10, and 8/30/10; and Individual #239, dated 5/27/10, and 8/30/10; o LBSSLC Policy - Health Services: Pharmacy Services and Safe Medication Practices, dated 11/19/09 (R); o SO SSLC Policy: Pharmacy Services, Policy #011, dated 8/10 o LBSSLC – Nursing: Medication Errors/Incidents, dated 2/16/10 (R); o LBSSLC – Health Services: Medication Adjustment, dated 4/13/10 (R); o LBSSLC – Health Services: Essential Position Elements RN II, and LVNS, dated 12/20/09 (R); o LBSSLC Nursing Duties, dated 6/26/09 (R); o SSLC Medication Error Report (TX-LB-1009-WZ-14.25); o Flow Diagram: Process for Handling Excess Medications Returned to Pharmacy; o Summary of Chemical Restraints January 2010 – August 2010; Sources: WORx STAT order report and Psychology Restraint Database; o Texas Health Monitoring Instrument, undated; o Lubbock SSLC Plan of Improvement, Section N, dated 5/17/10; and o Email dated 9/15/10, from Kim Lara, Administrative Coordinator-Health Services LBSSLC to Julia Henderson, Health Status Committee Coordinator LBSSLC. ▪ **Interviews with**: o Billy Bob Beck, Director of Pharmacy; and o John Todd, PharmD.
	Facility Self-Assessment: The Pharmacy Department had made significant advances in progressing toward compliance with the SA. The clinical pharmacist had been instrumental in many of these areas. However, as the department documented in its own assessment, they remained noncompliant in all areas. In the narrative portions of the POI, the Facility noted a number of deficiencies with regard to pharmacy, specifically documentation and follow-up of the pharmacist's recommended interventions when there was a significant potential drug interaction, or allergies were identified; spot checks of the Medication Administration Record (MAR) and Narcotic Count Sheet; and analysis of returned medication. Action steps included implementing a process for documenting communication between the pharmacist and the physician, documenting spot checks for MAR documentation, and reviewing every returned narcotic count sheet. All overages returned to the pharmacy were reviewed. According to the POI, the Facility was aware that it was in noncompliance with a number of indicators, for example, for the indicator: "labs are not available at order entry," because lab information was in a separate database in a different software program. With regard to Section N.4, the action plan indicated that the "clinical pharmacist and medical director …were reviewing possible modifications to the QDRR report that would facilitate documentation of physician actions for recommendations," because the QDRR did not have space for physician comments if they disagreed with the recommendations. Also, the POI indicates that most of the action steps for Section N.8. of the SA were not being addressed, and that overall, none of the subsections of Section N.8

	were in compliance.
	Summary of Monitor's Assessment: The Pharmacy Department had made a number of improvements in addressing such issues as documenting interventions with new orders when they were Level 1 alerts (i.e., no drug dispensed until clarifications received due to significant drug interactions, drug allergies, and other contraindications). This had not been resolved for Level 2 and 3 alerts for which pharmacists were allowed to use their professional discretion in notifying the providers and initiating appropriate changes such as timing of doses to minimize drug interactions. Quarterly Drug Regimen Reviews had improved, but had not yet addressed all areas, such as the use of benzodiazepines, anticholinergics, and polypharmacy. Tracking "stat" and chemical restraints remained elusive, because of lack of precise definitions. MOSES and DISCUS were tracked, but there was some noncompliance in the completion of these screenings, as identified by the Facility's own tracking form. Evidence was not found of immediate follow-up and/or resolution. The adverse drug reaction reporting system required additional training for staff in order to ensure identification of such reactions and proper reporting. Drug utilization evaluations were being completed and were in the beginning stages of implementation, a critical step in assuring compliance. Medication error review and monitoring remained in their early stages of implementation. A Medication Error Committee had begun meeting, and errors were being analyzed in a logical progression in order to ensure quality of data. However, additional work needed to be done to ensure accurate reporting, to collect and analyze data, and to develop and follow-through on recommendations to improve the system.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication	The pharmacy was conducting a review on all new prescriptions. This included a review of potential drug interactions with the individual's medication regimen, as well as allergies, and there was also documentation of the individual's age, sex, diagnosis, as well as a listing of primary practitioner and practitioner prescribing the medication. The software program WORx and the Avatar system were utilized by the pharmacy to assist with this process. However, the intervention reports reviewed did not indicate the need for laboratory results or a need for additional laboratory testing. This information was not readily available to the pharmacy as it was located in Avatar, which was not integrated with the WORx system. Most of the reports indicated a drug alert for adverse reaction with another medication currently being prescribed. A sample of Single Patient Intervention Reports was reviewed. The format that the	Noncompliance

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	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.	pharmacy followed was presented in a flow sheet entitled "Drug Interaction alerts – new order processing." The flow diagram identified Level 1 orders as those for which no drug would be dispensed until clarifications were received due to significant drug interactions, drug allergies, other contraindications, and indicated that the pharmacist would document interaction and physician response before proceeding. Level 2 and 3 alerts allowed the pharmacists to use their professional discretion in notifying the providers and initiating appropriate changes such as timing of doses to minimize drug interactions. The primary care practitioner might be contacted for these, and the order would be completed. The next step outlined in the flow sheet entitled "Drug Interaction Alerts – Monthly Activities," included a report of all interactions for all three levels, which was printed for the entire month and distributed to the PCPs. The PCPs were to review these reports and comment on interactions for Level 2 and 3 (the Level 1 interactions were already documented), and the report of the PCP entry information was sent to the pharmacy. In other words, at the end of the month, the pharmacy sent out a list of potential drug interactions or adverse reactions to each PCP. The PCPs entered their comments on the form, and returned it to the pharmacy. The pharmacy then entered their comments in the "single patient intervention form." This record would be printed and filed in the integrated progress notes, with a copy kept in the pharmacy. This system had both strengths and weaknesses. For the Level 1 concerns, the system assisted in ensuring that there was timely intervention and the results of the pharmacist's interaction with the PCP were documented. For the Level 2 and 3 concerns, which presumably were the many minor concerns and red flags that were reviewed by the pharmacist in the computer system, the process was not sufficient to ensure appropriate intervention with input from the PCP. The PCP appeared not to be notified until after the fact, so the system did not allow for an appropriate and timely intervention. The flow of information in providing communication between the pharmacist and physician changed with this new system with Level 2 and 3 concerns, so that the intervention was simply that the pharmacist reviewed the issues, determined that there was a Level 2 or 3 concern, and then, at the discretion of the pharmacist, there may or may not be contact with the PCP, and the pharmacist may change the timing of the dosage to minimize drug interactions. This is not consistent with the requirements of Section N.1 of the SA that requires a timely initial review of the order, and recommendations to be made to the PCP. There is also the concern that if the level of concern was low (level 2 or 3), and that it was not important to communicate initially with the PCP, then there was no ready explanation for the reason to be concerned and request follow up at the end of the treatment. If there was significant concern to generate follow up, perhaps the PCP should have been contacted initially and the communication recorded on the intervention sheet.	

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		Providing a computerized printout at the end of the month did not provide the drug interaction or significant side effect information the PCP needed prior to ordering/initiating the medication, nor did it provide timely communication of information in order to safely and effectively monitor the individual during the prescription of medication. The current system only provides this information after the prescription has been completed or has been administered for many days. The interventions that perhaps represented the minor red flag warnings should be reviewed by the medical department ahead of time to determine if they require modification, and if not, then the pharmacy should have little reason to follow-up after the medication was completed. Many of the Single Patient Intervention Reports did not reflect the initial communication response from the physician, which is the main concern when prescribing new medication. If the pharmacy chose to record a follow-up entry, then the date of the follow-up, including information that it was a review after completion and/or administration of the medication, should be clearly stated, along with the additional information from the red flag (i.e., describing the details of the potential drug interaction of concern between the two drugs to which the PCP needed to respond, or details as to the adverse drug effect for which observation was recommended). If this were written as the only entry from the communication with the physician, it would indicate the medication had already been dispensed and administered, which would diminish the purpose of the screening procedure. As mentioned above, there was also no recommendation for laboratory testing that should be considered prior to initiation of the order, or as part of the monitoring of side effects and drug interactions. The choice of words used in recording information in the intervention report document might not reflect what was intended. At times, it was written that the PCP informed the pharmacy that "no interaction occurred," when this would be difficult to determine without completing a battery of tests or blood levels. As the category was at times "adverse drug reaction," this probably was meant to indicate that: "no adverse drug reaction occurred." For instance: ▪ With the report of Individual #261, dated 8/23/10, doxycycline was prescribed with ferrous sulfate, calcium carbonate, multivitamins and Juven. The statement was recorded that "no interaction" occurred, although the category to which the pharmacy was referring was adverse drug reaction rather than a drug interaction. The pharmacy might have meant drug interaction, given the combination of medications administered to this individual, but the category adverse drug reaction was recorded. Primary care practitioners should report precisely what is observed, such as there was no adverse drug reaction, or that there was good clinical response, but it would be difficult to prove that there was	

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		no interaction between doxycycline and the other medications listed (there may well have been, but it was not identified, or might not have had a clinically apparent effect, but there might still have been an interaction). A comment that the doxycycline was administered two hours before or after the other medications or other rationale would have been helpful in providing evidence that there was no drug interaction, or that attempts were made to reduce the drug interaction in response to the information provided by the pharmacy. Such documentation would provide evidence that the information shared between the pharmacy and the PCPs had an impact on the prescribing of medication. As a later entry, whether the treatment was successful with doxycycline would have provided evidence that, despite any drug interaction, the absorption from the GI tract and drug level was sufficient to eradicate the infection. In that case, the drug interaction would not have had a clinical effect. As required in the HCG appendix that "all discussions between pharmacist and prescribing practitioner… shall be recorded for retrieval and review as needed by the pharmacist," it is recommended that the pharmacy utilize this intervention report as a tool in documenting initial communication with the PCPs, both the information that the pharmacy shares, and the date and time of response from the PCP (with name of PCP, which may be different from assigned doctor listed at the top of document), and the initial response/plan from the PCPs. Providing follow-up information is an additional step that could be taken, but does not replace the recording of this initial communication, which would include either documentation of a change or the rationale for not changing medication or dosage by the PCP. That aspect of communication appeared to be missing in many of the reports. The following represent additional examples of information on the "Single Patient Intervention Report" which would benefit from further precise information (date and time of initial contact, name of PCP responding, response/plan communicated to pharmacy by PCP, rationale for not changing order, and change of medication order) concerning the initial communication with the PCP. These concerns were reflected in the reports for the following individuals: Individual #323, dated 6/2/10; Individual #70, dated 6/2/10; Individual #312, dated 6/23/10; Individual #204, dated 6/23/10; Individual #127, dated 6/9/10; Individual #143, dated 6/14/10; Individual #33, dated 7/9/10; Individual #2, dated 6/1/10; Individual #260, dated 7/9/10; Individual #299, dated 7/21/10; Individual #136, dated 7/21/10; Individual #271, dated 7/13/10; Individual #143, dated 7/8/10; Individual #205, dated 7/22/10; Individual #205, dated 7/1/10; Individual #190, dated 7/1/10; Individual #237, dated 9/1/10; Individual #50, dated 9/1/10; Individual #29, dated 8/20/10; Individual #304, dated 8/17/10; Individual #138, dated 8/26/10; Individual #261, dated 8/23/10 (discussed above); Individual #226, dated 8/23/10; Individual #149, dated 8/18/10; Individual #162, dated	

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		8/2/07(?); Individual #279, dated 8/24/10; Individual #299, dated 8/31/10; Individual #323, dated 7/26/10; Individual #191, dated 7/12/10; Individual #193, dated 7/20/10; Individual #74, dated 7/27/10; Individual #267, dated 7/3/10; Individual #160, dated 7/23/10; Individual #79, dated 7/12/10; Individual #253, dated 8/11/10; Individual #51, dated 8/11/10; Individual #147, dated 8/16/10; and Individual #193, dated 8/12/10. Most of these reports did not include any initial communication with the PCP. Some documented a follow-up response to gather information rather than an initial intervention to discuss concerns. Certain of the Single Patient Intervention Reports did provide documentation of initial communication with the PCP, and/or initial clinical information from the PCP. These included the following reports: Individual #302, dated 7/16/10; Individual #44, dated 7/20/10; Individual #290, dated 7/9/10; Individual #197, dated 8/23/10; Individual #160, dated 8/11/10; Individual #242, dated 6/15/10; and Individual #128 dated 8/13/10. In one instance, in Individual #176's report dated 8/3/10, the PCP indicated a drug interaction had occurred. In this instance, it would have been helpful if the initial documentation of communication of information by the pharmacy to the PCP, and the initial response by the PCP, had been recorded and followed by this later information. On review of the submitted Single Patient Intervention Reports, there was only one recommendation that resulted in a change of medication (i.e., Individual #302's report dated 6/11/10). For the size of the Facility, one would expect several changes in medications or medication dosages as a result of the intervention communication. The paucity of such changes suggest the wording provided does not communicate that change, or there was not sufficient information provided at the time of the communication to make a decision to change or to consider an alternative. The words used to document the Pharmacy's intervention should reflect what the writer or the PCP intends. The focus should be on recording the initial communication with the physician to provide evidence of the Pharmacy's intervention. It should include the area of concern (e.g., drug interaction, significant side effect, etc.), and should record the response from the physician, the change in order, or the rationale for not changing the medication and the PCP's plan. If only brief information was communicated to the PCP, then there might be a need to review the depth of material shared, as well as alternative medication options suggested to assist the PCP in providing timely and effective clinical choices. It is recommended that the pharmacy review the purpose of the Single Patient Intervention Report to determine how it is to be used. The intervention report should focus on the communication prior to the start of the order or at the initiation of the order.	
N2	Within six months of the Effective	The Pharmacy Department submitted the QDRRs for August 2010. This totaled 50	Substantial

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	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.	QDRRs. The Clinical Pharmacist stated that each individual has a DRR completed every quarter. The following QDRRs were reviewed: Individual #241, dated 8/25/10; Individual #313, dated 8/25/10; Individual #204, dated 8/25/10; Individual #43, dated 8/25/10; Individual #16, dated 8/25/10; Individual #147, dated 8/25/10; Individual #111, dated 8/25/10; Individual #171, dated 8/25/10; Individual #182, dated 8/25/10; Individual #259, dated 8/25/10; Individual #80, dated 8/25/10; Individual #55, dated 8/25/10; Individual #28, dated 8/25/10; Individual #146, dated 8/25/10; Individual #70, dated 8/17/10; Individual #318, dated 8/17/10; Individual #183, dated 8/17/10; Individual #26, dated 8/17/10; Individual #222, dated 8/17/10; Individual #299, dated 8/17/10; Individual #203, dated 8/17/10; Individual #99, dated 8/17/10; Individual #238, dated 8/17/10; Individual #1, dated 8/20/10; Individual #35, dated 8/20/10; Individual #306, dated 8/20/10; Individual #170, dated 8/20/10; Individual #45, dated 8/24/10; Individual #245, dated 8/20/10; Individual #194, dated 8/20/10; Individual #95, dated 8/20/10; Individual #143, dated 8/20/10; Individual #271, dated 8/20/10; Individual #266, dated 8/20/10; Individual #132, dated 8/20/10; Individual #315, dated 8/20/10; Individual #202, dated 8/20/10; Individual #25, dated 8/16/10; Individual #323, dated 8/9/10; Individual #63, dated 8/9/10; Individual #258, dated 8/9/10; Individual #37, dated 8/9/10; Individual #312, dated 8/9/10; Individual #226, dated 8/9/10; Individual #217, dated 8/9/10; Individual #228, dated 8/9/10; Individual #17, dated 8/9/10; Individual #104, dated 8/9/10; Individual #321, dated 8/9/10; and Individual #270, dated 8/25/10. In 100% of the reviews, a variety of laboratory data was reviewed and recommendations made, if necessary. Pertinent results were included, especially if they were abnormally low or elevated, drug levels with values and interpretations were included, and there were recommendations for lab testing as indicated. For easier reading for the PCP, it is recommended that the lab values and recommendations be placed in a chart format for quick viewing. In the narrative style of the review, there was the potential for the reader to overlook important lab values, or other findings. It would also be important to list the recommendations separately to ensure the PCP is able to focus on this aspect of the report. Where thyroid medication is prescribed, it is recommended the last Thyroid Stimulating Hormone (TSH) or thyroid profile be listed or reviewed, as this was one area of that was well documented in some reviews and not in others. For instance: ▪ For Individual #321, in the report dated 8/9/10, the dose of Levothyroxine was followed by notation that the thyroid function test was within normal limits (WNL). ▪ For Individual #270, a notation stated that Levothyroxine had been increased, but there were no thyroid test results to indicate the reason, or test results after	Compliance

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		the dosage increase. Considering the dosage increase occurred on 2/24/10, and the review was 8/25/10, a test report should have been available.	
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.	"Stat" Medications and Chemical Restraints Restraint Checklist/Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms were reviewed for seven events, three in March 2010, two in July 2010, and two in August 2010. This number was consistent with the number of events from the chemical restraint database and represented 100% of those recorded in this system. The WORx report "stat orders" only listed three during this time period. The issue of the definition of "stat orders" is discussed in further detail below. For chemical restraints, the pharmacy interface was a post-event review, up to several days later. The form requested that three aspects of the chemical restraint be addressed: whether it was used in a clinically justifiable manner, the potential medication related risks that should be considered, and actions/recommendations, if any. There was space for both the pharmacist and psychiatrist to provide comments and guidance. Review of the records for the seven events revealed the following: ▪ For Individual #213, who was given Ativan 2 mg on 3/10/10, neither the pharmacist nor psychiatrist filled out their respective sections. ▪ For Individual #317, who was given Mellaril 25 mg at 10:40 a.m. on 3/25/10, and given an additional dose of Mellaril at 2:45 p.m. that same day, there were no Face-to-Face Assessment Debriefing, and Reviews for Crisis Intervention Restraint provided for either of these chemical restraints, and therefore no evidence of review by pharmacy or psychiatry. ▪ Individual #33 was given Ativan 2 mg on 7/9/10. The pharmacist only commented that the chemical restraint was necessary for safety reasons. There was no review of related risks of the medication that should be considered, such as prior use of this same medication and effect on the individual, or drug interaction with other medications currently being prescribed. Other recommendations were not offered, for example, with regard to the best dosage strength for the individual, other options for medications, and/or dosages and routes of administration based on the individual's clinical diagnoses and other current medications. The psychiatrist indicated there were no side effects. ▪ Individual #235 received Zydis 10 mg on 7/21/10. The pharmacist commented that the behavior could not be lowered by any other method, and there was a good effect with no undesired effects. Again, a discussion of risks, drug interactions, optimal dosage and route, a review of clinical diagnoses, or other options for medication choices were not presented. The psychiatrist commented on justification and side effects. ▪ Individual #288 received 2 mg Ativan on 8/4/10, and again on 8/6/10. The pharmacist commented that the desired results were obtained on entry and that	Noncompliance

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		it was necessary for protection from harm, with good results and no after effects. Similar to other entries, there was no mention of risks of the medication, drug interactions, optimal dosage and route, a review of clinical diagnoses, or other potential options. The psychiatrist also commented about good effect without side effects. The lack of detail in the entries by the pharmacist represented missed opportunities to provide direction to the team. As the pharmacist's review occurred post-event, there was detailed information available regarding the event that occurred, and an opportunity to review the drug regimen of each individual for drug interactions, and to review the history to determine what medication and dosage had been effective in the past, as well as to review whether attempts had been made with smaller doses of the medication. It is recommended that pharmacy take advantage of this process to provide needed guidance to the team on psychotropic uses and drug interactions. For those events that occur during regular business hours, it is recommended that the pharmacist also be involved in the decision-making process of the chemical restraint order as part of the team with the PCP, psychiatrist, nursing, and direct support professionals. Pharmacy has considerable expertise to share, but these forms do not reflect the potential guidance and information pharmacy can bring to the team. The Pharmacy and Therapeutics (P&T) Committee had been a forum for discussion about "stat" (emergency) medications and chemical restraints. Pharmacy and Therapeutics Committee meeting minutes were reviewed for meetings held on 9/22/09, 12/15/09, 3/16/10, 6/22/10, and 9/14/10. At the 9/22/09 meeting, the clinical pharmacist compared two data sets, one from the WORx system and the other from the Chemical Restraint log from the Psychology Database. There was one discrepancy noted. The group agreed it would be valuable to review these two reports together at future P&T Committee meetings, and it was agreed these would be pulled together for comparison at future committee meetings for review of chemical restraint use. The following describes the Committee's deliberations over this issue: ▪ At the 12/15/09 P&T Committee meeting, the two reports were reviewed. Inconsistencies were noted. According to the minutes, the Emergency Medication Lock Box medications were not properly documented when administered, causing a discrepancy. The committee also provided guidance in defining a "stat" medication versus a drug to be given "now," with the "stat" medication referring to such compelling issues as psychiatric indications, SIB, or seizures, and "now" medications for other important physiologic occurrences such as nausea, vomiting, diarrhea, rash, etc. It was believed that clarifying the definition of a "stat" medication would allow consistency between the two reports. ▪ At the 3/16/10 P&T Committee meeting, there continued to be confusion as to	

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		how a medication was categorized, especially if it was the first early dose of a medication to be administered routinely, or was an extra dose. It was suggested at the meeting that the Department of Developmental Services in Massachusetts be contacted about the Augmented Medication Plan to learn of their definitions and resolution to this issue. Further committee minutes did not address whether this contact occurred. ▪ At the 6/22/10 P&T Committee meeting, the "stat" medications were reviewed. The committee at that point was awaiting further policy/procedure from the SO. It was pointed out that the Emergency Restrictive Practice/Human Rights Committee Review Form was used for "stat" medications, and this could be used in determining which medications were considered "stat." ▪ At the 9/14/10 P&T Committee meeting, the WORx report and the chemical restraint database were again compared (Summary of Chemical Restraints January 2010- August 2010; Sources: WORx STAT order report and Psychology Restraint Database), and discrepancies were noted. The psychiatrist outlined medications that could have been labeled as "stat" emergency medications, but did not fit that category. The issue many months and meetings later, still had not been resolved, and the pharmacy department was planning on a future meeting with other departments (Psychiatry, Psychology, and Medicine) to discuss and resolve this issue. It was observed that the potential "stat" medications from January 2010 through August 2010 were one-time interventions and were not used as substitutes for a long-term treatment plan. However, it would be difficult to determine if a "stat" medication was used in a clinically justifiable manner until a clear definition of "stat" or emergency medication was agreed upon. Then the committee can take these medications, used in emergencies, and research the utilization to ensure they were clinically justified as required by the SA. <u>Use of Benzodiazepines and Anticholinergics</u> The Quarterly Drug Regimen Reviews (see above with regard to Section N.2 of the SA for the 50 QDRRs referenced) were the main tool used to monitor the use of benzodiazepines to ensure clinical justification. Of the 50 individuals reviewed, 11 had been prescribed benzodiazepines. In five of these individuals, the medication was prescribed for seizure control. One individual had a benzodiazepine prescribed for pre-treatment sedation, and another for extra pyramidal side effects. Four individuals had a benzodiazepine prescribed for a "psychiatric indication," but did not list the actual diagnosis. Clinical justification requires an accurate diagnosis. These diagnoses are available to the pharmacy department, so it was unclear as to the reason for not listing the specific diagnosis for the medication. Based on this review, compliance with regard to proper clinical justification for the use of benzodiazepines was 7 out of 11 records reviewed (64%).	

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		Medications with significant anticholinergic side effects, or combinations of medications prescribed which would contribute to a significant anticholinergic side effect profile were not identified in the QDRRs. Medications with anticholinergic activity, when given together, may create an anticholinergic drug load that affects the physical and mental wellbeing of the individual, at times with serious consequences. This topic may best be addressed by expanding the table already used in the QDRR, in order to highlight this clinical area to the PCPs, should it be recognized by the clinical pharmacist. Compliance with this aspect of the SA was 0%, because there was no mechanism for identifying the use of anticholinergics, and/or ensuring clinical justification. Use and Monitoring of Polypharmacy Polypharmacy was monitored through the Quarterly Drug Regimen Reviews. Of the 50 QDRRs reviewed, 12 individuals were identified with polypharmacy. There was a direct question on the review form: "Is polypharmacy present?" that clearly requires the clinical pharmacist to determine the presence or not of polypharmacy. The polypharmacy was not focused only on psychotropic medications, but included other categories of medication such as laxatives and allergy/respiratory medication. All 50 reviews included a determination of the presence or not of polypharmacy, representing 100% of the records reviewed. However, for the psychotropic medications, there was no clear diagnosis provided, only the phrase "psychiatric indication," which did not assure clinical justification. The form referred the reader to monthly psychiatric clinic notes if the individual received psychotropic medication, but there was no clear indication that the clinical pharmacist reviewed each medication to ensure there was a clinically justifiable indication. In 0% of the individuals prescribed psychotropic medication was a clinical diagnosis provided. It is recommended that a psychiatric diagnosis be listed instead of the phrase "psychiatric indication," and that the pharmacist provide a summary of the review conducted and findings with regard to the clinical justification for the use of polypharmacy. Polypharmacy was also monitored through the Psychoactive Medication Polypharmacy Committee that met monthly. Minutes of this committee were reviewed for the meetings that occurred on: 10/27/09, 11/17/09, 12/15/09, 1/26/10, 2/23/10, 3/30/10, 4/22/10, 5/25/10, 6/29/10, 7/28/09(10?), and 8/25/10. A member of the pharmacy department attended these meetings. In the minutes, each individual with polypharmacy, the psychoactive medication, the diagnoses, and interdisciplinary discussion was recorded. The medications were listed and the diagnoses were listed, but there was no clear delineation of the diagnostic justification for each individual's psychoactive medication.	

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		Monitoring of Newer Generation Antipsychotics Metabolic and endocrine risks were monitored through the QDRRs. Of the 50 individuals reviewed, 14 were documented to have been prescribed atypical, or newer generation, antipsychotics. Of these, there were recommendations to continue monitoring for such parameters as blood glucose, hemoglobin A1c, lipids, diet, and weight. Monitoring of metabolic and endocrine risk occurred in 100% of those with atypical antipsychotics included in the sample. Of the 14 records, 13 (93%) listed the actual glucose level. Of the 14 records, 9 (64%) referenced one or more aspects of the lipid panel.	
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.	For the QDRRs listed with regard to Section N.2 of the SA, each of the reviews included signatures of the PCP, and the psychiatrist, if indicated. PCPs checked the box for "I agree with the Pharmacist's recommendations" in most instances. Of the 50 reviews, there were only four instances in which the PCP or psychiatrist disagreed, and in each case the PCP or psychiatrist wrote a justification (Individual #28's QDRR dated 8/25/10, Individual #55's QDRR dated 8/25/10, Individual #25's QDRR dated 8/16/10, and Individual #241's QDRR dated 8/25/10). In two of the reviews, the PCP signed the document, but did not check whether they agreed or disagreed with the Pharmacist's recommendations (Individual #226's QDRR dated 8/9/10, and Individual #37's dated 8/9/10). All reviews were signed (100%). In 48/50, either the physician agreed with the recommendation, or disagreed but provided justification. Compliance was 48/50 = 96%. The next step would be an opportunity for a medical quality improvement process, in which those recommendations for changes in medications to which the physician agreed would be tracked to determine if a physician order was written. At the time of the review, this was not being done. As a result, there was no way to verify that when the physician agreed with the recommendation, that a change to the order actually was made. The development of a system to ensure that this was occurring would verify the impact of the QDRR.	Noncompliance
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.	DISCUS rating instruments for individuals requiring monitoring for dyskinesia were submitted for the months of May and August. The DISCUS forms were reviewed for completeness and timeliness compared to the last completed form. DISCUS ratings were submitted for the following individuals with the dates of the two most recent dates of rating and dates of review by PCP: Individual #61, rated on 6/21/10, with physician review on 6/22/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #237, rated on 5/26/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/1/10; Individual #50, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/1/10; Individual #235, rated on 5/26/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/1/10; Individual #166, rated on 5/25/10, with physician review on	Noncompliance

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		5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #140, rated on 5/26/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #300, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #155, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/1/10; Individual #232, rated on 5/254/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #60, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #239, rated on 5/27/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #288, rated on 5/26/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/2/10; Individual #240, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #147, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/1/10; Individual #111, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/1/10; Individual #259, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/1/10; Individual #241, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/31/10, with physician review on 9/1/10; Individual #264, rated on 5/28/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #276, rated on 5/25/10 with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; Individual #107, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10; and Individual #65, rated on 5/25/10, with physician review on 5/28/10 and rated on 8/30/10, with physician review on 9/1/10. All of these evaluations (for 20 individuals, including a total of 40 reviews) were complete and completed in a timely manner for 100% compliance. A request also was made for the MOSES for May and August 2010. It was reported that no MOSES were scored for those two months. However, a "MOSES/DISCUS Monitoring Form for Nursing/Psychiatry/Pharmacy" (implemented in the fall of 2009) was provided. This was a database listing all the individuals who required a MOSES and/or DISCUS, with the last date completed. For the MOSES, there were 20 individuals with dates that were overdue for an evaluation. For the DISCUS there were only two individuals with overdue DISCUS. The form indicated a census of 230, of which 20 individuals did not need to be screened by the MOSES, and 210 required the MOSES quarterly. With 20 overdue evaluations, the completion rate was 190/210, or 90% compliance. Seventy-three (73) individuals did not require a DISCUS score. Compliance for DISCUS was 155/157, or 99%. It is essential that MOSES be completed in a timely manner for individuals who require it.	

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N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The Pharmacy Director indicated that in 30 years, there had not been a report of an adverse drug reaction. Given the size of the population residing at LBSSLC, this would indicate that the reporting system is not working. It is recommended that the pharmacy department develop and implement a training program for direct support professionals, as well as nursing and habilitation department staff, to ensure they understand the definition of an adverse drug reaction (ADR), and are able to identify and report an ADR. Pharmacy did have a form to report ADRs that was from the Food and Drug Administration, which included detailed instructions on how to complete the form.	Noncompliance
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 Evaluations had been completed quarterly, and were reflected in the minutes of the Pharmacy and Therapeutics Committee meeting minutes. The following describes these reviews and their results: ▪ In the September 2009 minutes, a drug utilization evaluation was completed for Levaquin and the annual antibiogram. Compliance for key indicators ranged from 78 to 100%. As many treatment regimens for Levaquin were initiated at the hospital, the clinical pharmacist was going to share results of the culture sensitivities with the physicians treating the individuals referred by LBSSLC. Culture sensitivities were also shared with the staff at LBSSLC in order to choose the most effective antibiotic for the infection being treated. ▪ At the December 2009 Pharmacy and Therapeutics Committee meeting, a drug utilization evaluation on Valproic acid was reviewed. All items screened were within 80% compliance. The end result was that one potential drug interaction with Valproic acid was identified, and the medication was changed from Ibuprofen to Tylenol. ▪ At the March 16, 2010 Pharmacy and Therapeutics Committee meeting, a drug utilization evaluation for Keppra and its generic equivalent were reviewed. There was one item below the established threshold. Up to70% of the individuals prescribed Keppra were receiving dosages greater than the recommended dosage of 3000 mg per day. On review of the cases, all required multiple anti-seizure medications for difficult to control seizures, the neurologist prescribed and followed these individuals closely with serial drug levels that were within normal limits, and side effects were monitored. The committee agreed that the benefits outweighed the risks of continuing these dosages for these individuals. No serious side effects had been observed, and the seizures were better controlled on Keppra than prior to initiation of the medication. There was the observation that one individual had more seizures once switched to the generic form of Keppra, and individuals being switched to the generic form should be monitored closely to ensure comparable therapeutic benefit. ▪ At the June 22, 2010 Pharmacy and Therapeutics Committee meeting, a drug utilization evaluation was presented on Dilantin. It was reported that all measurable criteria had 100% compliance except for individuals on feeding	Noncompliance

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		tubes. In this subpopulation, only two individuals had their dosages separated from the tube feeding by at least two hours. Issues concerning feeding tubes and Dilantin administration became the focus for the next drug utilization evaluation, and the study was expanded to include 100% of those with feeding tubes on Dilantin. ▪ At the September 14, 2010 Pharmacy and Therapeutics Committee meeting, a follow-up drug utilization evaluation for Dilantin and tube feedings was presented, as well as a drug utilization evaluation of Clozapine. For the Dilantin and tube feeding DUE, data was presented including frequency of formula bolus or whether the feeding was continuous, and then determined the administration times of the tube feeding in relationship to the dosage times of the Dilantin. In all but one case, there was overlap. The actual Dilantin levels varied from low to high. There would be less ability to change dosage times with those having continuous feedings. One of the issues was whether the seizures were well controlled. The committee presented various options concerning next steps. The Clozapine drug utilization review was also discussed. There was 100% compliance with appropriate clinical indicators, 50% compliance with prescribing when a relative contraindication was present, and 100% compliance with recommended monitoring criteria. The minutes did not reflect a specific recommendation(s). A calendar was provided for future drug utilization evaluations. This included proton pump inhibitors for December 2010, Lacosamide for March 2011, and HMB-CoA inhibitors for June 2011. Additionally, during the September 14, 2010 Pharmacy and Therapeutics Committee meeting, the clinical pharmacist reviewed information concerning "traditional reasons to consider a drug for study," as well as "expanded reasons to consider a drug for study." The Facility had taken the first step in conducting DUEs by completing reviews of specific medications. Many of these reviews had identified important information. In order to complete the DUE process, the Facility needed to "close the loop." When there were findings that the Facility was below the identified thresholds for specific indicators, action steps needed to be developed and implemented, and any additional review needed to be completed to ensure that the issues identified were corrected.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year,	A number of policies and procedures were in place to address medication errors, both in the pharmacy and nursing departments, including: ▪ LBSSLC – Health Services: Essential Position Elements RN II, and LVNs, dated	Noncompliance

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	the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	12/30/09 (R); ▪ LBSSLC – Nursing Duties, dated 6/26/09 (R); ▪ LBSSLC – Nursing: Medication Errors/Incidents, dated 2/16/10 (R); ▪ Process for Handling Excess Medications Returned to Pharmacy: Flow diagram; and ▪ LBSSLC – Health Services: Medication Adjustment, dated 4/13/10 (R). The minutes of the Medication Error Committee were reviewed for the following meeting dates: February 9, 2010, April 29, 2010, June 30, 2010, August 25, 2010, and September 7, 2010. The Medication Error Committee was created on 2/9/10 with a focus on tracking and reducing medication errors. According to an email of 9/15/10, there had not been a committee meeting prior to that date. In narrative form, this committee reviewed each medication error that was reported. The following summarizes some of the key issues documented in the minutes: ▪ In one instance of a January 2010 medication error, the individual was sent to the ER with a life threatening adverse consequence. However, no other information was recorded in the February minutes other than the wrong individual received the wrong medication at the wrong dose. Another individual also was sent to the ER due to a medication error, but reportedly, there were no adverse consequences and no treatment was indicated. In the February minutes, it was documented that the "returns" to the pharmacy had steadily improved. There had been a number of medications returned that remained unexplained. There was also an incident in which three tablets of a narcotic were noted to be missing, and a new system was implemented to prevent recurrence. ▪ The April 2010 minutes documented that the physician was not always notified of a medication error. It also was noted that the return of medication to the pharmacy did not consistently result in a review as to reasons for the return. This could indicate a medication error or there could have been a justification, but there was no information gathered at that point in time. Several implementation steps were recorded in response to medication errors. According to the minutes, the number of times nurses were monitored during medication administration was increased from annually to quarterly. Those who were providing the monitoring were trained to provide standardization of observations. Also, there was an initiative to provide correction at the time of the error, as well as documentation of the error. The nursing department added a nurse educator assistant position that would focus on ensuring medication administration competency. It also was documented that the case managers	

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		were expected to do more monitoring as their caseloads had diminished, leaving them more time to assist with monitoring. There was no documentation in future meeting minutes that this occurred. Also, due to a medication error in which eardrops were used on the eyes of an individual instead of eye drops, there was the discussion about adding additional labels on the dropper bottles to ensure that a nurse used the correct medication. However, future minutes did not confirm this action had taken place. ▪ In the June 2010 meeting, it was noted that in one of the homes, each shift of nurses counted medications with the next shift to determine accuracy of administration. The medication error rate had increased, and it was assumed that it was due to introduction of a system that catches more errors. Agency nurses had been responsible for many of the errors, and the nursing department alerted the nursing agency that they were providing follow up and corrective action, rather than the nursing agency. To further assist with discovering medication errors and providing context to the errors, a camera with audio capabilities was to be placed in the medication room. However, future meeting minutes did not indicate this had been accomplished. In reviewing the medication errors, nursing had discovered that a number of the errors occurred when the nurses were distracted to resolve other problems on the unit. Nursing administration learned from other facilities that some have a "do not disturb" policy, and one facility had the nurse wear a vest indicating they were not to be disturbed during medication administration. The nurse would be able to call the supervisor who would send a nurse to take care of the problem in the home, allowing the medication administration to proceed with minimal interruption. Additionally, the unit directors and the direct support professionals would need training on whom to contact during a medication pass. However, later meeting minutes did not indicate that there was implementation of any of these recommendations. New orders, at times in the past, had not been discovered and processed, and red racks had been created in which records could be placed, which notified the nurse of an order transcription. It was not clear from the minutes whether all buildings had these red racks, whether the physicians were using the red racks, and whether staff understood that only records with newly written orders were to be placed on these red racks. Follow-up of these questions was not documented in the minutes. The minutes also documented that there was no error rate that could be calculated. There were 67,000 doses administered for the prior month. However, the medication error reporting rate may not have reflected the true medication error rate, and it was noted that punitive responses from administration rather than system improvements would not reduce the medication error rate. It also was recorded that the medication returns had still not begun to be counted. This was problematic, as	

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		some of the returns represented valid reasons for the overage, but other returns occurred because of medication errors. However, this information was not known. It was also reported that the State Office was going to maintain a medication error system and not change to a variance reporting system. ▪ From the August 25, 2010 committee minutes, errors had also occurred because a nurse, who was new to the home, gave medication to the wrong individual. Discussion was recorded as to the steps to avoid such a mistake. However, there was no discussion of implementation of these ideas. It was documented that pharmacy had begun to determine justification of the medication returns. This included all medications that were returned to the pharmacy. A monthly report was anticipated that reviewed the findings of this initiative. ▪ From the September 2010 meeting, there was discussion about the need for completing record checks. These were done daily/each shift and recorded on the physician order sheet. There was documentation in the minutes that in-service training was needed for this to occur across the campus. It also was recorded that distractions were occurring during medication administration. It was not clear what steps had been taken and what steps were anticipated to occur. Pharmacy provided some preliminary information concerning the returned medication. The time period of this data was not provided. However, it was noted there was great variation between buildings, from 149 tablets in one building to only four tablets in another. There was no information interpreting these preliminary findings. It was discussed that the return medication should also be tracked per individual. Based on review of these minutes, the following observations were made and recommendations should be considered: ▪ The minutes did not reflect closure to the many good suggestions offered during the meetings. Each of the suggestions should be discussed and agreement documented, regarding whether or not to proceed with a potential action step. That step should have follow-up information at each of the following meetings to note progress or lack of progress. Currently, many of the excellent suggestions appear to be lost, or if they are being accomplished, this is not clearly documented. ▪ The SA requires data collection and analysis of the data. It would be important to continue to gather data that can then be placed in chart and table format for pharmacy interpretation. It is difficult to determine trends from the narrative style minutes. The Facility is in an early stage of creating a system of accountability in determining the true medication error rate, which then can be the baseline on which to measure the success of corrective action steps. Information concerning the overages that are returned to the pharmacy is	

#	Provision	Assessment of Status	Compliance
		actively being pursued. This analytical approach is imperative to determine the true medication error rate. With accurate information, the pharmacy can then begin to provide guidance and corrective action. There seems to be good communication between the nursing and pharmacy departments in the area of medication error. Information should be available for all the main categories of medication error (wrong medication, wrong person, wrong time, wrong dose, wrong route, etc.) as well as inclusive of campus demographics (building, shift, off or on-site administration, etc.), and personnel involved. It will take several quarters of accurate data before trends can be determined, and further corrective action steps identified and implemented. Information was submitted as part of an interdepartmental record data set for the POI. It listed per month from 9/09 to 7/10, the number of errors by extra dose, omission, wrong administration technique, wrong patient, wrong time, wrong dosage, wrong route, and wrong drug. As the Medication Error Committee indicated, this information is incomplete, and one of the main steps to ensure accurate reporting will be the analysis of medications returned to the pharmacy. Also, as already mentioned, automatic punitive responses will not resolve the issues of medication errors. It will require changes in systems in medication administration. Record checks for orders were signed off by nursing staff serially per shift. This made the physician order sheet difficult to read, and physician orders could be buried in the many lines of record checks generated by the nursing department. Finding specific physician orders was visually difficult, as at times only one or two physician orders were on a page, and the remainder of the page was consumed by record checks by nursing. There is probably a better way to accomplish the record check system required without interfering with the physician order system, and it is recommended that nursing administration review some of these order sheets to understand the impact of the current approach and develop alternatives, creating a right hand margin for the nurse to document time and initials would allow separation of orders from chart check systems, for instance.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Single Patient Intervention Reports should be revised to include information such as recommendations for lab monitoring or the need for lab testing. Although lab data is not available through the WORx system, there should be information concerning lab work available to guide recommendations to the physician.
2. Level 2 and 3 drug interactions and concerns should be reviewed by the medical department to ensure the PCPs agree that there is no clinical need to modify a medication order. This review should occur as close as possible to the time the medication is prescribed.
3. Gathering information about Level 2 and 3 drug effects (i.e., side effects and drug interactions) after administration is a clinical concern

separate from interventions prior to administration of medication. If information is gathered after drug administration is completed, this should be processed and shared with the physicians, and also used to review whether a particular drug interaction or side effect would change the level of concern, up or down, or would provide evidence that it should remain at Level 2 or Level 3.

