United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

Dates of Review: March 28, 2011 through April 1, 2011

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Submitted By: Maria Laurence, MPA, Monitor

Monitoring Team: Patrick Heick, Ph.D., BCBA-D
Victoria Lund, Ph.D., MSN, ARNP, BC
Edwin J. Mikkelsen, MD
Elizabeth Jones, MS
Nancy Waglow, MS, MEd
Wayne Zwick, MD

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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 LBSSLC, 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 March 28, 2011, 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 non-compliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(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. The recommendation sections for some provisions include a subsection of additional suggestions for the Facility. These are presented in an effort to assist the Facility in prioritizing activities as the Facility staff work towards achieving substantial compliance with the provision.

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

During this most recent review, it was clear that the staff at LBSSLC had taken many steps to address issues that had been identified during the baseline review, as well as the first compliance review, and to comply with the Settlement Agreement. The Monitoring Team was struck by a renewed sense of teamwork, and an excitement across campus about the positive changes that were occurring. Notable progress had been made in a number of areas, and a number of initiatives were underway to continue to expand these improvements. In talking with staff, consistent themes were that the management team was responsive to staff's requests to obtain resources and materials needed to support individuals, and that, in many cases, departments across campus were working together to address issues. It also should be noted that LBSSLC was involved in many pilot projects, which were helping to improve processes at the Facility, but also helping to shape practice across all of the SSLCs.

The team at LBSSLC recognized that it still had significant work ahead to comply fully with the Settlement Agreement, and, most importantly, to improve the protections, supports, and services being offered to individuals living at the Facility. One of the major challenges continued to be stabilizing the direct support professional workforce, and ensuring that these staff were competent in all of the many areas in which their provision of supports and services directly impacted the individuals the Facility served. The Management Team was very aware of this need, and viewed it as a priority. The Monitoring Team encourages the Facility to continue to approach the many challenges ahead through a team approach, and with the same energy and commitment that have resulted in the many successes thus far.

As with previous reviews, 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.

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

<u>Restraints</u>

- The Monitoring Team continued to commend the Director of Behavioral Services and the psychologists working under his supervision for their diligent efforts to reduce the use of restraint at the Facility. Reportedly, their task had become more difficult with the admission of individuals who had intense behavioral and psychiatric needs.

- The policies at LBSSLC clearly stated the limitations for restraint use at the Facility, including a prohibition on prone restraint. Based on a review of a sample of records, prone restraint and mechanical restraint were not utilized at LBSSLC.
- The new PSP Addendum will likely promote more comprehensive review and documentation by the PST in regard to examining potential precipitating factors and/or underlying functions of target behaviors leading to restraint. These changes appeared to be thoughtfully implemented with direct mentoring support and feedback from the Director of Behavioral Services. This new process was likely facilitated by the use of a new rubric completed to ensure adequate PST examination and discussion regarding restraints.

Abuse, Neglect and Incident Management

- The strong leadership team at LBSSLC with its clearly articulated commitment to eliminating abuse, neglect, and exploitation was to be commended. There were important foundational elements in place that contributed to this goal. The Incident Management Review Team was cohesive and knowledgeable, the staff with investigative and risk management responsibilities were experienced and vigilant, there was a focus on strengthening the skills of the workforce, and there was a heightened sense of energy and purpose.
- There were positive developments in the documentation and analysis of unusual incidents. However, consistent efforts should continue to ensure timely reporting and the completion of investigations within the requisite timeframe.
- The evidence documented by the videotaping of the common areas underscored that there continued to be risk related to abuse and neglect in this environment. As a result, in order to ensure protection from harm, recruitment, training, and supervision of qualified and well-motivated staff should continue to be prioritized.

Quality Assurance

- Based on a review of the minutes of the Quality Assurance/Quality Improvement (QA/QI) Council as well as the Monitoring Team's observation of a Council meeting during the onsite review, progress was being made in the Council's development. The meetings were being held consistently. The agendas focused on new developments at both the State and Facility levels, as well as on the discrete areas of monitoring required by the Settlement Agreement. The minutes between the time the QA/QI Council was established in October 2010, and the time of the Monitoring Team's review showed increasing use of data and analysis of that data to identify and begin to address areas needing improvement.
- The Safety Committee was observed to be working diligently to analyze data about injuries. The efforts of the Director of Behavioral Services and other staff to monitor the use of restraint, and to reduce the incidence of pica behavior demonstrated an impressive level of attention to quality assurance processes.

Integrated Protections, Services, Treatments and Supports

- Since the previous review, LBSSLC had worked with the DADS State Office to provide facilitation training to the QMRPs to assist them in conducting team meetings, and in ensuring that the PST process was person-centered. This was a positive development, as well as the implementation of the Facilitation Checklist. This checklist could

be used as the basis for the development of a competency-based checklist and policy/procedure with regard to meeting facilitation.

- On 3/15/11, a PSP monitoring group was established. The reported goal of the group was to support teams with coaching, training, and feedback on integration of the PSP and risk process. At the time of the onsite review, this process was fairly new. A total of six observations had been completed, and two meetings had been held to discuss the weekly observations. As described with regard to Section I of the Settlement Agreement, the Facility was at the beginning stages of implementing the new at-risk process, and some teams were struggling. This initiative was a very positive one, and the Monitoring Team looks forward to reviewing the results during the next review.

Integrated Clinical Services

- The Facility was in the early stages of developing integrated systems that will enhance the lives of the individuals residing at LBSSLC. There were several forums where integrated services had the potential to have great impact on the individuals, the staff, and the Facility. For example, morning medical meetings were being held, and a Pica Committee and a Dental Desensitization Committee had been formed to address these issues. With continued efforts, these groups should assist the Facility in achieving positive outcomes for individuals.

Minimum Common Elements of Clinical Care

- Medical diagnoses that were made appeared to have excellent clinical justification recorded in the medical record.

At-Risk Individuals

- In January 2011, LBSSLC had implemented the new risk system and State policy regarding At-Risk Individuals. The policy included Risk Guidelines, which were specific criteria to assist teams during individuals' PSP meetings to determine the appropriate risk levels for each risk indicator. To ensure that all individuals had been screened for their at-risk status, and plans developed to address risks by the end of May 2011, a number of PSP addendum meetings were being held.
- The Facility was methodically completing the risk rating process. Overall, in observing a number of meetings while onsite, the Monitoring Team noted improvements in the clinical discussions and the use of supporting clinical data when the PSTs were determining the risks levels. However, the quality of the results of this process was dependent on each member being prepared to contribute his or her area of expertise, for the teams to work in an integrated fashion to develop new solutions to address areas of risk identified, for critical reviews to occur of the actions taken and their results, and for teams to aggressively pursue additional options when risks factors were not ameliorated, or reduced, to the extent possible.

Psychiatric Care and Services

- Area where some progress had been made related to the identification of the symptoms that support the psychiatric diagnosis of record, and the delineation of the derivation of the target symptoms of the psychotropic medications with regard to whether they are related to a biologically-based psychiatric disorder, or are

precipitated by environmental and/or behavioral factors. Although the Facility was at the beginning stages of this process, there had been concerted efforts to attempt to make improvements for a number of individuals.

- The Facility had made incremental progress in the area of polypharmacy. The statistics tracking polypharmacy dated back several years, and the longitudinal perspective this information provided was quite helpful.
- During the onsite review, the Psychiatric Reviews of four newly-admitted individuals were observed, and it was clear that the teams had already begun to formulate strategies to begin to carefully reduce medications that might be unnecessary. The Monitoring Team has raised the possibility of separately tracking the polypharmacy related to individuals who were admitted from the community, because their pharmacological regimens skewed the Facility's polypharmacy statistics in a negative manner. It also might provide the State with important information about psychiatric supports currently available to individuals with Intellectual/Developmental Disabilities (IDD) in the community.
- The Neurology Clinic was observed during the onsite review, and an active dialogue was noted between the Neurologist, the Psychiatrist, and the PCP.

Psychological Care and Services

- Progress had been made with Psychological Services since the previous monitoring visit. An additional BCBA was hired within behavior services, and eight of the nine current psychologists had completed previous classes and were enrolled in Spring 2011 coursework. The majority of staff taking classes also had begun necessary supervision. One staff member had completed all coursework and supervision, and was expected to take the exam in April 2011.
- Progress had been made in the area of data collection and monitoring of Positive Behavior Support Plans (PBSPs). That is, a new data management system had been developed allowing weekly data monitoring, as well as more standardization across graphs. Improvement in the monitoring and graphing of replacement behavior also was noted. Specific guidelines are needed to identify the nature of data display (when and where to include).
- Structural and Functional Assessment Reports (SFARs) continued to be an area of strength within psychological services. Substantial progress had been made in the format, content, and quality of the SFARs. Progress in developing a system to update standardized tests of intelligence and adaptive behavior also had been made.

Medical Care

- Emergency treatment appeared to be appropriate and timely.
- With regard to the neurology consultations reviewed, the quality of care and completeness of documentation was appropriate and consistent throughout the clinic reports.
- The system of clinical death review and administrative death review was efficient and timely. There were no outstanding deaths to review except the most recent cases. All individuals appeared to have been provided quality medical care.

Nursing Care

- Since the last review, the Facility had maintained a fill-rate of 89% of their total nursing positions. The Facility's extraordinary efforts and strategies were effective in maintaining consistent nursing staff, which ultimately should result in positive clinical outcomes for the individuals residing at LBSSLC.
- Of significant importance, in response to the Monitoring Team's consistent past findings indicating problems regarding nursing competency regarding assessments, in March 2011, the State developed and implemented a competency-based pilot training program at LBSSLC, addressing physical assessment skills, utilizing Nurse Practitioners with development disabilities experience. At the time of the review, the training program recently had been conducted, and had focused on training the RN Case Managers and Nurse Educators. The competency-based training program that the State Office had initiated was a very promising step forward for nursing.
- Since January 2011, the Quality Assurance (QA) Nurse and the Nursing Department began using the newly modified monitoring tools for nursing. Some of the data from the QA Nurse and the Nursing Department indicated that the Facility was beginning to critically audit the area regarding Urgent Care/ER Visits and Hospitalizations, and had identified findings similar to those of the Monitoring Team. However, at the time of the review, no corrective action plans had yet been developed addressing the problematic areas identified from the audit data.

Pharmacy Services and Safe Medication Practices

- There was a thorough review of new orders, and the recent additional capability to review lab results should allow compliance to be achieved.
- The drug utilization evaluations were timely and effective in raising the standard of care. Follow-up was being completed to apply the lessons learned to improve the drug regimens of individuals the Facility supported.

Physical and Nutritional Supports

- The PNMT's membership was consistent with the Settlement Agreement requirements. In addition, the Medical Director and Chief Nurse Executive attended the PNMT meetings. The PNMT had evaluated and completed an action plan for seven individuals since the last compliance review.
- The Facility is to be commended for developing an interdisciplinary problem-solving approach to address mealtime concerns. LBSSLC Administration had established a Meal Time Improvement Committee, whose members covered a broad array of disciplines and programs. The Committee's purpose was to identify issues/concerns occurring during meal times that could negatively impact the safety, and proactively work toward systemic solutions. A policy has been developed to define the role of Mealtime Coordinators, responsible for oversight at each meal. This was a positive initiative, but for it to fulfill its intent, the Mealtime Coordinators required additional training.

Dental Services

- The Dental Department had made great strides in improving oral hygiene across the campus, which is an essential aspect of preventive dental care.

- There was a user-friendly dental summary created for the PST, and available in individuals' records.

Habilitation, Training, Education, and Skill Acquisition Programs

- Progress had been made in developing a system for completing preference assessments in association with SAPs. The new assessment appeared to have been integrated within the PFA process. The new PFA format appeared to be well integrated within the PSP process.

Most Integrated Setting

- The Facility had begun to use the new Community Living Discharge Plan (CLDP) process. It was resulting in better documentation of many of the planning efforts.
- The Facility had been conducting pre-move monitoring, and this was resulting in better confirmation that essential supports were in place prior to the individual's transition to the community.
- Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community.