4. If the Pharmacy's intervention occurs at any time other than at the initiation of the drug order, then there should be clear documentation of date and time of the Pharmacy's communication with the PCP to verify it was a communication after administration of medication and not prior to administration of medication.
5. The words used to document the Pharmacy's intervention should reflect what the writer or the PCP intends. The focus should be on recording the initial communication with the physician to provide evidence of the Pharmacy's intervention. It should include the area of concern (e.g., drug interaction, significant side effect, etc.), and should record the response from the physician, the change in order, or the rationale for not changing the medication and the PCP's plan.
6. The Pharmacy should review the purpose of the Single Patient Intervention Report to determine how it is to be used. It is recommended that the pharmacy utilize this intervention report as a tool in documenting initial communication with the PCPs, both the information that the pharmacy shares, and the date and time of response from the PCP (with name of PCP, which may be different from assigned doctor listed at the top of document), and the initial response/plan from the PCPs.
7. For the QDRRs, due to the richness of the information presented, it is recommended that the findings (e.g., lab values), and recommendations be placed in chart form rather than narrative.
8. When thyroid medication is prescribed, it would be valuable to list the most recent TSH or thyroid profile, and any follow up thyroid testing after the medication introduction or change, if available.
9. The Pharmacy should use the Face-to-Face Debriefing and Reviews for Crisis Intervention Restraint as a post-event opportunity to provide valuable information, including but not limited to, review of the drug regimen to determine the appropriate chemical restraint choice and dosage, and review of the individual's history to determine what medication was most effective in the past and whether smaller doses are indicated or should be attempted. The comments should provide valuable guidance to the team for future, potential chemical restraint use.
10. There should be a clear definition of the term "stat" medication, including its relationship to chemical restraint. There also should be agreement and resolution of the documentation of chemical restraint information in the different database sources used. As this has been a yearlong process without resolution, the conclusion to this issue needs to be accomplished in a timely manner. It will be difficult to determine if a "stat" medication is used appropriately if there is no clear definition of a "stat" medication, and "stat" medications are not being tracked properly.
11. Concerning benzodiazepine use, Pharmacy staff should be attentive to detail in identifying the diagnosis or the purpose of the medication. Listing the term "psychiatric diagnosis" is not sufficient, and does not document the clinical justification for the benzodiazepine, and if it is the best choice for the individual.
12. Medications with significant anticholinergic side effects, and regimens of medications which in combination have an increased anticholinergic drug load, should be thoroughly reviewed in the QDRRs to determine if an adequate clinical justification is present. This would be another valuable role of the pharmacist in assisting the physician in choice of medication.
13. With regard to polypharmacy, there should be a clear indication that the clinical pharmacist reviewed each psychotropic medication to ensure there was a clinically justifiable indication for each one. It is recommended that a specific psychiatric diagnosis be listed instead of the phrase "psychiatric indication."
14. Providing justification for each medication separately, rather than having only lists of diagnoses and medications also could enhance the work of the Psychoactive Medication Polypharmacy Committee.
15. A valuable next step in the medical QI process would be to develop a tracking system to ensure that for the QDRRs that recommend changes in orders to which the PCP agrees, that orders are written to ensure completion of the process.
16. The pharmacy department should develop and implement a training program for direct support professionals, as well as nursing and habilitation department staff to ensure they understand the definition of an adverse drug reaction, and are able to identify and report an ADR.

17. Suggestions from the Medication Error Committee should be discussed and agreed upon in the context of creating action steps. These action steps should be tracked at each follow-up meeting until completion, and revised, as necessary. To ensure adequate follow up, these minutes should document any progress accomplished, and any modifications made to the action plans.
18. Pharmacy should create a system in which a medication error rate can be calculated and trends reviewed and analyzed at each meeting of the Medication Error Committee. The minutes should reflect progress toward defining true error occurrence, ensuring errors are not missed and creating a system in which the quality of the data is reliable. Accurate and complete data will be required to determine trends. Trends can most easily be visualized by chart and graph presentation rather than narrative form.
19. Determination of the reason(s) for overages that are returned to the Pharmacy should continue to be actively pursued.
20. It is recommended that nursing administration review some of the order sheets to understand the impact of the current way in which nurses are documenting review of physician orders on the ease-of-read of the orders, and develop alternatives, for example, creating a right hand margin for the nurse to document time and initials would allow separation of orders from chart check systems.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) Assessment and Updates for last year, Nutrition Assessment, Nursing Care Plan, OT/PT/SLP consultations for the last year, outside medical consultations for the last year, PSP and PSP Addendums for the last year, current and revised for the last year Physical and Nutritional Management Plan (PNMP) with pictures, Nutritional Management Team (NMT) Individual Record with recommendations, PNMP person-specific monitoring for the past year, Nutritional At Risk Assessment by NMT, PNMP Clinic Notes for last year, Mealtime person-specific monitoring, competency-based training for staff for PNMPs and dining plans, daily schedule, Integrated Progress Notes for last quarter, ER/hospital discharge summary and dining plan with pictures for the following individuals: Individual #261, Individual #226, Individual #301, Individual #6, Individual #161, Individual #176, Individual #203, Individual #192, Individual #320, Individual #184, Individual #243, Individual #313, Individual #34, and Individual #276; o OT/PT/SLP Assessment and Updates for last year, Nutrition Assessment, Nursing Care Plan, OT/PT/SLP consultations for the last year, outside medical consultations for the last year, PSP and PSP Addendums for the last year, PNMP current and revised for the last year with pictures, NMT Individual Record with recommendations, PNMP person-specific monitoring for the past year, Nutritional At Risk Assessment by NMT, PNMP Clinic Notes for last year, Mealtime person-specific monitoring, competency-based training for staff for PNMPs and dining plans, daily schedule, Integrated Progress Notes for last quarter, ER/hospital discharge summary and dining plan with pictures for the following individuals: Individual #193, Individual #43, Individual #33, Individual #199, Individual #283, Individual #66, Individual #275, Individual #274, Individual #235, Individual #109, Individual #204, Individual #23, Individual #257, Individual #215, and Individual #162; o OT/PT/SLP Assessment, Nutrition Assessment, OT/SLP consultations for the last year, PSP and PSP Addendums for the last year, current and revised PNMP for the last year with pictures, NMT Individual Record with recommendations, Nursing Care Plan, Integrated Progress Notes for the last quarter, person-specific PNMP monitoring, competency-based training for staff for PNMPs, daily schedule, and a therapeutic feeding program, if any of the individuals received one (per report, no one was receiving a therapeutic feeding program) for the following individuals: Individual #253, Individual #128, Individual #312, Individual #16, Individual #199, Individual #281, Individual #66, Individual #68, Individual #7, Individual #191, and Individual #6; o OT/PT/SLP Assessment and Updates, NMT Individual Record with recommendations, PSP, current and revised PNMP with pictures, and OT/PT/SLP consultations for the last year for the following individuals: Individual #285, Individual #292, Individual #208, and

	Individual #229; o Draft Physical Nutritional Management (PNM) Policy, undated; o PNMT (Physical and Nutritional Management Team) Evaluation (draft), undated; o List of Individuals by home, dated 8/18/10; o Draft At Risk Individuals Policy, revised 9/3/10; o Draft Risk Factor Definitions, 9/10; o Respiratory Profile Report, 1/1/10 through 7/31/10; o List of Individuals Referred for community placement since 1/10/10, undated; o Plan of Improvement, dated 5/17/10; o List of Individuals admitted to hospital within last six months, dated 9/13/10; o List of Individuals admitted to ER in 2010, dated 9/16/10; o List of Individuals, PSP (Personal Support Plan) dates and Work Program for 2009 and 2010; undated; o List of Individuals (do not restrain) with Crisis Intervention Physical Restraint order, undated; o Handout entitled The Verbal Behavior Approach: Teaching Children with Autism, undated; o Integrated Meeting Minutes, dated 8/24/10, 9/2/10, and 9/15/10; o Program Observation Tools, dated 7/10 through 9/10; o Communication Handbook for PST, undated; o Integrated Progress Notes for Multiple Individuals for the month of 9/10; o Training Agenda for Core PNMT, not dated; o Dedicated PNMT Members list, undated; o List of PNMP Coordinators by home, undated; o PNMP Coordinators: Training and Agenda, various dates; o Meal Monitoring forms for various homes, week of 9/13/10; o Caseloads for Therapists, undated; o Meal Time Coordinator Duties, undated; o PNMP Training Sheets, dated 7/23/10; o Dining Plans for Multiple Individuals, from 5/09 through 9/10; o Competency Based Training Documents for Meal Time Coordinators, dated 8/10; o Meal Time Coordinator Training Agenda, for 8/10 and 9/10; o List of Staff and Positions, dated 8/10; o Continuing Education Units, from 1/10 through 7/10; o PNMT Evaluation and Meetings, for 7/10, 8/10, and 9/10; o Notes/Recommendations on Restraints, Contractures, PICA and Meal Assistance by home, from 3/10 through 8/10; o NMT/PST Meeting Attendees, dated 1/5/09; o Habilitation Therapies (HT)/NMT/PNMP Health Status Meeting Attendees, dated 1/8/10; o NMT/PST Meeting Updated Minutes by home, from 1/10 through 7/10; o PNMT Evaluation, dated 7/23/10; o HT Protocol for Hospital return (blank), undated; o PSPs for Multiple Individuals, from 9/09 through 7/10;

	- PNMPs for Multiple Individuals, from 3/10 through 8/10; - HT PNMP Observation (blank), revised 7/22/10; - HT Meal Observation (blank), revised 7/19/10; - PNMP checklist for compliance (blank), dated 7/10; - PNMP checklist for compliance, dated 6/10 and 7/10; - NMT Report (blank), undated; - Dining Plan Template, undated; - List of Individuals on Modified Diets, dated 7/31/10; - Diet Texture Downgrades, from 3/20/10 through 7/31/10; - List of Individuals with Body Mass Index (BMI) greater than or equal to (≥) 30, undated; - List of Individuals with BMI less than or equal to (≤) 20, undated; - List of Individuals with Weight Loss greater than or equal to 10% within past six months, from 1/1/10 through 6/30/10; - List of Individuals with Choking Incidents, from 9/09 through 7/10; - Individual Diagnosis Report from 7/1/09 through 8/1/10, dated 8/19/10; - List of Individuals with Skin Breakdown during past year, undated; - List of Individuals who incurred Slip, Trip, and/or Fall Injuries between 9/09 and 8/10; - Health Issue - Injury with rating levels, dated 8/20/10; - List of Individuals with Poor Oral Hygiene Status (2009 through 2010), undated; - List of Individuals on Enteral Feeding, dated 7/31/10; - List of Individuals with Modified Barium Swallow Study and corresponding NMT Reports for multiple individuals, from 7/09 through 8/10; - Dining Plans for Multiple Individuals, from 9/09 through 9/10; - Individuals on Enteral Feeding Report, 8/10; - Master HT/PNMP data, from 8/09 through 8/10; - Meal Time Schedule, undated; - HT Schedule for the week of 9/13/10, dated 9/7/10; - PNM Curricula used to train staff, dated 9/3/10; - Dining Plan template, undated; - HT/PNMP Observation (blank), dated 7/22/10; - HT Meal Observation (blank), dated 7/19/10; - PNMP (blank), undated; - PNMP Evaluation, dated 7/28/10; - Active Employee Course Participation Report from 9/09 through 9/10, dated 9/1/10; - Competency Based Training Compliance Report, dated 9/2/10; - List of Individuals with ER Visits between 1/10 and 8/10 with reasons/diagnosis, dated 8/16/10; - Hospital Rounds Reports for Multiple Individuals, from 1/10 through 8/10; - Respiratory Profile Report for Multiple Individuals between 1/10 and 7/10, dated 8/20/10; - 2010 Pneumonia/Habilitation Therapies, from 1/10 through 8/10; - Unusual Incident Reports, dated 6/26/10 and 5/19/10;

	- Settlement Agreement Implemented Monitoring Tools (blank), undated; - Series of Memoranda (via emails) from Program Compliance Monitor regarding Unusual Incident Investigations along with Recommendations/Follow Up, from 1/10 through 8/10; - Incident Management Reports by facility, from 9/09 through 8/10; - Monthly Data Reports, from 1/10 through 7/10; - Health Status List, dated 8/25/10; - List of Multiple Individuals with Dental Risk/Categories by home, undated; - List of Multiple Individuals with Injuries resulting from bite, hit, scratch, bumped into, choked, friction, slap, kick, push, shove, from 9/09 through 8/10; - List of Multiple Individuals with Poor Oral Hygiene, from 2009 through 2010; - Enteral Feeding and Frequency Report, from 7/1/10 through 7/31/10; - New Employee Orientation Schedule from 9/1/10 through 10/04/10, dated 8/25/10; - Staff Vacancy Report, dated 8/23/10; and - Curriculum Vitae of PNMT dedicated members. ▪ **Interviews with**: - Karen Hardwick, State Coordinator of Habilitation Therapies; - Linda Thomas, LBSSLC Habilitation Therapies Director; - Corey Verett, LBSSLC Registered Dietician (RD), LD, and dedicated PNMT member; - Sarah Burton, LBSSLC OTR/L and dedicated PNMT member; - Frances Shaw, LBSSLC PT and dedicated PNMT member; - Debbie Jones Ellison, LBSSLC SLP/CCC and dedicated PNMT member; - Robin Seale, LBSSLC Assistant Director of Programs; - Donna Jessee, DADS Director of Operations for the State Supported Living Centers; and - Becky McPherson, DADS Settlement Agreement Compliance Unit. ▪ **Observations of**: - PNMT Meeting, on 9/15/10; and - 504 E. Mesquite Drive, 504 W. Mesquite Drive, 517 S. Cedar Avenue, 518 S. Cedar Avenue, 528 N. Cedar Avenue, 516 S. Cedar Avenue, 521 S. Cedar Avenue, 525 N. Cedar Avenue, 526 N. Cedar Avenue, 513 S. Cedar Avenue, 515 S. Cedar Avenue, and 520 S. Cedar Avenue.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for LBSSLC did not include this component, LBSSLC did not identify compliance with any of the Section O indicators. This was consistent with the Monitoring Team's findings. During the entrance conference, the LBSSLC Habilitation Therapies Director indicated that the Habilitation Therapy Department had implemented the following activities related to Section O following the initial baseline review: ▪ Collaborated with Nursing and Dental in regards to the integration of PNMPs and positioning plans for individuals; ▪ Developed and implemented a guideline for change of diet following involved dental procedures;

	▪ Initiated a core PNMT using the Health Care Guidelines. The State Office Coordinator of Habilitation Therapies provided training; ▪ Mealtime oversight guidelines for Mealtime Coordinators were developed, in-service training was provided, and the process was implemented; ▪ Implemented the provision of pre-thickened liquids; and ▪ Implemented a process for all Habilitation Therapists to participate in-self monitoring for Sections O, P, and R utilizing the monitoring tools.
	Summary of Monitor's Assessment: The PNMT initiated the completion of the first PNMT comprehensive assessment for Individual #301 on 7/23/10. PNMT dedicated members in attendance were a Speech Language Pathologist, Physical Therapist, Occupational Therapist, and Registered Dietitian. Additional disciplines attending the PNMT meeting were a Registered Nurse Case Manager and a Unit Manager Nurse. A dedicated nurse had not been assigned to the team at the time of the on-site review. There were no ancillary members attending the PNMT meeting as documented on the PNMT Evaluation attendance sheet. Review of clinical instruction documentation for the current PNMT members (including the SLP, OT, PT, and RD) showed that all of these members had had clinical instruction and professional development in the area of physical and nutritional supports. Documentation of clinical instruction within the last 12 months related to physical and nutritional supports was not submitted for a nurse, because there was not a dedicated nurse on the PNM Team. The Facility was to be commended for identifying and providing training to Mealtime Coordinators (MTC). Mealtime Coordinators were staff designated by residential services to coordinate the services provided to individuals during meal times. However, there were some areas of concern noted. Although they had responsibilities related to ensuring that dining plans were implemented as written, during the Monitoring Team's observations, they did not intervene to address issues such as individuals not being in proper alignment and support, or if the instructions on dining plans were not being followed. Although Mealtime Coordinators had been provided with some basic training, there was not a process for ensuring their competency with regard to general PNMP competencies or individual-specific plans. Likewise, there was no competency-based written test and/or skills-based performance check-off to establish competency of PNMP Coordinators. The Monitoring Team's observation of a PNMP Coordinator in a dining area did not indicate that the PNMP Coordinator was competent to provide coaching, mentoring, and monitoring to the staff during mealtimes. Specifically, during the observation, the PNMP Coordinator did not intervene to correct position and alignment, or model for staff the correct techniques when dining instructions were not being followed. Based on review of the Facility's policy, LBSSLC did not have an adequate policy defining the monitoring system for PNMPs and meal observation. A policy should be developed to ensure that a system is in place to monitor staff implementation of PNMPs, including mealtime plans. At a minimum, such a policy should include: ▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is

	determined to be at risk; ▪ Identification of monitors and their roles and responsibilities; ▪ Formal schedule for homes to be monitored on a quarterly basis, with an identified staff schedule; ▪ A revalidation of monitors on an annual basis by therapists and/or assistants; and ▪ Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor. A review of Facility reports, including those from Quality Improvement/Quality Enhancement, did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM Team for analysis leading to the identification and ensuring the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine the efficacy of the supports provided at both the individual-specific and systemic levels. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems. In addition, PNMT members should be actively involved in internal mortality reviews as a learning process, as well as a mechanism for improving supports to individuals with the most complex health, physical, and nutritional support needs.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan	Due to the multiple requirements included in this provision of the SA, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O of the SA, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. The assessment and planning processes in which the team is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the SA. The PNM team consists of qualified Speech Language Pathologist (SLP), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietician (RD), and, as needed, ancillary members [e.g., MD, Physician's Assistant (PA), Registered Nurse Practitioner (RNP)]. The LBSSLC PNMT initiated the first PNMT comprehensive assessment for Individual #301 on 7/23/10 (PNMT Evaluation, dated 7/23 and 7/28/10). PNMT dedicated members attending were a Speech Language Pathologist, Physical Therapist, Occupational Therapist, and Registered Dietitian. Additional disciplines attending the PNMT meeting were a Registered Nurse (RN) Case Manager and a Unit Manager Nurse. A dedicated nurse had not been assigned to the team at the time of the on-site review.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>
There were no ancillary members attending the PNMT meeting as documented on the PNMT Evaluation.
At the time of the review, there were two RD's supporting 229 (current LBSSLC census reported) individuals living at LBSSLC. The following chart identified their current caseloads and/or responsibilities with a census provided by HT that totaled 230 individuals:
<table>
<tr><th>RDs</th><th>Current Caseloads</th></tr>
<tr><td>RD #1</td><td>Dedicated PNMT member and responsible for homes 504E, 504W, 514, 516, 520, 523 (partial), and 526, and supporting 115 individuals.</td></tr>
<tr><td>RD #2</td><td>Responsible for homes 515, 517, 518, 521, 523 (partial), 525, 527 (temp. 528), and 513, and supporting 115 individuals</td></tr>
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The assignment of a RD as a dedicated PNMT member will significantly impact the workload of this RD. The current caseloads will not allow the RDs to be active members of individual's PST.
With regard to the qualifications of the PNMT members, review of Curriculum Vitae (CVs) submitted for the dedicated PNMT members (SLP, OT, PT, and RD) documented that each had five years of experience within their respective fields. The SLP, OT, PT, and RD were licensed to practice in the state of Texas, per report. During the next on-site review, the curriculum vitae of the dedicated nurse will be reviewed, if one has been assigned.
Review of the clinical instruction of the current PNMT members (SLP, OT, PT, and RD) revealed that the following:
In four of four individual clinical instruction records reviewed (100%) (SLP, OT, PT, and RD) clinical instruction within the last 12 months related to physical and nutritional supports for individuals with complex physical and nutritional supports had been completed.
Because a dedicated nurse had not been assigned, documentation of clinical instruction within the last 12 months related to physical and nutritional supports was not submitted.
Each of these PNMT members (SLP, PT, OT, and RD) had attended two clinical instruction courses entitled Physical Management Team and Nutritional Management/GI issues that
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		the State Coordinator of Habilitation Therapy Services provided. Per report, training for PNMT members was expected to be ongoing.
		
		As documented in the training agenda for core PNMT members entitled Physical Nutritional Management Team Initial Training (undated), clinical instruction for the PNMT members was expected to include the following:
		▪ Physical Nutritional Management Team
		    o Settlement Agreement Section O (PNMP);
		    o Draft PNMT Policy;
		    o Draft Evaluation Form from Health Care Guidelines; and
		    o Roles of PNMT members;
		▪ Nutritional Management/GI Issues;
		▪ Assessment Technologies;
		▪ Seating and Positioning for Dysphagia;
		▪ Evaluation of Seating and Positioning;
		▪ Wound Investigation Protocol;
		▪ Nursing Issues in PNMP; and
		▪ Dietary Issues in PNMP.
		
		According to the training courses submitted by HT staff, additional continuing education courses attended by the PNMT dedicated members were as follows:
		▪ Overcoming the Challenges of Applying the Nutritional Care Process/Standardized Language Today;
		▪ Technical Advances in the Management of Dysphagia;
		▪ Essential Lean Body Mass;
		▪ PNM and Wheelchair Clinic;
		▪ Dysphagia and Nutritional Management;
		▪ Mealtime Success for Kids on the Spectrum;
		▪ PNM for Nurses/Issues in Nutritional Management;
		▪ Texas Laryngectopmee Association Annual Conference 2010;
		▪ Texas Speech Language Hearing Association Annual Convention; and
		▪ Texas Assistive Technology Network Latitude Conference.
		
		All of this training was helpful training for PNMT members to have, and the Facility and State are encouraged to continue to offer such training opportunities to PNMT dedicated team members, as well as ancillary members of the PNMT, and other therapists. All PNMT dedicated members (not just therapists) and ancillary members should attend a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of supports to individuals with the most complex physical and nutritional supports needs.	

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		PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results. Based on a review 14 individual records (for Individual #261, Individual #226, Individual #301, Individual #6, Individual #161, Individual #176, Individual #203, Individual #192, Individual #320, Individual #184, Individual #243, Individual #313, Individual #34, and Individual #276) for one of 14 (7%), documentation supported that the PNM Team had met regularly to address change in status, complete a comprehensive assessment, and review clinical data and monitoring results. The individual record sample was drawn from lists of individuals at risk based on the following criteria: ▪ Individuals who had Emergency Room visits; ▪ Individuals who had hospitalizations; ▪ PNM (NMT) Team meeting minutes; ▪ Individuals with an active pressure ulcer within the last six months; ▪ Individuals with severe dysphagia; ▪ Individuals with chronic constipation or who experienced fecal impaction within the last six months; ▪ Individuals with unexplained weight loss or BMI ≤ 20; ▪ Individuals with BMI ≥ of 30; ▪ Individuals who experienced a choking incident that required the abdominal thrust within the last six months; ▪ Individuals with a diagnosis of aspiration pneumonia; ▪ Individuals who had experienced significant falls related to transfers and/or ambulation; ▪ Individuals with chronic respiratory infections; ▪ Individuals with chronic dehydration; ▪ Individuals with a diagnosis of osteoporosis and/or osteopenia; ▪ Individuals who experienced a fracture; and ▪ Reviewer observations of mealtime, positioning, transfers, medication administration, tooth brushing, personal care, and functional communication. A comprehensive Physical and Nutritional Management Team Evaluation was completed for Individual #301, dated 7/23 and 7/28/10. The comprehensive evaluation sections addressed the following: ▪ Behavioral Challenges; ▪ Active Problem List; ▪ Frequency of hospitalization in the past year; ▪ Medical History (choking, aspiration pneumonia, gastroesophageal reflux); ▪ Gastric emptying; ▪ Vomiting;	

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		▪ Pneumonia; ▪ Dysphagia; ▪ Upper respiratory congestion; ▪ Noisy respiration; ▪ Neurological/musculoskeletal conditions which could result in improper body alignment due to orthopedic deformities; ▪ Medical conditions that alter intake or nutrient requirements; ▪ Documented or suspected GI bleeding/ulcers; ▪ Enteral nutrition tubes; ▪ Alteration in lab values; ▪ Current medications; ▪ Pertinent medication side effects; ▪ Physical clinical indicators; ▪ Current nutritional indicators; ▪ Diagnostic workup/referral to NMT occurred for the following diagnoses; ▪ Analysis; and ▪ Recommendations. Individual #301's PNMT Evaluation recommendations documented the need for further assessment, measurable outcomes, monitoring requirements, and the type/frequency of data to be collected. The PNMT's recommendations needed to identify the responsible person, as well as assignment of a due date to ensure recommendations were completed. In addition, the strategies developed by the PNMT to be implemented should identify baseline objective clinical data and the continued documentation of identified clinical data to enable an analysis of the data to be completed to determine the efficacy of their interventions. The Team should review the status of identified strategies at every meeting until the individual is discharged from the PNMT. The PNMT should be mindful of not including elongated timeframes for the completion of recommendations, because the Team should be working with individuals with the most complex health, physical, and nutritional needs, which should generate a sense of urgency to complete all recommendations leading the individual to improved health and wellness. For example, in Individual #301's evaluation, the completion of "Monthly weight/feeding assessments" may be too long of a timeframe between monitoring/assessments for an individual who was designated at high risk by the PNMT. The PNMT should provide monitoring oversight on a daily and/or weekly basis depending on the importance of the strategy being implemented to minimize risk until Individual #301 is discharged from the PNM Team. In addition, the PNM Team should work with Individual #301's PST members to initiate a Personal Support Plan Addendum to incorporate the PNMT Evaluation and recommendations into the PSP. During the on-site visit, the PNMT was in the process of developing an action plan format to track the	

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		status of individual recommendations, as well as identifying individual triggers that would alert staff of immediate concerns. Individual examples of where the PNM Team did not regularly address change in status, review of clinical data, development of comprehensive assessments, and monitoring of the efficacy of strategy results included the following: ▪ Individual #226 was hospitalized multiple times on 2/16/10, 2/24/10, 6/25/10 and 8/13/10, with diagnoses of gastrointestinal hemorrhage unspecified, pneumonia organism unspecified, respiratory abnormality, and food/vomit pneumonitis. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identify complex physical and nutritional support needs. ▪ Individual #261 was hospitalized multiple times on 3/21/10, 5/1/10, 5/9/10, 8/4/10, 8/20/10, and 8/24/10, with diagnoses of dehydration and urinary tract infection unspecified. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #6 returned to LBSSLC after being hospitalized for a PEG placement on 6/15/10, and treatment for skin breakdown in the sacral and anal area (Habilitation Therapies Consultation, dated 6/25/10). The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #161 was hospitalized multiple times on 1/9/10, 1/14/10, 1/23/10, and 3/10/10, with diagnoses of gastrostomy complications and urinary tract infection unspecified. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #176 was hospitalized multiple times on 1/13/10, 5/24/10, 7/28/10, 8/4/10, and 8/26/10, with diagnoses of pneumonia organism unspecified and gastrointestinal hemorrhage. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #203 experienced an unplanned weight loss greater than 10 percent over the past six months. He also experienced a choking incident that required the use of the abdominal thrust. The NMT Report, dated 5/20/10, stated: "no current policy/procedure is in place regarding proper preparation of food textures (i.e. chopped/ground) which the Facility kitchen does not prepare. Director will speak direction with RC. Administration is aware of the situation." The Monitoring Team observed him during an evening meal during which staff were not following the presentation techniques in his dining plan, which placed	

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		him at risk. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #313 was hospitalized on 3/19/10 for constipation. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ From September 2009 to August 2010, Individual #243 had 16 documented falls. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ The Monitoring Team requested, during the on-site review, a list of individuals with Body Mass Index equal to and/or greater than 30, with individual-specific BMIs. Individual #34 had a documented BMI of 50.6. Clinically, body weight and thus the extent of obesity, is classified by using the Body Mass Index. A BMI score over 50 placed her in the "super obesity" category. A Nutritional Evaluation, dated 1/20/10, documented a BMI of 49.8 and stated "this body mass index puts client at significant risk for developing chronic disease (diabetes, heart disease, cancer, high blood pressure, etc.)." The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. The following chart represents a very basic analysis of the number of emergency room visits and hospitalizations per home from January to August 2010. As illustrated below, there were homes with higher levels of emergency room visits and hospitalizations in contrast to other homes. Such an analysis could be expanded to include reasons for ER visits and hospitalization, individuals involved, etc. The Facility should conduct an analysis of this type of information to begin the process of initially identifying individuals who are in need of physical and nutritional supports, and develop thresholds using objective data to trigger further evaluation. The purpose of such an analysis should be to determine if there were causal factors leading to an increase in emergency room visits and/or hospitalizations. The Facility Incident Management and/or Risk Management/Safety and Investigation departments could conduct such an analysis to determine if there were systemic issues that required resolution. Actions taken to address issues identified might result in decreases in the number of emergency room visits and/or hospitalizations. The PNMT could play an integral role in this process. The PNMT should be responsible for determining not only the efficacy of the individual-specific outcomes for those individuals at highest risk and with the most complex health, physical, and nutritional needs, but also should be responsible for providing an analysis on a systemic level, and developing and monitoring thresholds/triggers for integration	

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		into the Facility Risk Management and Quality Improvement Systems.	

Home	Number of ER Visits	Hospital Admissions	Total
513 S. Cedar	18	16	34
514 S. Cedar	9	6	15
515 S. Cedar	6	8	14
516 S. Cedar	6	1	7
517 S. Cedar	8	15	23
518 S. Cedar	10	13	23
520 S. Cedar	5	2	7
521 N. Cedar	8	5	13
523 N. Cedar	7	2	9
525 N. Cedar	12	6	18
526 N. Cedar	9	0	9
528 N. Cedar	9	11	20
504 W. Mesquite	9	12	21
504 E. Mesquite	20	19	39

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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	<u>A process is in place that identifies individuals with PNM concerns.</u> Based on policy review (State and Facility) and record review of 14 individuals (Individual #261, Individual #226, Individual #301, Individual #6, Individual #161, Individual #176, Individual #203, Individual #192, Individual #320, Individual #184, Individual #243, Individual #313, Individual #34, and Individual #276), a process that identified individuals with PNM concerns was not defined sufficiently, as illustrated by: ▪ In zero of the 14 records reviewed (0%), there was documentation of risk identification levels based upon physical and nutritional history, and current status, including specific criteria for guiding placement of individuals in specific risk levels. ▪ In one of the 14 records reviewed (Individual #301) (7%), there was documentation of a comprehensive assessment process for individuals at highest risk that included analysis of discipline specific assessments (OT, PT, SLP, nursing, medical, nutrition, psychology), PNMP Clinic results, PNM (NMT) Meeting Summary, and individual specific consultations leading to the development of measurable, functional outcomes to minimize and/or reduce the identified health risk. ▪ In one of the 14 records reviewed (Individual #301) (7%), there was documentation of development of implementation strategies. ▪ In zero of the 14 records reviewed (0%), there was documentation of competency-based training for individual strategies.	Noncompliance

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	the causes of such problems.	▪ In zero of the 14 records reviewed (7%), there was documentation of a monitoring schedule for individuals at highest risk. ▪ In zero of the 14 records reviewed (0%), there was documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes. As illustrated in the individual examples provided above, with regard to Section O.1 of the SA, except for Individual #301, the PNMT had not yet conducted the necessary screenings and assessments to address the needs of the individuals in the sample. <u>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.</u> A review of 15 records of individuals who had been identified by the Facility at highest risk (Individual #193, Individual #43, Individual #33, Individual #199, Individual #283, Individual #66, Individual #275, Individual #274, Individual #235, Individual #109, Individual #204, Individual #23, Individual #257, Individual #215, and Individual #162) revealed the following: ▪ In zero of the 15 records reviewed (0%), there was documentation of PNMT review/analysis of the findings, including but not limited to relevant discipline-specific assessment(s), PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. The summary addressed: o Physical health status; o Nutritional health status; o Oral care; o Medication administration; o Mealtime strategies; o Proper alignment; and o Positioning during the course of the day and nutritional intake. ▪ In zero of the 15 records reviewed (0%), measurable, functional outcomes were identified. ▪ In zero of the 15 records reviewed (0%), there was documentation of PNMPs developed with input from the PNMT for those individuals at highest risk. ▪ In zero of the 15 records reviewed (0%), there was congruency between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. ▪ In zero of the 15 records reviewed (0%), comprehensive summary results were integrated into the design of the appropriate PNM support plans as outlined in	

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		HCG VI and VIII and SA O.3 through O.8. ▪ In zero of the 15 records reviewed (0%), PNM updates were provided as needed until the individual was discharged from the PNM Team. Examples of where the PNMT had not reviewed individuals at risk, provided individuals a comprehensive assessment/summary, integration of results of the comprehensive assessment summary into the PNMP, and/or provided an update were as follows: ▪ Individual #193 was identified by the Facility at high risk for skin integrity (Health Issue-Skin Integrity 8/20/10). Individual #193 was reviewed multiple times by the Nutritional Management Team for pneumonia, but there was no discussion of her high-risk designation for skin integrity. The PNMT did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address her complex health, physical and nutritional support needs. ▪ Individual #199 and Individual #283 were identified by the Facility at high risk for aspiration (Health Issue-Aspiration 8/20/10), but they had not been reviewed by the PNMT. ▪ Individual #66 and Individual #275 were identified by the Facility at high risk for respiratory concerns (Health Issue-Skin Integrity 8/20/10), but they had not been reviewed by the PNMT. ▪ Individual #109 and Individual #204 were identified by the Facility at high risk for gastrointestinal (GI) concerns (Health Issue-Skin Integrity 8/20/10), but they had not been reviewed by the PNMT. ▪ Individual #43, Individual #33, and Individual #257 were identified by the Facility at high risk for constipation (Health Issue-Skin Integrity 8/20/10), but they had not been reviewed by the PNMT. ▪ The Health Issue-Osteoporosis list documented all individuals living at LBSSLC at low health risk for osteoporosis, but a document entitled Do Not Restrain with a Crisis Intervention Physical Restraint, dated 9/7/10, identified 116 individuals due to their diagnosis of osteoporosis, osteopenia, risk of fractures, and/or brittle bones who were not be restrained. Individual #215 and Individual #162 were identified at low risk for osteoporosis by the Facility, but were designated as individuals who were not to be restrained due to their diagnosis of osteoporosis, which appeared to be incongruent with the assignment of low risk for osteoporosis.	
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,	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> Based on a review of an identified sample of 29 individual records (Individual #261, Individual #226, Individual #301, Individual #6, Individual #161, Individual #176, Individual #203, Individual #192, Individual #320, Individual #184,	Noncompliance

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	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.	Individual #243, Individual #313, Individual #34, Individual #276, Individual #193, Individual #43, Individual #33, Individual #199, Individual #283, Individual #66, Individual #275, Individual #274, Individual #235, Individual #109, Individual #204, Individual #23, Individual #257, Individual #215, and Individual #162) individuals were not provided consistently with a comprehensive PNMP. Although a number of the components of a comprehensive PNMP were present for many individuals, there were a number of components missing. More specifically: ▪ In 28 of 29 records reviewed (97%) positioning instructions for wheelchair and alternate positions instructions were included. With the exception of one individual in this sample (Individual #33) who did not have a PNMP, all PNMPs reviewed in this sample had positioning instructions and/or documented the individual was independent. ▪ In 28 of 29 records reviewed (97%) transfer instructions were included. With the exception of one individual in this sample who did not have a PNMP, all PNMPs reviewed in this sample had transfer instructions and/or documented the individual was independent with transfers. ▪ In 29 of 29 records reviewed (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks and/or addressed receiving nutrition through a feeding tube. ▪ In 29 of 29 records reviewed (100%) the mealtime/dining plan included food/fluid textures and/or addressed receiving nutrition through a feeding tube. ▪ In 29 of 29 records reviewed (100%) the mealtime/dining plan included behavioral concerns related to intake and/or addressed receiving nutrition through a feeding tube. ▪ In 7 of 29 records reviewed (24%) strategies for medication administration were included. For example, Individual #226 did not have strategies for medication administration, and Individual #199 who was identified by the Facility at high-risk for aspiration, did not have strategies for medication administration. ▪ In zero of 29 records reviewed (0%), strategies for oral hygiene were included. None of the 29 individual PNMPs had strategies for oral care. ▪ In 28 of 29 records reviewed (97%), individual adaptive equipment was included. ▪ In one of 29 records reviewed (3%), bathing/showering positioning and related instructions were included. For example, Individual #283 was identified by the Facility at high risk for aspiration, but her PNMP did not incorporate strategies for bathing/showering positioning. ▪ In 28 of 29 records reviewed (97%), personal care instructions were included. ▪ In 28 of 29 records reviewed (97%) communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included:	

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		▪ Individual #33 was identified at high risk for constipation by the Facility, but did not have a PNMP submitted for review. However, Nutritional Management Team Report, dated 6/10/10, documented "PNMP current."
		▪ Per the SA, PNMPs need to incorporate strategies for medication administration, bathing/showering, and/or oral care for those individuals identified at risk. In addition, these PNMP strategies need to be integrated within an individual's Nursing Care Plan. As noted above, such strategies generally were not included in the PNMPs reviewed.
		
		<u>PNM plans were incorporated into individual's Personal Support Plans.</u>
		In 10 records reviewed (Individual #274, Individual #199, Individual #283, Individual #215, Individual #313, Individual #226, Individual #192, Individual #243, Individual #161, and Individual #176), none of the PNMPs (0%) were incorporated into individual Personal Support Plans. Information from PNMP should have been integrated within the PSP not simply referenced and/or listed. In addition, relevant PSP recommendations should be integrated into PNMPs.
		