Consent

- LBSSLC had and continued to take a number of steps to attempt to identify guardians for individuals whose teams had identified a need for a guardian. The Facility had held one "brainstorming" session to address way to find guardians for individual who needed them, as well as identifying funding mechanisms to assist with the costs of guardianship proceedings. The group brought with it a number of different connections and contacts, and had generated a number of ideas, which were in different stages of development.
- One promising possibility that required further cultivation was the 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.

Recordkeeping and General Plan Implementation

- Since the last review, all of the remaining records had been converted to the new Active Record Table of Contents. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department.
- The Facility provided a list of 40 procedures that were developed or revised since the previous compliance review. The OPM Committee had reviewed an additional 10, nine of which were undergoing final edits, and would be implemented. The remaining policy was undergoing more substantive changes. The Facility continued to develop or revise policies to meet the requirements of the Settlement Agreement.
- As required by the Settlement Agreement, five audits were being completed of records each month. These audits were identifying numerous problems with the records.
- Although no formal action plans had been developed, two workgroups had been created, which represented multiple departments/disciplines. These workgroups had developed creative solutions to addressing issues related to timely submission and filing of documents, as well as tracking the location of records that were

removed from the residences temporarily. At the time of the review, the workgroups were finalizing draft procedures that would then require approval from the policy oversight committee.

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

Restraints

- Since the last review, a new Dental Desensitization policy had been implemented, dated 3/1/11, as well as the formation of a Desensitization Committee. According to the policy, anyone requiring medical restraint or sedation for routine dental care would have a desensitization plan developed by the PST, in collaboration with the Dental staff, and reviewed by the Desensitization Committee. Documentation evidenced three meetings of the committee, and progress toward developing a standard format for desensitization plans. However, only one plan had been drafted. This plan required additional specification with regard to the identified goal and objective, steps of the task analysis, data collection methodology, etc.

Abuse, Neglect and Incident Management

- In two cases reviewed, it was of concern that DFPS' investigation findings were not as stringent as needed to ensure protection from harm. In other cases, investigation reports did not provide adequate bases for the conclusions reached.
- Another area in which focused efforts were needed was the development and implementation of recommendations to address findings of investigations. Related to this was the need for improved trending and analysis of incident management data, as well as in the development and implementation of plans to address issues identified as a result of these activities.
- While it was not questioned that the Facility's leadership had a strong commitment to ensure that abuse and neglect were not tolerated and that individuals were protected from harm, during the monitoring visit, it was noted that there were environmental and programmatic constraints that impeded these important efforts. Since the last monitoring visit, five individuals had been admitted to LBSSLC, all of whom had serious behavioral concerns. The residential space was limited, and had definite constraints in terms of privacy and individualization. To alleviate the potentially risky congregation of individuals who required, and were entitled to, effective individualized supports, the admissions at LBSSLC should be examined in light of the policy expectations and the responsibility to protect individuals from harm.

Quality Assurance

- While there was evidence of monitoring by the Quality Assurance and departmental staff, the processes and procedures were not yet fully implemented in a consistent and continuous manner. The Facility was at the beginning stages of collecting, and beginning to analyze the monitoring data for use in improving the quality of care and habilitation at the Facility.

- Although a Quality Assurance Plan had been drafted, it lacked adequate detail regarding the use of data collected through the various monitoring efforts, and the assignment of responsibility for implementing remedial actions.

Integrated Protections, Services, Treatments and Supports

- LBSSLC had completed PSPs in the new format for approximately half of the individuals it served. Although it was clear that teams were trying to identify and incorporate individuals' preferences and work in a more integrated manner, the resulting PSPs still did not show an integrated plan that set forth the full array of protections, supports, and services individuals required. In addition, plans did not identify functional, measurable outcomes designed to allow teams to determine if treatment, services, and supports were assisting individuals to live healthier, fuller, productive, and meaningful lives. Integration of individuals into the community was not a priority in the plans reviewed.
- Documentation was not submitted to confirm that monthly reviews of programs and supports were occurring consistently. Specifically, on a monthly basis, each responsible team member should conduct a data-driven review of the assigned program(s) or support(s), take appropriate action based on this review, and document this review and any follow-up. The QMRP, as the team's facilitator, should ensure this occurs. To close the loop, however, the QMRP would need to take action, if any of these requirements were not met. Team meetings also might need to be held to address issues identified.

Integrated Clinical Services

- Many consultation reports were followed by a dictated PCP summary of the report, but there were many consultation reports for which this did not occur. In addition, further tracking was needed to ensure that if there were recommendations with which the PCP agreed, that there was a follow-up order, and that the order was executed in a timely manner.

Minimum Common Elements of Clinical Care

- Timeliness of evaluations remained a concern, with overdue clinical assessments. However, adequate evaluation also means identifying the problem as well as the potential causes, and methodically analyzing each possibility thoroughly. This is perhaps the greatest challenge in those with frequent hospitalizations for aspiration pneumonia, in those with recurrent pica events, and in those with recurrent escalation of behaviors. For instance, the Medical Department provided excellent care once an individual was diagnosed with aspiration pneumonia, but challenges remained in anticipating and preventing the cause of the recurrence. The morning meeting would be an excellent forum to discuss these critical areas of clinical care.
- The psychiatric diagnoses utilized at the LBSSLC were consistent with the nomenclature in the DSM-IV-TR. The current deficiency in this area was that there was incomplete (or missing) documentation in the individual records, which set forth the specific symptoms that the individual presented with in a manner that would support the validity of the psychiatric diagnosis.

At-Risk Individuals

- LBSSLC had begun to implement the at-risk process defined in State policy, but significant additional work was necessary to ensure that individuals' levels of risk were identified accurately, sufficient plans were developed, thorough implementation of the plans occurred, reviews of individuals' status occurred using objective data to measure individuals' progress, and, as appropriate, changes were made to the plans to address either lack of progress, or changes in individuals' status. The process will require strong QMRP leadership, and collaboration and cooperation from all medical and clinical departments. It will require extensive preparatory work on the part of all PST members, and the PCPs will need to take a lead role in this area.

Psychiatric Care and Services

- An area needing significant focus was the identification of Empirical evidence that the prescribed psychotropic medication was effective in diminishing the identified behavioral symptoms of the psychiatric disorder. The primary factors that made it difficult to determine if the psychotropic medications had been effective for individuals were the lack of adequate baseline data, and the co-existence of multiple psychotropic medications, which made it impossible to discern differential effects.
- A difficult area that will require further work is the matter of actually being able to demonstrate that the burden of the side effects presented by the psychotropic medications is justified by the clinical benefits of the medication. This issue directly relates to obtaining adequate informed consent.
- The issue of pre-treatment sedation for medical and dental appointments was also an area in which limited progress had been made. The lead discipline for that initiative had recently been identified as the Dental Department, with support from the Psychology Department. A newly revised template for individual Desensitization Plans had begun to be implemented, but it was too early to assess whether this process would be effective. Only one plan had been developed using the new format, and no plans were in place to address the use of pre-treatment sedation for medical appointments.

Psychological Care and Services

- Inter-observer agreement (IOA) data collection has been initiated in a small sample of residential programs, and efforts to measure and improve treatment integrity had continued. However, these efforts had been just initiated, and did not provide sufficient data to establish accurate estimates. In addition, concerns regarding the timeliness and adequacy of data collection remained.
- Progress in improving the quality of PBSPs continued to be observed. However, specific areas for continued improvement remained. Training of and staff competency in implementing PBSPs also remained a concern. In addition, the adequate provision of other psychological services (e.g., counseling services) appeared problematic.

Medical Care

- A continuing challenge for the Medical Department was ensuring routine, preventive, and emergency medical care consistent with current professional standards. With regard to Section L.1 of the Settlement Agreement,

systems were in place to ensure quality with some aspects of routine assessments, such as the quarterly physician reviews, but there also were areas of concern, such as outdated annual examinations. Preventive care had improved, but remained in need of additional attention.

- An area of remaining concern related to the prevention of the acute illness event. The Medical Department needs to move the focus of care to preventing acute illness by determining the causative factors leading to morbidity.
- A non-Facility medical peer review had been completed, and five percent of the records had been reviewed. For compliance to be achieved, the goal would be a 20% record review. Additionally, consideration should be given to reviewing clinical quality, as well as the administrative aspects of medical care currently reviewed.
- The Medical Department's quality improvement initiatives remained rudimentary. This should be assisted with completion of the clinical guidelines. Some important data was being collected, but was not yet being analyzed or acted upon. For example, based on the fact that 27 out of the 33 individuals that had pneumonia had gastrostomy tubes (82%) suggested the need to review any aggravating factors that would exacerbate GERD, such as flat positioning, or bolus feeding, and the need to consider diagnostic testing to rule out the presence of GERD as another source of aspiration. Medications and surgical procedures might be indicated depending on the findings.

<u>Nursing Care</u>

- Consistent with the findings from the previous reviews, there continued to be significant number of problematic issues regarding the nursing documentation addressing complete and adequate nursing assessments of symptoms for acute changes in status, Nursing Quarterly/Annual Assessments, and Nursing Care Plans.
- The Monitoring Team's onsite review of Medication Administration Records (MARs) resulted in the Facility generating 117 Medication Error Reports. This finding did not comport with the Facility's medication variance data, which showed between two and four errors each month between September 2010 and February 2011. Although serious problematic issues clearly continued to exist regarding the medication administration and medication variance systems at LBSSLC, the Facility implemented a Brainstorming Work Session meeting that generated a thorough and promising systematic process for reviewing some of the medication issues, such as the number of unexplained returned medications to the pharmacy.

<u>Pharmacy Services and Safe Medication Practices</u>

- The quarterly drug regimen review process was an area that had improved over time. However, the Facility was not consistently completing them on a quarterly basis, due to a misinterpretation of how to calculate quarterly reviews. Additionally, the recommendations on the QDRRs needed to be more definitive.
- A remaining challenge related to the use of chemical restraints. The pharmacy comments on the chemical restraint form needed improvement.

- The cause and resolution of medication errors remained a challenge. Focused efforts needed to be applied to improving reporting of medication variances, as well as developing and implementing plans to reduce variances to the extent possible.

Physical and Nutritional Supports

- The PNMT had evaluated and completed an action plan for seven individuals since the last compliance review. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs, the PNMT needs to take a number of actions to improve its assessment, planning, and follow-up processes.
- A review was conducted of a sample of individuals identified at risk due enteral feeding, pneumonia, and pica, all of whom met the priority criteria for review by the PNMT. None of these individuals had been referred and/or evaluated by the PNMT.
- Although LBSSLC had developed a number of competency-based checklists for staff related to physical and nutritional management, additional checklists needed to be developed to cover the full array of staff competencies. During the onsite review, the Monitoring Team observed many errors as staff were implementing PNMPs. Monitoring is another area that requires focused attention to assist in remedying these issues.

Physical and Occupational Therapy

- Therapists were not active members of the PSTs, as evidenced by insufficient provision of direct therapy, lack of completion of comprehensive OT/PT Evaluation updates when a change in status occurred, lack of development and integration of therapy recommendations into formal skill acquisition programs, and the lack of development of informal strategies to reinforce assessment recommendations and measurable outcomes.
- Systems were not in place to ensure the timely delivery of, or the ongoing fit, availability, function, condition, and effectiveness of individuals' adaptive and assistive equipment.

Dental Services

- Although the Dental Department did not have significant issues with refusals for appointments, the number of missed appointments remained high, and the Department needed to begin to review and expand the categories of missed appointments.
- Desensitization programs continued to be a challenge, and the Dental Department has taken the lead in creating an interdisciplinary process for developing revised desensitization programs. This process was in the initial stages, and its success was still to be determined.
- For acute care dental problems, there was a need to review pain management, documentation of follow-up, as well as the length of time from beginning of the acute care need to closure of the problem. Database management and a review of documentation content would assist in this process.
- Monitoring of sedation before and after the dental visit remained inconsistent across the campus.

Communication

- SLPs were completing evaluations that did not recommend direct and/or indirect therapy supports for individuals who presented with severe communication deficits, but had documented strengths, potentials, and abilities for functional communication. Insufficient direct and/or indirect speech therapy supports were provided for individuals with an identified need.
- Facility Administration, in collaboration with the SLPs, should continue to problem-solve and identify solutions to significantly increase staff compliance with utilization of individual communication systems. Furthermore, SLPs should continue to monitor individuals' current communication devices to ensure they are effective to support functional communication.

Habilitation, Training, Education, and Skill Acquisition Programs

- Limited progress had been made in providing habilitation training, and specifically with regard to skill acquisition programs being developed and implemented to promote growth, development, and independence for all individuals. An initial pilot had been discontinued, and a second pilot was started recently. This second pilot appeared to be supported by professionals from behavioral services and revisions to the SAP format and process, including the responsibilities of several PST members, had been made. At the time of the current review, only a limited number of sample SAPs were available for review.
- Limited increases in on-campus and off-campus vocational opportunities were observed. The number of individuals employed in competitive positions did not change. Recent data evidenced a decrease in community integration for some residential programs. Sampled documentation suggested fewer skill acquisition programs targeting implementation in community settings. However, these plans appeared to more integrated within on-campus vocational settings.

Most Integrated Setting

- PSPs had begun to identify obstacles to individuals moving to the most integrated setting appropriate to meet their needs. However, the obstacles often listed areas of need 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. Obstacles had not yet been analyzed, which will be an essential support in developing plans to overcome them on a more systemic level.
- The Community Living Discharge Plans (CLDPs) reviewed included essential and non-essential supports. However, the Facility continued to be refining this process. Teams did not consistently identify all the protections, services, and supports that the individual needed to transition safely to the community, nor did teams adequately define the essential and non-essential supports in measurable ways.
- With regard to the content of the post-move monitoring checklists, 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.

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 Settlement Agreement 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 103 individuals served by LBSSLC. At the time of the review, Lubbock supported 227 individuals, of whom approximately 45% needed guardians.

Recordkeeping and General Plan Implementation

- Although there was evidence that new policies were being disseminated, no information was provided with regard to the training provided, or whether or not adequate efforts were made to ensure staff had the necessary knowledge and skills to implement the policies.
- Based on observations of team meetings, teams were not consistently using data, and other information contained within individuals' records, to make care, treatment, and training decisions. In addition, issues related to the timely and accurate filing of information, and the maintenance of complete data, had the potential to impact negatively on teams' decision-making ability.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
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.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o For Sample #C.1, complete restraint records, including Restraint Checklists, Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms, Positive Behavior Support Plan (PBSP), and Safety Plan for Crisis Intervention (SPCI) and, for each restraint, the documentation of any and all reviews of this restraint information for Individual #33, Individual #190 and Individual #288; o For Sample #C.2, the following documentation was reviewed for a sample of 25 staff: ▪ The names of staff with their start dates and the dates on which they were determined to be competent with regard to the required restraint-related topics; ▪ The training records to show that each identified staff member had completed competency-based training on abuse and neglect prior to working directly with individuals; ▪ The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect; o For Sample #C.3, for the period from 8/1/10 to 1/31/11, the physicians' orders for nine individuals for whom medical restraint was ordered, and the documentation of the monitoring that occurred. Those individuals included: Individual #6, Individual #34, Individual #60, Individual #70, Individual #175, Individual #257, Individual #299, Individual #302, and Individual #306; o For Sample #C.4, chemical restraint documentation for Individual #34, Individual #51, and Individual #288, including restraint checklists, face-to-face assessments, and debriefing forms; o For Sample #C.5, restraint checklists, face-to-face assessments, and debriefing forms for Individual #33, Individual #60, and Individual #82; o Minutes of the Restraint Reduction Committee meetings, from 9/16/10 to 2/17/11; o Restraint Monitor training packet; o List of 22 injuries (none serious) to 13 individuals during restraint, from 2/1/10 through 1/31/11; o List of individuals (9) with Safety Plans; o LBSSLC Policy "Positive Behavior Support: Prevention and Treatment of Pica," dated 12/14/10; o Restraint reports for Residence 514, since 10/1/10; o Monthly summary of behavior for all individuals on living unit 514, since 10/1/10; o Most recent "Do not Restrain" list with the names of 135 individuals; o List of 17 individuals considered to be at high risk due to challenging behaviors; o Restraint Analysis Trend Report for Second Quarter, FY 2011; o Restraint Report, for the period 12/1/10 to 2/28/11;

	o New Restraint Checklist rubric, dated 12/29/10 revised; o LBSSLC –Health Services: Dental Desensitization, dated 3/1/11; o Desensitization Committee Meeting minutes/staff signature sheets, dated 1/13/11, 2/10/11, and 3/18/11; o New Personal Support Plan (PSP) Addendum – Review of four or more restraints in any 30-day period; o Guidelines regarding PST Mentoring for Initial PSPA Conducted for More than three Restraints in a 30-day period, and Evaluation of Quality of PSPA Analysis for Section C Monitoring; o New rubric for Evaluation of PSPA Analysis of More Than three Restraints in 30-Day Period; o Training Documentation of PST Training: Analysis of risk factors associated with behaviors resulting in restraint, dated 2/22/11, 2/23/11, and 3/22/11; o Training Documentation for new Restraint Checklist, dated 12/8/10, 2/8/11, and 2/22/11 to 2/26/11; o Restraint Report for LBSSLC – Report Date: 8/1/10 to 1/31/11; o Section C Restraint Compliance Trends and Summary; o Prevention and Management of Aggressive Behavior (PMAB) Training Curriculum; o With regard to nursing documentation, 16 episodes of restraint documentation for the following: Individual #4, Individual #33, Individual #190, and Individual #288; o Safety Plan for Crisis Intervention (SPCI) for: Individual #33, Individual #190, and Individual #288; o Positive Behavior Support Plans (PBSPs) for: Individual #33, Individual #190, Individual #4, Individual #124, Individual #156, Individual #315, Individual #240, Individual #242, Individual #304, Individual #75, Individual #94, Individual #38, Individual #318, Individual #271, Individual #108, Individual #173, Individual #125, Individual #174, Individual #306, and Individual #118; and o For Sample #C.7 Restraint Checklists, Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms, the PSP, PSP addendums, Psychological Assessment, Structural and Functional Assessment Report (SFAR), Positive Behavior Support Plan (PBSP), and Safety Plan for Crisis Intervention (SPCI) for: Individual #33, Individual #190, and Individual #288. ▪ **Interviews with**: o Libby Allen, Facility Director; o Jim Forbes, M.Ed, C.B.A., Director of Behavioral Services; o Melinda Voight, Risk Manager; o Dawn Ripley, Director of Quality Assurance; and o Informal interviews/conversations with staff, Foster Grandparents and individuals. ▪ **Observations of**: o Incident Management Review Team meetings, on 3/28/11, 3/29/11, and 3/31/11; o Restraint Reduction Committee meeting, on 3/29/11; o Quality Assurance/Quality Improvement Committee meeting, on 3/31/11;

	o Safety Committee meeting, on 3/30/11; o Observations of Individual #33, Individual #190, and Individual #288; o Site visits to all residences and the workshop. 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: For this section of the Settlement Agreement, the Facility's POI incorporated objective data to substantiate its findings with regard to compliance. This was one of the few sections of the POI that reported data. This was a very positive step. However, it would be helpful to know the source of the data to enable the reader to determine the type and validity of the data reported. For example, for Section C.2, the Facility reported that: "Restraint documentation (Restraint Checklist and/or face-to-face assessment) reports that 77 of 97 physical restraints were terminated as soon as the individuals were no longer a danger to self or others." What was unclear was whether this was a quantitative or qualitative review of the data contained on the restraint checklists and face-to-face assessments. In other words, it could not be determined if this data represented the number of forms that indicated the individual had been released as soon as he/she was no longer a danger to self of others, or if it represented a review of information to actually determine that this criterion was met. Section C.2 of the Settlement Agreement requires that any restraint be terminated as soon as the individual is no longer a danger to him/herself or others. The Facility assessed itself to be in substantial compliance with this requirement of the Settlement Agreement. For the remaining provisions in this Section, the Facility reported non-compliance.
	Summary of Monitor's Assessment: The Monitoring Team continued to commend the Director of Behavioral Services and the psychologists working under his supervision for their diligent efforts to reduce the use of restraint at the Facility. Reportedly, their task had become more difficult with the admission of individuals who had intense behavioral and psychiatric needs. Additionally, the census in certain living units, particularly 514 and 520, had increased. As a result, the environments had become noisier, more congested, and had less harmonious groupings of individuals. Reportedly, these factors had affected individuals with a history of problematic behavior, including aggression and self-injurious behavior. The policies at LBSSLC clearly stated the limitations for restraint use at the Facility, including a prohibition on prone restraint. Based on a review of a sample of records, prone restraint and mechanical restraint were not utilized at LBSSLC. Since the last monitoring visit, the Facility had entered into a formal cooperative relationship with Texas Tech University. This collaboration should result in clinical consultation about individuals with challenging behavior, including self-injurious behavior, and enhanced opportunities for professional growth for the Psychology Department staff.

	Documentation requirements were being tightened to ensure that alternatives to restraint were applied, and that any restraint use was consistent with the individual's PSP, PBSP and Safety Plan. Training regarding the use of restraint was completed for 93% of the applicable staff. Since the last review, a new Dental Desensitization policy had been implemented, dated 3/1/11, as well as the formation of a Desensitization Committee. According to the policy, anyone requiring medical restraint or sedation for routine dental care would have a desensitization plan developed by the PST, in collaboration with the Dental staff, and reviewed by the Desensitization Committee. Documentation evidenced three meetings of the committee, and progress toward developing a standard format for desensitization plans. However, only one plan had been drafted. This plan required additional specification with regard to the identified goal and objective, steps of the task analysis, data collection methodology, etc. The new PSP Addendum will likely promote more comprehensive review and documentation by the PST in regard to examining potential precipitating factors and/or underlying functions of target behaviors leading to restraint. These changes appeared to be thoughtfully implemented with direct mentoring support and feedback from the Director of Behavioral Services. This new process was likely facilitated by the use of a new rubric completed to ensure adequate PST examination and discussion regarding restraints.

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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 accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Based on information the Facility provided in its Restraint Report for LBSSLC and its underlying documentation, between 12/1/10 and 2/28/11: ▪ 15 individuals were the subject of restraints; ▪ 83 restraints occurred; ▪ None of these were mechanical restraints; ▪ 58 of these were physical holds; ▪ 24 of these were emergency restraints; ▪ 39 of these were crisis intervention restraints that were administered according to Safety Plans; ▪ Five of these were chemical restraints; and ▪ 20 of these were medical/dental restraints. There were 5 individuals (Individual #20, Individual #127, Individual #276, Individual #306, and Individual #315) restrained for medical/dental purposes. There were 11 individuals (Individual #33, Individual #36, Individual #51, Individual #60, Individual #131, Individual #134, Individual #143, Individual #190, Individual #220, Individual #240, and Individual #288) restrained for behavioral reasons. Individual #190 and Individual #33 had the most number of restraints, with 25 and 14 restraints, respectively. In the month of 2/11 alone, there were 30 physical restraints and three chemical	Noncompliance

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		restraints. Individual #190 was restrained 13 times, Individual #288 was restrained six times, and Individual #33 was restrained five times. The Restraint Trend Analysis Report for Second Quarter, FY 2011 stated that there was "a significant increase in restraints for the past two quarters when compared to the equivalent quarters of the previous fiscal year." No explanation for this increase was offered in the report. <u>Prone Restraint</u> Based on the review of Facility policy, as well as discussion with the Director of Behavioral Services, prone restraint was prohibited at LBSSLC, and reportedly had never been used as a routine practice. During the last monitoring visit, the Director of Behavioral Services stated that staff had been instructed, through training, that this was a prohibited technique; there had been no incident reports documenting 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. During this monitoring visit, the Director of Behavioral Services referred to these prior statements and reaffirmed them. He added that videotape footage did not show any prone restraint use, and that there was documentation to confirm that the restraint was discontinued if the proper technique could not be maintained. Examples of this documentation were reviewed, and the discontinuation of restraint holds was noted as described. During the last six months (8/1/10 to 1/31/11), the Facility's review of 121 restraint checklists and other relevant documentation substantiated 120 correct (i.e., not prone) positions during restraint. The restraint checklist for one individual, Individual #82, indicated that an arm and leg restraint occurred in a van during a community outing. It could not be verified that the correct position was utilized for this restraint, because documentation was missing. A sample, referred to as Sample #C.1, was selected. This included all of the restraint records for three individuals, representing 20% of restraint records over the last Quarter. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included. The individuals in this sample included: Individual #33, Individual #190, and Individual #288. Based on a review of the restraint records for individuals in Sample #C.1, none showed use of prone restraint.	