		Examples of where individual PNMPs were not incorporated in PSPs included:
		▪ Individual #274 experienced choking incidents on May 4 and 7, 2010, without the use of abdominal thrust when he choked on lettuce and bread, respectively. His dining plan was updated on 6/25/10 with the following changes: encourage fluids throughout the meal (small amounts in cup at a time), and he was to remain upright for one hour after meals. A Personal Support Plan Addendum meeting was held to address the initial PSP Health Status Team Follow-Up, because the Health Status Team placed Individual #274 at high risk for gastrointestinal issues and choking. The PSP Addendum did not address the revision of the dining plan to "encourage remaining upright 1 hour after meals." The Nutritional Management Team Report documented NMT/PST meetings on 5/12/10 and 6/03/10, but these results were not documented in a PSP Addendum.
		▪ Individual #199's PNMP was revised on 9/1/10, with the following revision only, to add a hospital bed with padded bed rails to his inventory of assistive equipment. His PST met on 8/2/10 to discuss his return from the hospital with the "possible diagnosis of pneumonia," and his admission to 504 E Mesquite. It was documented that the team reviewed his PNMP and "no changes were noted at this time," but recommendations were made that should have been incorporated into his PNMP. For example:
		    o Continue use of bathing trolley and staff to ensure the safety strap was used. This recommendation was not incorporated into his PNMP.
		    o Oral care was to be provided by nursing using a suctioning	

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		toothbrush due to the placement of a tube. This recommendation was not incorporated into his PNMP. o Required a motion detector over his bed in order to monitor his positioning. This recommendation was not incorporated into his PNMP. ▪ Individual #283's PNMP was revised on 6/3/10 with the following changes: reposition every two hours, limit time in wheelchair and recliner to two hours at a time. Her PSP, dated 6/25/10 stated: "continue PNMP to maintain good skin integrity, prevent aspiration/reflux by upright positioning and to encourage mobility," but the PSP did not integrate PNMP strategies across all disciplines. ▪ Individual #215's PNMP, revised on 7/23/10, indicated a change of "2 person or more manual lift." The PSP, dated 2/24/10, documented "continue PNMP," but the PSP did not integrate PNMP strategies across all disciplines, and no PSPA was found integrating the change noted in the revised 7/23/10 PNMP. ▪ Individual #313's Dining Plan, revised 8/25/10, indicated the following change: "promote independent dining skills with equipment." Individual #313's PSP, dated 10/13/09, documented "PNMP was reviewed and remains accurate and no changes are needed at this time." The PSP did not integrate PNMP strategies across all disciplines, and no PSPA was found integrating the changed noted in the revised dining plan. ▪ Individual #226's PSP, dated 2/4/10, stated: "continue PNMP." The PSP did not integrate PNMP strategies across all disciplines. ▪ Individual #192's PSP Addendum, dated 4/30/10, was convened to discuss the NMT placing her at high risk for dehydration. The PSP Addendum stated: "she is on a plan of 30 oz. a day of fluids and not receiving those fluids. It is recommended that when staff walks by, they hand her a cup/glass of water/tea, and offer it that way and not just ask her if she is thirsty." Her Dining Plan was not revised to incorporate this recommendation. ▪ Individual #243's PSP, dated 7/20/10, stated: "continue PNMP." The PSP did not integrate PNMP strategies across all disciplines. ▪ Individual #176's PSP Addendum, dated 5/25/10, stated: "Individual #176 was placed on High Risk for Respiratory issues due to his recent hospitalization and diagnosis of pneumonia. He will remain high risk and be monitored by HT with follow up x-ray." The signature section did not document participation by an OT, PT, and/or SLP. Individual #176's annual PSP, dated 2/3/10, stated: "continue PNMP." The PSP did not integrate PNMP strategies across all disciplines. PNMPs are developed with input from the PST, home staff, medical, and nursing staff. In 10 records reviewed (Individual #274, Individual #199, Individual #283, Individual #215, Individual #313, Individual #226, Individual #192, Individual #243, Individual #161, and Individual #176), none (0%) of the PNMPs were developed with input from	

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		the PST with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Examples of where individual PNMPs were not developed with input from the IDT included: ▪ Individual #283's PSP, dated 6/25/10, stated: "continue PNMP." There was no OT, PT, and SLP in attendance to discuss the rationale for the PNMP strategies, and ensure the integration of these strategies across multiple disciplines. ▪ Individual #215's PSP, dated 2/24/10, stated: "continue PNMP." There was no OT, PT, and SLP in attendance to discuss the rationale for the PNMP strategies, and ensure the integration of these strategies across multiple disciplines. ▪ Individual #313's PSP, dated 10/13/09, included an Action Plan that stated: "will receive intervention through a PNMP with a focus to maintain transfer/walking skills with assistance and assistive equipment; to promote independence with self care skills and to improve weight and self feeding with dining plan/equipment." The responsible persons were the PNMP Coordinator and Residential Coordinator. The OT, PT, SLP, and/or PNMP Coordinator did not attend the PSP to discuss the rationale for the PNMP strategies, and to ensure the integration of these strategies across multiple disciplines. ▪ Individual #226's PSP did not have participation by the OT, PT, and/or SLP to address his PNMP and collaborate with PST members in the development of his PNMP. ▪ Individual #243's PSP Team meeting, dated 7/20/10, did not have the support of an OT, PT, and/or SLP team members even though she had experienced a significant number of falls over the past year. It would have been important for Habilitation Therapies staff to discuss strategies to prevent and/or minimize her high risk of falling. ▪ Individual #176's annual PSP, dated 2/3/10, did not include the expertise of an OT, PT, and/or SLP to collaborate on the development and/or revisions of his PNMP. <u>PNMPs are reviewed annually at the PSP meeting, and updated as needed.</u> In zero of 10 records reviewed (0%), PNMPs were reviewed annually at the PSP meeting, and updated as needed. As discussed above, there was not evidence that the PNMPs were actually reviewed at the PSP meetings, particularly for those individuals for whom habilitation therapies staff were not present to meaningfully review the PNMPs. Without such review, they were not adequately integrated across disciplines, and recommendations from other assessments and/or team members were not incorporated into the plans. <u>PNMPS are reviewed and updated as indicated by a change in the person's status,</u>	

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		transition (change in setting) or as dictated by monitoring results. In zero of five records reviewed (Individual #243, Individual #6, Individual #226, Individual #161, and Individual #176), were PNMPs reviewed and updated as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results. For example: ▪ Individual #243 experienced 16 falls, but her PNMP (revised 6/11/10, 3/15/10, and 1/15/10) did not document her risk of falls, nor were there any revisions for strategies to minimize her risk of falling. ▪ Individual #6 was hospitalized multiple times, on 1/8/10, 4/19/10, 6/12/10, and 6/20/10, and received a PEG tube on 6/15/10. He returned from the hospital with diagnoses of urinary tract infection (UTI), aspiration pneumonia and hypernutremia (NMT Report 6/24/10). His PNMP was not revised to include the PNMP components to minimize his risk for aspiration pneumonia. ▪ Individual #226 was hospitalized multiple times, on 2/16/10, 2/24/10, 6/25/10, and 8/13/10) with diagnoses of gastrointestinal hemorrhage unspecified, pneumonia, and respiratory abnormality. His PNMP was not revised to include the PNMP components as defined in the SA and HCG to minimize his risk for aspiration pneumonia. ▪ Individual #176 was hospitalized multiple times, on 1/13/10, 5/24/10, 7/28/10, and 8/4/10, with a diagnosis of pneumonia. His PNMP was not revised to include the PNMP components as defined in the SA and HCG to minimize his risk for aspiration pneumonia.	
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. Thirty-six (36) individual observations were completed of staff's implementation of dining plans and/or PNMPs. Overall, staff did not consistently implement interventions and recommendations outlined in the PNMPs and/or mealtime plans. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration, or other risks, such as skin breakdown, risks due to falls, etc. The following provides additional details regarding the observations: ▪ In five of 24 observations (21%), staff were following mealtime plans. ▪ In five of 25 observations (20%), staff were following wheelchair positioning instructions. ▪ In zero of one observation (0%), staff were following transfer (pivot) instructions. ▪ In zero of five observations (0%), nursing staff were following the PNMP to include diet texture/fluid consistency, positioning instructions, and use of appropriate adaptive equipment for medication administration. Examples of where staff did not implement interventions and recommendations outlined	Noncompliance

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		in the PNMP and/or mealtime plan: ▪ Individual #77 was presented his medication by a nurse who did not refer to his PNMP. He was not in optimal alignment and support in his seating system. A disposable plastic spoon was used to present his medication, but his dining plan prescribed a maroon mother-care spoon. The nurse did not place the spoon in his hand to support independence as recommended on his dining plan, dated 3/16/10. ▪ Individual #205's dining plan, dated 9/1/10, prescribed a nosey cup. He was presented water in a paper cup and his pelvic positioning device was not securing his pelvis. He was not in optimal alignment and support in his seating system. ▪ Individual #90's dining plan prescribed a nosey cup. The nurse gave him water in a paper cup. ▪ Multiple individuals were not in optimal alignment and support in their seating systems. ▪ Individual #192's dining plan, dated 9/14/10, stated: "take (Individual #192) to the dining room first **<u>per physicians order</u>** and seat at table if she prefers." This physician order was not followed in the dining room. ▪ Individual #222's dining plan, dated 7/22/10, documented a history of choking, overfilling mouth, and eating rapidly, and pneumonia. The dining instructions stated: "fill glass ¼ full of liquid at a time and encourage him to take small sips at a moderate pace." A large plastic glass was ½ filled and staff were not cueing him to slow his drinking pace. ▪ Individual #203's dining plan, revised 8/16/10, included instructions to: "provide dry spoon between each bite of food, encourage slow paces eating/drinking (using physical cues as needed), encourage to alternate food and fluids (using physical cues as needed), and encourage Individual #203 to chew his food thoroughly and swallow before taking another bite (using dry spoon between each bite of food)." Observation of Individual #203 during his meal showed that staff were allowing him to take too large a bite and at too fast a pace. Staff were not following the current dining plan instructions. The Facility was to be commended for identifying and providing training to Mealtime Coordinators (MTC), but there were some areas of concern. Mealtime Coordinators were staff designated by residential services to coordinate the services provided to individuals during mealtime. MTC responsibilities were: <u>Prior to the meal</u> ▪ Checking the environment (cleanliness, enough furniture, temperature); ▪ Ensuring dining room was presentable (placemats/napkins/communication devices/thick-it containers/table tents); ▪ Ensuring all equipment and dining plans were present; and	

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		▪ Ensuring there were enough staff to work the kitchen (per home procedure). During the meal ▪ Ensuring the appropriate number of persons served were in the dining area at one time (per home procedure); ▪ Ensuring diet textures, fluid consistencies, and adaptive equipment were correct (compare what is on the tray with the dining plan and diet card); ▪ Assisting persons served to get their tray or obtaining tray if they cannot (completed by MTC or direct support professional after texture, consistency, and adaptive equipment was checked); ▪ Checking the persons served (positioning, clothing, etc.); ▪ Assisting staff that were assigned to the tables by: o Assisting with positioning (before, during, and after the meals); o Requesting seconds and bringing more fluids to table; o Replacing utensils; o Promoting independence (serving self, clearing table, using napkin, etc.); o Assisting in cleaning the area in preparation for the next group; o Obtaining help from other direct support professionals/professional staff/nursing as needed; and o Notifying staff when to bring in the next group of persons served; ▪ Ensuring home dining programs were carried out and data was documented; ▪ Making sure food/fluid sheets were filled out for that meal; and ▪ Informing PST of any concerns. Active Employee Course Participation Report from 8/1/10 to 9/13/10, documented 151 staff had attended Mealtime Coordinator Training. Staff completed a written assessment consisting of five questions. There was no performance check-off, and this written test did not test their knowledge of mealtime position and alignment, generic and individual risk triggers, diet texture and fluid consistency, presentation techniques to enhance nutritional intake and hydration, and/or aspiration and choking precautions and rationale. The Monitoring Team strongly supports the designation and assignment of Mealtime Coordinators in the dining room, but there continued to be a need to provide ongoing competency-based mealtime training to ensure Mealtime Coordinators have the needed competencies to ensure mealtime safety. The Monitoring Team's observations did not show that Mealtime Coordinators intervened when individuals were not in alignment and support in their seating systems and/or regular dining chairs. In addition, staff were not consistently following dining plan instructions, and the Mealtime Coordinators did not intervene, which had the potential to place individuals at risk during mealtime. A document entitled PNMP Coordinator Duties (undated) documented the following	

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		duties: ▪ Monitor all snacks, meals, and bathing for the PNMP Coordinator's primary and secondary caseload during their assigned shift; ▪ Monitor therapy objectives for their caseloads; ▪ Monitor all PNMPs for their caseloads; and ▪ In-service staff on PNMPs and any changes that may occur. Each of these individual duties had identified instructions to complete the duties. The PNMP Coordinator Performance Outline documented that PNMP Coordinators needed to exhibit competency in mealtime monitoring in the dining room and for individuals receiving enteral feeding; to ensure that correct diet texture/thickened fluids were provided; to identify the purpose of adaptive feeding devices; to operate communication devices; to understand and identify the purpose of diet textures/fluid consistencies/triggers/dining techniques, adaptive feeding devices, positioners, and foot supports; to report any and all concerns; and in-service other staff. The Facility submitted multiple training program outlines that included staff name, signature, and date, but there was no competency-based written test and/or skills-based performance check-off to establish competency of PNMP Coordinators. The Monitoring Team's observation of a PNMP Coordinator in a dining area did not indicate that the PNMP Coordinator was competent to provide coaching, mentoring, and monitoring to the staff during mealtimes. Specifically, during the observation the PNMP Coordinator did not intervene to correct position and alignment, or model for staff the correct techniques when dining instructions were not being followed.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> Review of the Facility's training curricula revealed that it did not include adequate PNM training in the following areas: ▪ Generic and individual specific mealtime risk triggers that alert staff to problems, and what staff were to do if these triggers were observed; ▪ Mealtime position and alignment; ▪ Safe presentation techniques for food and fluid; ▪ Presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, and medication administration; and ▪ Techniques to promote independence and skill acquisition during mealtimes. These examples document that Facility training curricula did not provide foundational training in the following areas: ▪ New Employee Orientation (NEO) (for September 1st through September 20th) included the following training and time frames for physical and nutritional supports: Lifting People/Video (two hour duration), Alternate Means of	Noncompliance

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		Communication, Orientation and Mobility, Audiology and Physical Management, Handling and Positioning (four hour duration), Bracing and Positioning Return Demonstration (30 minute duration), Mealtime Assistance (30 minute duration). The total time for NEO to receive foundational training in physical and nutritional supports was seven hours. ▪ Feeding In-service Training Program Outline covered the following: oral-motor development, aspiration, Thick-It/Thick-It Check Off, adaptive feeding equipment, meal cards, diet texture, adaptive feeding equipment, reevaluation of diet or adaptive feeding equipment, and repair/replacement of adaptive feeding equipment. The training outline did not identify mealtime positioning and safe presentation techniques for food/fluid, although there were handouts entitled Helpful Hints in Feeding the Developmentally Disabled and Feeding Guideline: Some Do's and Don'ts. The length of the Feeding In-service was 30 to 40 minutes for new employees, which was not sufficient time to complete competency-based training for comprehensive mealtime foundational skills training. No specific learning objectives and competencies were identified to provide foundational knowledge and skills related to ensuring safety at mealtimes, including written testing and skills-based performance check-off, and/or definition of the minimum criterion for establishing competency of new and existing staff. <u>Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable.</u> The PNMPs Adaptive Equipment and Wheelchairs Training Program Outline identified the purpose of the class "to instruct on Physical/Nutritional Management Plans, applying/removing adaptive equipment and parts/use of wheelchair." No specific learning objectives and competencies were identified that would lead to the provision of foundational knowledge and skills related to ensuring safety at mealtimes. No written test and/or skills-based performance check-off, and/or minimum criterion for establishing competency of new and existing staff were identified. There were instructions for a PNMP Return Demonstration for NEO, but there were no performance check-off forms submitted that would be used to test staff competency. Based on a review of 29 individual records, in zero of 29 individual records (0%), was there confirmation of staff competency with regard to the implementation of PNMPs. Staff training records were submitted, but these forms did not consistently document staff completion of a performance check-off for foundational training, and/or individual-specific PNMPs. Likewise, there were PNMP training rosters submitted for staff training, but the forms, although present, did not document staff demonstration of competency, nor did the form have a competency checklist for the skills that were to be demonstrated.	

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		All foundational trainings are updated annually. Based on a review of staff development training schedules, staff training records and Facility training reports, foundational trainings were not scheduled annually. In zero of 29 staff training records (0%) reviewed, staff had completed competency-based performance check-off for foundational training. Based on information provided by the Facility in the Active Employee Course Participation Report, dated 9/1/10: ▪ The Deaf Awareness course was attended by 242 staff (25% of 951 total staff, and 49% of total 491 direct support professionals). ▪ Physical Management course was attended by 287 staff (30% of total staff and 58% of direct support professionals). ▪ Orientation and Mobility course was attended by 285 staff (30% of total staff and 58% of direct support professionals). ▪ Physical Management Practicum and Competency Assessment was attended by 283 staff (30% of total staff and 58% of direct support professionals). Examples of staff not having completed foundational training annually included: ▪ There was no staff training documentation submitted for Feeding In-service/Mealtime Assistance. ▪ The Active Employee Course Participation Report did not accurately reflect course titles documented in New Employee Orientation. For example, NEO did not include a course for Deaf Awareness, but this course was documented in the Active Employee Course Participation Report. It was not clear if this course was provided to staff outside of NEO. Staff are provided person specific training on the PNMP by the appropriately trained personnel. Based on a review of staff PNMP training records documented competency-based individual-specific training was not provided by appropriately trained personnel. This was illustrated as follows: ▪ In zero of 29 records reviewed (0%), PNMP coordinators had been provided instruction by licensed therapists and/or assistants. ▪ In zero of 29 records reviewed (0%), licensed therapists, assistants, and/or PNMP coordinators had trained supervisors and/or other designated staff who would be responsible for implementation of PNMPs. ▪ In zero of 29 records reviewed (0%), licensed therapists, assistants, PNMP coordinators, and/or competency-trained designated supervisors/home managers, etc. had provided instruction to direct support professionals.	

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		Examples of staff who were implementing PNMPs, but had not received person specific training: ▪ In multiple individual records, an In-service Due Date was attached to an individual PNMP with multiple staff signatures and dates. The form stated: "NOTE: In-services are competency-based. Staff must be able to demonstrate competency before 'passing' in-service." There was a Competency column with a "T" (test) or "D" (demonstration) to be circled by the instructor. For an individual PNMP this column could be left blank, "T" could be circled, "D" could be circled or both could be circled. There was no indication on the form what staff had been tested for and/or demonstrated to the instructor. The form did not document the individual specific strategies that staff were to demonstrate to "pass" the in-service. <u>PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual.</u> In zero of 29 staff training records reviewed (0%), staff who had successfully completed competency-based training provided assistance to individuals determined to be at an increased level of risk. Examples of staff who had received competency-based training providing supports to individuals determined to be at risk included: ▪ Individual #301 was assessed by the PNMT on 7/23 and 7/28/10. The following recommendations were documented: PST to monitor/assess positioning during all daily activities (e.g., bathing, bed, activities, oral care) as per PNMP. Individual #301's PNMP, revised 6/30/10, did not include staff instructions for bathing, activities, and oral care. Individual #301's PNMP needed to be revised by the PNMT and competency-based training provided to staff to ensure they were competent to monitor/assess his positioning during all daily activities. <u>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.</u> Based on a review of staff training in 29 individual records, zero out of 29 (0%) showed that staff were re-trained when changes occurred on the PNMP.	
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	<u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> Based on review of the Facility's policy, LBSSLC did not have an adequate policy defining the monitoring system for PNMPs and meal observation. A policy should be developed to ensure that a system is in place to monitor staff implementation of PNMPs, including mealtime plans. At a minimum, such a policy should include:	Noncompliance

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	staff demonstrates competence in safely and appropriately implementing such plans.	▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; ▪ Identification of monitors and their roles and responsibilities; ▪ Formal schedule for homes to be monitored on a quarterly basis, with an identified staff schedule; ▪ A revalidation of monitors on an annual basis by therapists and/or assistants; and ▪ Results of monitoring activities in which deficiencies noted are formally shared for appropriate follow-up by the relevant supervisor. As stated in the baseline report, the Physical and Nutritional Management Policy did not provide a formalized schedule for monitoring, training/validation procedures for supervisors, identification and definition of specific monitoring indicators for PNMPs, identified compliance levels expected, and/or the process to be followed if PNMPs were not being implemented as written. There were no revisions to this policy, nor did the Facility's POI address changes to monitoring. The Facility presented the following tools to be used to monitor implementation of PNM procedures and plans: ▪ HT (Habilitation Therapies) PNMP Observation form for individuals, revised 7/22/10, with the following indicators: o PNMP-available and in use; o Position in wheelchair correct-good alignment achieved; o Positioning in-supine, left and/or right; side-lying correct; o All supports/ equipment for positioning utilized-good alignment achieved; enteral feeding position correct, appropriate elevation, and all supports utilized; repositioning is occurring; transfers-correct transfer utilized; individuals communication devices in use; wheelchair clean and in good repair; communication device clean and in good repair and adaptive equipment clean and in good repair. The PNMP Observation form did not contain indicators to monitor oral care, medication administration, bathing/showering, skin care, and/or personal care (movement section on PNMP). ▪ An individual specific HT Meal Observation form, revised 7/19/10, was submitted with the following indicators: o Dining Plans-out and in use; o Position/reposition in wheelchair before, during, and after meals as needed; o Position at table/reposition as needed (table height appropriate/ feeding position correct); o Correct head position/support, if applicable;	

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		- Enteral feeding/position correct; - Correct texture provided-puree/smooth, ground/moist, uniform, chopped-uniform consistency; - Correct liquid consistency-honey/nectar; - Equipment present-adaptive equipment used and feeding strategies followed; - Instruction on table-table tents; - Wheelchair/all equipment clean; - Communication-Alternative and Augmentative Communication (AAC)/Alternative Technology (AT)-being used, clean/in good repair; and - Reported to nursing: excessive coughing, vomiting. Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). A review of 29 individuals' records illustrated that 15 individuals' staff (Individual #43, Individual #275, Individual #235, Individual #257, Individual #199, Individual #204, Individual #193, Individual #283, Individual #226, Individual #6, Individual #313, Individual #34, Individual #176, Individual #161, and Individual #301) (52%) were being monitored, but the monitoring did not encompass all aspects in which the individual was determined to be at increased risk. The following concerns were noted: - Individual #161's HT PNMP Observation form, dated 8/11/10, documented that staff were not using the PNMP, but there were no comments on the form to address this issue. The second page of the form documented "coaching on Individual 161's PNMP," and the action taken was documented as: "I tested the new staff on PNMP and positioning," although all positioning indicators were marked yes. - Individual #176's HT PNMP Observation form, dated 9/13/10, documented that the PNMP was not in use; enteral feeding supports were not utilized; and the communication device was not in use. Concerns noted were "booties not on feet and All About Me Book not present. Monitor went to room to get book. AAC switches not available. Staff went to get booties." The HT PNMP Observation form did not have an indicator to monitor if all adaptive equipment was available and in use. For example, the monitor documented that booties were not available, but there was not an indicator to address whether or not adaptive equipment was being used as listed on the PNMP. The form needed to be revised to monitor the availability of adaptive equipment, and if it was functioning. - Individual #283's HT PNMP Observation form, dated 7/8/10, documented Individual #283 "was not wearing shoes but all other adaptive equipment was being used." There was no follow-up documented to address the absence of	

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		shoes. ▪ Individual #193's HT PNMP Observation form, dated 8/11/10, documented the PNMP was not in use. No concerns were noted on the form, and it documented "Aspen staff was doing a Great job!" It was unclear why the monitor would make this comment when the form documented the PNMP was not in use. ▪ Individual #199's HT PNMP Observation forms, dated 7/22/10 and 8/24/10, documented the PNMP was not in use and repositioning was not occurring. Verbal training was provided to four staff on 9/24/10. Staff should have completed a performance check-off to demonstrate proper positioning for Individual #199, because this was the second monitoring in which non-compliance was noted with regard to repositioning. ▪ Individual #226's HT PNMP Observation form, dated 9/13/10, documented the PNMP was not in use. ▪ Individual #257's HT PNMP Observation forms, dated 8/24/10, documented all supports/equipment for positioning were not utilized, as she did not have her yellow heelbos and heel cup. The heel cup was not listed on her PNMP, dated 3/31/10. The correct transfer was not utilized and the comment section documented: "needs pic(ture) of assist of 1." There was no further follow-up and/or resolution discussed. ▪ Individual #275's HT PNMP Observation form, dated 7/22/10, documented that the PNMP was not in use. All supports/equipment for positioning utilized was marked as "yes," but the comments column stated "no jobst (support)socks." Good alignment was not achieved as his "trunk flexed over on lap pillow." The training provided section stated: "staff was able to answer questions about [Individual #275's] PNMP regarding positioning but there was no documentation of staff repositioning him. Concerns noted for his positioning and lack of confidence that he is only up in his wheelchair for 2 hours." The monitor stated: "every time I am on the home he is in his w/c." There were no additional PNMP monitoring forms. ▪ Individual #43's HT PNMP Observation form documented PNMP was not in use. The indicator for wheelchair clean and good repair was scored "Y" (yes) but comment stated "partially clean." <u>All members of the PNM team conduct monitoring.</u> Based on review of 29 individuals' records, the PNM Team completed the following: ▪ In one of 29 records reviewed (3%) (Individual #301), PNM Team members completed individual specific monitoring. ▪ In zero of 29 records reviewed (0%), monitoring was conducted on a frequent basis for those individuals at highest risk to ensure comprehensive summary strategies were implemented. ▪ In zero of 29 records reviewed (0%), deficiencies noted during monitoring were	

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		corrected within an appropriate period of time. ▪ In zero of 29 records reviewed (0%), issues noted during monitoring were followed by the PNM team, and remained open until all issues had been resolved and appropriate trainings conducted. ▪ In zero of 29 records reviewed (0%), results of monitoring activities in which deficiencies were noted were formally shared for appropriate follow-up by the relevant supervisor. Examples of an individual where the PNM Team did not complete adequate monitoring included: ▪ PNMT members monitored Individual #301 using the HT PNMP Observation form on 8/20, 8/31, 9/1 and 9/9/10. The results of the monitoring form, dated 8/20/10, documented that Individual #301 needed a pillow between his legs. The PNMT PT stated "discussed Individual #301's positioning pictures, use of buckwheat pillow against his buttocks in w/c card and use of pillow against buttocks for bed positioning. Also discussed need for pillow between legs and use of booties." The monitoring form, dated 8/31/10, again documented "needed pillow between legs." His hand splints could not be located and HT was to deliver replacement if not located. The monitoring form, dated 9/9/10, documented: "repositioned and pillow added." Individual #301 was assessed by the PNMT on 7/23 and 7/28/10. The PNMT evaluation monitoring recommendation stated: "Nursing to monitor positioning during feedings, bathing, oral care, and document in nursing notes." There was no documentation that the PNMT PT provided competency-based training to the nurse. In addition, a review of nursing notes did not document the status of Individual #301's positioning during feedings, bathing, and oral care. Currently, the PNMT did not have a dedicated nurse who could provide monitoring and monitoring oversight until Individual #301 was discharged from the PNMT. The timeframe for monitoring was not established and the documentation submitted for monitoring was not sufficient, and did not occur on a timely basis to ensure PNMT evaluation recommendations were being implemented. Individual #301's PNMP, dated 6/30/10, had not been revised to reflect integration of his PNMT evaluation recommendations. For example, his PNMP did not incorporate staff strategies to address oral care, medication administration, and bathing, which nursing was to monitor. The monitoring status in the Integrated Progress Notes was not sufficient and/or timely to ensure the implementation of his PNMT evaluation recommendations. The following	

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		entries were made in the Integrated Progress Notes: o Individual #301's Integrated Progress Notes had entries by the HT physical therapy assistant (PTA), dated 9/1/10, which documented correct position during enteral feeding. o The PNMT OT's 8/26/10 entry documented "positioning needed minor adjusting completed with staff assistance." o PNMT SLP's 8/25/10 entry documented "bathing assessment for maintenance of proper positioning per PNMT High Risk goals/objectives." o PNMT PT's 8/20/10 entry documented "as part of PNM Team, PT monitored Individual #301's PNMP and bed positioning. His PNMP need for pillow between legs and use of booties was included in discussion with staff as well as bed positioning and positioning on w/c cart." o PNMT RD's 8/16/10, 8/2/10, and 7/22/10 entries indicated that monitoring had occurred with regard to wound healing. o There was no entry by the PNM Team to document the initiation of the PNMT evaluation. The PNMT must ensure that the Integrated Progress notes provide an ongoing comprehensive update of the implementation of their recommendations to update PST members on the current status of their interventions. The information documented by PNMT dedicated members in the Integrated Progress Notes did not document the initiation date and subsequent content of the comprehensive assessment for Individual #301 whom the PNMT had identified as an individual at the highest level of risk with complex medical, physical ,and nutritional support needs. This process must be well documented in the Integrated Progress Notes for the process to remain public and not secluded from PST members. <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.</u> A review of Facility reports, including those from Quality Improvement/Quality Enhancement, did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM Team for analysis leading to the identification of potential issues, and ensuring the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine the efficacy of the supports provided at both the individual specific and systemic levels. This information	

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		should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems. In addition, PNMT members should be actively involved in internal mortality reviews as a learning process as well as a mechanism for improving supports to individuals with the most complex health, physical and nutritional support needs. Immediate intervention is provided if the person is determined to be at risk of harm. Eight individuals died within the time period from January to July 2010. The Death list, dated 9/13/10, did not specify the cause of death, but information related to an individual's death was documented in the Comments column. At the time of the review, some of the causes of death were not known. However, three of these individuals' deaths were attributed to pneumonia, aspiration pneumonia, or related to a bowel obstruction, which indicated that these individuals had potential physical and nutritional support needs, including: ▪ Individual #39's "death occurred over 4 day weekend from complications of pneumonia." ▪ Individual #292's death was described as "ER Dx: respiratory arrest/Cardiac arrest, probably aspiration. Autopsy requested… Death due to Medical Complications of Cerebral Palsy." ▪ Individual #208 "expired after bowel surgery. No autopsy per family." Three of the individuals who died were selected for review (Individual #285, Individual #292, and Individual #208). The Nutritional Management Team and Health Status Team had reviewed these three individuals multiple times prior to their deaths, but as stated in the baseline report, the NMT reviews consisted of a chart review leading to recommendations that did not support an aggressive approach to minimize identified health risk indicators such as aspiration pneumonia. The NMT did not provide an intensive, interdisciplinary, problem-solving approach for these individuals resulting in a timely and proactive comprehensive assessment, including the development of outcomes for which strategies would be implemented. The following examples illustrate that immediate intervention was not provided even when an individual was determined to be at risk of harm: ▪ Individual #285's NMT Report documented nine reviews by the NMT during the time period of 12/10/07 to 9/18/09. The NMT reasons for these reviews and their recommendations were: o Pneumonia review - discuss quarterly after she has adjusted to medicine changes (12/10/07); o One month follow-up to weight loss - discuss in two months after diarrhea subsides and follow up gastric emptying study (12/17/07); o Follow up gastric emptying study - discuss next month (2/11/08);	

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		o Discussed follow-up gastric emptying study - discuss PRN (3/21/08); o Update annual evaluation - She has had a history of losing weight when she eats orally and it is felt that she is not a good candidate for oral feeding at this time. Her health is also a factor (9/19/08); o Follow up pneumonia - review annually (2/20/09); o Follow up pneumonia - Dietitian concerned with loose stools. Laxatives are being held and labs are pending. CMP will be checked. Dietitian will consider changing formula, depending on lab results (6/26/09); o Pneumonia - Follow up pneumonia upon discharge from hospital (8/21/09); and o Pneumonia - Discharged from hospital on 9/9/09. No x-ray to confirm that pneumonia is resolved. Using nebulizer and receiving respiratory therapy. QMRP/RN will in-service staff on positioning and trach/oral care. Follow up pneumonia at October Health Status Meeting (9/18/09); Individual #285 needed the expertise of a PNM Team to provide an intensive, interdisciplinary, problem-solving approach. The team should have initiated a comprehensive assessment leading to the development of strategies to minimize her significant health risks, as evidenced by her history of dehydration, gastritis, constipation, anorexia, and recurrent episodes of pneumonia. ▪ Individual #292's NMT Report documented three reviews by the NMT with reason for review and recommendations as follows: o Weight loss (high risk medical) - dietitian recommends lipid panel, Registered Nurse (RN) to monitor amount of food spillage and report to OT, follow up lipid panel results in two months (3/21/08); o Follow up pneumonia - Discuss PRN (6/27/08); and o Weight loss - Dietitian reported that no meal refusals have been reported, but questioned documentation. Feeding assessment and CMP are recommended. Food/fluid intake sheets will be initiated. Follow up meal documentation through PSP Addendum and weight, labs, feeding at August Health Status Meeting (6/26/09). This was the last review by the NMT. Individual #292 needed the expertise of a PNMT to provide an intensive, interdisciplinary, problem-solving approach. This team should have initiated a comprehensive assessment leading to the development of strategies to minimize his significant health risks, as evidenced by his history of weight loss, bronchitis, impaction, urinary tract infections, and pneumonia/aspiration pneumonia. Furthermore, an extensive, critical review of events leading up these individual deaths would be an important learning strategy to identify future person specific strategies and systemic changes that could be employed to minimize the risk of harm for individuals	

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		with physical and nutritional support needs, most importantly, for individuals at the highest health risk levels.	
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. Based on the review of 28 individual records (Individual #261, Individual #226, Individual #6, Individual #161, Individual #176, Individual #203, Individual #192, Individual #320, Individual #184, Individual #243, Individual #313, Individual #34, Individual #276, Individual #193, Individual #43, Individual #33, Individual #199, Individual #283, Individual #66, Individual #275, Individual #274, Individual #235, Individual #109, Individual #204, Individual #23, Individual #257, Individual #215, and Individual #162), for none of these individuals (0%) did the PNM Team complete a comprehensive assessment leading to the development of strategies, and as a result, the PNMT did not document progress of individual strategies on a monthly basis to ensure their efficacy. Person specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators. Based on the review of 28 individual records, in none (0%) did the PNMT document the progress of individuals with PNM needs to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators. In none of the 28 records reviewed (0%) was it documented that if PNMPs were found through this monitoring not to be effective, the PNMPs were updated.	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status. Based on the review of 11 individual records (Individual #253, Individual #128, Individual #312, Individual #16, Individual #199, Individual #281, Individual #66, Individual #68, Individual #7, Individual #191, and Individual #6) who were enterally nourished and/or received supplemental tube feedings, none (0%) of these individuals had received an annual assessment that addressed the medical necessity of the tube and potential pathways to PO (by mouth) status. Examples of individuals who received enteral nutrition and did not receive an annual assessment included: ▪ Individual #253's PSP, dated 2/25/10, stated: "Team does not believe he is a good candidate for oral feeding," but there was no evidence of an annual assessment to address the medical necessity of the tube. ▪ Individual #312's Nutritional Management Team Report, dated 7/27/10, documented: "Team agrees that, due to high risk for aspiration and multiple	Noncompliance

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		incidents of respiratory illnesses, the significant health risk outweigh the possible benefits of returning to PO feedings," but there was no evidence of an annual assessment to address the medical necessity of the tube and, if appropriate, to implement potential pathways to PO status. ▪ Individual #7's received nutrition through a jejunostomy tube. There was no evidence of an annual assessment to address the medical necessity of the tube and, if appropriate, to implement potential pathways to PO status. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.</u> Based on a review of an identified sample of 11 individual records, individuals were provided with a PNMP that included: ▪ In 11 of 11 records reviewed (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In 11 of 11 records reviewed (100%), transfer instructions were included. ▪ In zero of 11 records reviewed (0%), strategies for medication administration were included. ▪ In zero of 11 records reviewed (0%), strategies for oral hygiene were included. ▪ In 11 of 11 records reviewed (100%), individual adaptive equipment was included. ▪ In one of 11 records reviewed (3%), bathing/showering positioning and instructions were included. ▪ In 11 of 11 records reviewed (100%), personal care instructions were included. ▪ In 11 of 11 records reviewed (100%), communication strategies were included. <u>The need for continued enteral nutrition is integrated into the PSP.</u> Based on a review of 11 individuals' PSPs who received enteral nutrition, none (0%) of the individuals' PSPs documented the rationale for the continued need for enteral nutrition. <u>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.</u> Per SLP report, currently there were no individuals participating in an oral feeding program. <u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP, or OT).</u> Facility policies for Physical Nutritional Management, implemented 1/31/10, and Nutritional Management Team, implemented 1/31/10, did not clearly define the frequency and depth of evaluations required for an individual receiving enteral nutrition.	

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		Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. A review of one individual record for Individual #6 who recently received a feeding tube showed the individual received the following: ▪ In zero of 1 record reviewed, the individual was referred to the PNM Team for review and the development of a comprehensive assessment/summary. ▪ In zero of 1 record reviewed, the individual received interventions to promote continued oral intake. ▪ In zero of 1 record reviewed, monitoring was completed by the PNM Team to support the efficacy of the interventions. More specifically: ▪ Individual #6's PSP Addendum, dated 5/17/10, stated that the "Team met as [Individual #6] has been followed for a lengthy period by the physicians, Personal Support Team, and Nutritional Management Team for weight loss and nutritional issues." Nutritional Management Team Report(s) were not submitted for Individual #6. The PNMT did not complete a comprehensive assessment to develop strategies to promote continued oral intake prior to the placement of a feeding tube.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. A nurse should be identified to be a dedicated member of the PNMT.
2. Ongoing opportunities should be provided for continuing education for all PNMT members, not just therapists, to support their responsibilities in working with individuals with complex physical and nutritional support needs.
3. In order for a dedicated PNM team to carry out the full responsibilities of a properly functioning team, there will be a substantial increase in the caseloads of the remaining therapists and dietitians. The Facility should complete an analysis to determine the number of therapy and nutritionist positions necessary to support these professionals being active members of individuals' PSTs.
4. Individuals identified with complex physical and nutritional support needs should have a timely, proactive comprehensive assessment completed; development and implementation of identified strategies to meet measurable functional outcomes including an appropriate PNMP; a schedule for regular review, ongoing documentation, monitoring, and analysis to determine the efficacy of the supports provided; and modifications to strategies/plans, as necessary.
5. Criteria should be defined for referral of individuals to the PNMT. Individuals at highest risk should be prioritized to receive a PNMT comprehensive assessment. Upon completion of the comprehensive assessment, the PNMT should develop and implement intervention plans, conduct individual-specific monitoring, develop and implement documentation guidelines, and complete a review and analysis to determine the efficacy of supports provided at both the individual-specific and systemic level(s).
6. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria should be clearly recorded, utilized for monitoring, and analyzed to determine efficacy of the supports provided at both the individual-specific and systemic level. This information should be integrated into the

Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems.