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		Other Restraint Requirements Based on document review, the Facility policies stated that restraints could only be used if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. A number of randomly selected restraint records were reviewed for Sample #C.1, for the period from 10/13/10 to 1/30/11, which included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ During this timeframe, there were 27 restraint episodes documented for Individual #33. Of these, seven records for 10/13/10, 10/16/10, 10/24/10, 1/19/10, 1/20/10, and 1/30/11 were reviewed for this report. There were seven restraint episodes for Individual #288. Of these, seven records for 10/16/10 (three episodes), and 11/1/11 (four episodes) were reviewed. There were 13 episodes for Individual #188. Of these, 12 records for 11/23/10, 12/1/10, 12/2/10 (two), 12/5/10, 12/12/10, 12/15/10, 12/28/10, 1/2/11, 1/5/11, 1/12/11 (two) were reviewed. In total, 26 records drawn from a total of 47 restraint episodes for these three individuals were reviewed. ▪ In 26 of the 26 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Examples of where this was the case included: o Individual #33 had repeated incidents of head-banging and other self-injurious behavior. Restraints were used to stop her self-injury. o On 12/2/10, Individual #190 was aggressive towards others in his living unit, posing a potential danger to them. o Individual #288 became agitated after being sent home from school on 11/1/10. He attempted to push down a light pole, which fell into the category of extremely dangerous behavior according to his Safety Plan, which triggered the restraint. ▪ For the 26 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 26 of the 26 records (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. ▪ In 26 out of 26 records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justified manner. Facility policies identified a list of approved restraints. ▪ Based on the review of 26 restraints, 26 (100%) were approved restraints.	

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		However, as noted in the Monitoring Team's last report, there continued 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 of living space, many individuals living together, and the lack of privacy likely negatively influenced behavior, and might provoke undesirable reactions from individuals. For example, according to staff, at certain times, Individual #33 required personal space and distance from others in order to remain calm, and free from self-injurious behavior. Her "private" space was a corner of the dayroom in her residence. The Monitoring Team witnessed staff attempting to keep other individuals out of the one dayroom in which Individual #33 was lying curled up on a sofa, and redirecting them out of this common space into the other dayroom, the dining room, or outside on the patio. This had implications for the rights of all of the individuals involved. Individual #190 was observed with one-to-one staffing in his residence. He was lying on the floor. Staff brought him to sit at a table, but there were no activities offered to him. In contrast to these two examples, Individual #288 was observed in the workshop shredding papers. He was totally engaged in his task, even to the point of refusing his breaks, so that he could continue working. The sample of three individuals' records reviewed included the individuals' PBSPs and SPCIs. ▪ In one of the records (33%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Examples in which adequate treatment was present included: o The restraint record (dated 1/19/11, 5:58 a.m.) indicated that Individual #33 "… fell on the floor and attempted to headbang." Staff reported using a "wedge side by side" physical restraint in addition to verbal prompts. According to her SPCI, if Individual #33 "… drops to the floor, attempting to headbang … immediately use the modified Prevention and Management of Aggressive Behavior (PMAB) arms to side with a wedge …". According to the information on the restraint record as well as the SPCI, staff appeared to respond correctly given the current nature of responding demonstrated by Individual #33. Examples where this was not the case included: o Although the restraint record, dated 1/12/11, 6:44 a.m., for Individual #190 indicated, by check marks, that staff prompted coping skills, and interventions in both the PBSP and SPCI prior to using restraint, actual staff written description of their responses appeared to question the integrity with which these strategies were implemented. For example, the current PBSP, not dated, directed staff to use behavioral momentum,	

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		and/or a "hands down" prompt following aggression. These were not described in the current restraint checklist. In addition, staff checked using "coping skills." However, specific coping skills were not conspicuously described in the current PBSP. It might have been the case that staff felt clinically justified in implementing a PMAB physical restraint due to the nature of the peer aggression. In this case, the physical restraint (hand hold) was consistent with strategies outlined in the SPCI. Staff descriptions of the replacement behavior included "… asked what did he need." However, this appeared somewhat counter-therapeutic, given that one of the identified underlying functions to his aggression was to access tangibles. o Although the restraint record, dated 11/1/10, 2:54 p.m., for Individual #288 indicated, by check mark, that replacement behaviors, coping skills, and other interventions outlined in the PBSP and SPCI were implemented, these were not adequately described. That is, it was not obvious, based on staff descriptions, which coping skills and/or other interventions were implemented. Consequently, it was unknown if staff attempted to implement prescribed calming techniques (e.g., deep breathing, counting to ten, prompting listening to music, encourage talking, etc.) or other specific strategies (e.g., "… tell me why you are mad," or "Don't hurt others") outlined in the PBSP or SPCI. Staff indicated that they "changed environment," but no further information describing how this occurred while they were outside was included. Staff indicated using a PMAB physical restraint (basket hold), which was an approved strategy. The Settlement Agreement requires that restraint not be used in the absence of or as an alternative to treatment. As noted above, staff did not consistently implement Behavior Support Plans to potentially prevent the need for restraint, and concerns continued to exist with regard to the adequacy of programming. As a result, a finding of noncompliance has been made.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the three individuals in Sample #C.1 were reviewed. Of these, three of the three individuals had Safety Plans that defined the use of restraint: ▪ For three individuals who had Safety Plans, two (66%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Safety Plan. However, there was a restraint episode on 11/23/10, for Individual #190, in which the documentation indicated that there was no Safety Plan. In fact, this individual does have a safety plan.	Substantial Compliance

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C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. There were 25 staff selected randomly for review. A review of a list of current staff, including their start dates, the dates on which they were assigned to work with individuals, and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that 25 out of 25 (100%) staff had been properly trained on restraint and its related topics. As noted above with regard to Section C.1 of the SA, 100% of the 26 restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, in order to ensure that the least restrictive method is utilized, individuals' PBSPs must be followed, and the preventative steps outlined in PBSPs must be implemented. As discussed with regard to Section C.1, a review of three PBSPs and related restraint records showed that in only one of the three (33%) had staff implemented the potentially less restrictive alternatives with integrity. This has resulted in a finding of noncompliance.	Noncompliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 26 restraint records (Sample #C.1), in 26 (100%) there was evidence documented that restraint was used as a crisis intervention. In review of 20 Positive Behavior Support Plans (PBSPs), in 20 (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint) (for Individual #33, Individual #190, Individual #4, Individual #124, Individual #156, Individual #315, Individual #240, Individual #242, Individual #304, Individual #75, Individual #94, Individual #38, Individual #318, Individual #271, Individual #108, Individual #173, Individual #125, Individual #174, Individual #306, and Individual #118). In addition, Facility policy did not allow for the use of restraint for reasons other than crisis intervention. In general, PBSP consequence procedures for targeted behaviors, including aggression and self-injurious behavior (SIB), for example, typically directed staff, once the behavior occurred, to: 1) verbally prompt the individual to stop; 2) get in between the individual	Noncompliance

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		and any potential target/peers; 3) utilize soft object to block aggressive or self-injurious behavior; 4) and use PMAB protection techniques, including blocking and bite release. Many PBSPs conspicuously stated "not restraint" or "without grasping," when describing the consequence-based interventions (e.g., Individual #190, Individual #174, Individual #156, and Individual #240). Although restraint was not specifically prescribed in any of the PBSPs reviewed, further specification of prescribed strategies in some of the PBSPs would likely be helpful in avoiding any situations where staff utilize techniques that might be interpreted as restraint or restrictive. ▪ More specification regarding the use of physical prompts would likely avoid situations where staff might utilize physical force to overcome an individual's active resistance. For example, consequence-based interventions outlined in the PBSP for Individual #306 stated that, following aggression or SIB: "If he is trying to get out of something … physically prompt him to complete it …" Further clarification specifying the nature of the physical prompt would help avoid a situation where staff utilize physical force to encourage completion. ▪ More specification regarding the use of prompts in general would likely reduce the likelihood of staff employing restrictive interventions in inappropriate situations. For example, consequence-based strategies in the PBSP of Individual #94 encourage staff to "… not give up," and "Continue to prompt" if "… she does not get up." The ambiguity related to the type of prompt might increase the likelihood that a more intrusive prompt than clinically desired could be utilized. A similar level of specification might be helpful for other individuals as well (e.g., Individual #75). ▪ Additional specification regarding the consequence-based strategies in response to SIB for Individual #33 might also protect against staff utilizing more restrictive strategies than clinically desired. For example, direct support staff were encouraged to "… put gloves on and place your palms against [her] cheeks to protect her cheeks." Descriptions regarding what to do if she resists this procedure were not included. In addition, in response to hair pulling, staff were directed to "… grab her hand and attempt to weave your finger into her palm to release her grasp". Additional specification here likely would reduce the potential to utilize physical restraint unnecessarily. It should be noted, specification was provided that "… once she released, you can continue to hold her hand only If you move her hands with her. If you are pulling against her movement, then you must release or it is a physical restraint." In 26 of 26 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list. Individuals included in the "Do Not Restrain" list had diagnoses of brittle	

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		bones and osteoporosis, and restraint was prohibited. Progress had been made with regard to the use of medical restraint or sedation for routine dental care. Since the last review, a new Dental Desensitization policy had been implemented, dated 3/1/11, as well as the formation of a Desensitization Committee. According to the policy, anyone requiring medical restraint or sedation for routine dental care would have a desensitization plan developed by the PST, in collaboration with the Dental staff, and reviewed by the Desensitization Committee. Documentation evidenced three meetings of the committee, and progress toward developing a standard format for desensitization plans. More specifically, an initial draft of a plan was developed for Individual #119. This plan required additional specification with regard to the identified goal and objective, steps of the task analysis, data collection methodology, etc. Two residences also were selected as pilot homes (i.e., 521 N. Cedar and 523 N. Cedar) to begin the process of developing new desensitization plans across all residential sites. The Monitoring Team looks forward to examining the progress on the development and implementation of these plans at the next review.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject	Review of Facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. The training utilized at LBSSLC was entitled "Prevention and Management of Aggressive Behavior (PMAB)." It was competency-based training. Restraint monitors received additional training, including instruction on the completion of the restraint monitoring checklist. Information provided by the Director of Behavioral Services indicated that 93% of the relevant workforce had been trained. The Facility provided documentation of all staff trained in PMAB for the period from 3/29/10 to 3/29/11. In addition, it was reported that training on the analysis of factors leading to behaviors that result in restraint was provided for selected Personal Support Teams. The Personal Support Plan Addendum shell for more than three restraints in a rolling 30-day period was revised to prompt improved analysis. The use of this is discussed in further detail with regard to Section C.7. A checklist for mentoring Personal Support Teams in this regard was being implemented. Findings from the analysis of restraint data and from monitoring activities prompted additional restraint monitor training, and the training of nurses to ensure a timely response to a restraint episode. Based on a review of 26 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ In 22 out of 26 incidents of restraint (85%) by an adequately trained staff	Noncompliance

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	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.	member. Records that did not contain documentation of this included a restraint episode on 10/16/10 for Individual #288; ▪ In 22 out of 26 instances (85%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included a restraint episode on 10/16/10 for Individual #288. It is important to note again that the Director of Behavioral Services reviewed 102 restraints that occurred between 9/18/10 and 1/31/11. He reviewed his findings at the Restraint Reduction Committee meeting held during the monitoring visit. The failure to conduct a face-to-face assessment within 15 minutes was cited in nine episodes (9%). The Facility provided no alternative monitoring schedules. Based on a review of 16 restraint records for four individuals for restraints that occurred at the Facility (Individual #33, Individual #190, Individual #288, and Individual #4), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in seven (44%) of the instance of restraint. Records that did not contain timely documentation of this included: Individual #190, 1/2/11; Individual #190, 1/5/11; Individual #190, 1/12/11 at 6:44 a.m.; Individual #288, 11/1/10 at 2:54 p.m.; Individual #288, 11/1/11 at 2:58 p.m.; Individual #288, 11/1/10 at 3:01 p.m.; Individual #4, 10/6/10 at 3:05 p.m.; Individual #4, 10/6/10 at 3:28 p.m.; and Individual #4, 10/13/10. ▪ Monitored and documented vital signs in 13 (81%). Records that did not contain documentation of this included: Individual #33, 1/19/11 no respirations recorded; Individual #33, 1/30/11 no respirations recorded; Individual #190, 12/15/10 no respirations recorded. To obtain respirations, the individual's cooperation is not required. ▪ Monitored and documented mental status in 11 (69%). Records that did not contain documentation of this included: Individual #33, 1/30/11, blank spaces; Individual #190, 1/5/11, inadequate documentation; Individual #190, 1/12/11 at 6:44 a.m., inadequate documentation; Individual #190, 1/12/11 at 8:40 a.m., inadequate documentation; and Individual #288, 11/1/10, blank spaces. The inadequate documentation found in the records included nurses' statements that an individual's mental status was "within normal limits (WNL) for the individual." This was not an appropriate assessment and description of mental status. In the review of 102 restraint episodes by the Director of Behavioral Services, the failure of a licensed health care professional to conduct timely assessments was cited as a	

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		deficiency in 25 episodes (24%). Based on documentation provided by the Facility, three restraints had occurred off the grounds of the Facility between 9/18/10 and 1/31/11. All three were reviewed in the data submitted by the Director of Behavioral Services (Sample #C.5). A licensed health care professional: ▪ In two out of three incidents (67%), monitoring was conducted within 30 minutes of the individual's return to the Facility; vital signs were monitored and documented; and mental status was monitored and documented. This monitoring did not occur for Individual #82, on 10/11/10. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. The sample included 24% of the individuals for whom medical restraint was used, including the following: Individual #6, Individual #34, Individual #60, Individual #70, Individual #175, Individual #257, Individual #299, Individual #302, and Individual #306. For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ In none of the records reviewed (0%) did the physician specify the schedule of monitoring required; and ▪ In none of the records reviewed (0%) did the physician specify the type of monitoring required. The following provide example of issues identified with regard to the implementation of medical restraint: ▪ The physician's orders lacked any description of the type or schedule of monitoring required; ▪ Documentation was missing or incomplete.	
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	A sample (Sample #C.1) of 26 restraint checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ In 100%, continuous one-to-one supervision was provided; ▪ In 100%, the date and time restraint was begun was documented; ▪ In 100%, the location of the restraint was documented; ▪ In 100%, information about what happened before, including the change in the behavior that led to the use of restraint was included. This documentation demonstrated that environmental factors were a catalyst in certain restraint episodes. For example, on 12/15/10, Individual #190 became agitated when a peer was making noises and clapping his hands; and, on 12/5/10, became agitated when he wanted a coke, and there were no keys to open the cabinet. ▪ In 100%, the actions taken by staff prior to the use of restraint to permit	Noncompliance

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	minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	adequate review per Section C.8 of the Settlement Agreement were detailed; ▪ In 100%, the specific reasons for the use of the restraint was stated; ▪ In 100%, the method and type (e.g., medical, dental, crisis intervention) of restraint was identified; ▪ In 100%, the names of staff involved in the restraint episode were listed; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including: o In 100%, the observations documentation every 15 minutes and at release; o In 100%, the specific behaviors of the individual that required continuing restraint; and o In 100%, the care provided by staff during the restraint, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. There were two incidences when meals were offered to Individual #33 (10/13/10), and Individual #190 (11/23/10); ▪ In 100%, the level of supervision provided during the restraint episode was described; and ▪ In 100%, the date and time the individual was released from restraint was documented. Of the three SPCIs reviewed, three (100%) contained strategies specifically identifying the provision of one-to-one Level of Supervision (LOS) while individuals were in restraint. In addition, three (100%) SPCIs contained instructions for staff to release the restraint immediately if signs of physical distress or medical emergency were observed. Lastly, three (100%) outlined the specific notification of the nurse and Restraint Monitor, as soon as possible after starting the restraint. Of the three SPCIs reviewed, two (67%) contained strategies specifically outlining the provision of opportunities for movement of restrained limbs (upon release), to eat as near meal times as possible, to drink fluids with precautions to prevent choking, and to use a toilet or bedpan, if needed. One SPCI (i.e., Individual #190) did not identify the provision to utilize the toilet or bedpan if needed. According to summary data (i.e., Section C Restraint Compliance Trends), individuals were offered opportunities to exercise, drink fluids, and use a toilet in 90% of the restraints. It is assumed that these opportunities were offered only after the individual was calm and safely released from the restraint. This is based on the fact that only two (2%) restraints were released due to physical distress (since 9/18/10). However, if not already done, data should be collected and reviewed to determine whether or not restraints are released due to issues related to hunger, thirst, or the need to use the toilet.	

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		In 10 of the 16 records reviewed (63%) from a nursing perspective, the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were documented. Records that did not contain this documentation or inadequate descriptions of injuries included: Individual #33, 1/20/11; Individual #33, 1/30/11; Individual #288, 11/1/10 at 2:54 p.m.; Individual #288, 11/1/10 at 2:58 p.m.; Individual #288, 11/1/10 at 3:01 p.m.; and Individual #288, 11/1/10 at 3:34 p.m. In a sample of 26 records (Sample #C.1), restraint debriefing forms had been completed for all individuals involved in the restraint episodes. The Facility should be commended for the completion of the requisite forms. The high completion rate was credited to the high visibility of this issue, training of restraint monitors, and the review by the clinical staff in the Department of Behavioral Services. However, the concerns noted with regard to the lack of nursing documentation need to be addressed. In its own monitoring, the Facility noted that there were brief restraint episodes that did not include the explanation of antecedent behaviors, or the type of behavior that led to the restraint. However, these weaknesses were not evident in the sample drawn for review. For Sample #C.3, the Facility provided a list of 37 individuals who were the subjects of medical restraint between 8/1/10 and 1/31/11. One incident was selected for each of nine individuals included on the list, and documentation was requested about the monitoring of the medical restraint. Based on the pre-treatment sedation assessment forms reviewed, there was evidence that monitoring had been completed in three instances (33%). However, although the monitoring information was present, on two of the three forms, dated signatures were missing. There were no pre-treatment sedation assessment forms in the records of the remaining six individuals in the sample. Human Right Committee approval was included in the documentation for four of the nine episodes of medical restraint (44%). Sample #C.4 was selected using the list the Facility provided of five individuals who had had chemical restraint between 8/1/10 and 1/31/11, from which a sample of three individuals was selected. The sample included the following individuals: Individual #34, Individual #51, and Individual #288. In all but one of the three restraint episodes reviewed (67%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist. In one incident, the psychologist was present and reviewed the decision to use chemical	

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		restraint. In the other incidents, although the psychologist was contacted, there was no information clearly attributed to the psychologist's assessment of less intrusive measures. There was one episode, on 12/28/10, involving Individual #51 in which the chemical restraint was administered prior to the contact with the psychologist. The policy was not followed, and, in her consultation, the psychologist assigned to this individual stated that the chemical restraint was not warranted. The Director of Behavioral Services was notified and said he would follow-up with the Director of Nursing.	
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:	Progress had been made in the area of documentation of restraints, as well as the PST process and related documentation following restraint. More specifically, documentation provided evidenced significant improvement in the format of the Restraint Checklist, as well as the PSP Addendum when reviewing more than three restraints in any 30-day rolling period. The revised Restraint Checklist will likely promote the inclusion of more descriptive and targeted information from the direct support professionals involved in the restraint, as well as more comprehensive oversight by the Restraint Monitor. The new PSP Addendum will likely promote more comprehensive review and documentation by the PST in regard to examining potential precipitating factors and/or underlying functions of target behaviors leading to restraint. These changes appeared to be thoughtfully implemented with direct mentoring support and feedback from the Director of Behavioral Services. This new process was likely facilitated by the use of a new rubric completed to ensure adequate PST examination and discussion regarding restraints. According to the current LBSSLC Restraint Report, five individuals had more than three restraints in any rolling thirty-day period between August 1, 2010 and January 31, 2011. Of this group, three individuals (reflecting a sample of 60%) were selected for further review, and included Individual #33, Individual #190, and Individual #288. Selected Restraint Checklists, and Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms were reviewed for Individual #33 (dated 1/19/11, 1/19/11, 1/20/11, and 1/30/11), Individual #190 (dated 12/15/10, 1/2/11, 1/5/11, and 1/12/11), and Individual #288 (dated 11/1/10). In addition, requested documentation, including the PSP, PSP addendums, psychological assessment, SFBA, PBSP, and SPCI, was reviewed for each individual. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. Of the three individuals sampled, three (100%) individuals' PSTs met to discuss the restraints selected for review. More specifically: ▪ The PST for Individual #33 met on 1/24/11, and 2/10/11 to discuss the restraints that occurred on 1/19/11, 1/20/11, and 1/30/11. Indeed, since the Monitoring Team's last review, the PST met on nine occasions to discuss incidents where Individual #33 had more than three restraints in a rolling thirty-	

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		day period. This was in addition to the other 10 plus meetings held to discuss level of supervision, medication changes, injuries, and potential in-patient hospitalization. ▪ The PST for Individual #190 met on 1/13/11 to discuss the restraints that occurred on 12/15/11, 1/2/11, 1/5/11, and 1/12/11. This was in addition to the other 12 documented meetings held since the beginning of December to discuss his aggressive behavior, restraints, and level-of-supervision. ▪ The PST for Individual #288 met on 11/2/10 to discuss the four restraints that occurred on 11/1/10.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Of the three individuals reviewed, none (0%) of the individuals' PSTs reviewed the individuals' adaptive skills. The following are examples of where teams failed to do this adequately: ▪ Although the documentation for Individual #33 included a section of the PSP Addendum, dated 1/24/11 and 2/10/11, where content from the PST team meeting related to adaptive behavior was to be described, the information provided did not reflect data or other information on progress of adaptive/replacement behaviors. This section, when viewed across reports, reflected substantial "cut-and-paste" content, and only, in one report, focused on her lack of adaptive skills. It was surprising that the minutes did not reflect more intense discussion about the role of teaching/training new adaptive communication skills. Although communication was mentioned briefly (as related to behavioral function), no data was presented, and the PST did not appear to examine why data was lacking, or whether or not progress was being made in adaptive responding. ▪ Although the documentation included a section of the PSP Addendum, dated 1/13/11, that was devoted to issues related to adaptive behavior, the PST did not examine progress on skill training targeting the replacement behaviors (i.e., functional communication) listed in the current PBSP for Individual #190. Many variables discussed within this section referred to environmental factors associated with his target behaviors. Similar to the findings above for Individual #33, review of this section across reports reflected substantial "cut and pasted" content, suggesting limited discussion about current progress regarding adaptive skills. ▪ Although the documentation included a section of the PSP Addendum, dated 11/2/10, that was devoted to issues related to adaptive behavior, the PST did not examine progress on skill training targeting the replacement behaviors (i.e., daily scheduling or change in environment) listed in the current PBSP of Individual #288. There did not appear to be specific discussion of the effectiveness of identified replacement behaviors, or coping skills outlined in his PBSP, and the variables that either supported (or not) their use.	Noncompliance