7. With regard to training:
    a. The content for new employee orientation in the area of physical and nutritional supports should be reviewed to reassess the time allotment as well as course content to ensure staff receive the foundational knowledge and skills to implement physical and nutritional support plans safely.
    b. Competency-based physical support training should identify learner objectives to support the acquisition of specific basic knowledge and skills-based competencies required of direct support professionals for the implementation of physical assistance support plans.
    c. Foundational competency-based training should address both mealtimes and safe handling. This curricula should encompass techniques for safe and efficient lifting (body mechanics); physical assistance strategies for use in seating systems, mobility devices, and orthotics; alignment and support before, during and after a transfer; strategies for position and alignment in seating systems, alternate positions and mobility devices; mealtime position and alignment; diet texture and fluid consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions; strategies to minimize the risk of aspiration and choking; presentation of the Facility choking policy; and techniques to promote optimal levels of independence and skill acquisition during mealtimes. This training also should address the importance of implementing appropriate person-specific dining plan strategies that should be followed during oral hygiene and medication administration.
    d. Staff responsible for the direct provision of supports to individuals should be required to successfully complete a skill performance check-off to document staff competency with learning objectives. Job descriptions for direct support professionals should incorporate these training requirements, as well as their performance evaluations.
    e. Areas of staff performance check-offs should include demonstration of an understanding of position and alignment in wheelchairs, alternate positions and mobility systems; safe body mechanics; mechanical lift and two-person transfer; position and alignment at mealtimes; identification of food textures and fluid consistency; and safe presentation techniques for food and fluid.
    f. Specifically with regard to Mealtime Coordinators and PNMP Coordinators, the Facility's therapy staff should review the training that was provided to Mealtime Coordinators, as well as conduct frequent onsite audits to ensure Mealtime Coordinators and PNMP Coordinators are competent to provide coaching/mentoring, as well as conduct monitoring.
8. PNMPs need to incorporate strategies for medication administration, bathing/showering, and/or oral care for those individuals identified at risk. In addition, these PNMP strategies need to be integrated within an individual's Nursing Care Plan.
9. The Facility should make sure there are established policies to ensure the correct diet texture is presented if the kitchen staff do not prepare the food.
10. The monitoring policy for mealtime and PNMP monitoring should describe a monitoring system that includes criteria for and identification of who will complete the monitoring, competency-based training for monitors, description of each indicator with monitoring strategy, definition of staff retraining thresholds, a validation/inter-rater reliability process, the use of monitoring reports to assist in the identification of problematic issues and/or trends, the formulation of corrective strategies to address areas of deficiency, and integration of the monitoring system into facility Risk Management and Quality Improvement systems. Such policies should define "regular" monitoring as required by the Settlement Agreement. In addition, policies for monitoring staff's implementation of PNMPs should be reviewed and revised, and Facility procedures should be developed to ensure adequate monitoring as required by the SA and HCG.
11. PNMT members should be actively involved in internal mortality reviews as a learning process as well as an opportunity for improving supports to individuals with the most complex health, physical, and nutritional support needs.
12. Procedures should be developed and implemented to ensure individuals at risk of receiving enteral nutrition are referred to the PNMT.
13. Comprehensive evaluations should be conducted of individuals who are enterally nourished to determine the appropriateness of receiving enteral nutrition, and, if not, to identify strategies to transition the individual to oral intake. This will require assessment/evaluation by a number of team members, and review by the entire PST.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Requested documents: OT/PT Comprehensive Assessments/Updates for the past year, wheelchair assessment, OT/PT progress notes for Direct Therapy, OT/PT Instructional Plans for goals/objectives, OT/PT activity plans for goals/objectives, OT/PT Treatment plans for goals/objectives, OT/PT Consultations for the past year, dining plan, current and revised PNMP for the last year with pictures, PNMP Clinic Notes for the last year, PNMP person-specific monitoring for last quarter, competency-based training for staff for PNMPs, dining plans and therapy programs, daily schedule, and PSP OT/PT objectives and monthly updates for the following 15 individuals: Individual #308, Individual #80, Individual #290, Individual #171, Individual #185, Individual #324, Individual #63, Individual #73, Individual #203, Individual #183, Individual #125, Individual #4, Individual #206, Individual #54, and Individual #44; o OT (Occupational Therapy)/PT (Physical Therapy) Assessment (blank), not dated; o List of Individuals using equipment when away from home, dated 8/31/10; o OT/PT Update(s) for multiple Individuals, from 1/05 through 7/10; o OT/PT Update (blank), not dated; o Wheelchair/PNMP Clinic, by home, dated 8/20/10; o List of Individuals who use Wheelchair as primary means of mobility, dated 7/31/10; o List of Individuals with Transport Wheelchair, dated 7/31/10; o List of Individuals with Ambulation Devices, not dated; o List of Individuals with Orthotics and/or Braces, not dated; o List of Individuals who incurred Slip, Trip, and/or Fall Injuries, from 9/09 through 8/10; o OT/PT Assessment/Update (blank), not dated; o OT/PT Updates for Multiple Individuals, from 1/10 through 8/10; o PSPs for Multiple Individuals, from 8/09 through 7/10; o PNMP/Wheelchair Clinic Notes (blank), not dated; o PNMP Clinic Notes, from 1/10 through 7/10; o Master HT/PNMP data, dated 8/19/10; o Wheelchair/PNMP Clinic-by home, dated 8/20/10; o HT/PNMP Observation Sheet (Monitoring), dated 7/10; o Corrective Action Plan, dated 7/10; o OT/PT Checklist, dated 6/29/10; and o List of Individuals receiving direct OT/PT services and Focus of Intervention, not dated. ▪ **Interviews with**: o Linda Thomas, LBSSLC Habilitation Therapies Director. ▪ **Observations of**: o 504 E. Mesquite Drive, 504 W. Mesquite Drive, 517 S. Cedar Avenue, 518 S. Cedar Avenue, 528 N. Cedar Avenue, 516 S. Cedar Avenue, 521 N. Cedar Avenue, 525 N. Cedar Avenue,

	526 N. Cedar Avenue, 515 S. Cedar Avenue, and 520 S. Cedar Avenue.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for LBSSLC did not include this component, LBSSLC did not identify compliance with any indicators in Section P. This was consistent with the Monitoring Team's findings. The Habilitation Therapies Director indicated that the following practices had been implemented related to Section P following the initial baseline review: ▪ When completing OT/PT Assessments/Updates, therapists were considering medical issues, and were integrating analysis that established the rationale for recommendations/therapeutic interventions. ▪ HT PNMP monitoring and dining monitoring forms were revised to be individual specific. ▪ A process had been implemented for all HT Therapists to participate in self-monitoring for Sections O, P and R utilizing the monitoring tools.
	Summary of Monitor's Assessment: The current caseloads for occupational and physical therapists were not sufficient to enable the therapists to be active members of the individuals' PSTs, and were presenting significant challenges in meeting the standards set forth in Section P of the SA. Therapists were not active members of the PSTs as evidenced by their absence at annual PSP meetings, as well as a lack of integration of therapy goals/objectives into formal skill acquisition programs, and development of informal strategies to reinforce learned skills. The Facility, in collaboration with the Habilitation Therapy Director/staff, should revisit the therapy and dietitian staffing resources to enable these professionals to function as active members of the PST for individuals on their caseloads. Based on a review of CVs for each of the seven therapy clinicians and interviews with therapy staff, the appropriate qualifications were found for three OTs and three PTs. The CVs of the OTs and PTs documented continuing educations courses within the past 12 months. Based on review of the State and/or Facility's policy, a defined monitoring system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions, including: ▪ Definition of monitoring process; ▪ Identification of monitors (licensed professional for OT/PT intervention plans), and their roles and responsibilities; ▪ Formal schedule for monitoring to occur; ▪ A revalidation process for monitors on an annual basis by therapists and/or assistants; and ▪ A process for results of monitoring activities, in which deficiencies are noted, to be formally shared for appropriate follow-up by the relevant supervisor. The large caseloads of OTs and PTs along with the assigned responsibilities that included, but were not limited to completing evaluations, developing and revising PNMPs, and participating in PNMP clinics did not leave adequate time to provide direct therapy. This was evidenced by the absence of formal OT/PT

	therapy services found in the individual records reviewed. The OT/PT annual evaluation recommendations were generic in nature and did not provide functional recommendations to the PST for consideration.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There were 229 individuals living at LBSSLC per the current census provided to the Monitoring Team. The following chart represented the caseloads at the time of the review of the Occupational Therapists and Physical Therapists, the list of which indicated there were 230 individuals living at LBSSLC:	Noncompliance

Occupational Therapist(s)	Current Caseloads and Responsibility
OT #1	Dedicated PNMT member and responsible for home 520 S. Cedar Avenue, supporting 15 individuals
OT #2	Responsible for homes 504 E. Mesquite Drive, 504 W. Mesquite Drive, 514 S. Cedar Avenue, 518 S. Cedar Avenue, 525 N. Cedar Avenue, 526 N. Cedar Avenue and 528 N. Cedar Avenue (partial), supporting 113 individuals
OT #3	Responsible for homes 513 S. Cedar Avenue, 515 S. Cedar Avenue, 516 S. Cedar Avenue, 517 S. Cedar Avenue, 521 N. Cedar Avenue, 523 N. Cedar Avenue and 528 N. Cedar Avenue, supporting 102 individuals
Physical Therapist(s)	**Current Caseload**
PT #1	Dedicated PNMT members and responsible for home 504 W. Mesquite Drive, supporting 21 individuals
PT #2	Responsible for homes 504 E. Mesquite Drive, 514 S. Cedar Avenue, 515 S. Cedar Avenue, 516 S. Cedar Avenue, 520 S. Cedar Avenue, 523 N. Cedar Avenue and 518 N. Cedar Avenue (partial), supporting 99 individuals
PT #3	Responsible for homes 513 S. Cedar Avenue, 517 S. Cedar Avenue, 521 N. Cedar Avenue, 525 N. Cedar Avenue, 528 N. Cedar Avenue, 526 N. Cedar Avenue, 518 S. Cedar Avenue (partial), supporting 110 individuals

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		There were five budgeted positions for Occupational Therapy. At the time of the review, there were two vacancies for Occupational Therapy. There were three Physical Therapy budgeted positions. There were no Physical Therapy vacancies. Eight PNMP Coordinator positions were approved and these positions had been hired. The current caseloads for occupational and physical therapists were not sufficient to enable the therapists to be active members of the individuals' PSTs, and this was presenting significant challenges in meeting the standards set forth in Section P of the SA. According to the Staff Vacancy Report, dated 8/23/10, the LBSSLC staff-to-individual ratio for OT/PT/SLP was 1:77, whereas, for example, the Psychology staff-to-individual ratio was 1:25, with similar duties with regard to assessment, planning, monitoring, and provision of direct supports, and/or oversight. As a result, therapists were not active members of the PSTs, as evidenced by their lack of participation in annual PSP meetings, and these staff had insufficient time to integrate therapy goals/objectives into formal skill acquisition programs, and to develop informal strategies to reinforce learned skills. The Facility, in collaboration with Habilitation Therapy Director/staff, should revisit the therapy and dietitian staff-to-individual ratio to enable these professionals to function as active members of the PST for individuals on their caseloads. Based on a review of CVs for each of the seven therapy clinicians and interviews with therapy staff, the appropriate qualifications were found for the Habilitation Therapy Director, three OTs and three PTs. The CVs of the OTs and PTs documented continuing educations courses within the past 12 months. Clinical instruction was documented in the following areas in the last 12 months: ▪ PNM and Wheelchair Clinic; ▪ Dysphagia and Nutritional Management; ▪ Texas Assistive Technology Network Statewide Conference; ▪ Technical Advances in Management of Dysphagia; ▪ PNM for Nurses/Issues in Nutritional Management; ▪ Physical and Nutritional Management Team; ▪ Shoulder Disorders and Other Related Shoulder Injuries; ▪ Mealtime Success for Kids on the Spectrum; ▪ Essential Lean Body Mass; ▪ Medication Review and Autism-Spectrum Disorders; ▪ Pivotal Response Teaching: An Evidence-based Practice for Children with	

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		Autism Spectrum Disorders; ▪ Feeding Intervention and Specialized Diets for Children with ASD (Autism Spectrum Disorders); ▪ The Motivation in Teaching Early to Advanced Language and Social Initiation Skills; ▪ Teaching Non-Vocal Children with Autism to Speak; and ▪ Autism Conference 2010. The Facility should continue to support therapists to attend a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at LBSSLC. Five individuals were receiving direct OT services (Individual #171, Individual #185, Individual #324, Individual #258, and Individual #63), which represented two percent of the LBSSLC census. Eleven individuals were receiving direct PT services (Individual #308, Individual #283, Individual #80, Individual #199, Individual #66, Individual #312, Individual #223, Individual #290, Individual #6, Individual #261, and Individual #204), which represented five percent of the LBSSLC census. Fifteen (15) records were reviewed, including those for: Individual #308, Individual #80, Individual #290, Individual #171, Individual #185, Individual #324, Individual #63, Individual #73, Individual #203, Individual #183, Individual #125, Individual #4, Individual #206, Individual #54, and Individual #44. These 15 individuals had identified needs related to movement, mobility, range of motion, independence, regression of functional skills, and/or community transition. Of the 15 individuals for whom these needs were identified, three individuals were receiving direct PT services (Individual #308, Individual #80, and Individual #290) (20%), and four individuals were receiving direct OT services (Individual #171, Individual #185, Individual #324, and Individual #63) (27%). All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission. The following two individuals: Individual #201 and Individual #321 were recently admitted to LBSSLC and received an OT/PT Evaluation within 30 days of admission. The respective therapists had signed and dated the OT/PT evaluations. However, the evaluations did not follow the OT/PT Evaluation format as presented in the Habilitation Therapies Handbook Physical and Nutritional Management, revised 2009. All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification. Two of the 15 individual records reviewed did not have an OT/PT assessment	

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		(Individual #206 and Individual #44). One of the 15 records reviewed had a current PT assessment, but no current OT assessment (Individual #125). In summary, based on review of OT/PT assessments in 15 individual records, 12 individuals (80%) had received an OT/PT assessment. Based on these 12 OT/PT assessment, three (25%) documented the need for OT and/or PT supports/services (Individual #63, Individual #54, and Individual #324). The following specific individual concerns were identified: ▪ Individual #54's physician requested consultation for conditioning/ambulation status on 5/17/10. The consultation stated: "Individual #54 recently returned from a prolonged hospital stay, status post colostomy reversal compromised by healing complications. Prior to colostomy reversal, he was able to walk to and from work at the big workshop." Individual had a change in status, but a comprehensive OT/PT assessment was not completed to address his change in status. The consultation clinical impressions stated: "he may benefit from a bout of skilled physical therapy to build tolerance to standing and ambulation activities with the goals of returning to prior levels/baseline of function." The recommendation was to receive skilled physical therapy plan of care one to five times per week through the month of May. No therapy plan or progress notes were submitted for PT direct therapy. ▪ Individual #73 had experienced 14 slips/trips/falls from September 2009 to August 2010. Her OT/PT Evaluation, dated 5/4 and 5/12/10, Gait/Mobility section did not address her frequent falls. Individual #73 was admitted to the emergency room on 1/22/10, for a contusion of the eye and adnexa. She was hospitalized on 2/1/10 for convulsions. Her OT/PT assessment did not address her hospitalization. She had a temporary PNMP, dated 8/20/10, that stated: "do not wear helmet, use wheelchair for all mobility with seatbelt, stand pivot transfers with hands-on assist of 1 with gait belt and if agitated, wait and try again later, and use shower chair with seatbelt." Her previous PNMP, revised 7/16/10, stated under mobility that she walked independently with knee pads, wore a soft helmet during waking hours, transfers were independent, and there was no discussion of a shower chair. The temporary PNMP documented a significant change in status for Individual #73, but she had not been reassessed. ▪ Individual #171 was admitted to the Emergency Room for a contusion to his hands on 3/23/10, and for a fall on 8/14/10. His OT/PT Evaluation, dated 5/14 and 5/19/10, did not discuss his emergency room visit in March. The OT/PT hand assessment section documented Individual #171 allowed therapist to range his left hand, however, he pulled his right hand away and began to push away and swing at the therapist, refusing any movement with that hand." There was no further assessment and/or discussion of the function	

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		of his right hand, and/or the impact of potential loss of function with his right hand. Individual #171's physician requested a consultation for skilled OT services on 5/21/10. The recommendations were to "begin skill occupational therapy 1-3 times per week for 6 weeks; staff should encourage [Individual #171] to extend his fingers out as he tolerates; OT will re-evaluate at the end of 6 weeks for continue need of skilled occupational therapy services and consult HT as needed." It was unclear why his OT/PT assessment, dated 5/14 and 5/19/10, did not address the need for skilled occupational therapy. ▪ Individual #290 was transferred to the Emergency Room on 3/17/10, for vomiting, and admitted to the hospital for severe gingival recession on 6/7/10, and epilepsy unspecified on 6/15/10. His OT/PT Evaluation, dated 7/1, 7/2, 7/16, and 7/27/10, documented: "following [Individual #290's] recent hospitalization (6/15 to 6/25/10) for multiple seizures, he has been observed to have decrease in his functional mobility skills as more assistance is required. Skilled habilitation therapy has been initiated with emphasis on improving [Individual #290's] ambulation endurance, gait pattern, and ambulation independence and encourage active use of his right upper extremity." His emergency room visit for vomiting was not discussed in his OT/PT evaluation, nor was he assessed for his oral motor/dining skills. However, the Nutritional Management Team section stated: "the OT/SLP evaluated feedings and staff have been in-serviced in feeding strategies. Reflux precautions are in place. The large caseloads of OTs and PTs with the responsibilities including, but not limited to completing evaluations, developing, and revising PNMPs, and participating in PNMP clinics did not leave adequate time to provide direct therapy. This was evidenced by the absence of formal OT/PT therapy services found in the individual record review of 15 individuals. The OT/PT annual evaluation recommendations were generic in nature and did not provide functional recommendations to the PST for consideration. The following chart identifies the occupational and/or physical therapy services provided to seven of the 15 individuals reviewed:	

Individual	Direct OT Services
Individual #171	To increase range of motion and decrease edema in his right hand
Individual #185	To offer gentle movement and fine motor activities to

#	Provision	Assessment of Status	Compliance
		(see nested table and text below)	

Individual #324	To be provided with gentle movement to her bilateral upper extremity and right leg for the purpose of maintaining joint range of motion and preventing further deformity
Individual #63	To improve or maintain upper extremity range of motion and activity tolerance
Individual	**Direct PT Services**
Individual #308	Passive range of motion (PROM) exercises, strengthening exercises, transfer training
Individual #80	Gait training and transfer training
Individual #290	Gait training, lower extremity and trunk musculature stretching exercise, endurance training by increasing distance ambulated as tolerated

<u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every three years, with annual interim updates or as indicated by a change in status.</u>
Based on individual record reviews, 13 of the 15 individuals (72%) reviewed had received a comprehensive OT/PT assessment within the last three years. However, as noted in the examples provided above, it did not appear that these assessments were updated consistently when there were changes in status as documented by the following example:

- Individual #44 experienced eight falls from September 2009 to August 2010. Her most current PT assessment was dated 4/5/06. Her QMRP requested a gait assessment on 4/14/10, "as Individual #44 has experienced several falls." The clinical impressions from the consultation stated: "despite attempts from staff to re-direct [Individual #44], she also often demonstrated aggressive behaviors towards others and purposefully drops to the ground; however she currently has a positive behavior support plan to address these issue. Her gait pattern demonstrated increased hip internal rotation the left and hip adduction bilaterally, therefore, her left toes come into close proximity of her right foot. This gait deviation is accentuated when [Individual #44] runs or walks very quickly; therefore, [Individual #44] is more at risk for tripping when walking quickly. Although it is often difficult to re-direct [Individual #44], she would benefit form being encouraged to slow down during ambulation. Skill habilitation therapy is not indicated." She did not have a current OT assessment although she had a consultation for adaptive feeding equipment and diet texture update. She recently transitioned to the community, but a comprehensive OT/PT assessment was not completed to address her transition from LBSSLC to the community.

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		Findings of comprehensive assessment drive the need for further assessment such a wheelchair/seating assessment. An example of an assessment that did not contain probes for additional assessment included: ▪ Individual #324's OT/PT assessment, dated 12/18, 12/21, and 12/25/09, documented: "[Individual #324's] seating system supports her posture and contractures. However, her system is in need of being modified to improve the support it provides. She will be scheduled to receive a mat assessment and new seating system. Her seating system will continue to receive quarterly preventative maintenance assessments per schedule with work orders submitted as needed." There was no recommendation for a comprehensive seating assessment, nor was a seating assessment submitted. Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. Zero of the 12 (0%) assessments reviewed addressed medical issues and health risk indicators that would have an impact on the analysis utilized to establish rationale for recommendations/therapeutic interventions. Evidence of communication and or collaboration is present in the OT/PT assessments. Based on record review, 12 of the 12 OT/PT assessments (100%) included signatures and dates by the OT and PT.	
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	Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP. Based on review of comprehensive OT/PT assessments and/or updates, and OT and/or PT Activity Plans for seven individuals (Individual #308, Individual #80, Individual #290, Individual #171, Individual #185, Individual #324, and Individual #63), none (0%) had PT Service and/or Home Exercise plans developed within 30 days of the date of the assessment/update. For example: ▪ Individual #308's Activity Plan stated: "for the next 3 months (June-August 2010) [Individual #308] will participate in activities designed to improve his abilities with reducing his extensor tone, improving posture and repositioning." The PT therapy was initiated on 3/23/10, but the activity plan was signed and dated by the therapist on 6/4/10. His Activity Plan was not integrated into his PSP. ▪ Individual #324 was receiving direct OT services to "be provided with gentle movement to her bilateral upper extremity and right leg for the purpose of maintaining joint range of motion and preventing further deformity." She did	Noncompliance

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	movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	not have an Activity Plan for direct OT services. ▪ Individual #63 was receiving direct OT services to improve or maintain upper extremity range of motion and activity tolerance. He did not have an Activity Plan for direct OT services. ▪ Individual #185 was receiving direct OT services to offer gentle movement and fine motor activities to his bilateral upper extremities. He did not have an Activity Plan for direct OT services. ▪ Individual #290 was receiving direct PT services for gait training, lower extremity and trunk musculature stretching exercises; and endurance training by increasing distance ambulation as tolerated. Individual #290 had an Action Plan developed with the following purpose defined: "for the next three months (January, February, March of 2010), [Individual #290] will participate in activities designed to improve ambulation endurance, gait pattern, and ambulation independence. His Activity Plan was signed and dated by his therapist on 12/31/09. His PSP, dated 9/8/09, documented under the gait/mobility section: "the HT department is concerned with his decreased gait skills and is recommending skills therapy sessions, once the seizures are more managed. The Team agrees with the recommendations." His direct PT services were not integrated in his PSP nor reinforced through action plan objectives and/or skill acquisition programs. ▪ Individual #171's Activity Plan's documented purpose was: "for the next six weeks (May 2010-June 2010), [Individual #71] will participate in activities designed to increase range of motion and decrease edema in his right hand." Personal Support Team Approval on 5/20/10 consisted of approval by the QMRP, Residential Coordinator and Psychologist, which was limited approval by his PST. In addition, the direct OT services were not integrated into his PSP, nor reinforced through action plan objectives and/or skill acquisition programs. ▪ Individual #80's Activity Plan for direct PT services documented the purpose: "for the next three months (May-July, 2010), Individual #80 will participate in activities designed to improve his endurance, functional ambulation and transfers." His direct PT services were not integrated in his PSP, nor reinforced through action plan objectives and/or skill acquisition programs. <u>Within 30 days of development of the plan, it is implemented.</u> Based on a review of seven individuals receiving direct OT and/PT services, four of seven individuals (57%) had an Activity Plan developed. There was documentation that for three of the four individuals (75%) with Activity Plans, that the plan was implemented within 30 days of development. <u>Appropriate intervention plans are: integrated into the PSP, individualized, based on</u>	

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		objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes. As stated above, none of the four individuals (0%) with direct OT and/or PT Activity Plans had plans integrated into the PSP. 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. Four of the four individuals (100%) with direct OT and/or PT Activity Plans identified the therapy schedule (e.g., one to five times per week), activities to be implemented (e.g., strengthening exercise), and materials needed (e.g., mat/bed, wheelchair, etc.). 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. Based on review of OT/PT documentation for individuals in the sample with Activity Plans, there was evidence that one of the four individuals (25%) was reviewed at least monthly for OT/PT Status (Individual #308).	
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. Examples are provided above with regard to Section O.5 of the SA where staff were not following OT/PT plans. Based on observations of OT/PT interventions, all PNMPs and/or other intervention plans were not implemented. More specifically, a PNMP Coordinator did not intervene to coach staff during a lunch observation to correct poor alignment and support, and coach staff to follow dining plan presentation techniques. Observations by the Monitoring Team did not support that PNMP Coordinator(s) had achieved competency in the provision of foundational physical and nutritional support service delivery. PNMP Coordinators should be required to successfully complete competency-based physical assistance and mealtime supports training with specific learning objectives and identified competencies. Such training should include foundational knowledge and skills related to the appropriate implementation of physical assistance supports including, but not limited to: risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; mealtime position and alignment; diet texture and consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming and medication administration; and techniques to promote	Noncompliance

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		optimal levels of independence and skill acquisition. This training should include written tests and skills-based performance check-offs. Therapists need to conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required. It is essential that PNMP Coordinators are competent in the performance of their duties, because these staff are responsible for service delivery, as well as monitoring of direct support professionals. Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. Based on review of training rosters and in-service outlines, direct support professionals, PNMP Coordinators and therapy aides were identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs and other activity plans for zero of 12 individuals reviewed (0%) in the sample. For example: ▪ Staff were not following Individual #203's dining plan instructions, dated 8/16/10, during a meal observation. An In-service Due Date form documented 27 staff had demonstrated competency on dates ranging from 6/17/10 to 8/25/10. The staff training form did not identify specifically what staff demonstrated. ▪ Individual #73 had a temporary PNMP, dated 8/20/10. An In-service Due Date form was submitted with 29 staff signatures with date ranges from 8/20 to 8/29/10. The form documented that staff competency was demonstrated, but there was no documentation of what competencies had been demonstrated.	
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	System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology. The Checklist for Internal Compliance Review of Critical Process Indicators Related to Physical/Nutritional Management of Consumer Requiring Such Services (Habilitation Therapies Handbook Physical and Nutritional Management, Section V. PNMP Clinic) documented: ▪ "Assistive equipment should be appropriate for the prescribed use, effective, well-fitting, well-maintained, clean and attractive. Assistive equipment should be monitored daily by Direct Contact staff for correct us and repair. Assistive equipment should be assessed for continued need and appropriateness by professional staff at least annually and as otherwise indicated. ▪ PNMPs should be monitored by professional staff as scheduled/needed for proper application of equipment and techniques, to ensure effectiveness, and to correct problems at least annually and as other wise indicated." The Wheelchair/PNMP Clinic: List by Home, dated 8/20/10, was submitted which tracked the following information:	Noncompliance

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	of these interventions.	▪ Name; ▪ Has wheelchair; ▪ Priority level and funding; ▪ Mat assessment; ▪ Frame using and/or needed and how acquired; ▪ Seating goal; ▪ Three-month follow-up; ▪ Wheelchair fitting; ▪ Wheelchair clinic; ▪ PNMP Clinic; ▪ Therapeutic positioning; and ▪ Next review date. There were no policies/procedures that documented the frequency of updates provided to this database. The Wheelchair/PNMP Clinic List did not document a routine evaluation of the fit, availability, function, and/or condition of adaptive equipment and/or assistive technology. Ten of the 15 individual records reviewed (Individual #73, Individual #183, Individual #308, Individual #324, Individual #63, Individual #185, Individual #290, Individual #171, Individual #80, and Individual #54) (67%) were assessed in the PNMP Clinic. The following concerns were noted: ▪ The PNMP Clinic reviewed the PNMP, Adaptive Equipment and Orthotics with a check-off for "Y" (yes) and/or "N" (no). The form did not document if the adaptive equipment was appropriate for the prescribed use, effective, well-fitting, well-maintained, clean, and attractive. ▪ Individual #44's equipment was not reviewed in PNMP Clinic. She used adaptive equipment at mealtime, and wore knee pads for protection and prevention from injury if she purposefully dropped to the ground or should another fall occur. ▪ Individual #206 was not reviewed in PNMP Clinic, but had mealtime adaptive equipment. ▪ Individual #4 was not reviewed in PNMP Clinic, but his PNMP documented assistive equipment including blocks and communication book. His dining plan prescribed the use of a plate guard. ▪ Individual #203 was not reviewed in PNMP clinic. His prescribed adaptive equipment for his dining plan was a dycem mat, high-sided divided plate, built up weighted youth vinyl coated spoon, scooper bowls, wrist weight (optional), four ounce juice glass, and unbreakable brown spoon for dry spoon. His PNMP identified assistive equipment as knee pads, communication book, and gait belt. ▪ Individual #54's PNMP Clinic on 1/6/10, documented that the PNMP was	

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		reviewed, and current and PT assessment completed. The PNMP Clinic did not document if his assistive equipment (blocks for bed elevation, glasses, shoes or socks with traction treads to transfer and walk, and communication placement) were evaluated for fit (if appropriate), availability, function, and condition. The individual PNMP Clinic documentation did not document the monitoring of adaptive equipment as stated in the Checklist for Internal Compliance Review of Critical Process Indicators Related to Physical/Nutritional Management of Consumer Requiring Such Services (Habilitation Therapies Handbook Physical and Nutritional Management, Section V. PNMP Clinic). <u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> Based on review of the State and/or Facility's policy, a defined monitoring system was not in place to monitor staff implementation of PNMPs, and other OT/PT interventions. Such a policy should have included: ▪ Definition of monitoring process; ▪ Identification of monitors (licensed professional for OT/PT intervention plans), and their roles and responsibilities; ▪ Formal schedule for monitoring to occur; ▪ A revalidation of monitors on an annual basis by therapists and/or assistants; and ▪ A process for results of monitoring activities in which deficiencies are noted to be shared formally with the relevant supervisor for appropriate follow-up. <u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u> A policy did not exist that clearly defined the details of the monitoring system including frequency, and implementation. Such a system should require that the program author review intervention plans monthly, including observation of staff's implementation of the plans. <u>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 (as discussed further with regard to Section O.5 of the SA)</u>. As noted above, issues were identified related to the competencies of PNMP Coordinators who had responsibility for working with the individuals with the most complex needs and monitoring other staff's competence. It is essential that these staff consistently demonstrate competence in these areas.	

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		Responses to monitoring findings are clearly documented from identification to resolution of any issues identified (as discussed further with regard to Section O.4 of the SA). As noted above, a system for monitoring had not been developed and memorialized in policy. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. The PNMP Clinic reviewed an individual's PNMP, adaptive equipment and orthotics, but the Facility did not have written procedures to define how this equipment was assessed as discussed in further detail above. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs (as discussed further with regard to Section O.5 of the SA). As noted above, a system for monitoring had not been developed and memorialized in policy. Data collection method is validated by the program's author(s). As noted above, a system for monitoring had not been developed and memorialized in policy.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should complete an analysis to determine the adequacy of OT/PT therapy positions to support these professionals being active members of individuals' PSTs, and providing the supports and services required by the SA. Efforts should be made to continue to fill currently vacant OT positions.
2. The Facility should continue to support therapists to attend a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at LBSSLC.
3. OT positions should be filled to allow for the development of OT programs to provide adequate implementation of supports and services based on identified needs.
4. Current therapy services being provided to individuals should be integrated into PSP skill acquisition programs to provide multiple opportunities for incidental teaching, formally and informally.
5. PNMP Coordinators should receive competency-based physical assistance and mealtime supports training with specific learning objectives and competencies identified. Such training should provide foundational knowledge and skills related to the appropriate implementation of physical assistance supports, including but not limited to: risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; mealtime position and alignment; diet texture and consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include written tests and skill-based performance check-offs.
6. Therapists should conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required.
7. Policies/procedures should be developed for the OT/PT monitoring system with identified performance indicators that are defined clearly. This

system should include, but not be limited to: a systematic and routine review of the components of PNMPs and related equipment; OT/PT instructional/intervention programs and equipment; staff utilization of the equipment; fit, function, availability and use of adaptive equipment; and staff competency with PNMPs, therapy instructional/intervention plans, as well as activity plans. There should be established thresholds for staff retraining; and identification of monitors, and training and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Dental Services for the individuals residing at the Lubbock State Supported Living Center February 2010 – August 2010 – Initial Exams (admitted to the Facility within the last six months); o Oral Hygiene Status 2009-2010; o Dental Missed Appointments (TX-LB-1009-XIV.4c); o Dental List of Refusals (TX –LB-1009-XIV.4b); o Dental List of Extractions (TX-LB-1009-XIV.4d); o Dental List of Restorations (TX-LB-1009-XIV.4g); o Dental List of Exams (annual) (TX-LB-1009-XIV.4h); o Dental List of Prophylaxis (TX-LB-1009-XIV.4f); o Dental List of Emergencies (TX-LB-1009-XIV.4e); o Desensitization plans for the following individuals: Individual #2, dated 4/08; Individual #272, dated 10/10; Individual #2, dated 4/09; Individual #115, dated 2/10; Individual #19, dated 11/09; Individual #4, dated 6/09; Individual #25, dated 10/1/07; Individual #284, dated 4/15/10; Individual #151, dated 9/09; Individual #302, dated 11/09; Individual #223, dated 6/09; Individual #97, dated 10/09; Individual #68, dated 5/09; Individual #291, dated 10/08; Individual #59, dated 11/08; Individual #100, dated 3/09; Individual #160, dated 10/09; Individual #6, dated 2/10; Individual #175, dated 8/09; Individual #198 , dated 4/10; Individual #33, dated 7/10; Individual #73, dated 9/16/10; Individual #276, dated 7/10; Individual #241, dated 9/10; Individual #195, dated 8/10; Individual #50, dated 2/09; Individual #258, dated 10/09; Individual #37, dated 1/13/10; Individual #147, dated 5/10; Individual #313, dated 5/10; Individual #253, dated 5/10; and Individual #111, dated 5/10; o Medical/Dental Restraint Report, dated 2/1/10 through 7/31/10; o Pre-treatment Sedation Assessment Flow Sheet, revision date 1/21/10; o Post–Op Dental Instructions, dated 10/1/08; o Pre-treatment Sedation Assessment forms for Individual #226, dated 7/26/10; Individual #115, dated 7/27/10; Individual #38, dated 6/4/10; Individual #260, dated 6/25/10; Individual #41, dated 6/21/10; Individual #238, dated 7/8/10; Individual #16, dated 6/8/10; Individual #184, dated 9/2/10; and Individual #275, dated 6/3/10; o HRC Approved Dental Medical Restraint with sedation - List of individuals; o LSS Policy – Health Services: Dental/Medical sedation and Restraint , dated 1/14/10 (R); o Dental progress notes/Treatment Record for the following individuals: Individual #237, Individual #268, Individual #8, Individual #34, Individual #159, Individual #196, Individual #195, Individual #104, Individual#198, Individual #197, Individual #166, Individual #184, Individual #276, Individual #38, Individual #275, Individual #139, Individual #70, Individual #16, Individual #260, Individual #238, and Individual #41; o Dental anesthesia/dental progress notes/Treatment Record for the following individuals:

	Individual #86, Individual #243, Individual #97, Individual #299, Individual #107, and Individual #65; o Annual Dental Summaries on the following individuals: Individual #36, dated 5/18/10; Individual #255, dated 4/22/10; Individual #4, dated 4/22/10; Individual #185, dated 7/19/10; Individual #311, dated 4/22/10; Individual #68, dated 4/22/10; Individual #242, dated 4/22/10; Individual #95, dated 7/13/10; Individual #202, dated 4/22/10; Individual #114, dated 4/22/10; Individual #254, dated 5/201/0; Individual #8, dated 5/20/10; Individual #232, dated 6/24/10; Individual #76, dated 5/20/10; Individual #223, dated 8/25/10; Individual #10, dated 5/20/10; Individual #213, dated 8/30/10; Individual #206, dated 5/20/10; Individual #1, dated 7/28/10; Individual #193, dated 5/20/10; Individual #238, dated 6/24/10; Individual #276, dated 7/30/10; and Individual #137, dated 6/24/10; o Integrated progress notes for Individual #175 from 9/25/09 to 9/29/09, and 5/1/10 to 5/10/10; o Dental Record: Annual Examination for the following individuals: Individual #7, dated 6/1/10, and 6/1/09; Individual #191, dated 6/1/10, and 6/1/09; Individual #62, dated 6/1/10, and 6/1/09; Individual #324, dated 6/1/10, and 6/1/09; Individual #185, dated 6/1/10, and 6/1/09; Individual #122, dated 6/1/10, and 6/1/09; Individual #237, dated 6/28/10, and 7/21/09; Individual #288, dated 7/14/10, 3/10/09, and 3/9/09; Individual #240, dated 7/14/10, and 10/30/09; and Individual #250, dated 8/2/10, and 8/10/09; o Dental Department policies, including: Dental/Medical Sedation and Restraint, dated 1/14/10 (R); Dental Clinic Operations, dated 4/1/08; Dental Examinations, dated 4/1/08; Dental Sedation/NPO for an Appointment, dated 3/1/08; Denture and Partial Care, dated 2/1/08; Criteria for General Anesthesia, dated 7/1/08; Dental Anesthesiologist, dated 10/15/08; General Anesthesia Medical Clearance, dated 10/15/08; General Anesthesia Recovery, dated 10/15/08; General Anesthesia Surgery, dated 10/15/08; General Anesthesiology Personnel, dated 10/15/08; Instructions for Individuals Following the General Anesthesia Clinic , dated 10/1/08; Instructions for Individuals Prior to General Anesthesia Clinic, dated 10/1/08; General Anesthesia Policy, dated 10/15/08; Pre-operative Sedation prior to General Sedation, dated 7/1/08; Attendance Problem Tracking Protocol, dated 12/1/07; Client Accompaniment to Dental Appointments, dated 12/1/07; Informed Consent, dated 11/18/08; Request for a Consultation, dated 12/1/08; Comprehensive Annual Examination, dated 12/1/08; Dental Clinic Operations, dated 4/1/08; Dental Desensitization, dated 12/1/08; Dental Emergencies, dated 12/1/08; Dental Examinations, dated 4/1/08; Dental Recall Policy, dated 12/1/08; Dental Services Overview, dated 12/1/08; Dentist, dated 11/18/08; Policy for Dental Prophylaxis, dated 12/1/08; Dental Infection Control Policy, dated 12/1/08; and Hygiene Documentation, dated 12/2/08; o New Admissions since January 1, 2010, as of 8/19/10; o Texas Health Monitoring Instrument, dated 8/17/10; and o Lubbock SSLC Plan of Improvement for Section Q, dated 5/17/10.