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		Of the three individuals reviewed, three (100%) of the individuals' PST team appeared to discuss potential biological, medical, and psychosocial factors associated with the restraints. The following are examples of individuals for whom this was done appropriately: ▪ As documented in the multiple PSP Addendums reflecting meetings related to restraint (i.e., dated 1/24/11 and 2/10/11), injuries (dated 1/24/11), as well as changes in medication and other proposed changes and recommendations (dated 2/8/11), the PST discussed potential biological and medical issues, and other related proposed medical assessments and changes for Individual #33. ▪ As documented in PSP Addendums, dated 1/13/11 and 1/26/11, various psychiatric, medical, and psychosocial variables were examined for Individual #190 in an attempt to explain and/or treat aggressive behavior. ▪ As documented in the PSP Addendum, dated 11/2/11, the PST attempted to identify potential biological, medical, and psychosocial variables for Individual #288 in an attempt to explain his aggressive behavior.	
	(b) review possibly contributing environmental conditions;	Of the three individuals reviewed, three (100%) individuals' teams reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately: ▪ According to PST meeting minutes (i.e., PSP addendums dated 1/24/11 and 2/10/11) following the sampled restraints, the PST appeared to discuss the potential of several environmental variables to influence the self-injurious behavior (SIB) of Individual #33. Of note, medical issues (e.g., changes in medications, issues related to constipation, medical tests, etc.) should be discussed within the "biological/medical factors" section, and not under "contributing environmental conditions" section (i.e., PSP Addendum meeting minutes dated 3/4/11). ▪ As documented in multiple PSP Addendums, dated 12/31/10, 1/13/11, and 1/26/11, the PST discussed various potential environmental variables that might have been contributing to the aggressive behavior of Individual #190. ▪ As documented in the PSP Addendum, dated 11/2/11, the PST team attempted to identify potential environmental variables for Individual #288 in an attempt to explain his aggressive behavior.	Substantial Compliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Of the three individuals reviewed, two (67%) individuals' teams reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of individuals for whom this was done appropriately: ▪ As documented in multiple PSP Addendums (dated 12/31/10, 1/13/11 and 1/26/11), the PST appeared to discuss the specific events surrounding the selected restraints of Individual #190, as well as reviewed the likely function	Noncompliance

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		underlying his aggressive behavior. ▪ As documented in the PSP Addendum, dated 11/2/11, the PST team appeared to closely examine potential variables occasioning target behaviors as well as discussed potential underlying functions of behavior for Individual #288. The following is an example of an individual's team that had not adequately reviewed and/or performed structural assessments of the behavior provoking restraints. • Following the selected restraints, the PST appeared to review episodes of SIB that led to the restraint for Individual #33, as well as discussed potential precipitating variables and underlying function, as documented on PSP addendums, dated 1/24/11 and 2/10/11. However, it was unclear if the PST considered revising the SFAR immediately following these incidents or following the four other incidents where more than three restraints had occurred in any 30-day period. This is discussed in further detail below with regard to Section C.7.g.	
	(d) review or perform functional assessments of the behavior provoking restraints;	See Section C.7.c above.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the	Of the three individuals reviewed, three (100%) individuals had a PBSP at the time of the restraints. Of the three individuals in the sample who had PBSPs, the following was found: ▪ Two (67%) specified the objectively defined behavior to be treated that led to the use of the restraint; and ▪ Two (67%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint. The following is an example of an individual with an inadequate PBSP: ▪ The definitions of SIB (targeted behavior for decrease) and Communication Cards (replacement behavior for increase) were not sufficiently objective or measureable, as described in the PBSP for Individual #33. It should be noted that Individual #190 did not have a safety plan in place, when two of the five selected restraints took place (i.e., restraints on 12/15/10 and 1/2/11). In these cases, the restraints were considered emergency restraints. However, according to documentation provided, it appeared that the safety plan had been written and approved through BSC and HRC, but had not yet been approved by the Facility Director. Based on the dates of these PSP Addendums (i.e., 12/12/10 to 1/3/11), it took approximately three weeks to obtain this final approval and implement the plan. The observation regarding the delay in approval of the SPCI for Individual #190 was based on information	Noncompliance

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	individual's ISP;	presented within PSPAs dated 12/13/10 and 12/31/10. The first PSPA, dated 12/13/10, indicated that the Safety Plan "… has been through SBC and HRC and is awaiting approval from the director." Approximately three weeks and six meetings later, a subsequent PSPA, dated 12/31/10, under recommendations, indicated that the "PST is waiting on [Individual #190]'s safety plan for crisis intervention to be approved by the Director. Once the safety plan is approved, the Psychologist will in-service staff on [Individual #190]'s safety plan." In its response to the draft report, the State indicated that the Safety Plan had been approved by BSC on 12/8/01, approved by the Director on 12/20/10, and implemented on 12/23/10. Upon review of the actual SPCI, the implementation date was 12/23/10. However, no explanation for this discrepancy was provided, and based on the meeting notes, it did not appear that actual implementation occurred until some time after 12/31/10. The Safety Plans of the three (100%) individuals in the sample were reviewed. The following represents the results: ▪ In three (100%), the type of restraint authorized was delineated; ▪ In three (100%), the maximum duration of restraint authorized was specified; ▪ In three (100%), the designated approved restraint situation was specified; and ▪ In three (100%), the criteria for terminating the use of the restraint were specified.	
	(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 not substantial evidence for the PBSPs of the three individuals selected to indicate that treatment integrity was examined, and, in addition, that a high level of fidelity was found. However, there were two integrity probes completed that indicated that two separate direct support professionals were judged competent on the PBSP Observation-Guided Staff Training, dated 3/6/11, and PBSP Assessment-Guided Staff Training, dated 1/25/11, for Individual #288. It should be noted that some of the documentation provided included copies of completed probes that were missing the PBSP number. Consequently, identification of which individual's plan was examined was impossible. As presented with regard to Section K.11 of the SA, examination of treatment integrity had been initiated. However, since the last review, only a limited amount of data had been collected. Lastly, the provided sample of completed integrity check forms did not appear to target the PSBPs of Individual #33, or Individual #190.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Of the three individuals sampled, there was documentation for one individuals (33%) indicating that their PBSPs had been reviewed. The following is an example of an individual for whom this was done appropriately: ▪ Documentation provided (PSP Addendum, dated 1/13/11) reflected reports that the PST believed that the PBSP was successfully implemented for Individual #190, and that staff had utilized a number of strategies outlined in the plan.	Noncompliance

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		The following are examples of where teams failed to do this adequately: ▪ Documentation provided (PSP Addendum, dated 11/2/10) evidenced discussion about Individual #288's PBSP, including antecedent and consequence-based interventions, as well as its implementation at the Facility. However, the PST did not appear to make a determination of whether or not the PBSP required revision. Team discussion did reflect concerns regarding the effectiveness of his SPCI (i.e., "… this it is not always effective"). It was unclear if these concerns resulted in changes to the SPCI for Individual #288. ▪ Although the PST appeared to discuss issues related to behavioral programming (including refresher training for staff not implementing the PBSP), there was no evidence, prior to 3/7/11, that the PST considered revising or clarifying Individual #33's behavioral programming or her SFAR, despite the fact that the PST had considered multiple changes in medication and in-patient hospitalization. In addition, current data on replacement behavior was not presented at any of these meetings suggesting a lack of data-based decision making regarding her replacement behavior. In addition, presented data on target behaviors was often incomplete (i.e., LOS meetings dated 10/6/10, 1/5/11, and 2/28/11). The observation that comprehensive data on SIB was not available, and that no data on adaptive responding was ever presented, appeared to reflect the PST's tendency to underestimate the value of behavioral programming, and the resulting data. Although discussions regarding the communication system were evident (i.e., the relationship between communication and SIB), it was not obvious that the effectiveness (or ineffectiveness) of this system was examined (i.e., other than the need for more training). Lastly, review of documentation provided appeared to suggest that the PST was limited by their previous beliefs regarding the nature of her SIB, and perhaps missed clues that another function might be operating. That is, several observations regarding the potential influence of social attention were noted (e.g., documentation from 1/24/11 and 2/28/11). This was potentially significant, because one central intervention, enhanced LOS, appeared related to changes in rates of SIB. Consideration should be given to providing more behavioral expertise to this individual's PST to support of the completion of new assessments (SFAR, including a functional analysis), new intensive skill acquisition programming, and perhaps supplemental assessment-linked behavioral interventions targeting differential reinforcement with rich reinforcer schedules. In addition, limited discussion regarding the use of reinforcement within behavioral programming was evidenced throughout the document review.	
C8	Each Facility shall review each use	Through interview, record review and observation, it was documented that LBSSLC had	Noncompliance

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	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.	mandated a number of ongoing practices to ensure that each episode of restraint was analyzed and evaluated in accordance with the requirements of the Settlement Agreement. Each incident of restraint was to be reviewed at the Unit meeting and the Incident Management Review Team meeting, within three business days. During the monitoring visit, Incident Management Review Team meetings were observed and discussion of restraint was evident on the day after the episode. There was evidence that the Director of Behavioral Services had reviewed each incident of restraint and had analyzed conformance with the requirements of the Settlement Agreement. On 3/29/11, at the Restraint Reduction Committee meeting, documentation of his review for all 102 incidents of restraint that occurred during the months of 9/10 through 1/11 was distributed. According to this report, 95 of 102 restraint episodes (93%) were reviewed within the requisite timeframe. Later, this information was presented at the Quality Assurance/Quality Improvement Committee meeting, which the Monitoring Team observed. The Restraint Reduction Committee met monthly. At the meeting that was held during the monitoring visit, the program initiatives, including the alternatives to restraint, were discussed by the psychologist for each of the three individuals (Individual #33, Individual #190, and Individual #288) with the highest use of restraint. The psychologists' presentations were informative, based on data, and creative in describing treatment interventions. Members of the Committee were familiar with these individuals, and contributed suggestions for the implementation of alternatives to restraint. The review of the monthly summary of behavior since 10/10 for all individuals in residence 514 documented that the psychologist prepared integrated progress notes describing behavioral issues and the interventions utilized by staff. Some description of restraint use was included in the narrative of these notes. Information was provided to the Monitoring Team that documented monitoring initiatives undertaken by the Quality Assurance staff during the months of 12/10 through 2/11. The findings from this set of monitoring activities indicated the strengths and weaknesses related to Section C. The strengths included: restrictions/limitations governing the use of restraint; the monitoring by licensed health care professionals; supervision of the individual during restraint; timely review of restraint debriefing forms; and the hands-on involvement of the Director of Behavioral Services. The weaknesses included: the lack of specific instructions by the physician for the monitoring of pre-treatment sedation restraints; the lack of description or explanation of behavior occasionally found in the documentation of brief restraints; and "there is not always evidence of treatment integrity provided across all settings. For example, if an individual	

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		has a PBSP that is asking staff to prompt the individual to take deep breaths when he starts to get upset, there is no evidence this is happening at home, at the workshop, on community outings or wherever else the individual might be." A sample of documentation related to 26 incidents of non-medical restraint was reviewed (Sample #C.1), including the restraint checklists and the debriefing forms. This documentation showed that: ▪ In 19 (73%), this review occurred within three days of the restraint episode. In each instance, the circumstances leading to the use of restraint was discussed and an adequate review was conducted. For five incidents of restraint for Individuals #33 and Individual #190, the reviews did not occur timely, and for Individual #288, two episodes were not reviewed timely. ▪ As noted above with regard to Section C.7, teams did not consistently review and/or review appropriately individuals PBSPs. As a result, revisions were not always made as necessary and appropriate.	

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

1. Using the revised Restraint Checklist, which was developed to facilitate more descriptive information, staff need to more specifically note which replacement behavior (often there are multiple) was prompted and the result. More detailed information regarding other attempted preventative strategies (e.g., coping skills) might be helpful as well.
2. Trending and tracking of restraint use for recently admitted individuals should be conducted to determine the impact of new admissions on the rate of restraint.
3. As progress continues on developing desensitization plans, efforts should be made to ensure the plans are individualized. Assessments should be conducted to identify individual-specific preferences, current coping skills and/or deficits, and likely effective supports. Once identified, these elements should be incorporated into plans that can be implemented within natural settings, including opportunities to practice coping skills. In addition, desensitization plans should include components found within revised Skill Acquisition Plans (as discussed in detail with regard to Section S of the Settlement Agreement).
4. Individuals' progress on desensitization plans should be regularly documented and summarized. Consideration should be given to summarizing progress in Monthly PBSP Reviews (i.e., along with other behavioral data), or in Monthly PSP Reviews (i.e., along with other skill program data).
5. The Facility should ensure that a licensed health care professional monitors and documents vital signs and the 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.
6. If not already done, data should be collected and reviewed to determine whether or not restraints are released due to issues related to hunger, thirst, or the need to use the toilet.
7. The Facility should ensure that nursing staff assess and appropriately document any restraint-related injury.
8. In implementing the new format for PSP Addendum meetings following more than 3 restraints in a rolling 30-day period, the Facility should ensure that teams are: 1) reviewing the adaptive skills being taught to replace target behaviors; 2) explicitly stating support (or non-support) for current behavioral programming, including the rationale for and/or description of any necessary or desired revisions; 3) identifying the need to revise or conduct additional assessments (preference assessments, SFAR, FA, etc.); (4) examining actual data, including trends, Inter-

Observer Agreement, and/or treatment integrity data; and (5) providing the rationale as to why the PST decided to (or not to) revise the SFBA, PBSP, and/or SPCI.

9. The work of the various groups on the development of alternatives to restraint should continue to be a priority at each level of the organization, to realize the goal of substituting restraint with more positive and constructive interventions.

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 LBSSLC Policies: "Incident Management: Abuse, Neglect or Exploitation," revised 3/1/11, and "Incident Management: Managing Unusual Incidents," revised 3/1/11; o DADS Policies No. 002.2, "Incident Management," and No. 012, "Protection from Harm"; o 27 investigation reports involving 28 individuals; o Senate Bill 643; o Interagency Memorandum of Understanding Regarding Investigations of Abuse and Neglect in State Supported Living Centers, dated 5/28/10; o Minutes of the Self-Advocacy Group, for meetings from 10/10 through 2/11; o Minutes of the Pica Reduction Committee, for 1/11; o Minutes of the Human Rights Committee, from 10/6/10 to 3/9/11; o Minutes of the Incident Management Review Team meetings, for 10/10 through 2/11; o Injury reports, since 10/1/10, for individuals residing in living unit 514; o Injury reports from the last six months for Individual #60, Individual #203, Individual #73, Individual #171, Individual #301, and Individual #58; o Presentation Book for Section D; o Rights Poster; o Department of Family and Protective Services (DFPS) Investigator Training Modules (ILASD 1 through 4 and ILSD 7, 8, and 10); o Personal Support Plans (PSPs) for Individual #201, Individual #121, Individual #203, Individual #220, Individual #284, and Individual #316; o Corrective Action Plan in response to Medicaid surveyors' report, completed on 9/23/10; o Incident allegations referred to DADS Regulatory; o Training records/transcripts for Facility investigators; o Training records/transcripts for DFPS investigators; o Memorandum from Lori Henry regarding DFPS training, dated 3/7/11; o LBSSLC/DADS Regulatory/DFPS Joint Meeting Agenda, for 2/8/11; o Statements acknowledging reporting obligations signed by 103 employees; o Training transcripts for 33 employees regarding annual refresher training in the reporting of abuse, neglect and exploitation, and annual refresher training in PMAB; o Background Check documentation; o Fill and Turnover Summary report, YTD 2011-01 o Safety Committee Second Quarter Report dated 3/30/11; o List of incidents by Individual. ▪ **Interviews with**: o Libby Allen, Facility Director; o Donna Jessee, DADS, Director of Operations for State Supported Living Centers;

	○ Melinda Voight, Risk Manager; ○ Rick Robertson, Incident Management Coordinator; ○ Juli Ann Brown, Investigator; ○ Jim Forbes, M.Ed, C.B.A., Director of Behavioral Services; ○ Dawn Ripley, Director of Quality Assurance; and ○ Informal interviews/conversations with staff, Foster Grandparents and individuals. ▪ **Observations of**: ○ Site visits to all living units and the workshop. 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; ○ Incident Management Review Team Meetings, on 3/28/11, 3/29/11, and 3/31/11; ○ Self-Advocacy Group meeting, on 3/29/11; ○ Safety Committee meeting, on 3/30/11; ○ Quality Assurance/Quality Improvement Committee meeting, on 3/31/11; ○ Joint meetings (LBSSLC staff and Monitoring Team members) to discuss risk identification and intervention strategies for Individual #33, and Individual #253, on 3/29/11 and 3/31/11, respectively; and ○ PSP meeting for Individual #259, on 3/30/11.
	Facility Self-Assessment: In its Plan of Improvement, dated 3/14/11, the Facility stated that it was in substantial compliance with key requirements of Section D. Specifically, the POI indicated that the requisite policies had been issued, and revised to affirm the zero tolerance commitment and the duty to report allegations of abuse and neglect; the obligation to report was emphasized during New Employee Orientation and was confirmed by a signed statement; all alleged perpetrators were administratively reassigned to work duties without contact with the individuals residing at LBSSLC; annual competency-based training concerning the reporting of abuse, neglect and exploitation and other unusual incidents was mandatory; rights posters were posted throughout the Facility, including the 14 living units; Facility investigators had been trained as required; Facility investigators completed investigations of unusual incidents not involving allegations of abuse, neglect or exploitation, which were referred to DFPS for an independent investigation; there were cooperative relationships with the Office of Inspector General (OIG) and law enforcement agencies; the investigation reports were reviewed at the daily Incident Management Review Team meetings; recommendations were tracked; when allegations were confirmed, prompt and appropriate action was taken including, but not limited to, dismissal for any employee confirmed for physical abuse; there was a process in place for background checks and random drug testing. The Facility stated that additional effort was required to achieve substantial compliance with the requirement that semi-annual audits be conducted to determine whether significant resident injuries were reported for investigation; that each investigation of a serious incident be completed within 10 days; that each investigation report comply with the expected standards; that employee in-service training be completed as recommended; and that a system for the trending and tracking of unusual incidents and

	investigation results be fully implemented. It acknowledged a finding of noncompliance with these requirements of the Settlement Agreement. For Section D, the Facility included some data from its auditing activities, as well as narrative information, to substantiate its findings. However, for a number of the provisions for Section D, the POI did not include any data to support the findings of compliance or noncompliance. For example, no data was provided to substantiate the finding of noncompliance with regard to Section D.3.f, related to the content of investigation reports. As the Facility progresses in its self-assessment process, it will be important to utilize the information gained through the auditing process to identify areas in which improvements are needed, and to incorporate such information into the POI document.
	Summary of Monitor's Assessment: The strong leadership team at LBSSLC with its clearly articulated commitment to eliminating abuse, neglect, and exploitation was to be commended. There were important foundational elements in place that contributed to this goal. The Incident Management Review Team was cohesive and knowledgeable, the staff with investigative and risk management responsibilities were experienced and vigilant, there was a focus on strengthening the skills of the workforce, and there was a heightened sense of energy and purpose. There were positive developments in the documentation and analysis of unusual incidents. However, consistent efforts should continue to ensure timely reporting and the completion of investigations within the requisite timeframe. The evidence documented by the videotaping of the common areas underscored that there continued to be risk related to abuse and neglect in this environment. As a result, in order to ensure protection from harm, recruitment, training, and supervision of qualified and well-motivated staff should continue to be prioritized. In two cases reviewed, it was of concern that DFPS' investigation findings were not as stringent as needed to ensure protection from harm. In the first case, videotape footage clearly documented that one employee did not intervene when her co-worker, by holding the door shut, prevented an individual from leaving her room. DFPS did not cite the employee for failing to intervene. In the second case, DFPS failed to cite an employee for failing to intervene when his co-workers were tipping over a couch, causing Individual #284 to fall onto the floor. DFPS maintained its position despite the video footage documenting the failure to intervene, and OIG's finding of criminal activity by this employee. The Director appealed both DFPS decisions, but in one case, her request for appeal was denied, based on what appeared to be a technicality. Another area in which focused efforts were needed was the development and implementation of recommendations to address findings of investigations. Related to this was the need for improved trending and analysis, as well as in the development and implementation of plans to address issues identified as a result of these activities. The Facility had initiated a very positive approach to understanding and reducing behavioral concerns related to pica behavior that has the potential to place individuals at significant risk. A Pica Reduction Committee had been organized. Minutes for its meetings in 1/11 were reviewed. They revealed a depth of

	analysis, and clearly articulated interventions for specific individuals. A root cause analysis was conducted, and identified probable causes or contributing factors in seven areas, including staff skills and experience, and the environment. The environmental factors, including distraction, clutter, and supervision, were omnipresent, and were said to be difficult to address in a consistent manner due to the staff turnover, the design of the space, and the presence of so many people. While it was not questioned that the Facility's leadership had a strong commitment to ensure that abuse and neglect were not tolerated and that individuals were protected from harm, during the monitoring visit, it was noted that there were environmental and programmatic constraints that impeded these important efforts. Since the last monitoring visit, five individuals had been admitted to LBSSLC, all of whom had serious behavioral concerns. The residential space was limited, and had definite constraints in terms of privacy and individualization. Staffing had been affected by high turnover (51% annualized at the time of the monitoring visit). It was critical that there be an opportunity for the Facility to stabilize and implement its reform agenda. The promulgation of policies directed towards the elimination of abuse, neglect and exploitation have to be supported by practice. To alleviate the potentially risky congregation of individuals who required, and were entitled to, effective individualized supports, the admissions at LBSSLC should be examined in light of the policy expectations and the responsibility to protect individuals from harm.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The Facility's policies and procedures did: ▪ Include a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Require that staff report abuse and/or neglect of individuals. The Facility's policies regarding abuse, neglect, or exploitation mirrored those the DADS State Office issued. Since the last monitoring visit, revisions had been made to emphasize the commitment of zero tolerance for abuse, neglect, or exploitation of the individuals residing at LBSSLC. A section regarding disciplinary action had been added to the policy entitled "Incident Management: Abuse, Neglect or Exploitation." It stated: "Any DFPS finding that confirms Class I abuse will result in dismissal. Employee behavior that does not constitute abuse, neglect, or exploitation and is not determined to be reportable by DFPS but does violate HHS Employee Conduct standards as referenced in the HHS HR Manual, Chapter 4, may result in disciplinary action up to and including dismissal." The Facility's policies were supported by the strong leadership of the Director, and the competence of staff who participated in the daily Incident Management Review Team meetings. These meetings had evolved over the last year, and exemplified a strong working relationship among key staff. For example, there was evidence that information the Risk Manager obtained was more solidly incorporated into discussions about unusual incidents. This was not the case during earlier monitoring visits. In addition, the	Substantial Compliance

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		evidence obtained through videotaping had proven instrumental in implementing timely disciplinary action. Although the rate of staff turnover, currently annualized at 51%, needed close monitoring, it was reported to be attributable in part to a concerted effort to remove employees who did not meet expected standards. This commitment to making staffing changes, as appropriate and needed, ultimately will benefit the individuals LBSSLC supports, with improved protection from harm, as well as enhanced treatment and services. In practice, the Facility's commitment to ensure that abuse and neglect of individuals was not tolerated and to encourage staff to report abuse and/or neglect was illustrated by the following examples: ▪ All staff interviewed during the monitoring visit knew that abuse, neglect or exploitation would not be tolerated and stated that they were comfortable with the reporting requirements. None of the interviewed staff expressed concern about retaliation for reporting abuse, neglect, or exploitation. There was one example cited by the Facility that documented retaliation against a direct support professional, who reported physical abuse of an individual by a co-worker. However, the retaliation was not tolerated. The sister of the co-worker was employed at LBSSLC and retaliated, in an unspecified manner, against the reporter of the incident. The retaliation was confirmed, and the employee was dismissed from employment at LBSSLC. ▪ There was evidence that employees had been terminated for the abuse of individuals. While it was not questioned that the Facility's leadership had a strong commitment to ensure that abuse and neglect were not tolerated and that individuals were protected from harm, during the monitoring visit, it was noted that there were environmental and programmatic constraints that impeded these important efforts. First, LBSSLC had been admitting individuals with very challenging behavioral issues. These individuals required considerable attention from staff, and had intensified the possibility of disruptive interactions in certain residences. For example, the plans for creating stable learning and living environments in Residences 514 and 520 had been undermined by the increased census and the less harmonious grouping of individuals with significant needs for support. Staff reported increased stress and distraction. The already limited space was constrained by the addition of more people requiring very individualized and intense approaches. For example, a review of incident reports for Residence 514 documented that environmental factors created difficulty for certain individuals. On 1/28/11, one individual was instructed by staff to change his environment when "the home is at a noise level he does not like." The notation in the report described the home	