	▪ **Interviews with**: o Russell Reddell, DDS, Dental Director
	Facility Self-Assessment: In describing progress in dental care, the Dental Director informed the Monitoring Team that a dental hygienist had begun to attend the PNMT meetings, the standard of dental care was reviewed by chart audit by both the Dental Director as well as the QE nurse, and there had been an update to the policy and procedure to improve monitoring following pre-treatment sedation for medical and dental visits. The POI indicated that almost all action steps listed were considered to be in noncompliance. These findings were consistent with those of the Monitoring Team. For instance, according to the POI, there were problems documenting in the IPN when the medical chart did not accompany the individual to the dental office. In another area, the Dental Director was not made aware of the steps the PST had taken to address individuals' refusals to attend dental appointments. In implementing the Texas Health Monitoring Instrument monitoring tool, it was determined that 50% of the individuals did not attend all scheduled dental appointments, and that several of the missed appointments were due to refusals. It also indicated that although there were desensitization plans for five individuals, there was no documentation of implementation of these plans for any of the five individuals. For two individuals reviewed with the monitoring instrument, who were at risk for choking/aspiration, a PNM plan was not in place. For both the July 2010 and August 2010 Section Q reviews, 100% of the charts reviewed by the Dental Department showed that when individuals refused dental appointments, there was no PST meeting held to discuss refusal, and that if there was a desensitization plan, there was no implementation of the plan.
	Summary of Monitor's Assessment: Progress had been made in the cooperation between Habilitation Services and the Dental Department with regard to ensuring that the PNMPs for individuals were available to and implemented by the Dental Department. A dental hygienist was attending the PNMT meetings. Also, there had been improved monitoring after pre-treatment sedation had been administered. However, the Dental Department had significant challenges ahead. Many of the compliance issues depended on cooperation with other departments for resolution. The high rate of missed appointments translated into delays in care and inefficient use of time. To resolve this issue, accurate information will need to be collected regarding the reasons for missed appointments, and there will need to be coordination and cooperation with the homes and PSTs. According to the Dental Director, there were 163 dental desensitization plans in place. According to the Lubbock SSLC Plan of Improvement, many had not been updated recently. Further, according to the Dental Director, few, if any, have been implemented, and there was little information concerning any monitoring regarding the implementation of the plans. The revision/development and implementation of desensitization plans and other strategies to reduce the need for sedation will require significant coordination with and assistance from the Psychology Department. At the time of the review, the Dental

	Department had not received sufficient assistance, and as a result, there was an overuse of chemical sedation and IV sedation/general anesthesia.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	One of the measures of timeliness is completion of initial exams for new admissions. According to the "LSS-Health Services Dental Examinations" policy dated 4/1/08, "all newly admitted or transferred Persons Served will receive a comprehensive extraoral and intra-oral examination within the first 14 days following their admission to the Lubbock State School." This timeframe was different from that stated by the Dental Director and listed in the Lubbock SSLC Plan of Improvement. The latter referenced a timeframe of 30 days, which was not consistent with the facility/department policy and procedure. It is recommended that this inconsistency be reviewed and corrected to reduce confusion. From February 2010 through August 18, 2010 (date of scan), there were seven admissions (this was a discrepancy from information entitled: New Admissions since January 1, 2010, which listed eight individuals.) Of these, Individual #61, Individual #235, Individual #134, and Individual #190 had exams completed during the first 14-day time period. However, Individual #216, Individual #36, and Individual #201 did not have initial exams completed during this time period. This results in a 57% compliance rate with the Facility's policy. If 30 days was the acceptable timeframe, then Individual #216 and Individual #201 would have been the only new admissions not meeting this criteria, resulting in a compliance rate of 71% (5/7). A number of annual dental assessments were reviewed. Each had the following content: behavior classification and management needs, medical or physical limitations, extraoral exam, intra-oral exam, oral hygiene, medical history, updated diagnoses, medications, allergies to medication, category of risk for periodontal disease and dental caries, and an entry if radiographs were completed. Individual dental exams reviewed included those for: Individual #7, dated 6/1/10, and 6/1/09; Individual #191, dated 6/1/10, and 6/1/09; Individual #62, dated 6/1/10, and 6/1/09; Individual #324, dated 6/1/10, and 6/1/09; Individual #185, dated 6/1/10, and 6/1/09; Individual #122, dated 6/1/10, and 6/1/09; Individual #237, dated 6/28/10, and 7/21/09; Individual #288, dated 7/14/10, 3/10/09, and 3/9/09; Individual #240, dated 7/14/10, and 10/30/09; and Individual #250, dated 8/2/10, and 8/10/09 (although the list of medications seemed incomplete compared with prior year, 8/10/09). Except for a minor variation in the medication list for Individual #250 (the dental office also had the prior year for review if needed), the completion of this information was thorough. During the six-month period from March 1, 2010 through August 31, 2010, there were	Noncompliance

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		180 completed dental visits for prophylactic care. Another submitted list indicated 158 individuals completed an annual exam. According to the Facility, the reason for more prophylactic care than exams was that exams only occurred once per year, whereas prophylactic care might occur from twice per year to up to four times per year, depending on the individual's periodontal condition. In some instances, both did occur at the same time, usually during general anesthesia otherwise they were separate. In future data collection, it will be important for the Dental Department to define the meaning of the terms for the various categories of care, and clarify when overlap occurs at the same visit. In other information submitted, 39 individuals underwent dental restorations during the prior six months, 20 individuals underwent extractions, and 20 individuals refused care, The refusal rate was 20/231, or 8.6%. For example, Individual #166 refused scheduled visits on 3/10/10, 3/11/10, 4/7/10, 4/28/10, 5/19/10, 7/23/10, and 8/25/10. Others were listed under "no show" and missed appointments. The Dental Director had no readily available information as to whether the PST addressed the refusals and, if so, developed strategies to overcome the individual's refusal to attend dental appointments. Another report entitled "Dental visit refusals/all refusals for April 1, 2010 to August 31, 2010" stated there was no formal process for addressing dental refusals by the PST. Names on the list included Individual #166, Individual #214, Individual #154, Individual #82, Individual #197, Individual #159, Individual #35 and Individual #26. The refusal rate (if accurate) could be considered a baseline measure from which progress on the part of the Dental Department, in collaboration with the PSTs, could be measured. It was clear individuals' PSTs had not addressed this problem across many homes, and that the system needed review. It is recommended that ways to improve communication between the dental office and the PSTs be identified and implemented, and that there be increased accountability on the part of the PSTs to ensure dental refusals are addressed in a timely manner. The "no show" rate, according to the Dental Director, approached 50%. There seemed to be no system in place to begin to resolve this significant issue. A large percentage of "no shows" suggests inefficient use of the Dental Department resources, delay in care to the individuals, and a need for improvement in tracking and resolution of this problem. A number of individuals had serial rescheduling of missed appointments, with care that could have been accomplished in a more timely manner if there was resolution of the reasons for the missed appointments. Examples included Individual #70 with appointments rescheduled on 5/18/10, and 7/29/10, with an appointment completed on 8/6/10; Individual #184 rescheduled on 4/28/10, and 7/7/10, and appointment completed on 8/18/10; Individual #111 rescheduled on 5/27/10, with next appointment 9/2010; Individual #176 rescheduled on 2/4/10, 2/23/10, and 3/11/10, and appointment completed on 4/26/10; Individual #324 rescheduled on 2/12/10, with no	

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		follow-up appointment made; Individual #75 rescheduled on 3/18/10, with no follow-up appointment made; Individual #128 rescheduled on 2/12/10, 4/18/10, and 6/18/10, with no follow-up appointment made; Individual #48 rescheduled on 3/31/10, and 4/2/10, with no follow up appointment made; Individual #196 rescheduled on 6/26/09, and 8/7/09, (the dental hygienist made a home visit to evaluate oral hygiene on 9/16/10), 9/17/09, 2/4/10 and rescheduled for 2/18/10; Individual #195 rescheduled on 9/20/09, 9/21/09, 2/8/10, 2/23/10, 2/25/10, 3/9/10, and 4/15/10, and a prophylactic exam was completed on 4/27/10, and annual dental exam on 6/1/10; Individual #104 rescheduled on 12/1/09, 1/26/10, 2/8/10, 2/25/10, and a prophylactic visit was completed on 3/15/10; Individual #198 rescheduled on 4/3/09, 5/18/09, 7/9/09, 7/28/09, 8/6/09, and 9/15/09 with prophylactic visit on 1/13/10, and annual exam on 3/12/10; Individual #197 has not seen the dentist after 11/3/08, with prophylactic visit on 4/13/09 and 1/13/10, and missed appointments 5/21/09, 6/16/09, 9/8/09, 10/8/09 (due for annual), and 3/12/10; and Individual #159 saw the dentist on 8/25/08 and 3/12/10, and the hygienist for a prophylactic exam on 3/5/09, but missed appointments or cancelled appointments on 11/4/08, 11/5/08, 9/3/09, 9/8/09, 9/23/09, 10/23/09, 4/13/10, and 5/11/10. There were a wide variety of reasons for rescheduled appointments, and there needed to be review of the available information. Some of the rescheduling and lack of follow-up had led to delays of weeks and months in individuals being provided with adequate dental care. At the time of the review, some remained unresolved. This is only a small sampling of the larger "no show" rate. The Dental Department should create a detailed system listing all causes of "no show"/missed appointments (e.g., refusals, conflict in schedule for the individual, individual ill, short staff in the home, short staff in the Dental Department, inclement weather, transportation difficulties, individual in hospital, individual on leave with family, other reason, etc.). This will require frequent communication with the QMRPs to obtain accurate information. Providing a brief questionnaire requiring written responses with signature and date would be one way of implementing a tracking system to ensure this initial and essential information is obtained. Once the information is compiled, the Dental Department can begin to work on addressing the many issues causing the "no show" rate to be high. The Dental Department should define a baseline rate for measurement of future progress and improvement. A number of emergency visit entries in the dental progress notes were reviewed. As is described below, the documentation was not consistently clear with regard to the specific complaint that led to the visit, whether pain medication was prescribed as indicated, or what specific follow-up occurred to address identified areas of need. For example: ▪ Individual #237 had an emergency exam on 8/17/10 for a toothache. A limited	

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		exam was completed, followed by treatment the following day. There was no mention in the 8/17/10 note of pain medication or other comfort medication being prescribed until the treatment could be completed. ▪ Individual #268 underwent an emergency visit on 8/17/10 (date not clearly written). There was not a chief complaint written, but the brief note referenced pain, but the exact location was not documented. The dentist determined there were no problems and no treatment indicated. ▪ Individual #8 sustained a fractured tooth from an incident of peer-to-peer aggression on 3/1/10. The plan entered in the dental notes was "could restore with crown (?) upon individual or family request." There was no information as to whether the individual had complained of pain or discomfort, or if the visit was due to the team or nurse requesting an exam. There was a later entry on 3/8/10 that the individual complained of teeth hurting and wanted them out, although there was no information given as to whether the painful teeth were those that had been fractured. There was no further entry about the fractured tooth or the tooth pain. ▪ Individual #34 had several urgent visits. On 4/28/10, there was initial evaluation and treatment of tooth #20 (although legibility and abbreviations made it difficult to understand the details). On 4/30/10, the individual returned for an emergency visit concerning the same tooth. Antibiotic and pain medication were prescribed and this was followed by another emergency visit on 5/4/10, and pain medication was prescribed once the dentist confirmed with the psychiatrist there was no drug seeking behavior. This was followed by a dental hygienist prophylactic visit on 5/13/10, and a follow-up visit on 6/2/10 for further treatment of tooth #20, as well as tooth #19. The individual returned for an emergency visit on 6/25/10 for tooth #20. Antibiotic and Motrin were prescribed and there was the entry that there would be a request for consent for extraction. It was difficult to decipher the details of the notes, but it was clear the individual continued to have dental pain and discomfort for two months. A note dated 6/25/10 was the last one submitted for review, so it remained unclear as to the resolution of this issue. One of the approaches, to improve dental health across campus that was being used, was to focus on oral hygiene programs. For the participants of this program, the oral hygiene index should improve over time. A list of those with poor oral hygiene was submitted, totaling 25 individuals. Tooth brushing skills had begun to be taught in the home by the hygienist. There were a number of desensitization programs in which the current step was learning this skill in the home setting. There was a need for more hours for the dental hygienist to provide teaching and training to the individuals and direct support professionals in the home than currently provided. The Dental Department should begin to track the oral hygiene index of each individual. Individuals with no progress, or	

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		clusters of individuals in homes with little improvement might reflect the need for more intensive training and oversight. Whether this could be accomplished with one dental hygienist would need to be determined by the Dental Director. Improved dental hygiene is one approach to reduce the need for emergency care, and the need for chemical sedation or general anesthesia.	
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 medications and dental restraints.	A number of policies were in place in the Dental Department. These included: ▪ Dental/Medical Sedation and Restraint, dated 1/14/10 (R); ▪ Dental Clinic Operations, dated 4/1/08; ▪ Dental Examinations, dated 4/1/08; ▪ Dental Sedation/NPO for an Appointment, dated 3/1/08; ▪ Denture and Partial Care, dated 2/1/08; ▪ Criteria for General Anesthesia, dated 7/1/08; ▪ Dental Anesthesiologist, dated 10/15/08; ▪ General Anesthesia Medical Clearance, dated 10/15/08; ▪ General Anesthesia Recovery, dated 10/15/08; ▪ General Anesthesia Surgery, dated 10/15/08; ▪ General Anesthesiology Personnel, dated 10/15/08; ▪ Instructions for Individuals Following the General Anesthesia Clinic, dated 10/1/08; ▪ Instructions for Individuals Prior to General Anesthesia Clinic, dated 10/1/08; ▪ General Anesthesia Policy, dated 10/15/08; ▪ Pre-operative Sedation prior to General Sedation, dated 7/1/08; ▪ Attendance Problem Tracking Protocol, dated 12/1/07; ▪ Client Accompaniment to Dental Appointments, dated 12/1/07; ▪ Informed Consent, dated 11/18/08; Request for a Consultation, dated 12/1/08; ▪ Comprehensive Annual Examination, dated 12/1/08; ▪ Dental Clinic Operations, dated 4/1/08; ▪ Dental Desensitization, dated 12/1/08; ▪ Dental Emergencies, dated 12/1/08; ▪ Dental Examinations, dated 4/1/08; ▪ Dental Recall Policy, dated 12/1/08; ▪ Dental Services Overview, dated 12/1/08; ▪ Dentist, dated 11/18/08; ▪ Policy for Dental Prophylaxis, dated 12/1/08; ▪ Dental Infection Control Policy, dated 12/1/08; and ▪ Hygiene Documentation, dated 12/2/08. According to the Dental Director, there had been no new policies approved during the prior six months. The Facility was awaiting policies that the State Office was expected to	Noncompliance

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		issue prior to making changes to the current policies. According to the Dental Director, there were 163 dental desensitization plans in place. According to the Lubbock SSLC Plan of Improvement, many had not been updated recently. Further, according to the Dental Director, few if any have been implemented, and there was little information concerning any monitoring regarding the implementation of the plans. Desensitization plans were reviewed for the following individuals: Individual #2, dated 4/08; Individual #272; Individual #2, dated 4/09; Individual #115, dated 2/10; Individual #19, dated 11/09; Individual #4, dated 6/09; Individual #25, dated 10/1/07; Individual #284, dated 4/15/10; Individual #151, dated 9/09; Individual #302, dated 11/09; Individual #223, dated 6/09; Individual #97, dated 10/09; Individual #68, dated 5/09; Individual #291, dated 10/08; Individual #59, dated 11/08; Individual #100, dated 3/09; Individual #160, dated 10/09; Individual #6, dated 2/10; Individual #175, dated 8/09; Individual #198 , dated April 2010; Individual #33, dated 7/10; Individual #73, dated 9/16/10; Individual #276, dated 7/10; Individual #241, dated 9/10; Individual #195, dated 8/10; Individual #50, dated 2/09; Individual #258, dated 10/09; Individual #37, dated 1/13/10; Individual #147, dated 5/10; Individual #313, dated 5/10; Individual #253, dated 5/10; and Individual #111, dated 5/10. The Dental Department was involved directly or the dental office space/chair was involved for the following individuals: Individual #272, Individual #115, Individual #19, Individual #4, Individual #25, Individual #284, Individual #151, Individual #223, Individual #97, Individual #68, Individual #291, Individual #59, Individual #160, Individual #6, Individual #175, Individual #198, Individual #241, Individual #50, Individual #258, Individual #37, Individual #147, Individual #313, Individual #253, Individual #111, and Individual #195. That the Dental Director was not familiar with the steps in many of the desensitization plans, especially those that utilized Dental Department staff, or utilized dental clinic space, suggested the implementation phase had not yet occurred. There also had been discussion about transferring this area of responsibility from the QMRP to the psychology department. It was not clear the status of this change. The Dental Director stated his department was actively involved in up to three or four individuals' desensitization plans in the office, but there was little information available about monitoring or progress. This information suggested that, although the desensitization plans had been written, there were variations in implementation, with little evidence of implementation from the perspective of the Dental Department. Many of the desensitization plans included activities that were to take place, in which case it is	

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		recommended that progress be communicated with the Dental Department. Further action may need to await transfer of this responsibility to the Psychology Department, and this Department's review of the plans for each of the 163 individuals. At this time, although desensitization plans had been written, there seemed to be little practical evidence of their impact on the individuals' acceptance of dental procedures. Approximately 50% of the individuals at LBSSLC required chemical sedation. Twenty-five percent required general anesthesia, and reportedly, there was a trend that individuals with higher levels of intellectual functioning, and their family members, were requesting general anesthesia. From 2/1/10 to 7/31/10, there were a total of 70 medical restraints used, of which 48 were chemical sedation used for dental office procedures and involved 43 individuals. Fifty-five individuals had individual Human Rights Committee approval for general anesthesia or IV sedation. Another 108 had Human Rights Committee approval for pre-treatment sedation. According to information submitted: "Desensitization plans are required for HRC approval" of pre-treatment sedation. However, if there was evidence that the plans had not been implemented, this raises concerns about the systemic use of IV sedation, general anesthesia, and pre-treatment sedation without a rigorous system in place for the implementation of desensitization plans and other strategies to reduce the reliance on sedation. There are exceptions in which urgent need requires pre-treatment sedation or chemical restraint prior to completion of desensitization (which can take months to years to accomplish), but the lack of consistent implementation of desensitization plans and other strategies will continue to result in high utilization rates of chemical sedation and general anesthesia for dental procedures. One of the measurements of success for desensitization programs and other strategies, is a reduction in the use of pre-treatment sedation (type of medication or amount of medication required), and in the reduction of the use of general anesthesia. At the time of the review, LLSSLC had a baseline of 163 individuals for whom pre-treatment sedation or general anesthesia had been approved and who had desensitization plans. This information, including additional information regarding the type and amount of sedation used, should be used over time to measure the success of the plans and strategies in place. The monitoring of pre-treatment sedation from the initial administration to recovery was reviewed in two individuals. Specifically: ▪ Individual #226 received Ativan through a G-tube on 7/26/10. The following documentation was completed: a pre-treatment sedation assessment including pre-procedural monitoring every 15 minutes following administration of the medication, a patient safety section completed, a dental clinic entry describing the procedure with start and stop time, procedural monitoring in the dental office, and a list of sedation medications and post procedural monitoring every	

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		15 minutes until clinical criteria were met indicating monitoring was no longer indicated. Sections of the pre-treatment sedation assessment entitled narrative notes, and patient outcome, as well as the name and signature of staff completing the form were not filled out. A flow sheet with initials of those completing each step was also available. Only Step 8 remained without initials. The PSP dated 2/4/10 indicated, in the comments section of the Assessments/Services the Person Uses/Needs, that an email had been sent to justify the recommendation of Ativan. A later part of the PSP, Living Options Discussion Record contained information that was not in agreement with the use of Ativan. Under "The Supports and Services" needed by the person served section, in the area under subcategory Medical, it stated "Dental care performed by nursing staff for optimal oral care. General anesthesia needed to perform dental cleanings as necessary." Given that Ativan had been recommended and justification submitted, and later utilized successfully, the PSP should be updated to be consistent. ▪ Individual #115 received Lorazepam by mouth (po) on 7/27/10. The following documentation was completed: a pre-treatment sedation assessment including pre-procedural monitoring twice 15 minutes apart, then seen in dental clinic 1.5 hours later, a patient safety section completed, dental clinic procedure, and procedural monitoring, a list of sedation medications given, and post-procedural monitoring. A narrative notes section, patient outcomes section, and final area for staff completing the forms was not filled out. A 2/23/10 PSP indicated that tooth #9 was necrotic, oral hygiene and tissue were reported as good, and prophylaxis was recommended every six months with restraints personal, head, and wristlets, and 3 mg Ativan as sedation. In the comments section was the entry: "The Team reviewed the information from the dental summary. The Rights Assessment will review the need for restraint as well as sedation," on 7/27/10, the dental note indicated that cleaning of the teeth could only be done on the upper teeth, and that he resisted other procedures. In both instances a desensitization plan was attached to the PSP, but there was no attachment of ongoing monitoring forms to provide evidence of implementation and whether the desensitization was successful at the point in time at which pre-treatment sedation was being implemented. It is recommended that documentation verify that the appropriate procedures have been completed before pre-treatment sedation is administered, specifically implementation of the desensitization plan or other strategies identified by the PST. Authorization by the HRC should be briefly noted on the pre-treatment sedation assessment form, and the document that includes that authorization should be referenced. In some instances, the PSP had discrepancies concerning dental sedation within its own text, which should be corrected. Additionally, if the remaining	

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		portions of the pre-treatment sedation assessment are routinely incomplete, this may indicate the need for further training or the need to review the form to determine if it is appropriate to remove these sections. Overall, the increased monitoring of the individual once pre-treatment sedation was given was an important safety step that was well documented. A number of dental progress notes/treatment records were reviewed concerning pre-treatment sedation. The following provides a summary of this review: ▪ Individual #41 had an annual exam attempt on 9/9/08, with the recommendation that the next visit be prophylaxis with restraints. On 2/6/09, the prophylactic visit was completed, and the visit was described as "difficult to brush properly b/c combative…Rec(ommend) 2 staff assist to brush at home." There was the recommendation that the next prophylactic visit be completed with medication and restraints. The Dental Director stated that outside of an emergency situation, restraints were not used in the dental office, but these notes were not consistent with this information. An annual exam was completed on 9/14/09, and a prophylactic visit on 10/23/09. These two visits were not recorded as requiring pre-treatment sedation. Then on 6/21/10, a prophylactic treatment was attempted with Ativan. The individual's behavior was described as combative, and there was excessive head movement documented. It was recommended that there be IV sedation for exam, x-rays, and deep scaling and root planing. This was consistent with the policy that three attempts be made to treat the individual for routine care without medication or physical restraints before oral or conscious sedation was considered. According to the Dental Director, chemical sedation was attempted at least once, and this occurred with this individual. The recommendation was then to have IV sedation to complete the prophylactic exam and obtain x-rays. Based on the Dental/Medical Sedation and Restraint Policy, Section #7.b. which stated that: "the routine intra and extra yearly oral exam and preventive dental prophylaxis are not generally considered to be sufficient reason for requesting conscious sedation. Oral sedation will be the medication of choice for these procedures." For this individual, IV sedation was recommended for prophylactic care, and it is recommended that if the policy is not clearly followed, that more information about rationale be incorporated into the dental record, or the policy be amended to broaden the scope of use for IV sedation. ▪ The dental treatment record for Individual #70 documented the challenges of ordering pre-treatment sedation at LBSSLC. On 4/27/10, Individual #70 was referred from the medical department for bleeding gums, but the Dental Department was waiting for approval for the administration of pre-treatment sedation. The next entry was that the PSP was updated on 5/26/10. A week	

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		earlier, on 5/18/10, it was recorded that the "nurse did not get the pre med orders. No meds given." On 7/6/10, there was documentation that there was preparation for a new HRC approval for three mg Ativan [which the reader would interpret as the documents were being presented for approval of the chemical sedation]. On 7/29/10, the home contacted the dental office with the information that the "individual was NPO and was given Ativan, he had blood drawn, the staff thought he was NPO for medical [the blood draw], pt ate." This required the individual to be rescheduled. This raised the question of whether there was HRC approval for chemical sedation to complete a blood draw for this individual. If not, then the Ativan was given without HRC approval for the blood draw, as that was the only procedure that occurred. On 8/6/10, he was rescheduled for the dental work. He had been given three mg Ativan, and had been to the vision clinic where he was described as "asleep," but by the time he arrived at the dental office, the effect had worn off and he was uncooperative. The Dental Department had been attempting since 4/27/10 to complete a prophylactic exam, and Ativan had been administered twice, but Individual #70 still had not received the necessary care. It is recommended that an interdisciplinary group, including the appropriate departments (dental, medical, nursing, HRC) review such situations to identify individual as well as systemic issues that need to be addressed. In this case, dental care was delayed because of issues beyond the Dental Department's control. ▪ Individual #139 received a prophylactic treatment on 2/26/10. Ativan two mg was given. Documentation indicated that he required deep scaling and root planing, but that "due to unsafe head movement, clenching cheeks and lips and gag reflex, highly recommend IV sedation. Had DDS get a visual and he concurs. Also rec IV due to length of procedure and inability to tolerate pain." This was excellent documentation of the need for IV sedation, but the follow-up prophylactic visit on 6/29/10 described the use of three mg Ativan, and still the hygienist could not scale due to head movement. There was no information submitted about treatment under IV sedation, although reasons for its use were clearly documented. ▪ There were several other dental progress notes/treatment records reviewed in which Ativan was given as pre-treatment sedation. Ativan was given for prophylactic treatment to Individual #238 on 7/8/10, Individual #260 on 6/25/10, Individual #184 on 9/2/10, Individual #276 on 7/30/10, Individual #16 on 3/15/10 and 6/8/10, Individual #38 on 6/4/10, and Individual #275 on 6/3/10. Pre-treatment Sedation Assessments were reviewed for completion of pre-procedural and post-procedural monitoring for these prophylactic visits requiring Ativan for the following individuals: Individual #260 on 6/25/10, Individual #238 on 7/8/10, Individual #41 on 6/21/10, Individual #38 on	

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		6/4/10, Individual #16 on 6/8/10, Individual #184 on 9/2/10, and Individual #275 on 6/3/10. All had entries in these sections except Individual #38 who refused all efforts at obtaining vital signs. Several dental treatment records were reviewed for individuals undergoing general anesthesia. For example: ▪ Individual #65 underwent general anesthesia on 8/14/09 for fillings and extractions. A prophylactic treatment visit was completed on 3/4/10, followed by an 8/16/10 visit under general anesthesia for x-rays, and dental hygiene. It could not be determined from the entry whether anything other than prophylactic care was completed under general anesthesia for the second visit. The anesthesia record, consent authorization, HRC approval, and preoperative laboratory test results were complete. ▪ Individual #107 underwent IV sedation on 8/16/10, for prophylactic care and restorative care. The anesthesia record, consent authorization, HRC approval, and preoperative laboratory test results were complete, along with a post-operative handwritten summary. ▪ Individual #299 underwent IV sedation on 6/14/10 for prophylactic treatment and restorative care. The anesthesia record, consent authorization, HRC approval, and preoperative laboratory test results were completed, along with a post-operative handwritten summary. ▪ Individual #97 underwent IV sedation for a prophylactic treatment on 12/7/09. There was no rationale indicated for IV sedation with this note. It did not appear from the prior two notes on 8/10/09, and 10/29/10 that chemical pre-treatment sedation had been attempted, although earlier dental notes were not submitted. However, for the date of the IV sedation, it would be important to document the necessity for IV sedation. On 6/14/10, this individual had IV sedation for restorative dental care, although the Xerox copied handwritten note was difficult to interpret. ▪ Individual #243 underwent general anesthesia on 8/14/09, for an annual exam and on 7/17/10 for a prophylactic treatment and restorative care. No information in these notes indicated prior attempts at chemical sedation, nor any progress in desensitization. ▪ Individual #86 had an annual exam on 9/14/09, but it was not successful because the individual would not allow examination. There was no indication chemical pre-treatment sedation was attempted. She then underwent IV sedation on 1/22/10 for prophylactic treatment and extractions, and 7/12/10 for prophylactic treatment. Notes should include the rationale for IV sedation, and a risks/benefit analysis when only prophylactic treatment is completed. ▪ The integrated progress notes were reviewed for dental information on	

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		Individual #175. On 9/28/09, this individual underwent an annual edentulous exam under general anesthesia. The Medical Department also completed a pap smear and fecal occult blood test at the same time, and lab testing and EKG were completed while under anesthesia. Again on 5/7/10, she underwent general anesthesia for an annual edentulous exam, and pelvic and breast exam by the Medical Department. This case raises concern about potential overuse of general anesthesia. Such anesthesia is not risk free. The reason, including risk to reward benefit, for placing the individual under general anesthesia for an annual edentulous exam is not stated, nor a review of prior attempts under less intrusive measures. To complete two annual edentulous exams under general anesthesia in approximately an eight month span raises serious concerns about the potential overuse of this anesthesia technique, as well as the oversight role of the HRC. There was an attempt at an annual edentulous exam on 5/3/10, which was not successful, but the reason for completing one in May rather than September was not stated. It was also not documented as to whether or not chemical pre-treatment sedation was attempted. There was no information provided as to the reason this individual required general anesthesia, and why she required such measures for a dental exam when she had no teeth, and why she required an exam under general anesthesia eight months after a prior exam under general anesthesia. All of the entries in the dental progress note/treatment record were hand written, and there were many abbreviations. Despite a list of abbreviations provided by the Dental Department, it was difficult to determine the meaning of some of the notes due to legibility and due to use of abbreviations not on the list. It is recommended that the dentist have dictation and transcription services which would provide a document that can be read by all departments, does not rely so heavily on abbreviations, and also provides better use of the dentist's time. For the medical record, there was a one-page computerized "annual dental summary" that outlined all the important information needed by a member of the PST for any decision-making process. It clearly listed the following: number of missed appointments, the last annual exam, the last prophylaxis, the level of cooperation/behavior, oral hygiene, sedation required, restraint use, caries present, missing teeth, work completed, and recommended plans. These annual dental summaries were reviewed for the following individuals: Individual #36, dated 5/18/10; Individual #255, dated 4/22/10; Individual #4, dated 4/22/10; Individual #185, dated 7/19/10; Individual #311, dated 4/22/10; Individual #68, dated 4/22/10; Individual #242, dated 4/22/10; Individual #95, dated 7/13/10; Individual #202, dated 4/22/10; Individual #114, dated 4/22/10; Individual #254, dated 5/201/0; Individual #8, dated 5/20/10; Individual #232, dated	

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		6/24/10; Individual #76, dated 5/20/10; Individual #223, dated 8/25/10; Individual #10, dated 5/20/10; Individual #213, dated 8/30/10; Individual #206, dated 5/20/10; Individual #1, dated 7/28/10; Individual #193, dated 5/20/10; Individual #238, dated 6/24/10; Individual #276, dated 7/30/10; and Individual #137, dated 6/24/10. When this valuable form is revised in the future, it is recommended that under the present condition section, the number of caries and number of missing teeth be recorded, perhaps using one of the dental diagrams "x"ing out the missing teeth, and highlighting caries and areas of concern, showing current fillings, etc. This would be visually valuable to determine the dental health of the individual. It is recommended that the oral hygiene rating/grading be expanded to one of the numbered systems. Also, there is no mention of dental desensitization, and a brief entry about the status of such programs and any progress would be helpful to all departments. LBSSLC had a Health Services policy: Dental/Medical Sedation and Restraint that outlined the types of mechanical restraints that the HRC can approve, as well as guidance concerning the number of visits before considering chemical sedation, and the number of visits before considering general anesthesia/IV sedation/conscious sedation. Some of the above examples demonstrated this policy was not followed. There was also a Post-Op Dental Instructions sheet providing clear and concise orders/instructions to the nursing department on the individual's postoperative care.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The LBSSLC dental policies need to be reviewed to ensure consistency with the statewide policy. As policies are reviewed, one area in which clarification is needed is with regard to the required timeframe in which initial dental exams should occur when an individual is admitted to the Facility.
2. When counting visits per week or month, it is important to determine the category of the visit, and to determine if there was overlap in the type of care provided at visits (i.e., annual exam and prophylactic exam or restorative care).
3. Ways to improve communication between the Dental Department and the PSTs should be identified and implemented, and there should be increased accountability on the part of the PSTs to ensure dental refusals are addressed in a timely manner.
4. The Dental Department should create a detailed system listing all causes of "no show"/missed appointments (e.g., refusals, conflict in schedule for the individual, individual ill, short staff in the home, short staff in the Dental Department, inclement weather, transportation difficulties, individual in hospital, individual on leave with family, other reason, etc.). This will require frequent communication with the QMRPs to obtain accurate information. Providing a brief questionnaire requiring written responses with signature and date would be one way of implementing a tracking system to ensure this initial and essential information is obtained. Once the information is compiled, the Dental Department should begin to work on addressing the many issues causing the "no show" rate to be high.
5. The Dental Department should define a baseline rate for each category of missed appointment for measurement of future progress and improvement.
6. There should be more opportunities for the dental hygienist to provide teaching and training to the individuals and direct support

professionals in the home than is currently provided.

7. The Dental Department should begin to track the oral health index of individuals to determine if there are clusters of individuals with poor oral health index scores, which would suggest homes in need of an increased intensity of supervision.
8. Action and progress in the implementation of desensitization programs, and other strategies designed to reduce the need for pre-treatment sedation that are implemented in the homes, should be communicated to the Dental Department at agreed-upon intervals.
9. Documentation should verify that the appropriate procedures have been completed before pre-treatment sedation is administered, specifically that desensitization programs and other identified strategies have been consistently implemented.
10. The HRC's authorization should be briefly noted on the pre-treatment sedation assessment form, and the document that includes that authorization should be referenced.
11. For those portions of the pre-treatment sedation assessment form that are routinely left incomplete, there should be either retraining of the staff on how to complete the form, or review to determine if removing that part of the form is appropriate.
12. The Dental/Medical Sedation and Restraint Policy, Section #7.b. stated: "the routine intra and extra yearly oral exam and preventive dental prophylaxis are not generally considered to be sufficient reason for requesting conscious sedation. Oral sedation will be the medication of choice for these procedures" is not clearly followed. More information about rationale for not following the policy should be incorporated into the dental record, or the policy should be amended to broaden the scope of use for IV sedation.
13. An interdisciplinary group, including at a minimum the Nursing and Dental Departments, need to collaborate to identify individual and systemic issues that are contributing to missed appointments due to pre-treatment sedation complications (medication not given, given but individual is allowed to eat, etc.), and to develop and implement plans to address these issues.
14. It is recommended that the dentist use dictation and transcription services, which would provide a document that can be read by all departments, and which would not rely so heavily on abbreviations. This is especially important for those undergoing IV sedation or general anesthesia.
15. For those undergoing IV sedation/general anesthesia, a brief note justifying this choice should be documented. This is especially true for those undergoing only a prophylactic or annual evaluation, and the benefits and risk should be clearly stated. For those undergoing IV sedation or general anesthesia for an edentulous oral exam, compelling reasons should be articulated.
16. The Human Rights Committee should review cases for IV sedation or general anesthesia with particular attention to ensuring that there is a clear clinical dental indication/justification to ensure the benefits outweigh the risks.
17. A database/dental scheduling system should be developed and implemented to ensure that timely exams are scheduled and completed, but also to ensure that the individual is not treated too frequently.
18. When the "annual dental summary" is revised in the future, it is recommended that under the present condition section, the number of caries and number of missing teeth be recorded, perhaps using one of the dental diagrams "x"ing out the missing teeth, and highlighting caries and areas of concern, showing current fillings, etc. This would be visually valuable to determine the dental health of the individual. Also, a brief entry about the status of dental desensitization programs, and any progress would be helpful to all departments.
19. Consideration should be given to expanding the oral hygiene rating/grading to one of the numbered systems.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o SLP Comprehensive Assessment, SLP Updates for the last year, SLP Communication programs, PSP and PSP Addendums for last year, Behavior Support Plans, SLP Consultation for last year, Monthly SLP documentation for communication programs, Communication Dictionary, current and revised PNMP within last year with pictures, competency-based staff training for communication programs, person specific monitoring for communication devices for last quarter, daily schedule and PSP Communication objectives and monthly updates and Integrated Progress Notes for last quarter for the following individuals: Individual #210, Individual #54, Individual #53, Individual #49, Individual #98, Individual #264, Individual #26, Individual #66, Individual #312, Individual #62, Individual #176, and Individual #196; o Speech Language Evaluation (blank), not dated; o Augmentative Alternative Communication (AAC) Individual Equipment Monitoring Form (blank), revised 7/14/10 and 8/6/10; o PSPs for multiple individuals, from 8/09 through 7/10; o AAC Individual Equipment Monitoring Forms for Multiple Individuals, from 7/10 through 8/10; o Communication Quality Assurance Monitoring Report, dated 2/1/10; o Settlement Agreement-Communication Compliance, from 5/10 through 8/10; o List of Multiple Individuals with Communication Dictionary, updated 7/31/10; o AAC/AT Systems Spreadsheet for Multiple Individuals, not dated; and o List of Individuals receiving direct speech services and Focus of Intervention, updated 7/31/10. ▪ **Interviews with**: o Linda Thomas, Habilitation Therapies Director; o Megan Copeland, MOT, OTR/L; and o Joyce Ables, SLP/CCC. ▪ **Observations of**: o 504 E. Mesquite Drive, 504 W. Mesquite Drive, 517 S. Cedar Avenue, 518 S. Cedar Avenue, 528 N. Cedar Avenue, 516 S. Cedar Avenue, 521 S. Cedar Avenue, 525 N. Cedar Avenue, 526 N. Cedar Avenue, 513 S. Cedar Avenue, 515 S. Cedar Avenue, and 520 S. Cedar Avenue; o Pilot Communication Meeting for 520 S. Cedar on 9/15/10, with Megan Copeland, Occupational Therapist; Joyce Ables, Speech Language Pathologist; Kenny Kent, QMRP; Trent Lewis, Active Treatment Coordinator; Carolyn Milton, Behavior Analyst; Registered Nurse Case Manager, and Residential Coordinator.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for LBSSLC did not include this component, LBSSLC did not identify compliance with any indicators in Section R. This was consistent with

	the Monitoring Team's findings. The Habilitation Therapies Director indicated that the following processes had been implemented related to Section R following the initial baseline review: ▪ When completing Speech Assessment/Updates, therapists were considering medical issues, and integrating an analysis into the assessment that established rationale for recommendations/ therapeutic interventions. ▪ The AAC monitoring form was revised to be individual specific, and competency-based. ▪ Collaboration continued with Psychology through active participation in the Behavior Support Committee, integrated meetings, and continuing education. ▪ A communication Handbook and in-service were provided to PSTs to assist in the understanding of communication assessment and development of communication programs/skills. ▪ A pilot process had been initiated with a home where all disciplines were collaborating together to provide a plan for intensive integration of programs. ▪ Communication Dictionaries were implemented and were available at the PSP meetings and were part of the PNMP. When developing the dictionaries, BSP information was incorporated, as appropriate. ▪ A process was implemented for all HT Therapists to participate in self-monitoring for Sections O, P and R utilizing the monitoring tools.
	Summary of Monitor's Assessment: There were four budgeted positions for SLPs, with three SLPs on staff and one SLP vacancy. With one SLP dedicated to the PNMT, this resulted in caseloads of approximately 115 for the remaining two SLPs. At the time of the review, the caseloads for speech language pathologists would not allow therapists to be active members of individuals' Personal Support Teams, or provide adequate functional communication supports to individuals and their teams. This will provide significant challenges in meeting the requirements of Section R of the SA. Two of 229 individuals living at LBSSLC (less than one percent) were receiving direct speech services. While Speech Language Pathologists were completing evaluations that identified the need for augmentative/alternative communication devices, there were not sufficient resources to provide direct and/or indirect speech therapy supports for individuals with an identified need. To the credit of the SLPs, there were multiple individuals with communication devices on campus (low tech and high tech) as well as many generic devices, but there was not a current framework within the PSP process to integrate these devices into formal, teachable moments, such as integration into skills acquisition programs. The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to use the device in a variety of natural environments. Without this, the Facility will not meet the intent of the SA for a communication device to be an integral part of how an individual communicates on a daily basis. The Communication Services policy, dated 10/7/09, Section II.D Assessment stated: "Assessments will consider the behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions." The policy did not provide

		additional information beyond this statement. A review of individuals' evaluation updates and/or screenings did not support that SLPs were collaborating with psychology staff to assess and explore functional communication strategies for individuals involved in challenging behaviors. Procedures needed to be developed to define the SLPs' role in working with individuals with challenging behaviors, including collaboration with the individuals' psychologists and PSTs. There were no policies/procedures submitted to define the current speech (AAC) equipment monitoring process. There was a form called the AAC Individual Equipment Monitoring, but there were no staff instructions provided for the monitoring form.

#	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.	The Facility provides an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. Training should include augmentative and assistive communication. There were four budgeted positions for SLPs, with three SLPs on staff and one SLP vacancy. There were 229 individuals living at LBSSLC. The following chart represented the current caseloads of the Speech Language Pathologists (SLPs): **SLPs** — **Current Caseloads** SLP #1 — Dedicated PNMT/NMT SLP #2 — Responsible for homes 518, 523, 525, 526, 527 (Temp 528), 513 and 514, supporting 115 individuals SLP #3 — Responsible for homes 515, 516, 517, 520, 521, 504E and 504, supporting 115 individuals The SLP caseloads had been increased due to the assignment of one SLP as a dedicated member of the PNMT. At the time of the review, the caseloads for speech language pathologists would not allow therapists to be active members of individuals' Personal Support Teams, and provide adequate functional communication supports to the individuals and their teams. This will provide significant challenges in meeting the requirements of Section R of the SA. Clinical instruction completed by the Facility's three SLPs for the past 12 months documented attendance at statewide conferences, and courses in the area of physical and nutritional management and assistive technology. Communicative Aiders and Speech Generated Devices (simple and complex) are provided to individuals based on need and not staff availability. All individuals in need of AAC, receive AAC. SLPs actively participate in all facets of care in which communication	Noncompliance

#	Provision	Assessment of Status	Compliance
		is relevant. Two of the 12 records reviewed (17%) indicated that individuals with identified language difficulties were receiving active speech treatment and/or participating in a speech program. The individual records reviewed were: Individual #210, Individual #54, Individual #53, Individual #49, Individual #98, Individual #264, Individual #26, Individual #66, Individual #312, Individual #62, Individual #176, and Individual #196. It should be noted that two of 229 individuals (less than 1%) living at LBSSLC were receiving direct speech services and focused intervention (7/31/10), including Individual #210 and Individual #54. These two individuals were included in the record review: ▪ The Consultation Report, dated 3/16/10, for Individual #54 stated: "communication functioning was updated 2/9/10 and his AAC/AT needs were considered. Results indicate that [Individual #54] continued to be a candidate for using an AAC system due to his ability to recognize and utilize pictures consistently. [Individual #54's] SLP is currently working with him in using a sophisticated speech generating device (SGD)." Individual #54's PSP, dated 3/30/10, Action Plan did not incorporate the use of a SGD. There were no formal communication programs submitted, nor did his SLP document his progress with a SGD in the Integrated Progress Notes. ▪ Individual #210's Consultation Report, dated 4/22/10, documented: "currently utilizes a communication book for increased communication effectiveness and is presently receiving structured speech therapy to actively use a speech generating device for his expressive language needs. With his receptive and expressive language strengths using AAC equipment, an additional table top single message voice output communication aide (VOCA) with a Mayer-Johnson picture stimuli will be proved to assist [Individual #210] in requesting 'more paper' while completing his work task." HT Consultation Report, dated 4/9/10, recommended direct speech language services three times a week for eight weeks to individualize and encourage Individual #210 to utilize his DynaVox V-Max speech generating device for increased interactive communication to begin the week of April 5, 2010. A single monthly summary, dated 5/4/10, was submitted with the stated purpose of therapy being to "individualize and educate [Individual #210] in actively using his DynaVox V-MAX SGD for his receptive and expressive language in his activities of daily living." There was a temporary PSP Action Plan, dated 8/3/10, with the objective to "increase his communication skills by participating in activities that are important to him." The use of his communication device was integrated into two of the 15 objectives within this temporary Action Plan, but it was unclear if the SLP was involved in the development of these objectives.	

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		Examples of Individuals with identified speech or language difficulties not receiving services included the following: ▪ Individual #66 had a Communication Book "to supplement her communicative intents which include: requests, protests, comments and greetings. Encourage [Individual #66] to use her communication book to comment about her life. Use pictures in communication book when talking about her activities." Individual #66's PSP, dated 1/22/10, did not integrate her Communication Book into any formal skill acquisition programs to promote the use of her Communication Book. ▪ Individual #312's PNMP, dated 8/26/10, documented the following assistive equipment: "remote TV module (refer to picture adapter), personal radio with switch, Sip 'N' Puff switch, automatic door opener on laptray, call button, grip switch, adapted laptop computer and B table and chin mouse (refer to pictures)." His Speech Language Update, revised 9/9/10, documented: "Overall, [Individual #312] continues to communicate his wants and needs using complete sentences and requires assistive technology (AT) to access his environment. There are no changes to his assistive technology at this time. His hearing and vision are within functional limits for communication. In view of the above clinical impressions, direct Speech/Language services are not indicated at this time as needs can best be addressed in the context of daily living activities." The Consultation Report, dated 8/27/09, recommended the PST consider activity programming to include community education. Individual #312's PSP Action Plan steps did not incorporate the use of his assistive technology devices, nor did a SLP attend his PSP. ▪ Individual #26 was referred to HT (Consultation Report 9/22/09) for "production of a visual daily schedule per home request. Use of the visual schedule was discussed to increase cooperation of [Individual #26] in home programming. Previous evaluation of [Individual #26] as documented in a consultation dated 1/18/08, stated that he demonstrates ability to functionally use some sign language and has used visual schedules in the past to increase his cooperation in routine activities." Specific Program Objectives for Communication, dated 12/15/09, stated: "[Individual #26] will verbally say the list of words, 1 out of 3 trials upon verbal prompt for 24 data taking sessions." Individual #26 did not have a formal communication program developed by an SLP, nor did a SLP attend his PSP. Individual #26 did not have a PNMP to provide strategies for communication for direct support professionals. ▪ Individual #62's PSP, dated 8/2/10, documented the following communication equipment: Step-by-Step Communicator and Ultimate Switch with 19' Gooseneck. His PSP Action Plans did not integrate the use of his communication equipment into any action steps. ▪ Individual #264 had a Communication/Sensory Visual Schedule and Key Ring,	

#	Provision	Assessment of Status	Compliance
		dated 4/15/09, to use in his home to encourage the use of pictures to communicate his sensory needs, and to direct the sequences of sensory activities. This schedule included staff instructions for use. His PSP, dated 1/7/10, did not integrate the use of his communication devices into formal teaching strategies. A SLP did not attend his PSP.	
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 in need of AAC are identified as being in need of AAC. Two of the 12 records reviewed (17%) indicated individuals identified with severe expressive/receptive language had AAC investigated, assessed, were identified as being in need of AAC, and provided support by an SLP. All people have received a communication screening or assessment within 30 days of admission, readmission or change in status. Two of two new admission records reviewed (100%) (Individual #201 and Individual #321) revealed these individuals received SLP assessments within 30 days of admission. The Facility's Communication Assessment (Speech-Language Evaluation) addressed: ▪ General Information o Statistical Information o Diagnosis and Pertinent History o Medications/Precautions o Sensory Impairment o Behavioral Consideration ▪ Communication History o Method of Communication o Previous Evaluation and Treatment o Reports from Significant Others ▪ Receptive Language Skills o Response to Assessment o Response to Directions/Commands o Response to Questions o Identification of Objects/Pictures ▪ Expressive Language Skills o Response to Assessments ▪ Pragmatic/Social Communication ▪ Articulation o Response to Assessments o Oral Mechanism ▪ Voice and Fluency o Voice Quality and Resonance o Fluency	Noncompliance

#	Provision	Assessment of Status	Compliance

		▪ Augmentative/Alternative Communication
		  o Augmentative/Alternative Communication Assessment Components
		  o Development of an Augmentative/Alternative Means of Communication
		▪ Environmental Control Assessment
		▪ Clinical Impressions
		▪ Recommendations
		
		Twelve individuals' records were reviewed (Individual #210, Individual #54, Individual #53, Individual #49, Individual #98, Individual #264, Individual #26, Individual #66, Individual #312, Individual #62, Individual #176, and Individual #196). In zero of the 12 records reviewed (0%), the Speech Language Evaluation followed the Speech-Language Evaluation as presented in the Habilitation Therapies Handbook Physical and Nutritional Management, revised 2009.
		
		<u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u>
		In zero of 12 records reviewed (0%), individuals with goals/objectives related to language acquisition, had goals/objectives/outcomes written by the SLP, and followed on a monthly basis if service was direct, and quarterly if indirect.
		
		Examples of individuals diagnosed with severe language difficulties where AAC was assessed or investigated, but SLP supports were not recommended to provide direct guidance to the PST to integrate an AAC device across all natural environments for the individual were as follows:
		▪ Individual #66's Speech-Language Update, dated 11/05/09, 12/17/09 and 12/23/09, stated: "at the February 5, 2009 Health Status meeting, the QMRP and RC (Resident Coordinator) acknowledged that [Individual #66's] PST met and agreed that direct speech language services were warranted to introduce the use of a formalized picture object augmentative/alternative communication (AAC) system to facilitate expressive language skills. Direct speech-language services were begun during the week of February 9, 2009. Upon completion of 5 weeks of therapy, she was provided a communication book to supplement her expressive language skills." There was no evidence submitted to document direct therapy services. The previous Speech-Language Evaluation of 12/15/08 stated: "in view of the above clinical impressions, Speech/Language Therapy is not indicated as her needs can best be addressed in the context of daily living activities," even though the augmentative communication section documented "may be a candidate for augmentative/alternative communication in the form of a pictured communication book and/or simple voice output communication aide due to her abilities to recognize and utilize pictures consistently."	

#	Provision	Assessment of Status	Compliance
		▪ Individual #62's Speech-Language Update, dated 5/28/10 assessed AAC/AT and recommended "HT will continue to monitor switch access and sequenced speech generating voice output device and the SLP will be available to provide in-service to assist in planning appropriate communicative programming as requested." There were no recommendations for direct and/or indirect SLP supports to ensure implementation of his AAC device in a variety of natural environments. His PSP, dated 8/2/10, did not incorporate his communication device into learning objectives and his SLP was not represented during the PSP. ▪ Individual #312's Speech-Language Update, dated 8/3/09, documented "Individual #312 independently accesses a switch-operated remote control mounted via bed bracket, a switch-operated radio, and an adapted nurse call unit when they are appropriately placed by staff." The Update recommended: "in view of the above clinical impressions, Speech/Language therapy is not indicated as needs can best be addressed in the context of daily living activities." There were staff instructions on how to set up his laptop computer equipment, but these strategies were not incorporated in his PSP, dated 9/24/09, or subsequent PSP Addendums nor did a SLP attend his PSP. These examples illustrate the impact of not having an adequate number of speech language pathologists to address the functional communication needs of the individuals residing at LBSSLC. While Speech Language Pathologists were completing evaluations that identified the need for augmentative/alternative communication devices, there were not sufficient resources to provide direct and/or indirect speech therapy supports for individuals with an identified need. To the credit of the SLPs, there were multiple individuals with communication devices on campus (low tech and high tech) as well as many generic devices, but there was not a current framework within the PSP process to integrate these devices into formal, teachable moments, such as integration into skills acquisition programs. The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to use the device in a variety of natural environments. Without this, the Facility will not meet the intent of the SA for a communication device to be an integral part of how an individual communicates on a daily basis. The use of AAC devices can modify classroom, home, work, and social environments for individuals with intellectual disabilities through increasing participation, making choices, and enhancing communication skills. Most importantly, when an individual has learned how to use an AAC device to communicate successfully, the perceptions and stereotypes of a familiar and/or unfamiliar communication partner changes from not believing the individual would be able to communicate to exploring multiple strategies to communicate with an individual.	

#	Provision	Assessment of Status	Compliance
		Habilitation Therapies staff developed a Communication Handbook for PSTs. The handbook contained the following: ▪ Ways Person Served Communicate; ▪ Object Cues Examples; ▪ Choices; ▪ Augmentative/Alternative Communication Equipment; ▪ Terms and Examples for the PST; ▪ Communication Dictionary Sample #1; ▪ Communication Dictionary Sample #2; ▪ Communication Dictionary Sample #3; and ▪ 100 Functional Ways to use AAC. The Speech Pathologists were working diligently to support communication for individuals living at LBSSLC, but were significantly hampered by limited staffing resources, which translated into SLPs not being active, participating members of an individual's PST. In addition, there must be a commitment from staff to utilize the multiple generic communication devices on campus. During the on-site review, the Monitoring Team attended a meeting with staff from 520 S. Cedar Avenue on 9/15/10, at which planning continued on the implementation of a pilot communication project. Staff present included the QMRP, Residential Coordinator, Behavior Analyst, Occupational Therapist, Speech Language Pathologist, Nurse Case Manager, and Active Treatment Director. This team had met two times prior to this meeting on 8/24/10, and 9/2/10. The Monitoring Team will review the progress of this pilot project during the next on-site review. For persons receiving behavioral supports or interventions, the Facility has a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP. The Communication Services policy, dated 10/7/09, Section II.D on Assessment stated: "Assessments will consider the behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions." The policy did not provide additional information beyond this statement. A review of individuals' evaluation updates and/or screenings did not support that SLPs were collaborating with psychology staff to assess and explore functional communication strategies for individuals involved in challenging behaviors. Procedures needed to be developed to define the SLPs' role in working with individuals with challenging behaviors, including collaboration with the individuals' psychologists and PSTs.	

#	Provision	Assessment of Status	Compliance
		Zero of the three individual records with BSPs reviewed (0%) (Individual #264, Individual #26, and Individual #66) documented collaboration with the psychologist and SLP in the development of the Behavior Support Plans (BSP). Examples of BSPs implemented without SLP collaboration were: ▪ Individual #264's BSP was implemented on 6/28/10. A consultation was requested from HT after the implementation of his BSP on 8/6/10 for "the development of 'Mand' Cards for implementation by psychology." His BSP had not been revised to reflect the results of this consultation. ▪ Individual #26's BSP was implemented on 11/18/09, but there was no evidence of SLP collaboration in the development of his BSP. ▪ Individual #66's BSP was implemented on 6/25/10, but there was no evidence of SLP collaboration in the development of her BSP. Per report, therapists and psychologists attended training regarding the role of communication in behavior, but this was not documented in the continuing education documentation submitted. The ABA Tool Chest had been purchased with the following seven modules: ▪ Introduction to Applied Behavior Analysis (ABA) and Verbal Behavior; ▪ Teaching Learner Cooperation: Part I; ▪ Teaching Leaner Cooperation: Part II; ▪ Instructional Variables and Teaching Procedures; ▪ B.F. Skinner's Analysis of Verbal Behavior; ▪ Selecting an Augmentative/Alternative Method of Communication; and ▪ Teaching Non-Vocal Learners to Talk. This should be a valuable training tool because it incorporates the importance of communication with Applied Behavioral Analysis concepts on which the Facility is basing its behavioral programming. <u>Policy exists that outlines assessment schedule and staff responsibilities.</u> A policy did not exist that outlined the assessment schedule and staff responsibilities. The Communication Services policy, dated 10/7/09, Section II on Assessments stated: "comprehensive communication assessment will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need." LBSSLC did not have a Master Communication Plan for the prioritization and implementation schedule for SLP assessments, or development and implementation of direct and indirect SLP therapy supports for those individuals with significant functional communication needs, for example, individuals with BSPs. Procedures needed to be developed to provide consistency in the implementation of SLP assessments. At the time of the review, SLP evaluations reviewed did not follow the established format in Habilitation Therapies Handbook Physical and Nutritional Management, revised 2009.	

#	Provision	Assessment of Status	Compliance
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.	Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP. None of the 12 records reviewed (Individual #210, Individual #54, Individual #53, Individual #49, Individual #98, Individual #264, Individual #26, Individual #66, Individual #312, Individual #62, Individual #176, and Individual #196) (0%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication strategies were listed, but these strategies were not integrated into action plans and/or skill acquisition programs included: ▪ Individual #53's PSP, dated 11/30/09, did not integrate the use of her Dynavox into action plan objectives and/or skill acquisition programs. ▪ Individual #62's PSP, dated 8/2/10, integrated the use of his communication device in one of 20 action plan objectives. ▪ Individual #264's utilization of his Communication/Sensory Visual Schedule and Key Ring was not integrated into his PSP, dated 1/7/10, action plan objectives and/or skill acquisition programs. ▪ Individual #49's received direct speech services "to individualize and train Individual #49 in utilizing her Dynavox M3 speech generating device for increased interactive communication. Her PSP, dated 4/14/09, integrated the use of her communication device in two of 21 action plan objectives. As stated above, for an individual to succeed in learning how to communicate effectively and give themselves a voice with an AAC device, there must be multiple learning opportunities, formal and informal, in all environments. Communication information is not only present in the PSP, but integrated into the daily schedule. None of the 12 records reviewed (0%) in which communication interventions were referenced in the assessment section of the PSP had evidence of integration of the individual's methods for functional communication, as well as strategies for use by staff integrated throughout the PSP. Such programs generally were just listed or referenced, but not integrated into other programs including, but not limited to the individual's BSP, day program, skills training in the home, leisure activity programs, work environments, and informal activities within their daily schedule. AAC devices are portable and functional in a variety of settings. None of the PNMPs and/or AAC device instructions reviewed with an AAC component (0%) reinforced the use of AAC devices that were portable and functional in a variety of settings (i.e., mealtime, work, leisure, home, community outings, etc.).	Noncompliance

#	Provision	Assessment of Status	Compliance
		AAC devices are individualized and meaningful to the individual. None of the two records reviewed for individuals receiving direct speech services and focused intervention (0%) clearly indicated how the direct speech language services would be individualized and encouraged the use of speech generating devices beyond the direct speech services sessions to ensure these devices were meaningful and functional for the individual. For example: ▪ Individual #210's SGD and communication book was integrated into three of 28 action plan objectives, which would not support that the AAC device was meaningful and functional in his daily activities. ▪ Individual #54' PSP Action Plan objectives did not integrate his communication device. There were no formal communication programs developed with individualized strategies for each individual's AAC device for use by staff to reinforce what was being learned in direct speech therapy. The absence of formal integration of the AAC communication device in their daily schedules did not support the AAC devices being functional and meaningful to the individual and provide multiple opportunities to practice the use of their AAC device. Staff are trained in the use of the AAC. Based on a review of 12 individuals' records (Individual #210, Individual #54, Individual #53, Individual #49, Individual #98, Individual #264, Individual #26, Individual #66, Individual #312, Individual #62, Individual #176, and Individual #196), none (0%) included competency-based staff training documentation. In-service Due Date forms were submitted with staff names and signatures, but these forms did not consistently document competency-based performance check-off for staff. These forms would identify that staff verbalized and/or demonstrated the skill, or there would be no indication that staff had verbalized and/or demonstrated the skill. Staff must be able to demonstrate their competency in understanding and operating an AAC system (low tech and high tech), as well as understand how to engage/prompt an individual with the AAC device in multiple environments, and competency-based assessment should require staff to demonstrate both of these sets of skills. Moreover, there were no formal communication programs (for staff use to reinforce what was being learned in direct SLP therapy sessions) documented in the 12 records reviewed, even though two of these individuals were receiving speech therapy services. Communication strategies/devices are implemented and used. In zero of the six observations (0%) did staff implement interventions and recommendations for a communication device.	

#	Provision	Assessment of Status	Compliance
		Examples of individuals where staff did not implement a communication program as written included: ▪ Individual #53's Dynavox was not easily accessible to her and was not turned on when the Monitoring Team conducted an observation. A staff person turned on the Dynavox, but the volume was so low it could not be heard over the shredder. Individual #53's device was not functional and meaningful to her in the work setting. ▪ Individual #98 did not have his communication book on his person during the Monitoring Team's observation. ▪ Individual #264's system was broken. ▪ Individual #26's communication book was not with him. Staff showed the communication book to the Monitoring Team, but it was not readily accessible for use by Individual #26. ▪ Individual #176's communication device could not be located by staff. ▪ Individual #62 communication device was not plugged in, and he was not accessing the device. General AAC devices are available in common areas. Observations in 12 homes (504 E. Mesquite Drive, 504 W. Mesquite Drive, 517 S. Cedar Avenue, 518 S. Cedar Avenue, 528 N. Cedar Avenue, 516 S. Cedar Avenue, 521 S. Cedar Avenue, 525 N. Cedar Avenue, 526 N. Cedar Avenue, 513 S. Cedar Avenue, 515 S. Cedar Avenue, and 520 S. Cedar Avenue) confirmed that general AAC devices were present in the Common areas. None of the observations in these 12 homes (0%) demonstrated that staff encouraged individuals to utilize common area AAC devices.	
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	Monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device. There were no policies/procedures submitted to define the current speech equipment (AAC) monitoring process. The AAC Individual Equipment Monitoring Form tracked if the communication device was: "present, clean, in use, staff demonstrated and comments." The second page of the form had spaces for staff signature, training provided, competency (verbal and/or demonstration), date, concerns, action taken, and notification. There were no staff instructions provided on this monitoring form. Three of 12 individual records (25%) (Individual #54, Individual #210, and Individual #66) documented AAC monitoring in some of the following aspects of AAC utilization:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	▪ In two of 12 reports reviewed (17%), the presence of the ACC was documented; ▪ In zero of 12 reports reviewed (0%), the working condition of the AAC was addressed; ▪ In two of 12 reports reviewed (17%), the implementation of the device was addressed; and ▪ In zero of 12 reports reviewed (0%), the effectiveness of the device was documented. Examples of staff non-compliance with AAC devices included: ▪ AAC Individual Equipment Monitoring Form, dated 8/17/10, documented that Individual #66's AAC device was not present, with no comments and/or resolution. ▪ AAC Individual Equipment Monitoring Form, dated 8/11 and 8/12/10, documented that Individual #210's AAC device was not available, with no further comment. Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home. The individual monitoring forms documented "psych program, vocational, and home program," but the monitoring form did not provide instructions for monitoring the use of an AAC device in multiple environments such as the home, work, day programs, leisure, community activities, etc. Validation checks are built into the monitoring process and conducted by the plan's author. As noted above, the current monitoring had not been developed and memorialized in policy, and, therefore, it was not clear that this validation process was in place.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The State and Facility should provide supports to the Habilitation Therapies Director to recruit and hire the SLP vacancy at LBSSLC.
2. Habilitation Therapies should complete an analysis of duties required of an SLP to be an active, participating member of an individual's PSP, including but not limited to attending annual, quarterly, and addendum PST meetings; development and implementation of SLP programs for direct and/or indirect services; competency-based training; monitoring; etc. This analysis should identify the number of SLP positions needed to achieve compliance with Section R of the SA.
3. Individuals' communication strategies should be consistently integrated into their PSPs through skill acquisition programs, as well as their BSPs.
4. Speech and language department staff should continue working with psychology staff to ensure that functional communication skill strengthening and training is included in Behavior Support Plans, as appropriate. Further, it is recommended that clear descriptions of replacement behavior related to communication be included in these plans.
5. All individuals who do not have effective means of communication should be assessed, and, as appropriate, provided with training objectives to

address their needs. If augmentative devices are recommended, these should be individualized. All systems should provide the individual with a "voice" so that he/she can at a minimum make his/her basic wants and needs known.

6. The LBSSLC Management Team, in collaboration with the Speech Pathologists, should develop and implement a plan to support the implementation of generic and individual-specific communication systems across a 24-hour day. The Facility should continue the implementation of the pilot communication project in the home at 520 S. Cedar Avenue, which is focused on the development and implementation of functional communication systems across all environments. This should promote interdisciplinary planning, development, and implementation of an environment that supports and encourages functional communication throughout the 24-hour day.
7. LBSSLC should develop and implement a policy/procedure including a prioritization and implementation schedule for SLP assessments, and development and implementation of direct and indirect SLP therapy supports for those individuals with significant functional communication needs, for example, individuals with BSPs.
8. Appropriate methods to test staff's competency with regard to the use of AAC devices, as well as to engage the individuals in the use of these devices, should be developed and implemented.
9. Policies/procedures should be developed for the communication monitoring system with identified performance indicators that are defined clearly. This system should include, but not be limited to a systematic and routine review of the components of the functional communication programs and equipment; staff utilization of generic AAC devices; fit, function, availability, and use of AAC devices; and staff competency with regard to functional communication devices and programs. There should be established thresholds for staff re-training; identification of monitors, training, and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o LBSSLC Plan of Improvement, dated 5/17/10; o LBSSLC Supplemental Plan of Improvement, dated 5/17/10; o LBSSLC Assessment of Vocational Development – past/currently used rubric; and, LBSSLC Proposed/Revised Vocational Assessment – draft rubric (TX-LB-1009-PH-16.33); o Performance Improvement Council (PIC) Summary Data – Integrated Protections, Services, Treatments, and Supports (i.e., Individuals employed on and off campus across settings (TX-LB-1009-PH-16.32); o LBSSLC Person Served Employed Off-Campus Number of Hours Worked Per Week and How They are Supported (TX-LB-1109-VIII.18); o Graph of "Community Inclusion & % Involvement in Active Treatment" (TX-LB-1009-PH-16.32); o Community Integration Reports (Listing of Community Outings Across Residential Programs for the Past Six Months (TX-LB-1009-VIII.19); o Person Directed Planning: Your Role as a new Employee – training power point slides (TX-LB-1009-V.4); o New QMRP Training Documentation "Supporting Visions: Personal Support Planning" Workbook (TX.LB.1009.PH-14.3); o State Supported Living Centers Procedures – Personal Focus Assessment Policy, dated 7/23/10 (TX-LB.1009-PH-14.3); o State Supported Living Centers Procedures – Personal Support Plan Instructions, dated 7/23/10 (TX-LB.1009-PH-14.3); o LBSSLC – Interdisciplinary Team (IDT) process Program Development: QMRP Role in Coordinating Active Treatment Programs, revised 6/30/10 (TX-LB-1009-PH-14.3); o QMRP Training Survey, dated 8/12/2010 (TX-LB-1009-PH-14.3); o QMRP Check Sheet for Personal Support Plan Process, dated July 23, 2010 (TX-LB.1009-PH-14.3); o LBSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 7/23/10 (TX-LB-1009-PH-14.3); o LBSSLC Program Observation Drill and Active Treatment Monitoring/Coaching Tool (TX-LB-1009-PH.15.2.a); o Action Plan: Efforts to Increase Meaningful Activities for Residents of LBSSLC, revised date 8/25/10 (TX-LB-1009-PH.15.2.a); o Active Treatment Schedule, examples from 515 S. Cedar for the week of July 25-31, 2010 and 516 S. Cedar for the month of August 2010 (TX-LB-1009-PH.15.2.a); o LBSSLC Skill Acquisition Plan Instructions, LBS Strategy Sheet, and Performance Probe (TX-LB-1009-PH.15.2.b);

	o Program Observation Drill and Active Treatment Monitoring, August weekly data for Canna (521) and Birch (514), respectively (TX-LB-1009-PH.15.2.b); o Training Surveys (15 completed) and Training Summary Chart (TX-LB-1009-PH.15.2.b); o LBSSLC – IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring, dated 6/30/10 (TX-LB-1009.VIII.1.b); o Minutes from Active Treatment Team Meetings across Residential Programs from March-August 2010 (TX-LB-1009-PH-16.36.a); o Personal Support Plans (PSPs), Personal Focus Worksheet: Individualized Assessment Screening Tool (PFWs), Positive Adaptive Living Skills (PALS), and Monthly/Quarterly Reviews, when available, for: Individual #264, Individual #36, Individual #159, Individual #213, Individual #107, Individual #183, Individual #181, Individual #317, Individual #235, Individual #82, Individual #126, Individual #268, Individual #108, Individual #99, Individual #66, Individual #109, Individual #237, Individual #190, Individual #167, Individual #298, Individual #106, Individual #320, Individual #33, and Individual #2; o Specific Program Objectives (SPOs) as well as associated SPO data for the last three months, as available, for: Individual #264, Individual #36, Individual 107, Individual 317, Individual 181, Individual 203, Individual #183, Individual #82, Individual #126, Individual #268, Individual 108, and Individual #99; and o Brief on-site informal chart reviews of: Individual #235, Individual #58, Individual #264, Individual #165, Individual #82, and Individual #4. ▪ **Interviews with**: o Lola Walker, QMRP Coordinator, Marisol Gonzales, ISP Coordinator, and Trent Lewis, Director of Active Treatment, on 9/14/10; o Jim Forbes, Director of Behavioral Services, on 9/13/10 and 9/15/10; o Bob Robbins, Program Compliance Monitor, on 9/14/10; o Trent Lewis, Director of Active Treatment, on 9/15/10; o Laura Anciso, Director of Vocational and Day Programs, Paul Thomas, Recreation Supervisor, and Rodshadi Moore, Active Treatment Supervisor, on 9/15/10; ▪ **Observations of**: o Observation and discussion with staff members at Psychiatric Clinic for Individual #235, on 9/13/10; o Incident Management Meeting, on 9/14/10; o Integrated Treatment Meeting, on 9/15/10; o Behavior Support Committee, on 9/16/10; o Restraint Reduction Committee, on 9/16/10; o On-site direct observation, including interaction with direct care staff and other professionals including residence coordinators, psychologists, psychology assistants, home team leaders and assistants, active treatment staff, and/or site QMRPs were conducted throughout the morning, day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Quail (504 E), on 9/13/10; ▪ Sparrow (504 W), on 9/13/10;

	▪ Maple (517), on 9/15/10; ▪ Oak (518), on 9/15/10; ▪ Zinna (528), on 9/16/10; ▪ Fir (516), on 9/15/10; ▪ Canna (521), on 9/16/10; ▪ Rose (525), on 9/16/10; ▪ Tulip (526), on 9/16/10; ▪ Violet (523), on 9/16/10; ▪ Aspen (513), on 9/13/10; ▪ Birch (514), on 9/15/10; ▪ Elm (515), on 9/15/10; ▪ Willow (520), on 9/15/10 and 9/16/10; ▪ Estacado Industries Residential Services (EIRS), on 9/15/10; ▪ Estacado Industries Workshop (EIWS), on 9/16/10; and ▪ Educational Building, on 9/15/10.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for LBSSLC did not include this component, the POI did contain action steps, a description of evidence, Facility target dates, full SA implementation dates, judgment on current non-compliance (N) or substantial compliance (S), and additional comments. The Facility target dates identified in the POI were for May 2011 or later (some dates including May 2012) and the assessment of many sections was dependent upon the full implementation of new policies and procedures, including additional necessary training as well as outcomes associated with piloting a new skill acquisition format. It appeared that the POI was in its initial stages of development and might change as new policies, procedures and formats were introduced and implemented across all settings. According to the current POI, LBSSLC indicated that it was in non-compliance with all sub-sections within Habilitation, Training, Education, and Skill Acquisition Plans (S.1-S.3). This finding was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: Summary of Monitor's Assessment: In general, progress was observed in many areas of habilitation, training, and skill acquisition programs. It was evident that staff had begun the challenging process of improving the services and supports at LBSSLC as they progressed toward compliance with the Settlement Agreement (SA). Although changes were observed since the baseline review, many areas still required additional resources and effort to adequately address components of the SA. Indeed, discussions and interactions with many administrative, clinical and direct support professionals reflected an acknowledgement of and sincere investment in the continued work that will be required to progress toward compliance. Since the baseline review, LBSSLC had made progress by developing an Active Treatment Policy that included a new process and format for the development, implementation, and monitoring of skill

	acquisition programs (SAPs). This change was based on previous feedback and was necessary to improve the quality of current skill acquisition programs, as well as improve ongoing monitoring. Indeed, newly developed Performance Probes and Learning Based Support Data Graphs are likely to promote improved treatment integrity and consistent data collection. The Monitoring Team looks forward to reviewing the Facility's progress as it begins developing, implementing and monitoring these new SAPs. The PSP process had been recently revised as well. The new process included a new assessment, called the Comprehensive Functional Assessment. In addition, the first draft of a revised Vocational Assessment was developed. In combination with improvements within active treatment programming, the new PSP process is likely to support the identification and prioritization of skill acquisition programs, as well as the integration of individualized preferences within these programs. Since the baseline review, LBSSLC also had made progress in the area of engagement. During the recent visit, engagement across residential programs was estimated at 72%, showing an improvement since baseline. Training of staff continued to be an area of great concern. Baseline reviews and more recent observations continued to produce mixed findings regarding staff knowledge of and competencies in implementing skill acquisition plans. The Monitoring Team looks forward to reviewing the content and process of the new competency-based trainings, as well as related outcomes during the next visit. Lastly, it appeared that efforts to integrate individuals more fully into the community had continued. Indeed, data suggested that more individuals were engaged in the community. Since the baseline visit, the number of skill acquisition programs implemented in the community increased. Unfortunately, the number of individuals in community-based supportive employment had remained the same.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of	During the baseline reviews, it was determined that individuals served at LBSSLC appeared to have multiple skill acquisition plans, described as Specific Program Objectives (SPOs), that addressed needs identified through assessments summarized within Personal Support Plans (PSPs). At that time, the SPOs appeared to follow a specific format, including indentifying a goal or objective, providing baseline data, specific plan for instruction and implementation (i.e., setting, schedule, materials, reinforcement, and teaching procedures), and evaluative procedures. However, review of sampled plans, at that time, revealed that the detail and comprehensiveness of the plans varied greatly. That is, many of the required elements were relatively vague and did not provide enough specificity for their consistent and complete application across staff. For example, some behavioral objectives did not provide enough detail to ensure consistent identification and reliable measurement of the target response. Also, the objectives of the SPOs often did not match the steps specified to teach the skill. More	Noncompliance

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	skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	importantly, many of the sampled SPOs did not typically include: 1) an operational definition of the target behavior (i.e., what was being taught); 2) specific detailed teaching steps (based on a task analysis); 3) detailed instructions on the use differential reinforcement; 4) programming for maintenance and/or generalization; and/or 5) sufficient trials per day (or week) to promote acquisition. For the current review, review of requested sampled documentation, primarily provided SPOs and available SPO data, evidenced similar findings as reported during the baseline review. More specifically, inconsistencies in format, inadequacies within required elements, and lack of critical teaching components within SPOs continued to be evident. Several examples will be provided below to illustrate these continued limitations within recently reviewed SPOs. However, as clearly indicated during the recent on-site review, the policy and processes regarding the development (including the format), implementation (including training), and monitoring of skill acquisition programs had been changed significantly. These changes will be discussed following current findings from sampled plans. The current sample (N=12) of selected SPOs and associated data were reviewed to examine whether or not they included components necessary for learning and skill development, as well as to determine if any changes within these programs had occurred since the baseline review. In general, the current review evidenced many of the same limitations as found during baseline. The following are examples of these limitations: ▪ Although the majority of reviewed SPOs appeared to be specifically identified in PSPs, a minority of SPOs were not clearly indentified within the PSP (i.e., “following directions” SPO for Individual #82, “laundry” SPO for Individual #108, or “fitness” SPO for Individual #268). In addition, and perhaps more importantly, it was not always obvious which assessment(s), and related recommendation(s) were the basis for specific SPOs. For example: o The utilization of an adaptive switch to facilitate communication and access to preferred activities, as outlined in an SPO for Individual #181, did not appear to be based on any speech or communication assessment and was not found in any discussion within the PSP. o It was unclear, for example, what assessment the laundry SPO for Individual #108 was based. That is, under the Residential Services Assessment the PSP indicated: “continue current programs” and “see discussions record,” however, specific information regarding this SPO was not found. It is recommended that in the future, SPOs contain a very brief section describing the rationale (i.e., identifying the assessment, individual preferences) underlying the SPO. ▪ Although every SPO had an objective, all of those reviewed were somewhat	

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		unclear. That is, objectives simply did not provide sufficient and descriptive information to ensure clarity of comprehension. For example, some objectives indicated that an individual would "participate" for a certain criteria, but never defined "participation" (e.g., SPOs for Individual #317 and Individual #126). Indeed, operational definitions of targeted responses were rarely found. In addition, objectives often included a criterion identifying a response occurring in "… 1 out of 1 trial …" (or more trials) for some period of time. It was unclear why a level of criterion requiring 100 percent mastery was chosen. Presumably, SPOs have been developed because an individual has a need to develop a new skill. Usually, when someone is learning a new skill, 100 percent mastery on the first trial would be an unrealistic expectation. Indeed, the objective as written for Individual #268 would appear to require perfect responding on the first trial, twice a week, for 12 consecutive weeks. And, if multiple trials were included in the objective (e.g., 1 out of 2 trials, or 1 out of 3 trials), information regarding the multiple trials (i.e., on how to implement or document on more than 1 trial per session) was never provided (e.g., SPOs for Individual #317, Individual #181, and Individual #99). It is recommended that more clear and comprehensive objectives be developed, including an operational definition of the targeted response, with a clear and reasonable criterion for success. ▪ All SPOs included information on the setting, schedule and materials needed to complete the program. This information appeared helpful to staff when determining where, when and how to accurately complete the SPO. However, in some cases, it was unclear how identified session lengths were determined or how they were related to the skill program. Indeed, many of these times appeared arbitrary and not particularly meaningful. For example: o Individual #36 had an SPO developed to support his learning to contact his family independently, and the identified session length was 30 minutes. It would seem more appropriate that a time period be identified when to call (after Mother gets home from work) than to identify the duration of the session (i.e., is he only allowed to talk for 30 minutes – i.e., the identified session length?). In addition, materials (pen and paper) were identified as necessary, but a description of how they would be utilized or why they were necessary was never provided. ▪ The reviewed objectives at times did not appear to be related or consistent with the overall goal of the SPO. The following examples provide evidence that the link between the identified objective and the skills being taught was not always readily apparent: o A money management program was designed to teach Individual #264 to " … pick out 6 objects out of 10 objects …" It was unclear if the individual was being taught to choose items that he wanted to purchase, if he was labeling or manding for items, or if this was simply an informal	

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		preference assessment. In general, it was not obvious how this was related to money management. o A money management SPO with an objective of making a small purchase for Individual #203 targeted coin matching. Although a coin matching SPO may support the acquisition of pre-requisite purchasing skills, the objective should include criteria reflecting the successful acquisition of the specific desired response, in this case, accurately matching coins. o Similar concerns were identified with other SPOs (e.g., a hand washing SPO for Individual #183 as the basis for improving self medication skills). It is recommended that SPOs provide a description of how the SPO is related to the overall goal of the SPO when the association is less than obvious (i.e., the connection could be more readily apparent with the inclusion of a rationale). ▪ In many cases, the SPOs included teaching procedures that were often incomplete, inconsistent, vague, or seemingly generic. The generic procedures appeared to be the result of a "cookie cutter" approach to writing some of the programs. For example, the same three of four sentences could be found across a variety of programs. This is not to suggest that the use of similar procedures, utilized consistently across SPOs, is inappropriate. Indeed, it is generally acceptable to gather necessary materials, obtain an individual's attention during skill acquisition programming, and provide consistent prompting hierarchies when helpful in training staff and supporting skill acquisition. However, when these general procedures are the only procedures (e.g., Money Management SPO for Individual #203 or #264), it appears that there is a real need for more individualization and specification within teaching procedures. ▪ In most cases, SPOs did not include the use of task analysis to facilitate the identification of specific responses to teach. Two exceptions included the laundry objective for Individual #108 and a tooth brushing SPO for Individual #99. The objective in the later SPO, however, appeared to identify "… rinsing his teeth …" as the targeted skill and, subsequently, it was unclear if total task or backward chaining was being used. ▪ In all cases, SPOs did not appear to include any programming to support generalization or maintenance of skills. In addition, other than the typical statement regarding the prompting hierarchy, SPOs did not include specific error correction procedures. There were several SPOs that provided direction for when individuals were unwilling to participate in the SPO or became agitated during teaching sessions (e.g., Communication and Appropriate Distance SPOs for Individual #36 and Individual #107, respectively). ▪ Although reference to reinforcement was identified in almost all of the reviewed SPOs with one exception where it was not described (i.e., Tactile Stimulation and Communication SPO for Individual #317), the reinforcer identified in the	

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		majority of SPOs was "verbal praise" or "social praise." In three cases (i.e., SPOs for money management for Individual #264 and Individual #203 as well as the SPO for participation in sensory activities for Individual #126), seemingly individualized reinforcers were identified. However, specific identification of "edibles" or "drinks" was not provided. In addition, the use of differential reinforcement, especially when reinforcing correct responding (and not incorrect responding), was typically not highlighted. ▪ All of the SPOs reviewed contained directions on data collection. Some of these directions were unclear and erroneous. For example, collecting the number of "… straight leg raises …" on a Communication SPO was an obvious error (for Individual #181). In addition, although the format of SPOs clearly included a section for Baseline information, only one of the SPOs reviewed reported actual baseline data (i.e., SPO for "Following Directions" for Individual #82). In general, the above findings are consistent with those observed during the previous baseline monitoring. Within the current sample (N=12), individuals typically had, on average, six SPOs each (range of four to 10). These skill acquisition programs appeared to be developed to address a variety of needs and, at times, appeared to involve individual preferences (e.g., the Communication SPO for Individual #181). Review suggested consistency across individuals in the types of SPOs of those sampled as well. That is, most individuals had SPOs targeting money management, self–administration of medication (SAMs), and/or dental desensitization. Of the SPOs reviewed within the current sample, approximately 75% were specifically identified or discussed in the PSP. However, for many SPOs, it was a challenge to identify the assessment(s) that highlighted the particular skill deficit or specific need. In addition, SPOs did not appear to be related to needs identified in (or recommendations from) psychological assessments or structural and functional behavior assessments (SFBAs). Lastly, it continued to be difficult to determine how individual's needs or skill deficits were selected or ranked for inclusions as SPOs. At the time of the baseline review, QMRPs facilitated the collection, summary and integration of assessment findings, as well as subsequent recommendations from the Personal Support Team during the PSP process. These results were collapsed and identified within Action Plans that were the basis for programming, services and supports. Residence Coordinators (RCs) utilized the PSP, including the developed action plans, to develop appropriate SPOs and, along with Home Team Leaders and Assistant Home Team Leaders, were responsible for training staff to implement these plans. Monthly review of the program and progress was completed by the QMRP and RC. At the time of the recent compliance visit, this process appeared to have changed significantly with the revision of the PSP process, as well as how skill acquisition plans were developed, implemented and monitored.	

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		It appeared that, since the baseline review, progress had been initiated in the area of Active Treatment, including significant changes to the way in which skill acquisition plans were developed, implemented and monitored. According to the Director of Active Treatment, efforts since the baseline review had been directed at developing a new local policy (i.e., " LBSSLC – IDT Process Program Development: Active Treatment Program Development, Implementation, and Monitoring", dated 6/30/10), as well as specific procedures and formats associated with the development, implementation, and monitoring of new and improved skill acquisition programs (i.e., Skill Acquisition Plan Guidelines, LBS Strategy Sheet, and Performance Probe). This new local active treatment policy indicated that a new assessment, called the Comprehensive Functional Assessment (CFA), would be completed by the PST and utilized to identify each individual's strengths, needs, and preferences. Once completed, the PST would use the results of the CFA to develop an Individual Support Plan (ISP) that would be the basis of active treatment programming for each individual. More specifically, the ISP would facilitate the identification of goals and objectives that would be targeted by skill acquisition programming. It was unclear how this new local policy would correspond with recent revisions and changes within the PSP process, including the addition of the Personal Focus Assessment (PFA) as described in the State Supported Living Centers Procedures – Personal Focus Assessment Policy and Personal Support Plan Instructions, dated 7/23/10. That is, it was unknown whether or not these new policies would be complimentary or redundant. For example, it was challenging to determine the benefit of completing both a CFA and PFA as they both appeared to attempt to facilitate the same outcome. Similarly, it was difficult to determine the differences between the PSP and ISP. Alternatively, the newly developed Skill Acquisition Plan (SAP) format and procedures, formally replacing the previous SPO format and procedures, appeared to be a strong step in the right direction. The new format was thoughtfully developed through the active collaboration of several disciplines at LBSSLC, including Active Treatment, Behavioral Services, and QMRPs. The new SAP format included many new sections and additions that addressed limitations identified on previous baseline and current compliance visits. This new format appeared to: 1) integrate the objective with the overall goal; 2) include a behavioral objective; 3) identify a method of training, forward, backward or total task chaining; 4) determine a schedule of training; 5) provide relevant discriminative stimuli; 6) specify consequences for correct and incorrect responding; 7) identify a criterion for mastery; and 8) highlight programming for generalization and maintenance. In general, development of the new SAP format appeared to be very positive and had the potential to significant improve the quality of the skill acquisition programs at LBSSLC. Unfortunately, there were no new SAPs to review during the recent compliance visit.	

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		Subsequently, these new SAPs will be closely reviewed during the next compliance visit. Following the previous baseline visit, it was presented that it was fairly difficult, given the method in which data on SPOs was tracked and displayed, to determine performance of individuals over time. At that time, SPO data was not displayed in tables or graphs similar to the target or replacement behaviors found in Positive Behavior Support Plans. Subsequently, interpretation of progress was challenging. At the time of this current review, data was still not displayed in a format (i.e., table or graph) that would facilitate efficient analysis of individual performance on SPOs. Current revisions to the skill acquisition programming (as presented above) also included changes to how progress on SAPs would be tracked. New procedures included the use of Performance Probes as well as Learning Based Support Data Graphs. These new data collection and display formats appeared to increase the likelihood that individual performance would be more efficiently and effectively monitored. Unfortunately, these were not in place at the time of the recent compliance visit. Subsequent on-site visits will examine the utilization of these new monitoring systems. Given the above findings, it was unlikely that the majority of skill acquisition programs were currently promoting growth, development, and independence across most individuals served at LBSSLC. However, proposed changes that had been recently initiated were likely to facilitate the development of more rigorous and fundamentally sound skill acquisition programs and monitoring. At the time of the most recent on-site monitoring visit, these new procedures were being "piloted" in only three residential programs (i.e., Aspen, Violet, and Iris) and outcome data (e.g., new skill acquisition plans) were not yet completed and available for review. It is likely that as a result of the pilot process, there will be revisions to the active treatment policy or modifications to the SAP format or related procedures. Upcoming compliance visits will closely examine how such changes have been adopted and whether or not they have translated into improved outcomes for the individuals served at LBSSLC. As similar to the previous baseline visit, observations during the recent site visit evidenced a continued effort to promote engagement in recreational, leisure and other activities, including opportunities for community outings, across residential programs. Engagement was measured in residences (see below) at different times across multiple days. Engagement was measured by briefly observing the individuals who were within a particular setting at the given moment and the number of staff available at that time was recorded as well. The definition of engagement was very liberal and included active (e.g., playing games, looking through magazines, talking with staff or other peers, assisting with household activities, etc.) and passive forms (e.g., listening to the radio, watching TV, etc.) of engagement. The table below provides specific information on the observed	

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		level of engagement (individuals engaged: total number of individuals) in relation to staff-to-individual ratios across residential programs.	

Engagement Observations

Location	*Engaged*	*Staff-to-individual ratio in room*
Quail	3:3	0:3
Sparrow	3:3	1:3
Aspen	4:4	4:5
Aspen	5:5	5:7
Birch	2:2	1:2
Elm	4:5	1:5
Elm	3:5	1:5
Fir	4:4	1:4
Fir	1:2	0:2
Oak	0:4	0:4
Oak	1:6	2:5
Zinna	6:9	1:9
Zinna	6:6	3:6
Tulip	1:1	1:1
Rose	2:9	1:9
Willow	0:2	0:2
Willow	2:2	1:2
Willow	3:4	1:4
Cannan	5:5	2:5
Violet	4:4	2:4
Violet	3:3	1:3

According to collected data during brief residential visits, overall engagement was 72%. An engagement level of at least 75% would be a typical target for a facility like LBSSLC. It should be noted that this recent estimate is much higher than the percentage of observations of active engagement (i.e., average of 48%; range of 33 to 62%) reported by LBSSLC over the past year (i.e., PIC Summary Data of percentage of Observations Actively Engaged in Home, Work, or Day Program). In general, direct observations suggested that many staff worked hard to keep individuals engaged by offering a lot of choices and consistent encouragement. At times, it appeared that engagement was limited due to the staffing ratios. However, all the interactions observed between staff and individuals were appropriate. As similar to baseline findings, current observations reflected multiple observations including staff and individuals actively participating in activities, including recreational (going for walk, going to the gym, etc.) or leisure activities (e.g.,

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		games, crafts, etc.). Observation of direct care staff implementing more structured skill acquisition programs (e.g., SPOs), however, was relatively rare during brief visits to residential programs. Although engagement data was not taken, visits to on-campus educational and vocational sites, especially EIWS and EIRS, also reflected a high level of active engagement. Review of requested documentation on completed community outings also reflected an emphasis on ensuring that individuals served at LBSSLC had access to the community on a regular basis. Summary data indicated an increasing trend in the number of persons involved in community-based activities over the past nine months (i.e., Community Inclusion and Percentage of Involvement in Active Treatment). Summarized data of the percentage of observations of active engagement in home, work, or day program also reflected an increasing trend over the past five months. However, the trend for the last 11 months appeared to be relatively flat. As previously presented, a new LBSSLC policy (dated 6/30/10) was written to clearly outline the process of developing, implementing and monitoring active treatment programs. This policy detailed the systematic monitoring of active treatment using the Active Treatment Monitoring/Coaching Tool as well as the Program Observation Drill. According to the Director of Active Treatment and the Active Treatment Supervisor, these tools were currently being completed each week by at least one reviewer [e.g., RCs, QMRPs, Active Treatment Coordinators (ATCs), etc.]. It appeared that, although these reviews had been completed for some time (approximately three to four months), the data had not yet been summarized and/or analyzed. The examples that were provided of initial attempts at active treatment monitoring (e.g., weeks 8/9 through 8/27/10 at Birch) and Program Observation Drills (e.g., weeks 8/1 through 9/4/10 at Canna) appeared incomplete and were difficult to read and understand. Further data review, including summary analysis, will need to be completed during the next compliance visit. Efforts to enhance individual engagement continued to be facilitated by the presence of Active Treatment Coordinators. Since the baseline review, an additional Coordinator and Supervisor had been hired. These five professionals appeared to be well positioned to assist with on-the-job training of new direct support professionals, as well as monitor the on-going quality of programs and any necessary performance coaching. The additional hires also appeared to support regular attendance by ATCs at PSP meetings. According to verbal reports, recent revision to Active Treatment Schedules and more regular monthly monitoring of community outings (as evidenced in the Community Integration Reports) appeared to support higher levels of engagement within on-campus settings as well as off-site community integration. Reviewed documentation also suggested that active treatment team meetings continued to occur (as initially reported during the baseline review) on a monthly basis across residential settings. Verbal reports from staff	

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		suggested that these positions continued to assist in supporting higher levels of active and meaningful programming. It was difficult to assess, however, the regularity of the active treatment team meetings across all residential sites, as well as determine the number of individuals involved in these meetings. Active efforts at providing meaningful engagement, including skill building opportunities, within vocational/employment settings both on and off the LBSSLC campus continued to occur. Current observations were consistent with those from the previous baseline review. That is, individuals continued to be encouraged to engage in a variety of work activities (e.g., meal kits, document preparation and shredding, gravel bags, cable television materials, etc.) that were completed both on-site (i.e., EIWS, EIRS, and Pine workshop) and off-site (i.e., supported enclaves in the community). Individuals continued to be involved in designing, making and selling items at the Heart and Hands store. This enterprise certainly appeared to allow individuals the opportunity to pursue their own creative interests and make money as well. The number of individuals involved in this enterprise, however, had surprisingly decreased (i.e., from 28 to 17 individuals over the past 12 months). The Director of Vocational and Day Programs reported that, in an effort to support more individualized vocational experiences, efforts to encourage more individuals to become involved in the "Client Worker" program have been in place. Reviewed documentation indicated that, within the last year, approximately seven to 10 individuals per month were involved in this program and that the total was increasing over time. These paid positions were created or identified on campus, based on individual interest, to provide the vocational training necessary to prepare individuals to pursue similar community-based jobs. Examples of the types of jobs in which individuals were engaged included LBSSLC had made recent efforts to individualize programming within current day programs as well since the baseline visit. According to the Director of Vocational and Day Programs, several changes had been implemented (or were underway) since the baseline review. As described, many of these changes appeared to be aimed at supporting more individualized programming. For example, the length of programs has been shortened (from 45 to 15 minutes) which was designed to support greater choice as well as flexibility in when programs are scheduled. In addition, efforts had started to individualize programming by identifying individual preferences and integrating those preferences into planned activities. These changes, theoretically, appeared to offer the potential for more individualized programming. Future reviews will determine if these changes have facilitated more individualized programming. The changes described above represented improvements being made to address individuals' experiences and opportunities on campus. However, it appeared that	

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		availability of work off-campus had not improved since the previous baseline visit. Based on available data, the number of individuals in supported employment, enclave work, or competitive employment had not changed significantly within the last year. As of August 2010, there were only two, three, and one individual(s) in supported employment, enclave work, and competitive employment, respectively. Several barriers to off campus employment were identified during the baseline visit, including the economy and lack of transportation. According to the Director of Vocational and Day Programs, access to transportation had improved based on improved communication between RCs. In addition, two new vehicles that were assigned to day and vocational programs had been ordered and were expected to arrive soon.	
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.	As reported during the baseline review, the Personal Focus Worksheet: Individualized Assessment Screening Tool (PFW) was completed in an attempt to identify individual goals, interests, likes/dislikes, achievements, and lifestyle preferences. It also functioned as the primary screening device that assisted with the identification of additional necessary assessments. In the current sample (N=24), 54% of the individuals had completed PFWs, although two were not dated (i.e., Individual #82 and Individual #268) and one (for Individual #320) was obviously dated in error (i.e., "7/10/12"). PFWs were unavailable for Individual #264, Individual #36, Individual #213, Individual #183, Individual #317, Individual #235, Individual #99, Individual #109, Individual #237, Individual #190, and Individual #298. As reported during the baseline review, the Positive Assessment of Living Skills (PALS) was also completed for each individual annually to assist with the development of the Personal Support Plan (PSP). This assessment evaluated a substantial number of skill areas and offered additional information on an individual's preferences, strengths, needs, and barriers to community integration. In the current sample (N=24), 75% of the individuals had completed PALs, although five were not dated (i.e., Individual #159, Individual #183, Individual #99, Individual #106, and Individual #320). Of those not dated, a completion date was indicated within the PSP (for Individual #159, Individual #183, and Individual #106). Completed PALS were unavailable for six individuals within the sample (Individual #36, Individual #82, Individual #109, Individual #237, Individual #190, and Individual #298). Review of PSPs indicated that completion dates were documented for two of these individuals (e.g., Individual #82, and Individual #237), and it appeared that PALs were not yet completed (but planned) for two individuals (i.e., Individual #36, and Individual #190) due to the fact that they had just been admitted within the last 30 days. Interestingly, the dates listed within the PSP and on the actual PALS documents were inconsistent for several individuals (e.g., Individual #268 and Individual #167).	Noncompliance

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		As reported during the baseline review, a third assessment called the Personal Adaptive Skills Essential for Privacy and Independence (also known as the Residential Services Assessment) had been completed in the past to assess individuals' skills and needs in preparation of the PSP. Of the current sample (N=24), this assessment was completed for three individuals (i.e., Individual #82, Individual #109, and Individual #237), most recently in May 2010. In addition, although documentation was not available, information within the PSP suggested that this assessment might have been completed for several other individuals sampled as well (e.g., Individual #159, Individual #99, Individual #298, and Individual #320). As similar to findings reported during the baseline review, this assessment continued to be completed independent of and, at times, concurrent with the PALs. Based on the above review of the sampled documentation, it was unclear how staff determined which of these assessments were to be completed. In addition, the thoroughness with which these assessments were completed, including how they were summarized, appeared to vary considerably across reports. For example, several sampled PALS appeared to be incomplete or appeared to have only a few sections completed without any justification provided (e.g., Individual #99, Individual #126, Individual #181, and Individual #183) while others seemed to be fully completed (e.g., Individual #320 and Individual #268). In addition, a few assessments contained concluding comments (e.g., Individual #126, Individual #268, and Individual #213), but none of the sampled reports contained completed summary tables (at the end of the assessment). In addition, assessment results were inconsistently found in PSPs. That is, for some individuals, the results of adaptive assessments were not described (e.g., Individual #108, Individual #99, Individual #167, and Individual #106). It is recommended that narrative within the PSP clearly indicate which assessment(s) was completed: the PALs, Personal Adaptive Skills Essential for Privacy and Independence, or both. Policies should be developed, if they do not already exist, to assist staff in determining which assessment(s) to complete. In addition, further training in scoring, summarizing and presenting assessment findings (in the PSP) should be provided to targeted staff. During the previous baseline review, it was discovered that, for a number of PSPs, Physical/Medical assessments were not available prior to or at the PSP meeting. Upon review of sampled PSPs (N=24), it appeared that this trend had continued. More specifically, the Physical/Medical assessment was unavailable to PST teams at the time of the PSP for several individuals within the sample (i.e., PSP reports for Individual #82, Individual #159, Individual #213, Individual #183, and Individual #237). As previously reported, the absence of this important information was likely to be a significant barrier to the provision of necessary supports and services, as well as limit the overall	

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		comprehensiveness of the PSP process. This repeated finding within sampled documentation reflected a consistent trend since the last baseline review. Overall, the current review evidenced mixed findings, that is, that the assessments listed in some PSPs appeared to be completed in a timely fashion while PSPs referenced assessments that were delayed or unavailable. In addition, the PSP will likely reflect new assessments (e.g., PFA, vocational) in the future (see below). Since the baseline visit, many significant changes had been initiated that are likely to profoundly influence the habilitation, training and education of individuals served at LBSSLC. A new PSP process was implemented (effective August 23, 2010) following training of the Facility's Qualified Mental Retardation Professionals and Personal Support Team members. Related statewide policies outlining the new PSP process were recently implemented in July 2010, as described in the State Support Living Centers Procedures – Personal Support Plan Instructions and Personal Focus Assessment. The new PSP process emphasized Person Directed Planning principles and included a new assessment, called the Personal Focus Assessment (PFA), which was designed to facilitate the identification of individual goals and preferences, as well as the necessary assessments and supports. The PFA was developed to replace the PFW. Therefore, future compliance visits will include review of newly completed PFAs. According to documentation, the PALS will continue to be central to the PSP assessment process. In addition to this new assessment, monitoring tools (e.g., PSP Meeting/Documentation Checklist as well as the QMRP Check Sheet for PSP Process) were developed to facilitate the PSP process and ensure that necessary activities, assessments and related recommendations were completed. Unfortunately, due to the timing of the recent compliance visit, there were no "new" PSPs developed using the new PSP process available for review. An additional change involving assessments within the PSP process included the work that has been initiated since the baseline visit on a new Vocational Assessment. According to the Director of Vocational and Day Programming, the first draft of the new vocational assessment had been developed to replace the "in-house" vocational assessment previously utilized. This new assessment appeared to be more comprehensive and included an open-ended item/question format designed to elicit responses related to an identified central vocational/employment vision. It was reported that, once approved, this new assessment would be adopted statewide. Because this revised assessment was still in draft form, there were no available completed examples to review. This new assessment will need to be examined during subsequent compliance reviews.	

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S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As previously presented with regard to Section S.1 of the SA, it was often difficult to identify the specific assessment that was the basis for the skills targeted within sampled SPOs. It was not clear that individuals' needs were being systematically identified, or, as required by this sub-section of the SA, effectively addressed through planned interventions, strategies, and supports. In addition as is discussed above in greater detail with regard to Section K.5 of the SA, the recommendations found within Psychological Assessments or Structural and Functional Behavior Assessments often identified the need for further assessment, continuation of the positive behavior support plan, the continued use of psychotropic medications, or addressed issues related to community integration. These assessments rarely identified needs that were targeted through SPOs. This current finding was consistent with findings from the baseline monitoring review. According to the Directors of Active Treatment and Behavioral Services, as well as the QMRP Coordinator, the new PSP and Active Treatment policies and formats (including the new SAPs) were expected to facilitate the development of SAPs specifically targeting needs the PSTs identified and prioritized in the PSP. These new policies and formats had only recently been developed and staff had recently been trained on them. Future monitoring reviews will need to closely examine how they improve the PST process and, ultimately, upcoming PSPs and SAPs. Concerns regarding staff knowledge of skill training programs and their ability to correctly implement them were reported during the initial baseline review. Similar concerns were evidenced during brief visits to residential settings during the on-site compliance visit. That is, brief observations and discussions with residential staff (including home team leaders, assistant home team leaders, direct care staff, etc.) provided mixed results of their estimated knowledge of plans as well as their ability to implement the plans with integrity. Some staff who were interviewed accurately identified components (e.g., descriptions of targets, prescribed procedures, etc.) necessary for fidelity of treatment. However, many staff had difficulty identifying or explaining important components of skill training. On several occasions, this included difficulty finding specific skill training programs, accessing related data sheets, and conveying accurate data collection procedures. LBSSLC staff recognized these challenges, and efforts since baseline had demonstrated their commitment to improving	Noncompliance

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		staff training. Indeed, verbal reports from administrative and professional staff emphasized the need for rigorous competency-based training, as well as more systematic and valid monitoring of implementation integrity. Systems to address these challenges had been developed or were in the process of being developed or tested as discussed in further detail with regard to Section S.1 and K.11. Adequate and appropriate reinforcement is key to ensuring that interventions are effective. As found during the previous baseline and current review of sampled documentation, reinforcement descriptors and/or strategies were generally found within all SPOs. This usually included the identification of the reinforcer(s) as well as a description of how/when it should be utilized. In most cases, verbal or social praise was identified as the specific reinforcer. In rare cases, a seemingly unique reinforcer (e.g., "rocking") was identified and described (e.g., SPO for money management for Individual #264). In addition, the use of differential reinforcement following correct verses incorrect responding was not typically clarified. It appeared, then, that the utilization of preference assessments to indentify more individualized reinforcer(s) would be beneficial. Standard practice suggests that formal preference assessments should be conducted at least annually. In addition, strategies related to differential reinforcement should be described clearly in future SAOs. In order to determine if interventions are effective, regular review of progress needs to be completed, and plans modified, as necessary. None of the sampled documentation evidenced any skill acquisition data that was graphed. According to recent verbal report and provided documentation, however, it was expected that monthly SAO data would be graphed using the newly developed LBSSLC Learning Based Support Data Graph. At the time of the compliance review, these graphs had not been implemented yet. Future compliance visits will examine collected SAO data, including data illustrated on the new graph format. Lastly, as previously discussed with regard to Section S1 of the SA, it was unlikely that the majority of skill acquisition programs (SPOs) were currently promoting significant growth, development, and independence across most individuals served at LBSSLC. However, proposed changes as well as those that had been recently initiated were likely to facilitate the development of more rigorous and fundamentally sound skill acquisition programs, as well as more effective implementation (training) and systematic monitoring.	
	(b) Include to the degree practicable training opportunities in community	Findings from the baseline review indicated that several sampled SPOs prescribed implementation within a community-based setting. At that time, however, it appeared that the majority of individuals did not have SPOs that specifically targeted skill	Noncompliance

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	settings.	acquisition training within a community setting. Based on the most recent review, of the individuals sampled (N=12), 50 percent had at least one SPO identifying the community as the setting (or potential setting) for training. More specifically, the setting described on several SPOs offered options of both on- and off-campus (e.g., money management SPO for Individual #317 and Individual #183; healthy choice SPO for Individual #82; and, fitness SPO for Individual #268). Other SPOs prescribed the setting as "away from home" (e.g., environmental awareness SPO for Individual # 181) or "community outing" (e.g., money management SPO for Individual #126). Consequently, it would appear that greater emphasis is being placed on skill acquisition in the community. However, significant additional work needs to be done to ensure that individuals regularly are provided opportunities to learn skills in natural settings in the community. In the current sample (N=12), only 16% (2 out of 12) had SPOs that targeted implementation within a work setting. In both of these programs, the targeted setting was an on-campus vocational setting (i.e., SPOs completed at EIWS for Individual #36 and Individual #82). It is unknown at this time if the individuals involved in the enterprise program (N=17) or the "client worker" program (N=10) participated in formal skill acquisition training in these on-campus work settings. As previously presented with regard to Section S.1 of the SA, only a very small number of individuals (N=5) worked in supported employment, enclave, or competitive work settings within the community. In general, the number of individuals in community-based employment positions had not changed significantly over the past 12 months. According to requested documentation, a larger group of individuals (N=22) work part-time on campus and part-time off campus. It is unknown given the available documentation, however, who these individuals were, where they worked in the community, and/or why this was not considered supported, enclave, or competitive employment. Currently, the Active Treatment Coordinators monitored community integration during interactions with staff during active treatment team meetings at each residence, as well as through the completion of monthly community integration reports. These reports reflected data on the nature of community inclusion for each individual (i.e., including where they went, the date, skills trained and reinforced, and individual response), and were collapsed across each residential program. In addition, an action plan was recently developed and implemented to increase meaningful activities for residents of LBSSLC (i.e., Action Plan, dated 8/25/10). This action plan contained multiple strategies (e.g., hiring new staff, integrating active treatment schedules, ongoing training and feedback, etc.) that appeared likely to improve opportunities for individuals to experience meaningful and functional activities both on and off campus. Indeed, according to	

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		provided data, it appeared that increasing numbers of residents were experiencing regular community outings. However, many of these strategies (e.g., the role of the ATC in new staff training) as well as established expectations (e.g., how often active treatment meetings need to occur, how many outings per month for each individual, etc.) did not appear to be integrated within the newly developed local active treatment policy.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. As recommended in the baseline report and as outlined in the new SAP format, all training objectives should be written to include the following: a) specific conditions under which the behavior will occur; b) a definition of the behavior in observable and measurable terms; c) identification of the criteria that will be used to indicate mastery of the skill; and d) a plan for the maintenance and generalization of the skill. Additionally, specific guidelines for teaching the skill must be provided. This should include relevant discriminative stimuli, prompting strategies, shaping guidelines, and steps for teaching behavioral chains.
2. In addition, skill acquisition programs should:
    a. Identify or highlight the rationale for each skill acquisition program within the actual program. This information should include which assessment(s) identified the specific need, as well as how individual's preferences were considered. In addition, this information should be conspicuously placed (perhaps at the top) of each skill plan/document; and
    b. Provide a description of how the SPO is related to the overall goal of the SPO when the association is less than obvious (i.e., the connection could be more readily apparent with the inclusion of a rationale).
3. As LBSSLC proceeds with changes to the PSP, including revisions to how skill acquisition programs (SAPs) are developed, implemented and monitored, the Facility should provide guidance to teams on the process to be used in prioritizing SAPs, and how individual preferences need to be addressed and incorporated, including ensuring that this process is conspicuous.
4. Within the PSP document, teams should describe how the PST identified (or ranked) the needs or recommendations that would be addressed through skill acquisition programming.
5. As LBSSLC proceeds with implementation of the new SAPs, the Facility should ensure that QMRPs, RCs, and other PST team members receive the training necessary to adequately develop, train and monitor these skill programs according to the new policy and format. The SAP training is currently being piloted in three residences and training should continue across all residential, day and vocational programs.
6. If already not in place, a grid should be developed containing the last date of completed assessments (e.g., PFA, PALS, ICAP, etc.) typically utilized within the PSP process. Such a grid would facilitate efficient monitoring of required and/or optional assessments as well as help ensure their timely completion. In addition, this grid would support internal (QE) reviews of the PSP process.
7. Collaborative efforts across disciplines (e.g., psychology, QMRP, and active treatment services) should continue to ensure that each discipline's strengths are utilized to improve current supports and services. For example, as training continues on the new SAP process, contributions from psychology will likely facilitate a better outcome.
8. Efforts to expand meaningful day and vocational programs should continue. The teams of individuals currently not attending a day or vocational program away from their residential unit should identify what the barriers are for participation in an off-unit program. Unless there is clinical justification for an individual remaining on the unit, individuals should attend off-unit day and vocational programs. In addition, closer examination of the potential barriers limiting individuals in working community-based settings should take place.
9. If not already completed, the Facility should examine how the local active treatment policy and related processes will integrate with the new PSP process. Special attention should be give when evaluating proposed assessments and language in an effort to avoid redundancy.
10. Efforts should continue in developing and piloting the new Vocational Assessment.

11. Efforts should be made to integrate or complete skill acquisition programs in day program, vocational settings, or community-based settings, as opposed to the majority being completed in residential programs. Consideration should be given to adding expectations regarding these programs to the current policy.
12. Regular preference assessments should be conducted in an attempt to identify more individualized reinforcers.
13. Creative efforts should continue to increase the availability of transportation to facilitate individuals' community integration.
14. As increasing numbers of individuals begin to complete skill acquisition programs in the community, efforts should be made to conspicuously indicate on program documents where (the specific location off campus) the programs should be implemented.
15. If not already collected, more detailed summary information should be compiled and analyzed regarding monthly active treatment team meetings. Although monthly data sheets are available, regular summary data (number of meetings per month for each residence, number of staff in attendance, etc.) would assist with evaluating the consistency and breath of these meetings.
16. If not already collected, more detailed summary information should be collected and analyzed regarding community outings. Currently, monthly Community Integration Reports are completed (detailing each individual and outing) and PIC summary monthly data (total number of persons involved in community activities) is provided. Having information on, for example, the average number and range of community outings per month per residence would facilitate analysis of community integration. This information appears to be a natural next step to the data currently collected.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Individuals Assessed for Placement since 7/1/09, and resulting recommendations; o List of Individuals Referred for Placement since 1/1/10; o List of Individuals who Have Requested Placement with No Recommended Movement, 8/23/10; o List of Individuals who Have Had a Community Living Discharge Plan Developed Since 1/1/10; o List of Individuals who Have Been Transferred to a Community Setting Since 1/1/10; o List of Individuals who Have Returned from a Community Placement Since 1/1/10; o List of Individuals Discharged Pursuant to an Alternate Discharge since 1/1/10; o List of Alleged Offenders at LBSSLC (none), not dated; o List of Obstacles to Community Living for three individuals, undated; o Community Placement Reports, from 7/1/09 through 7/31/10; o Client Assignment and Registration System "MR Needs", revised 2/03; o Description of How the Facility Assesses Individuals for Placement, undated; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; o LSS - Continuity of Services: Community Placement; o Section T. Serving Institutionalized Person in the Most Integrated Setting Appropriate to Their Needs monitoring form, including sample of completed forms; o SSLC and MRA Plan for Staff Training Regarding Community Living Options, undated; o Staff Record of Community Interaction, from 12/28/09 through 8/20/10; o Sign-in Sheets for State Office Training on Living Options, on August 3, 2010, with agenda, and handouts, including: ▪ Living Options Draft, June 2010; ▪ Home and Community Based Services (HCS) Individual Plan of Care (IPC), dated June 2010; ▪ Community Referral Process; o Agenda and Handouts from Admission Placement/Post-Move Monitor 9/16/10 Scan Call; o PSPs and related assessments for the following individuals: Individual #10, Individual #202, and Individual #76; o Community Living Discharge Plans, PSPs, and related assessments for: Individual #218, Individual # 237, Individual #268, and Individual #44; o Post-Move Monitoring Checklists for: Individual #279, Individual #49, Individual #177, Individual #110, Individual #218, and Individual #237; and o Presentation Book for Section T.

	▪ **Interviews with**: o Carla Prell, Admissions/Placement Coordinator; o Annette Webster, Post-Move Monitor and Guardianship Coordinator o Trent Lewis, Director of Active Treatment; o Marisol Gonazales, ISP Coordinator; and o Lola Walker, QMRP Coordinator. ▪ **Observations of**: o Post Move Monitoring Visits at Individual #44's Home and Day Program; o PSP Meeting for Individual #241; and o PFA Meeting for Individual #107.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for LBSSLC did not include this component, the POI correctly identified that overall LBSSLC was currently not in substantial compliance with the requirements of Section T of the SA. The POI indicated compliance with one of the indicators within this section, specifically, the indicator that 50 percent of the individuals had been assessed for placement. However, as is discussed below, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. The Monitoring Team found the Facility in compliance with T.1.h. of the Settlement Agreement. This provision requires the Facility and/or State to provide the Monitor with a community placement report. It was unclear why the Facility did not find compliance with this requirement. The notation on the POI indicated that the report had been submitted, but changes in State Office policy with regard to Section T were forthcoming. The Monitoring Team also found the Facility in compliance with regard to subsection T.1.c.2 regarding the identification of person(s) responsible and timeframes for completion of action steps required in the CLDPs. The POI indicated that expected revisions were forthcoming from the State Office.
	Summary of Monitor's Assessment: Individuals' PSPs did not consistently identify all of the protections, services and supports that needed to be provided to ensure safety, and the provision of adequate habilitation. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. PSPs had begun to identify obstacles to individuals moving to the most integrated setting appropriate to meet their needs. However, the following issues were noted: 1) the obstacles often were listed as need areas for the individual, such as behavioral issues, medical concerns, etc., as opposed to identifying services or supports that either were unavailable or did not exist in the community; 2) the plans to overcome the obstacles often were not measurable, did not identify person(s) responsible or timeframes for completion; and 3) the strategies often involved services to be provided to the individuals at the Facility, but did not include identifying support configurations in the community that would address individuals' needs.

	The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. However, there continued to be concerns regarding the content of the checklists in relation to documenting the process that was used to confirm that essential and non-essential supports were adequately in place. There also was concern with regard to adequate follow-up being conducted for the concerns that were identified.

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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	On 10/30/09, DADS issued a policy entitled "Most Integrated Setting Practices." This policy was updated on 3/31/10, with minor revisions. This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals 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. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding for community transition of individuals from LBSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe.	Noncompliance

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	disabilities.	At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. Although Community Living Options Discussion Records included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations. The professional teams supporting individuals at LBSSLC should make independent recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.	
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:	Based on interview with the Admissions Placement Coordinator and document review, LBSSLC's Continuity of Care: Community Placement policy had not been revised since 3/6/08. It was anticipated that DADS would be updating its policy, and then the Facility would revise its policy to be consistent with the State's policy. Concerns regarding the Facility's policy were detailed in the baseline report, and should be considered when the policy is revised.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify,	The two major requirements of this section of the SA are discussed separately below: <u>Identification in PSP of needed protections, services and supports</u>: As was reported with regard to the baseline review and is further discussed in the section of this report that addresses Section F of the SA, as well as throughout other sections of the report, PSPs generally did not identify the comprehensive array of protections, services, and supports that individuals needed to ensure their safety and the provision of adequate habilitation. In all of the PSPs reviewed, concerns were noted with regard to their completeness. Some of these issues related to timely, thorough and adequate assessments not being completed (e.g., medical, nursing, physical and nutritional management, and communication); services and supports not being adequately integrated with one another (e.g., psychology and dental/medical, nursing and habilitation therapies, and medical and habilitation therapies); protections, services, and supports not being adequately defined, such as a lack of specificity about the supports that direct support professionals need to provide to protect and support individuals with regard to behavioral, therapeutic, or healthcare issues; and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychology and	Noncompliance

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	and implement, strategies intended to overcome such obstacles.	habilitation, physical and nutritional supports, and communication). As was found with the baseline review, a Living Options Discussion Record (LODR) was included as part of individuals' PSPs. This portion of the PSP had various sections, including an optimistic vision for the person; discussion notes about the individual and LAR's awareness of community living options; preferences of the individual and LAR; the supports needed by the person served in various areas, including safety, mobility, medical, behavioral/psychiatric, work/day activities, and quality of life; MRA input and recommendations, permanency plans, as appropriate; and a determination of the most integrated setting. As also indicated in the baseline report, a major concern about the LODRs was the lack of integration of these documents within the overall PSP. In a person-directed planning process, the discussion, for example, about the "Optimistic Vision" for the individual should lead the team's entire discussion about the protections, supports and services to be provided to the individual in no matter what setting the individual will be served. It should not only apply to the discussion about living options. Likewise, it was not clear why the LODR included a section that described the supports and services needed by the individual. Again, the overall PSP should define these protections, supports, and services clearly. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports and services. This is important for two reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them as well as potential providers to have a clear idea about what protections, supports and services the individual needs to ensure that the perspective provider agencies are able to support the individual appropriately; and 2) as the process progresses, the PSP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move. If all of the necessary protections, supports and services are not outlined in the PSP, it will be much more difficult to ensure the individual's safe transition. <u>Identification of obstacles and strategies to overcome them</u>: As part of the document request, the Facility provided copies of three of the most recent PSPs. These included PSPs for Individual #76, Individual #202, and Individual #10. Although the PSPs identified barriers, the barriers were generally conditions of the individual or issues related to their treatment and care, as opposed to protections, supports, or services that were not available in the community. Plans to overcome the barriers were generally inadequate. Specifically: ▪ For Individual #76, the barrier to community transition was that she needed	

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		emergency doses of Ativan to control seizures, and "The RN indicated that the response time with EMS to get to [Individual #76's] home in the community would place her at serious risk." The plan to overcome the barrier was "for [Individual #76] to remain at the LBSSLC." Clearly, this was not a plan to overcome the barrier. There was no documentation of team discussion of whether the nurse's assessment was correct with regard to the response time of EMS and/or options for addressing this issue (e.g., living close to emergency services), if Ativan could be provided in homes in the community (e.g., a small ICFs/MR), or if alternatives to Ativan were an option for Individual #76 (e.g., Diastat, which is used successfully in many community settings). ▪ Although Individual #202's LODR included a substantial amount of information about his needs for support, the section designed to identify obstacles just reiterated a number of his needs. No obstacles were identified specifically, and no plans to overcome them. The section on the "MRA input and recommendations" was concerning. It stated: "The Contract MRA agreed with the team and [Individual #202's] guardian that the expectations for [him] to move out into the community at this time and be successful at slim to none." ▪ Individual #10's LODR identified two obstacles to transition, including: 1) his guardian's preference that he remain at LBSSLC; and 2) the concern that the community would not provide him as much freedom of movement as he had at LBSSLC. The first obstacle was not defined specifically, although it was implied from the documentation that the guardian was concerned about a previous failed placement in the community at which it appeared Individual #10 did not have adequate supports. The plan to overcome this was to inform the guardian of "any alternative living available." With regard to his freedom of movement, it appeared from the discussion record that Individual #10 rides his bike on the LBSSLC campus, and the team believed he could not do this safely in a community setting. This is a good example of an individual who clearly has the potential of being more independent becoming "institutionalized," because the system had not been adequate to teach him important independent living skills. The plan to overcome this was that he "would receive training regarding safety in the community." A corresponding action plan read: "[Individual #10] will be given the opportunity to identify safety in the community to increase his awareness." This action plan along with the plan to overcome this obstacle was inadequate. The action plan was not measurable, nor did it set forth an aggressive plan to address this individual's need to learn safety skills. In addressing the obstacle, the team did not consider any other options, such as identifying a home that would allow him to ride his bike safely in the community, and/or staffing supports in a community setting that would allow him to learn additional safety skills.	

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	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.	Similarly to the baseline review, LBSSLC had engaged in a number of activities to provide education about community placements to individuals and their families or guardians to enable them to make informed decisions. This had taken a number of forms, including: ▪ On 3/14/10, a provider fair was held. According to the Admissions/Placement Coordinator (APC), all families were sent an invitation. This event had been held at the each March in conjunction with a meeting of the Family Association. ▪ Visits to community group homes and day programs continued to occur. The Facility worked in conjunction with the local MRA to schedule these visits. A schedule was provided for the months of March 2010 through August 2010. It listed visits to ICFs/MR, as well as HSC providers, and day habilitation/ vocational programs. Such visits offered individuals and Facility staff the opportunity to obtain first-hand knowledge of what community supports were available, to meet provider staff, and potentially other people with whom they might have the opportunity to live or work. The tracking system that captured information regarding the staff who either participated in these visits, or were exposed to community options when they assisted individuals with the selection and transition process showed that a variety of staff including QMRPs, nurses, psychologists, and direct support professionals had had the opportunity to visit community programs. LBSSLC is encouraged to continue offering regular visits to community homes and day programs. ▪ Individuals and their guardians also were provided information through the Mental Retardation Authority (MRA) Community Living Options Information Plan (CLOIP) process. This was occurring regularly as part of the individual planning process. ▪ In addition, on August 3, 2010, the State Office provided training on Living Options at LBSSLC. The attendance roster showed that approximately 30 staff from LBSSLC participated in this training. These staff included the Admissions Placement Coordinator, the Post Move Monitor, QMRPs, Residential Coordinators, behavioral services staff, and a nurse. The agenda for the meeting included a description of living options, including information about funding and various support models; review of the draft living options plan; the HCS Individual Plan of Care; and the Community Referral Process. ▪ In October 2010, it was anticipated that the MRAs would meet with PST members in meetings designed specifically to provide information about services and supports that were available in the community. This year, families and guardians, as well as individuals and the staff from LBSSLC would be invited to attend as well. The Facility is encouraged to continue offering a variety of educational options to individuals and families, and to expand these options to creatively meet the needs of various individuals and guardians. For example, as individuals successfully transition to	Noncompliance

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		community settings, with their and their guardians' permission, newsletter articles could highlight such success stories. At times, it might be helpful to match individuals and/or guardians who have gone through the process with individuals and/or guardians who are considering a placement referral. This would allow someone with first-hand knowledge about the process, including the challenges as well as the successes to share information and provide support. The individualization of this process is key to ensuring that individuals and their guardians have been provided education that allows them to make an informed choice, as required by the SA.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The SA anticipated that the Facility would require 18 months to complete this activity. However, to assess the Facility's progress, the Monitoring Team requested as part of its document request a list of individuals who had been assessed for placement since July 1, 2009, pursuant to the new or revised policies, procedures, and practices related to transition and discharge practices. The list provided appeared to be a list of all individuals who had had an annual staffing meeting since 7/1/09. As is discussed above with regard to Section T.1.a of the SA, the individuals' PSPs that were reviewed did not document an independent assessment by the professionals on the team of the individuals' appropriateness for transition to the most integrated setting appropriate to meet their needs. The Facility's POI documented that compliance had been attained with regard to the indicator that 50 percent of the individuals at LBSSLC had been assessed for placement. This was inconsistent with the Monitoring Team's findings.	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Community Living Discharge Plans were reviewed for four individuals. This sample was drawn from the list of seven individuals whom the Facility identified as having had a CLDP developed since July 1, 2009 (a 57% sample). As noted during the baseline review, the CLDPs at LBSSLC contained a substantial amount of very valuable information. Clearly, much thought and effort had gone into the development of the plans. Efforts appeared to have been made to include as full a complement of team members at the CLDP meetings as possible. Some of the efforts made prior to the CLDP meeting were not yet documented well, but were assisting individuals to safely transition to the community. As is described below, though, the CLDPs continued to need to be further enhanced because they are the documents that define what is provided to the individual by the new provider agency, and should be used by Post-move Monitors and MRAs to ensure the provision of protections, supports and services once the individual leaves LBSSLC. With regard to the timeliness of the Community Living Discharge Plans, it appeared that	Noncompliance

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		all four that were reviewed were developed only a few weeks prior to the individual's transition date, making adequate transition planning difficult. Particularly because the Facility was attempting to define essential and non-essential supports during the CLDP meeting, as opposed, for example, to identifying them for each individual as part of the annual PSP meeting, such a short window between the CLDP and transition date made it difficult to ensure that all essential supports were identified, and that provider and Facility responsibilities with regard to discharge were both identified and implemented. Reportedly, CLDPs were going to be developed sooner in the process.	
	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.	As was noted after the baseline review, the Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, many of the CLDPs did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. As is described in further detail in the section of this report that addresses Section T.1.e of the SA, the CLDPs also did not consistently identify the essential supports required by the individuals. The monitoring activities were identified in the CLDPs, including the role of the MRA, as well as the role of Facility staff in the post-move monitoring and follow-up process. The following are examples of some of the concerns noted with regard to the CLDPs reviewed with respect to defining the role of the Facility staff in the transition process: ▪ Generally, all of the individuals who were transitioned had some plans being implemented at the Facility such as Behavior Support Plans, Physical and Nutritional Management Plans, and Nursing Care Plans. None of six CLDPs (0%) adequately defined the Facility staff's role in assisting community provider staff to learn about these plans and their implementation. When such training was referenced, the CLDP did not define what the training would consist of or what the expectations were with regard to the competency of the community provider staff in implementing the programs (e.g., Individual #268 and Individual #44). ▪ Although based on interview, it appeared that LBSSLC staff were assisting in the transition by accompanying individuals to their new homes, and attending portions of pre-move visits, this was not formalized in the CLDPs reviewed. Sometimes this was mentioned in the narrative regarding activities that had occurred before the meeting. But again, because the CLDPs were being developed sometimes days before a transition, these activities were not defined as measurable action steps. For example: o Individual #218's CLDP indicated that: "It is important that [Individual #218] be provided with staff support and supervision that will assist him in a successful transition to the community." This support and supervision was not defined. In fact, it was unclear if this referred to	Noncompliance

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		Facility staff, community provider staff, or both.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Based on the sample reviewed, teams identified target dates for the completion of actions steps included in CLDPs, as well as the person responsible by name. This was evident in four out of four of the plans reviewed (100%).	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	From the sign-in sheets provided with the CLDPs that were reviewed, it appeared that teams consistently reviewed CLDPs with the individuals and their guardians prior to discharge. For three of the four plans reviewed (75%) sign-in sheets were provided that confirmed the presence of the individual and his/her guardian. For Individual #44, this could not be confirmed. Although it appeared that efforts were made to include as many team members as possible in the CLDP meetings, some key team members were missing at some of the meetings. For example, for Individual #268, Habilitation Therapies staff should have been present, but were not.	Noncompliance
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.	Based on the documented dates of assessments reviewed at the CLDP meetings, it appeared that assessments had been updated within 45 days. In order for this item to be in substantial compliance, however, some sort of checklist or tracking tool should be used that lists all required and optional (i.e., as needed depending upon the individual) assessments, so that PSTs and community providers can be assured that no relevant assessments are missing. The assessment documents for the four individuals for whom CLDPs were developed were reviewed. Although numerous assessments were included, it was not possible for the Monitoring Team to determine if these assessments represented the full set of assessments relevant for the individual.	Noncompliance
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-	The four CLDPs reviewed included essential and non-essential supports. However, as during the baseline review, it appeared that the Facility was still refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This made it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. In none of the four plans reviewed (0%) was a comprehensive set of essential and non-essential supports identified in measurable terms.	Noncompliance

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	essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The following provides only a few examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ For Individual #218, he had a behavior support plan, the implementation of which appeared to be essential in ensuring his success in the community. The CLDP indicated: "continue PBSP" as an essential support. However, no measurable supports were identified with regard to the oversight or updating of this plan. For example, the CLDP did not indicate that behavioral services needed to be provided. In the discussion section of his CLDP, a recommendation was made regarding the need to educate him about his rights and responsibilities related to pornographic materials. This recommendation was not specifically translated into a measurable essential or non-essential support. Although counseling services were identified as a non-essential support, the definition of what supports a counselor would provide were not articulated. As was illustrated in one of the post-move monitoring checklists, the issue of inappropriate use of pornographic materials had been a problem after Individual #218's transition to the community. ▪ Individual #237 had transitioned to the community in the late spring, and, a few weeks later returned to the Facility due to a series of behavioral incidents that led to his arrest. Due to a disappointment related to an expected recreational outing, Individual #237's behavior escalated to the point of his threatening staff with a knife. The police were called, and left the scene after Individual #237 became calm. However, his behavior escalated again after the police left, staff called them again, and he was later arrested. At the time of the review, it was unclear if charges were being pursued. In discussing this situation with staff, and reviewing the CLDP, a number of questions arose. Evidently, Individual #237 went on three visits to the potential home prior to his transition. Two of these ended in EMS being called, because he complained of chest pain. After the team talked with Individual #237, a third visit was attempted for which he brought a number of personal items with him to make him more comfortable. This visit was a success. Although it appeared that the team had discussed strategies to try to prevent him calling 911, these were not incorporated into the essential and non-essential components of the CLDP that was developed. Although staff recognized that he liked and needed a lot of staff attention and access to a nurse, the CLDP merely required "24 hour awake staff," and according to Facility staff, the ratio during awake hours was one staff to four individuals. The CLDP listed the continuation of his PBSP as an essential service, as well as follow-up with a psychologist. However, the level of availability and/or oversight of the psychologist was not defined. It did not appear that the individual required the use of restraint or protective holds frequently at the Facility. However, given his behavioral history, it was unclear why the team did not consider the need to include in his CLDP the need for staff to be trained on	

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		the use of physical holds should they be necessary. The State and the Facility should conduct a critical analysis of this individual's transition, including the factors related to address a crisis situation for this individual that resulted staff calling the police, and his subsequent arrest. ▪ Individual #44's CLDP in defining day/vocational support simply stated: "[Name of Provider] Day Hab." This did not define the types of supports and activities to be provided, the schedule, or staffing requirements necessary to adequately meet the individual's needs. As was demonstrated during the post-move monitoring visit that a member of the Monitoring Team attended, Individual #44 was not receiving adequate day supports. With regard to monitoring by the MRA or other means to ensure essential supports were in place prior to an individual's transition, the MRA was conducting a review. However, based on interview, the Post-Move Monitor and Admissions Placement Coordinator recognized that these were not adequate assessments. In an attempt to correct this deficiency, the Facility had developed a form entitled "Verification of Essential Supports and Services." However, this form was simply a sign-off by a provider representative and Facility representative of the statement: "We attest to the fact that the above essential supports and services are available prior to or at the time of the transition to the community." On the two forms reviewed, the essential supports were listed, but there was no description of the activities undertaken to confirm that the essential supports were in place or available.	
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.	Based on documentation provided, both the QE Department and Admissions Placement Coordinator were implementing checklists to evaluate the Facility's compliance with Section T of the SA. The checklists that were being at the time of the baseline review had been substituted for those that the Monitoring Teams had developed. As noted above with regard to Section E, the QE Department had begun to make some changes to the forms to facilitate the use of the forms at the Facility. This was positive and should continue. One of the issues the Admissions Placement Coordinator raised was with regard to sampling. As was discussed, in order to capture all of the indicators on the review tools, two different samples need to be drawn, including one for individuals who still live at the Facility, and the other for individuals who have moved. As is recommended with regard to Section E of the SA, in addition to developing instructions for the review tools, monitoring methodologies also need to be developed that define how samples are selected, the size of the samples, and the review techniques that will be utilized in conducting the reviews. At the time of the review, this monitoring process was fairly new. However, as is discussed with regard to Section E of the SA that addresses Quality Assurance, it was not clear that information being collected through monitoring processes was consistently	Noncompliance

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		being analyzed, and, as appropriate, plans being developed to address identified areas of need.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	Based on interview, the Facility had not yet been entering data with regard to obstacles into a database to allow it to be aggregated. As noted above, the obstacles that teams were identifying were not yet adequately defined. The Monitoring Team looks forward to reviewing such reports as part of future reviews. Based on interviews with staff, anecdotally, a number of potential obstacles to individuals receiving the supports they need in the community included: ▪ Many individuals who worked in the work center on campus might not have the same opportunity in the community. Although reportedly there were some work centers and other vocational opportunities in the community, these were limited, and many did not offer behavioral supports. As a result, when an individual engaged in a behavior considered to be inappropriate, they often would be discharged from the community work center or vocational program. ▪ Individuals who had received one-to-one staff at LBSSLC could not access a similar support in the community unless they were categorized as a Level 9 on the Inventory for Client and Agency Planning (ICAP), which was unusual. ▪ In the Lubbock area, it reportedly was difficult to identify a configuration of services and supports to meet the needs of individuals with complex medical needs. For example, providers generally had access to nursing staff, but many nursing tasks could be delegated to direct support professionals in the community, with the exception of tasks that required a judgment to be made. Examples of this would be checking for residuals for an individual who was fed by tube, or administering Diastat. This made it difficult to identify appropriate supports for individuals who needed more intense nursing services. Likewise, although therapy services were available in the community, the level of support and coordination provided by a PNMT was generally not available. It will be important as teams discuss potential community transition that if such obstacles impact individuals that these are clearly identified to provide the State with the information it needs to take appropriate steps to overcome such obstacles. As indicated in the SA, the State would need to take such steps subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Noncompliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of	In response to a document request, the Facility submitted to the Monitoring Team two Community Living Placement Report, one for the period between 7/1/09 and 2/28/10, and another for the period between 2/1/10 and 7/31/10. The reports listed individuals	Substantial Compliance

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	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 Report submitted pursuant to Section III.I.	who had been referred by their teams for community placement, including the individual's name, the date of referral, and, if applicable, the date the referral had been rescinded. Between the two lists, a total of 12 individuals had been referred between 7/1/09 and 7/31/10. The second page of the documents listed individuals who had been transitioned to the community during these time periods. These lists included a total of 10 individuals who had transitioned to the community. According to State Office staff, these reports also had been provided to the Department of Justice.	
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	Timeliness of Checklists: Post-move monitoring documentation was provided for six individuals. For these individuals, 16 reviews should have been completed. Of the 16 required visits, 14 (88%) had been documented as having been completed on time; and the remaining two (12%) were late or not provided (i.e., for Individual #177 for the eight-to-45 day monitoring, and Individual #237).	Noncompliance

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	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.	In addition, based on the documentation, it could not be determined if visits had been made to both the residential and day sites of the individuals. Often, the notes indicated that either one setting or the other was visited, but not both. In one situation, it appeared that the Post Move Monitor did not visit either the day program or the home, but met the individual at the MRA office (i.e., Individual #177 for the eight-to-45 day monitoring for which no monitoring form was completed, but notes provided). In order to adequately ensure that all essential and non-essential supports are in place, visits should be conducted in whatever settings protections, supports and services are being provided. <u>Content of Checklists</u>: With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. As discussed in the baseline review report, it would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews, and the information gathered with regard to each indicator. For example, it was unclear from the monitoring checklists if on-site visits were conducted, which documents were reviewed, and if staff and/or the individual was interviewed. Other than a "yes" or "no" response, no additional information was provided to substantiate that essential and non-essential supports were in place. The new format that was used for the monitoring visit report completed for the visit conducted for Individual #44 that a member of the Monitoring Team attended seemed to better capture this information. It had a column for evidence reviewed. The primary reasons for conducting post-move monitoring are to identify if all protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The Post Move Monitor had identified a number of issues as a result of the monitoring efforts. In a number of instances, it was clear that the Facility had used its best efforts to attempt to resolve the issues. However, in other instances, the documentation provided did not substantiate that adequate follow-up had occurred. The following provides some examples of where it appeared appropriate follow-up had occurred: ▪ Individual #177 was supposed to have a vision exam, but had not. The Post Move Monitor called the case manager who agreed to resolve the issue. ▪ During the 46-to-90-day monitoring for Individual #49, the Post Move Monitor identified a number of concerns. The ones for which appropriate follow-up appeared to have occurred were with regard to Individual #49's communication device not being functional, and her appearance being poor. The Post Move Monitor contacted the case manager and discussed these issues. Subsequently, there was documentation that case manager reported that staff had been provided in-service training on the communication device, because they had not been using it correctly, and training also had been provided regarding the need	

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		to assist Individual #49 with proper grooming. Other concerns are discussed below. The following provides some examples of situations in which it was not clear that the Facility had used its best efforts to ameliorate the issues identified: ▪ Individual #279's CLDP included a requirement that services be established with a psychiatrist. His 46-to-90-day monitoring, dated 4/5/10, indicated that the primary care physician was monitoring his psychotropic medication because "the provider cannot find a Psychiatrist who will accept Medicaid." His medication had been changed from Seroquel to Risperdal. No documentation was provided to show that there had been follow-up to ensure that the service of a psychiatrist that was listed as a non-essential support was made available to Individual #279. It appeared that Individual #279 returned to the Facility from the community in August 2010. ▪ Individual #177's CLDP indicated that she was to have "employment at" a specific work center. Notes related to her 30-day meeting, as well as notes from her 46-to-90-day monitoring indicated that they had no paid contracts. Although this did not equate to "employment," it did not appear from the documentation provided that action was taken to ensure Individual #177 had appropriate employment. ▪ Individual #49's CLDP included requirements that she be provided with a vision evaluation, dental evaluation, and mammogram. There was a note on the monitoring form dated 4/29/10, indicating that she was waiting for a dental appointment, and was on a waiting list because she needed sedation. There was no indication regarding follow-up related to the need for a vision exam and/or mammogram that had not been scheduled at the time of the last review the PMM conducted. ▪ With regard to Individual #110, a non-essential support was listed as "establish services with a psychiatrist by 5/30/10." As of the last visit the PMM conducted on 5/25/10, this had not occurred. No further follow-up was noted. His transition to the community had occurred on 2/26/10. ▪ Despite the requirement in the non-essential support section of Individual #218's CLDP that services be established with a psychiatrist, the community provider had not done so, and indicated that a referral would be made "by the counselor if needed." His PCP was managing his medication. From the documentation, it did not appear that this issue that was still an issue at the time of the last monitoring that the PMM completed was referred to the service coordinator/case manager, or to the regulatory entity. Other medical appointments had not been scheduled for Individual #218 within the timeframes set forth in the CLDP.	

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T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the on-site review, a member of the Monitoring Team accompanied the Post-Move Monitor on two post-move monitoring visits for Individual #44, one at her day program and one at her home. The Post-Move Monitor followed the format, asked many good questions, and conducted observations. An area in which additional review should have been completed was with regard to documentation review. For example, Individual #44's Community Living Discharge Plan required that staff "follow her PBSP as needed," and that she have a "chopped diet to ½ inch cubes." Individual #44 engaged in a number of behavioral incidents during the visit to her day program. However, the PMM did not ask to review behavioral data. With regard to observations, although the home visit was conducted specifically at a time when the PMM could observe a meal, the day program visit was not. The PMM asked a staff member at the day program to show her how big the food was chopped using her fingers. There appeared to be some discrepancy between what was prescribed on Individual #44's Dining Plan, and what staff were describing. However, without actually seeing the food, it was difficult to determine if her diet texture was being followed. It should be noted that the environment at the day program was quite chaotic, and little meaningful activity was being offered to any of the individuals, including Individual #44. As noted above, Individual #44 engaged in target behaviors during the visit, and it did not appear that her PBSP was being implemented appropriately. The Post Move Monitor and Admissions Placement Coordinator noted this, and verbally reported after the visit that they had made a call to the provider describing the concerns noted. Staff also pointed out that a number of individuals who were at the day program were individuals who had been transitioned from the Facility into work programs. However, due to behavioral issues, they had been terminated from those programs and were now attending the day habilitation program that did not offer vocational options. It is important to note that the concerns identified above with regard to the continuing need for the depth and quality of CLDPs to be improved will affect the level of monitoring that will be required. As CLDPs are improved, and there are additional measurable services, supports, and protections included in the plans, the expectations for the Post-Move Monitor will increase. At this juncture, the plans included few, if any requirements, regarding the implementation of plans, for example, Behavior Support Plans, Physical and Nutritional Support Plans, etc. As is noted above, it is essential that modifications be made to the CLDPs to ensure they include comprehensive and measurable definitions of the protections, services and supports provided. This will require the Post-Move Monitor to conduct many more observations of, for example, meal times, and will require much more extensive review of data, such as behavioral data, data related to PNMPs, interviews with direct support professionals to ensure their understanding of such supports, etc.	Noncompliance

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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.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days;	Since 7/1/09 and the time of the review, there had been no alternate discharges of individuals served by the Facility. There were two individuals who were discharged to other SSLCs. These do not meet the definition of "alternate discharge" per the Settlement Agreement. As a result of no alternate discharges having occurred, this component of the SA was not rated.	Not Rated

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	(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: The following recommendations are offered for consideration by the State and the Facility:

1. The professional teams supporting individuals at LBSSLC should make independent recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.
2. LBSSLC's Continuity of Care: Community Placement policy should be reviewed, and revised, as appropriate to be consistent with the SA and State policy.
3. The Facility is encouraged to continue to offer a variety of educational opportunities with regard to community options to ensure that individuals and their guardians make informed decisions regarding movement to the community. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
4. Plans should be implemented to begin the process of developing the CLDP much sooner in the transition process to ensure that a comprehensive plan is developed, and that there is time to implement an adequate transition process.
5. Plans should move forward to identify essential and non-essential supports as a standard part of developing annual PSPs. In addition to the resulting documents being helpful to direct support professionals and others at LBSSLC, it would begin this process much earlier for individuals who eventually transition to the community.
6. Essential and non-essential supports should be better defined in Community Living Discharge Plans. Likewise, the role of the Facility staff in the transition and discharge process should be better defined.
7. Teams should be provided with additional competency-based training on the identification of obstacles to movement of individuals to the most integrated setting appropriate to their needs and preferences. Such obstacles should be defined in terms of protections, services, and supports that currently are lacking or not available in the community. Obstacles also should be defined with sufficient detail to allow the State to identify and address issues related to the current community system. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, the timeliness with which services can be accessed in the community (e.g., certain types of medical services) might be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes.
8. Likewise when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the State.
9. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based.

10. The State and Facility should conduct critical analyses of the transition planning and implementation processes for any individuals who return to the Facility, who require more restrictive levels of placement from their community setting (e.g., are transferred to a mental health hospital after transitioning to the community), or whose community transitions are in jeopardy.
11. A checklist or tracking tool should be developed and used that lists all required and optional (i.e., as needed depending upon the individual) assessments, so that PSTs and community providers can be assured that no relevant assessments are missing.
12. Whether the Facility is going to assume responsibility or the MRAs are going to continue to be responsible for ensuring that essential supports are in place before the individual departs from the Facility, then the process for confirming this needs to be substantially improved. As required by the Settlement Agreement, the State needs to ensure that supports considered to be essential to the individual's health and safety are verified as being present. This will require more than conversations with staff, but will entail onsite monitoring, review of documentation, observations, as well as interview. Documentation should include verification of each and every essential support identified in the CLDP, as well as the methodology used to verify their existence.
13. With regard to Post-Move Monitoring, clear expectations should be established with regard to the process that needs to be used for monitoring, and the documentation that needs to be maintained.
14. Post-Move Monitoring Checklists should include: 1) a description of the monitoring methodology (e.g., documents reviewed, people interviewed, observations made); and 2) information to substantiate conclusions that essential and non-essential supports are in place, and/or steps being taken by the provider agency to ensure that such supports and services are provided.
15. Staff responsible for the completion of post-move monitoring activities should complete competency based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified.
16. With regard to monitoring activities, the Facility should:
    a. As is recommended with regard to Section E of the SA, in addition to developing instructions for the review tools, monitoring methodologies also need to be developed that define how samples are selected, the size of the samples, and the review techniques that will be utilized in conducting the reviews. In order to capture all of the indicators on the review tools for Section T, two different samples need to be drawn, including one for individuals who still live at the Facility, and the other for individuals who have moved. It might be beneficial to further divide the tools to capture activities that need to occur for all individuals at the Facility, and those that pertain to individuals who are in the transition process; and
    b. Analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 591. General Provisions, Subchapter A. General Provisions, Section 591.006. Consent; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle B. State Facilities, Chapter 551. General Provisions, Subchapter C. Powers and Duties Relating to Patient Care, Section 551.041. Medical and Dental Care; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 592. Rights of Persons with Mental Retardation, Subchapter A. General Provisions, Section 592.054. Duties of Superintendent or Director; o LBSSLC Final prioritized list of those persons needing guardians based on information obtained from the QMRPs, revised 8/10/10; o Statement in response to record request number TX-LB-1009-XVII.1; o Statement in response to record request number TX-LB-1009-XVII.3; o Statement in response to record request number TX-LB-1009-XVII.4; o List of individuals for whom an Legally Authorized Representative (LAR) has been obtained since January 1, 2010; o Contact Log regarding guardianship from 3/1/10 through 9/6/10; o Presentation Book for Section U of the SA; o Four (4) completed monitoring forms for Section U of the SA completed in July and August 2010; o Handouts entitled “Why Guardianship?”; o LSS – Rights: Informed Consent for Treatment/Procedure, revised 11/30/06; o Description of outreach activities related to identifying potential guardians; o Guardianship Attorney List, dated 3/8/10; and o “Families Must Become Guardians” from the Parent Association for the Retarded of Texas, copyright 2007 ▪ **Interviews with**: o Carla Prell, Admissions/Placement Coordinator; and o Annette Webster, Post-Move Monitor and Guardianship Coordinator
	Facility Self-Assessment: The Facility self-assessment showed that it continued to be in noncompliance with most of the requirements of Section U of the SA. This was consistent with the findings of the Monitoring Team. The only inconsistency was that the Facility found itself in compliance with the indicators related to the Facility maintaining a list of individuals who “lack both functional capacity to render a decision regarding the individual’s health or welfare and an LAR to render such a decision,” and to

	update the list semi-annually. Although the Facility has a list, and continues to update it, the Facility's response to the document request, as well as the Monitoring Team's review of individuals' PSPs showed that no process was in place to determine an individual's "functional capacity to render a decision." The Facility also indicated it was waiting for State Office to provide guidance on the prioritization process. Until such a processes are in place, it remains unclear whether the list is accurate. The Facility had begun to monitor compliance with it compliance with Section U of the SA. It was using a monitoring tool based off of the Monitoring Teams' review protocol. It appeared from review of the samples provided that there were some issues related to entry of data into the spreadsheet. Specifically, the scores obtained appeared inaccurate due to data being entered that was not consistent with the formulas embedded in the spreadsheet.
	Summary of Monitor's Assessment: At the time of the review, DADS State Office was still in the process of finalizing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. LBSSLC indicated that there "was not any instrument or process to determine functional capacity," or "any instruments or processes used to prioritize the needs of individuals" for guardians. It was anticipated that the State Office policy would provide guidance with regard to these issues. LBSSLC had continued to update a prioritized list of individuals needing guardians based on information obtained from the QMRPs. This list included names of 114 individuals served by LBSSLC. At the time of the review, Lubbock supported 229 individuals, of whom approximately half needed guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined or how individuals had been prioritized, this was a good initial step. LBSSLC had taken a number of steps to attempt to identify guardians for individuals whose teams had identified a need for a guardian. One of the most promising possibilities was a newly formed relationship between LBSSLC staff and community groups who also had a need to assist in identifying guardians for individuals who lived in the community. It was hoped that by coordinating with one another, potential guardians might be found for each group. For example, many staff at LBSSLC were interested in becoming guardians, but could not be guardians for individuals living there, but potentially could become guardians for individuals living in community settings. Likewise, it was anticipated that community-based staff might be a potential guardian pool for individuals living at LBSSLC.

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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	At the time of the review, DADS State Office was still in the process of finalizing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. In a document produced with regard to the pre-review document request (number TX-LB-1009-XVII.3), LBSSLC indicated that there "was not any instrument or process to determine functional	Noncompliance

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	individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	capacity," or "any instruments or processes used to prioritize the needs of individuals" for guardians. It was anticipated that the State Office policy would provide guidance with regard to these issues. As reported after the baseline review, LBSSLC did not have a specific guardianship policy, but had policies that referenced guardianship and/or consent, including: LSS – Rights: Informed Consent for Treatment/Procedure, revised 11/30/06; and LSS – Rights: Rights of Persons Served, revised 1/17/08. None of these provided a description of the processes to be used for: 1) determining an individual's capacity to make informed decisions; or 2) identifying an individual's level of priority for pursuing guardianship. In the absence of a State policy, the Facility had developed a list of factors to be used in determining priority on the list of individuals whose teams had identified a need for guardianship. These included factors consistent with the Settlement Agreement, including the use of a Safety Plan or PBSP, the use of psychoactive medication, as well as the individual's potential guardianship resources. Issues such as the frequency of the need for guardianship, or the individual's ability to make their wishes known, did not appear to be included. LBSSLC had a prioritized list of individuals needing guardians based on information obtained from the QMRPs. This list had been revised several times, with the last revision, at the time of the review, being on 8/10/10. This list included names of 114 individuals served by LBSSLC. At the time of the review, Lubbock supported approximately 229 individuals, of whom approximately half needed guardians. The Facility developed this list without the benefit of a State policy on this subject. As noted above, the Facility did not yet have a formal process in place for determining the need for guardianship by assessing an individual's functional capacity to make decisions. In addition, the prioritization of the need for guardianship did not include all of the factors required by the SA. Once the State policy is issued, the Facility may need to reconsider the prioritization of individuals on the list. The Facility should be commended, though, for the effort it undertook to identify individuals needing guardians, and attempting to prioritize the list.	
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	According to a list provided by the Facility, since 1/1/10, guardians had been identified for a total of six individuals. As noted above, the list provided by the Facility showed that a total of 114 individuals of the 229 individuals served by the Facility (50%) had been identified as needing guardians. Based on staff interview as well as review of a contact log listing attempts that had been	Noncompliance

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	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.	made to obtain guardians for individuals, a number of actions continued to be implemented to try to identify potential resources for guardians, as well as funding to pay for the guardianship process. One of the most promising possibilities was a newly formed relationship between LBSSLC staff and community groups who also had a need to assist in identifying guardians for individuals who lived in the community. At the time of the review, a "brainstorming" session was being scheduled for the end of September. It was expected that in addition to staff from LBSSLC, staff from the local MRA and DADS would attend, as well as representatives from LBSSLC's parent association. It was hoped that by LBSSLC and the local MRA coordinating with one another, potential guardians might be found for individuals at LBSSLC as well as those living in community settings. For example, many staff at LBSSLC were interested in becoming guardians, but could not be guardians for individuals living there, but potentially could become guardians for individuals living in community settings. Likewise, it was anticipated that community-based staff might be a potential guardian pool for individuals living at LBSSLC. The group planned to share information about other possible guardianship resources. This is a very creative way of addressing the lack of guardianship resources. The Facility is encouraged to continue to pursue these opportunities. A local private guardianship association was also expected to attend the brainstorming section to present information about what his company was able to offer. This organization was a for-profit agency, and although the agency's representative indicated there would be no cost for guardianship services, it was unclear how this would be accomplished. It also was unclear what model of guardianship the agency used, and/or if it would meet the needs of the individuals at LBSSLC. The following provides some additional examples of efforts that staff had undertaken to identify new guardianship resources, as well as to maintain individuals' current guardians: ▪ A letter was sent out to families and correspondents of individuals who need guardians with a handout that explained why guardianship is important; ▪ When asked, Facility staff assisted current guardians in completing annual reports necessary for them to maintain guardianship; ▪ As reported in the baseline report, numerous groups and individuals had been approached to determine their interest in identifying people to become guardians. For example, those contacted included an attorney at Texas Tech School of Law, the Director of Special Education for the local school district, a local autism network, and a local law clinic. Unfortunately, for various reasons, these had not materialized. ▪ On an annual basis, and most recently on 9/13/09, Facility staff made a	

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		presentation at a Family Association Meeting. Materials regarding guardianship were provided. In addition, staff sent a letter to all current guardians and correspondents asking about interest in becoming a guardian for someone else living at LBSSLC. No interest was generated from this letter. A couple of legal resources had been identified that could be used if a person was identified who wanted to become a guardian, but needed assistance with the cost of the initial legal process. These included private attorneys, and a local law clinic. The Facility was maintaining a contact log documenting any attempts made to identify a guardian for the individuals on the prioritized list. At times, these attempts included trying to work with family members or correspondents to become the guardian for the individual, or being in touch with inactive guardians. At the baseline review, one of the questions staff raised was if or how information about an individual whom the team had determined was not able to make informed decisions could be shared with a potential guardian, while ensuring compliance with the Health Insurance Portability and Accountability Act, as well as other federal and state privacy laws. As was discussed with the State's attorney during the most recent on-site review, the State should provide LBSSLC, as well as the other SSLCs, with guidance regarding this question. The Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that would be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, and/or investigators may be appointed to assist the court in evaluating the need for guardianship as well as the type of guardianship needed. In addition, it appeared that it was possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings included family members, as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs and preferences, teams could potentially provide valuable information both in terms of written reports as well as verbal information regarding individuals who become the subject of guardianship proceedings. As the State finalizes its policy on consent and guardianship, it should define the potential roles of SSLC staff in the process.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The State should finalize the state policy on guardianship and consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies alternatives to guardianship, including potential supports or resources that would either allow an individual to make informed decisions or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.);
    c. A standard tool/process for identifying priority with regard to the need for guardianship; and
    d. Definition of the role of State and Facility staff in the guardianship process, including potentially completing assessments for use in guardianship proceedings, participating in guardianship proceedings, and assisting in the identification of potential guardians for consideration by the Court.
2. The State should provide the Facility(ies) with guidance regarding if or how information about an individual whom the team has determined is not able to make informed decisions can be shared with a potential guardian, while ensuring compliance with the Health Insurance Portability and Accountability Act, as well as other federal and state privacy laws.
3. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.
4. Once the State policy is finalized, LBSSLC should develop/modify its policy on guardianship to reflect the State policy.
5. Based on any additional information provided in State policy regarding determination of an individual's capacity to make decisions and the prioritization for guardianship, LBSSLC should review the list that identifies individuals who need the support of a guardian, and re-constitute the list, as needed.
6. LBSSLC should continue its diligent efforts to identify potential resources for guardians, as well as funding for the guardianship process. The Facility is particularly encouraged to continue to partner with the local MRA to identify potential guardianship resources.
7. The State should consider seeking or providing funding for a guardianship program in the Lubbock area that would be responsible for the identification, training, and oversight of guardians, such as those programs that are available in other parts of the state.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS policy #020 entitled "Recordkeeping", dated 9/28/09; o LBSSLC Communication Process: Recordkeeping, revised 8/9/10; o List of Persons Responsible for Record Maintenance; o Presentation Book for Section U; and o Various individuals' records. ▪ **Interviews with**: o Cheryl Lutzen, Unified Records Clerk; o Martha Castillo, Lead File Clerk; and o Dawn Ripley, Director of Quality Enhancement.
	Facility Self-Assessment: The POI indicated that the Facility was not in compliance with any of the requirements of Section V of the SA. This was consistent with the findings of the Monitoring Team. As noted below, though, substantial progress had been made including with regard to the conversion of records to the new Table of Contents (TOC). Further refinement the auditing process, including the analysis of information and development and implementation of corrective action plans, is necessary to ensure that the Facility is able to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: Significant progress had been made in converting the active records to the new Table of Contents required by the State Office. At the time of the review, all but three homes on campus had been converted. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department and the Clerks assigned to the Units. Since the baseline review, a process had been revitalized requiring review of policies prior to their finalization. It required that policies be sent to the leadership group for review. The group reviewed any draft policies to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements. Audits were being completed of records. No action plans had been developed yet to address issues related to records. Less formally, steps had been taken to address issues that had been identified in records. For example, emails were being sent requesting that issues identified be corrected. As illustrated in this report, a number of issues negatively impacting the quality and availability of records needed to be addressed through the development and implementation of action plans.

#	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.	A review of the LBSSLC policy on recordkeeping, revised in 8/9/10, revealed that it was consistent with the DADS policy on record keeping, and Appendix D of the Settlement Agreement. Staff reported that on 8/9/10, an in-service training on the new record guidelines was held that included the Department Heads and Unit Managers. The conversion of records then began. As of July 2010, one Unified Records Clerk, a Lead File Clerk, and four File Clerks were assigned to the Quality Enhancement division. Their primary responsibilities related to the maintenance of records. At the time of the review, the Facility had converted the records in alignment with the Guidelines in all but three homes (525, 526, and 528). The records consisted of an Active Record, a Master Record, and an individual notebook, known as the "All About Me" books. It was anticipated that within approximately three weeks of the on-site review that the records would all be converted to the new format. However, in reviewing records onsite, it was noted that a number of documents were not in the medical records, and had to be obtained from the units. This was consistent with the findings during the baseline review. For example: ▪ A number of Nursing Quarterly Assessments, Nursing Annual Assessments, Nursing Care Plans, and Hospital Liaison Nurse's notes were not found in the records. As was discussed above with regard to Section M.1 of the SA, a review of the 16 cases of individuals found that the documentation from the Hospital Liaison Nurse was present in only one (for Individual #41) of the 16 records reviewed. LBSSLC's Supplemental POI indicated that the hospital liaison would be documenting daily progress notes for individuals in the hospital, and that these notes would be placed in a shared drive and printed by the Case Managers and submitted for filing by 12/30/10. Clearly, this documentation is important for continuity of care and to keep the individuals' PSTs apprised of their status to enable the team to coordinate the needed services in preparation for the individuals' return to the Facility. ▪ As also noted above with regard to Section M.1 of the SA, in interviews with the CNE, QE Nurse, and other nursing staff indicated that the Facility had locked "chart boxes" in each building where information was placed for filing in the medical records. However, all nursing staff that were spoken to reported that often times the filing was not completed in a timely manner, and that when the staff needed a document that was placed in one of the chart box, they have to flip the box over and shake the contents out to be able to retrieve the needed information. Although having consistency regarding where the contents of the medical records are kept is essential, having all the appropriate documents timely filed in the medical records is crucial. The Facility needs to ensure that	Noncompliance

#	Provision	Assessment of Status	Compliance
		documents are filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. With regard to the security of the records, one issue identified related to the destruction of records. As reported by the records management staff, documents ready for destruction were sent to the work center on campus. It did not appear that all of the materials being shredded at the work center were done so in a manner that adequately protected individuals' health information. In other words, the text remained legible. This issue should be reviewed to ensure that the confidentiality of the individuals LBSSLC serves is protected.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development. On a positive note, a group had been revitalized to review policies as they were drafted. At the time of the review, the group was meeting approximately two times a month. The group included the Director of the Facility, the Assistant Directors for Programs and Administration, the Director of QE, and various department heads. The group reviewed any draft policies to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements. As appropriate, the group made recommendations to the policies' authors, and approval for policies was provided when all recommendations had been addressed. This process should be very helpful as the Facility moves through the process of finalizing the many policies currently under development or revision.	Noncompliance
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	At the time of the review, the Lead File Clerk was responsible for completing 20 record audits per month. The Unified Records Clerk subsequently completed a review of a sample of five of these 20 records using the same monitoring tool. The information was then used to respond to the questions on a different monitoring tool. The Facility was in the process of converting from use of the audit form they had been using to conduct these reviews that reflected the Chart Maintenance Guidelines to a newer form. The newer form was designed to address all of the requirements of the SA with regard to recordkeeping. Reportedly, these reviews had identified some issues. Staff indicated that when issues were identified, the Lead File Clerk fixed them or asked that they be addressed. To facilitate this process, emails were being sent requesting specific corrections. However, at the time of the review, information regarding the reviews was not being analyzed, and	Noncompliance

#	Provision	Assessment of Status	Compliance
	review to ensure that adequate corrective action is taken to limit possible reoccurrence.	action plans had not been developed or implemented to address identified issues. As is illustrated in this report, there were issues related to records that were negatively impacting the delivery and coordination of supports and services. Corrective action plans should be developed and implemented to address these issues.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	During the review, the following issues were noted with regard to the availability and quality of the records, and the impact on the ability of staff to utilize records in making medical treatment and training decisions: ▪ As was discussed in greater detail with regard to Section M.1 of the SA, Individual #253 was seen at the Clinic and the physician's note indicated that the individual had a "croupy cough x unknown number of days. Staff and nurse accompanying patient to medical clinic unable to give any history. Patient's chart not available." The physician further documented: "Went to home and reviewed patient's chart. Apparently had an episode of emesis on (date). Probably aspiration pneumonia." Although subsequent physicians' notes indicated that the individual was sent and admitted to the hospital for two days, no nurses' notes were found documenting the individual's transfer to the hospital. Both the unavailability of the individual's record, as well as the lack of adequate documentation in the record had the ability to delay or otherwise compromise adequate treatment of the individual. ▪ Legibility was sometimes an issue. For example, all of the entries in the dental progress note/treatment record were hand written, and there were many abbreviations. Despite a list of abbreviations provided by the Dental Department, it was difficult to determine the meaning of some of the notes due to legibility and due to use of abbreviations not on the list. It is recommended that the dentist have dictation and transcription services which would both provide a document that can be read by all departments and does not rely so heavily on abbreviations, but also provide better use of the dentist's time in his daily schedule.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures.
2. Monitoring of records should result in action steps/plans to address individual as well as systemic issues as they are identified.
3. The Facility should ensure that documents are timely filed in the medical and programmatic records, so that pertinent clinical information is readily available to clinicians and others needing this information when making decisions regarding treatments and health care services. The Facility should determine if adequate staff supports are currently available to ensure the timely filing of records.
4. A corrective action plan(s) should be developed and implemented to address the issues negatively impacting the quality and availability of records.

5. The quality of the shredding completed on campus should be reviewed to ensure that individuals' protected health information is adequately protected, and their confidentiality maintained.

List of Acronyms

Acronym/ Symbol	Meaning
°	Degrees
≥	Greater than or equal to
≤	Less than or equal to
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ADA	American Dental Association
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
ANA	American Nurses Association
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ART	Administrative Review Team
AT	Alternative Technology
ATC	Active Treatment Coordinators
BCABA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BCBA-D	Doctoral-level Board Certified Behavior Analyst
BID	Twice a Day
BM	Bowel Movement
BMI	Body Mass Index
BP	Blood Pressure
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BUN	Blood Urea Nitrogen
CBC	Complete Blood Count
cc	Cubic Centimeter
CCC	Certificate of Clinical Competence
C-Diff	Clostridium difficile
CFA	Comprehensive Functional Assessment
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid
CNE	Chief Nursing Executive

COTA	Certified Occupational Therapy Assistant
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed tomography
CTD	Competency Training and Development
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Data, Assessment, and Plan
DART	Data, Action, Response and Treatment
DEXA	Dual Energy X-ray Absorptiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DRR	Drug Regimen Reviews
DSM	Diagnostic and Statistical Manual
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DWR	Desired Weight Range
E. coli	Escherichia coli
EEG	Electroencephalogram
EGDs	Esophagogaastroduodenoscopies
EIRS	Estacado Industries Residential Services
EIWS	Estacado Industries Workshop
EMS	Emergency Medical Services
ENT	Ear, Nose and Throat
ER	Emergency Room
F	Fahrenheit
FA	Functional Analysis
FAST	Functional Analysis Screening Tool
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
gm	Grams
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
HSM	Health Status Meeting
HST	Health Status Team
HT	Habilitation Therapies
IC	Infection Control

ICAP	Inventory for Client and Agency Planning
ICD	International Classification of Diseases
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
ID/DD	Intellectual Disability/Developmental Disability
IDT	Interdisciplinary Team
IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
INR	International Normalized Ratio
IOA	Inter-observer Agreement
IPN	Integrated Progress Notes
IQ	Intelligence Quotient
ISP	Individual Support Plan
IV	Intravenous
J-tube	Jejunostomy Tube
KUB	X-ray of abdomen
LAR	Legally Authorized Representative
LBSSLC	Lubbock State Supported Living Center
LODR	Living Options Discussion Record
LSS	Lubbock State School
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MAS	Motivation Assessment Tool
MBS(S)	Modified Barium Swallow Study
mcg	Micrograms
MD	Medical Doctor
mg	Milligrams
MH	Mental Health
MHMR	Mental Health/Mental Retardation
MICU	Medical Intensive Care Unit
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MTC	Mealtime Coordinator
Na	Sodium
NEO	New Employee Orientation
NM	Nutritional Management
NMT	Nutritional Management Team

NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OIG	Office of Inspector General
ORSA	Oxacillin Resistant Staph aureus
OT(R)	Occupational Therapist
P&T	Pharmacy and Therapeutics (Committee)
PA	Physician Assistant
PALS	Positive Assessment of Living Skills
PBSP	Positive Behavior Support Plan
PCP	Primary Care Provider
PEG	Percutaneous Endoscopic Gastrostomy
PFW	Personal Focus Worksheet
PMAB	Prevention and Management of Aggressive Behavior
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical Nutritional Management Team
PO	By mouth
PP	Permanency Plan
PPD	Purified Protein Derivative
PRN	Pro re nata (as needed)
PROM	Passive Range of Motion
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapist
PTA	Physical Therapist Assistant
PFW	Personal Focus Worksheet
QA	Quality Assurance
QAM	Every morning
QDRR	Quarterly Drug Regimen Reviews
QE	Quality Enhancement
QID	Four times a day
QMRP	Qualified Mental Retardation Professional
RC	Residential Coordinator
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RWR	Recommended Weight Range
SA	Settlement Agreement in U.S. v. Texas
SAMS	Self-Administration of Medications
SAP	Skill Acquisition Plan

SFAR	Structural Functional Assessment Report
SFBA	Structural and Functional Behavior Assessment
SGA	Second-generation Antipsychotic
SGD	Speech Generating Device
SIB	Self-Injurious Behavior
SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment and Plan
s/p	Status Post
SPCI	Safety Plans for Crisis Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
STAT	Immediately or Without Delay
STD	Sexually-transmitted disease
TID	Three times a day
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
URI	Unusual Incident Report
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulators
VOCA	Voice Output Communication Aide
VPA	Valproic Acid
WNL	Within Normal Limits