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		as "a little chaotic." On 3/12/11, one individual took another's soda, and was punched in the face. Another individual then came up and bit the individual on the wrist. On 3/7/11, one individual was sitting in a chair in the living room when another individual walked by, reached out and slapped him, causing scrapes to his forehead and lower lip. The admissions at LBSSLC should be examined in light of the policy expectations and the responsibility to protect individuals from harm.	
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.	According to the LBSSLC policy "Incident Management: Abuse, Neglect or Exploitation," staff were required to verbally report abuse, neglect, and exploitation within one hour. This was consistent with the requirements of the Settlement Agreement. With regard to serious incidents, the Facility policy entitled "Incident Management: Managing Unusual Incidents" required staff to report serious incidents within one hour of the discovery or observance of the incident to the Director or her designee. This policy was consistent with the requirements of the Settlement Agreement. During the monitoring visit, significant problems with the analysis of serious incident data were described in interviews with the Director, Risk Manager, Incident Management Coordinator, and Director of Quality Assurance. Timely reporting of trend analysis had not occurred as expected and as required by the Settlement Agreement. Accordingly, the data included in the document entitled "Trend Analysis Report for 6 Month Review Safety Committee" was considered unreliable for the purposes of this report. Information obtained from other sources indicated that there were 50 incidents reported during the month of 1/11. The majority of these incidents (32) involved injuries of a determined cause. During the period from 1/1/10 to 1/31/11: ▪ There were 199 case dispositions. Many times, cases involved multiple allegations of abuse and/or neglect surrounding the same incident. For example, an allegation might include physical, as well as verbal abuse. ▪ Of these, 75 involved allegations of neglect. There were 29 confirmed cases of neglect, 40 unconfirmed cases, and six cases considered inconclusive.	Noncompliance

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		▪ Cases involving physical or verbal abuse totaled 124 of the 199 case dispositions. There was a single case involving the most serious category of physical abuse (Physical Abuse I), which was unconfirmed. There were 99 cases of Physical Abuse II. Of these, 18 were confirmed, 72 were unconfirmed and 9 were inconclusive. ▪ There were 20 cases alleging verbal/emotional abuse. Of these, three were confirmed, 16 were unconfirmed, and one was inconclusive. ▪ The four cases alleging sexual abuse were either unconfirmed (three) or inconclusive (one). Based on informal interviews with 15 staff responsible for the provision of supports to individuals, all (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The Facility provided a list of all investigations regarding allegations of abuse, neglect, or exploitation that were begun between September 2010 and mid-February 2011. A random sample of 27 (22%) investigations was selected for review from this list. Two samples of investigations were selected for review. These included: ▪ Sample #D.1, which included a sample of DFPS investigations of abuse, neglect, and/or exploitation. This sample included the following investigation numbers: a) 385101155 (neglect of Individual #202 in a pica incident); b) 38521434 (physical abuse of Individual #288); c) 38543580 (neglect of Individual #109 in a pica incident); d) 38559456 (physical abuse of Individual #190 and Individual #203); e) 38619448 (neglect of Individual #310); f) 37844520 (physical and verbal abuse of Individual #154); g) 37948260 (neglect of Individual #122, Individual #136, Individual #211, Individual #293, and Individual #176); h) 38150061(neglect of Individual #34); i) 38410344 (neglect of Individual #293); j) 38479002 (neglect of Individual #184, causing serious injury); k) 38479980 (neglect of an unknown individual in 516); l) 38492722 (neglect due to pica incident by Individual #135); m) 38493487 (neglect of Individual #225); n) 38493890 (neglect of Individual #220 and Individual #284 in peer aggression); and o) 38503299 (neglect of Individual #315). ▪ Sample #D.2 included a sample of Facility investigations. One of these was an investigation that had been referred to the Facility by DFPS, while the others were investigations the Facility completed related to serious incidents. This	

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		sample included the following investigations: a) 11-09-003 (unauthorized departure of Individual #240 from LBSSLC); b) 11-10-032 (serious injury to Individual #175 from fractured fingers); c) 11-10-045 (serious injury to Individual #213 from a fall); d) 11-11-049 (serious injury to Individual #106 from a fall); e) 11-11-054 (peer-to-peer aggression involving Individual #276, and Individual #220); f) 11-11-066 (verbal abuse of Individual #26); and g) 11-12-080 (serious injury to Individual #4 from a fall). In addition to the investigation reports contained in Samples #D.1 and #D.2, five additional investigation reports were selected non-randomly for review. These incident reports included: ▪ Investigation #11-09-023 involving Individual #203. This incident was documented by video footage, and resulted in charges of criminal activity against four employees. Three of these employees were terminated, and the Director appealed the DFPS finding regarding the fourth employee. ▪ Investigation #11-01-104 involving Individual #203. This investigation resulted in the termination of the employee confirmed for physical abuse. ▪ Investigation #11-02-123 involving Individual #318. The OIG found criminal activity in this case, and at least one employee was terminated for physical abuse. The information regarding disciplinary action against two other employees who failed to intervene was not included in the file. They both were cited for neglect. This case also identified a Campus Coordinator's failure to respond to a request for assistance at the residence, so that a report could be called in to the hotline. The Campus Coordinator was counseled, and received additional training in prioritization of tasks. ▪ Investigation #11-12-096 involving Individual #45. In this case, neglect was confirmed. The employee failed to conduct bed checks and, as a result, the Individual was found soaked thoroughly by urine. He was noted to have an early stage decubitus after the incident. The bed checks were ordered due to his high sensitivity to urine on his skin. ▪ Investigation #11-11-072 did not involve any individuals. It concerned the theft of drugs from the medication room. The incident was referred to the OIG, who confirmed the allegation. The alleged perpetrator was referred to the office of the Criminal District Attorney. Based on a review of the 22 investigation reports included in both Sample #D.1 and Sample #D.2: ▪ Only five of the 15 investigations conducted by DFPS included evidence that allegations of abuse, neglect, and/or exploitation were reported within the	

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		timeframes required by Facility policy. Those investigations included #37844520 #38503299, #38521434, #38559456, and #38479980. There were two investigations (#38410344 and #38543580) that were reported after the injury was reported/identified. The actual time of the event was not known. The remaining eight incidents were not reported timely (i.e., within one hour of their occurrence). This resulted in five of 13 (38%) being reported timely. ▪ The investigations of serious incidents conducted by the Facility documented that three of seven incidents (67%) were reported within one hour. In Incident #11-12-080, the report was nearly an hour late. In Incident #11-10-032, reporting was 15 hours late. ▪ All 22 reports (100%) included evidence that allegations of abuse, neglect, exploitation and reports of serious injury were reported to the appropriate party as required by Facility policy Four of the five investigations included in Sample #D.3 were governed by the reporting timelines included in the Settlement Agreement and Facility policy. (The fifth investigation involving theft of medication was referred to the OIG for investigation.) Based on a review of these four reports: ▪ Two reports (50%) showed evidence that serious incidents were reported within the timeframes required by Facility policy. The following incidents were not reported in a timely manner: o Incident #11-12-096: Individual #45 was found soaked in urine at 6:30 a.m. on 12/31/10. The direct support professional reported this to the Licensed Vocational Nurse (LVN). DFPS was notified at 8:32 a.m.; and o Incident #11-09-023: Individual #284 was tipped off the couch in the day room on 9/23/10 at 5:10 p.m. The incident was reported to DFPS at 10:03 pm on the same day. ▪ All four reports (100%) showed evidence that serious incidents were reported to the appropriate party as required by Facility policy. The Facility had a standardized reporting format. This format was comprehensive, and included reference to all of the criteria required by the Settlement Agreement. In addition, LBSSLC had developed an Unusual Incident Report (UIR) tracking cover sheet, which summarized relevant information about reporting, and an Investigation Review Sheet, which noted and tracked the contents of the investigation file. An Investigation Review/Approval Form that the Incident Management Coordinator signed also had been developed. Unfortunately, these forms were not always present in the files that were reviewed. Based on a review of 22 investigation reports included in Sample #D.1 and Sample #D.2, 22 of them (100%) contained a copy of the report utilizing the required standardized	

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		format. However, not all sections of the report form were completed in the final investigations. The omissions were noted on the signature pages. Additionally, although not related to compliance, reports signed by the Assistant Ombudsman were reviewed months after the final report was submitted. Based on a review of five reports included in Sample #D.3: ▪ Five (100%) utilized the standardized reporting format; and ▪ Two (40%) were completed fully. The following incidents did not have a fully completed form: o Incident #11-12-096 lacked the APS Supervisor's signature; o Incident #11-11-072 lacked the signatures of both the Incident Management Coordinator and the Director; and o Incident #11-02-123 lacked the signature of the Incident Management Coordinator.	
	(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.	According to LBSSLC's policy "Incident Management: Abuse, Neglect or Exploitation," the Facility must immediately remove alleged perpetrators, if known, and must take actions to ensure the safety of the individual. Based on a review of 22 investigation reports included in Sample #D.1 and Sample #D.2, all (100%) of the alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. Reportedly, it is the policy/practice of LBSSLC to assign alleged perpetrators away from the site of the allegation until the investigation is completed and they are cleared. However, the Facility had not yet developed a database to track the date of return to duty or the final action, if any, taken against the employee. Until a system is in place to demonstrate that staff are not returned to work until they are cleared of wrongdoing, compliance with this provision cannot be confirmed. The progress of this initiative will be reviewed during the next monitoring visit. Clearly, the Facility had demonstrated its commitment to fulfill this obligation of the Settlement Agreement. In addition, it had taken steps to reassign alleged perpetrators, under supervision, to administrative tasks. This practice had reduced greatly the possibility that false reports would be called in so that leave with pay was granted for the employee's convenience. Based on a review of all of the above investigation reports, it was documented that adequate additional action was taken in each instance to protect individuals who were the alleged victim in an investigation. For example: ▪ The Critical Incident Team met the same day as the peer-to-peer aggression	Noncompliance

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		occurred in Incident #11-11-054. A PSP Addendum was prepared after the team's review of the incident. ▪ A revised PNMP was developed in response to Incident #11-11-049, after Individual #106 experienced a serious fall from a van. ▪ After Individual #240, upset with a peer, rode his bike into University Street, placing himself and staff in danger, one-to-one supervision was initiated to keep the individual safe, until the team could meet with him to review the events leading up to the incident.	
	(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.	According to LBSSLC policy "Incident Management: Abuse, Neglect or Exploitation," all staff were obligated to attend competency-based training on preventing abuse and neglect during pre-service and every 12 months thereafter. All required training must be appropriately documented by certification and by date of completion. Supervisors were to periodically assess employee knowledge, and provide additional training as needed. This was consistent with the requirements of the Settlement Agreement. Review of hiring records for 1/11 and 2/11 indicated that 70 staff (100%) had completed competency-based training on abuse and neglect prior to working directly with individuals. Acknowledgement of responsibility for reporting forms were provided for 69 (99%) of these employees. A list of staff delinquent in the annual abuse and neglect refresher training (Course ABU0100) indicated that 23 out of 874 staff had not completed this training in a timely manner. As a result, the completion rate for this requirement was 97%. During the informal site visits to the living units and to the workshop, 15 direct support professionals were queried about the process of reporting allegations of abuse, neglect, or exploitation, and their comfort level with these obligations. Some of the staff interviewed had reported allegations of abuse and neglect. All were confident that their reporting was taken seriously, and all but one knew the outcome of the investigation. All (100%) of these staff were able to describe reporting procedures accurately. All wore identification badges listing the steps for reporting abuse, neglect, exploitation, or other serious incidents.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are	According to LBSSLC's policy "Incident Management: Abuse, Neglect or Exploitation," all staff must sign a statement acknowledging zero tolerance for abuse, neglect, and exploitation of individuals, and the obligations for reporting any suspected abuse, neglect, or exploitation during pre-service and every twelve months thereafter. LBSSLC was to maintain copies of these signed forms. As discussed above, copies were requested of the forms for staff hired during the two full	Substantial Compliance

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	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.	months prior to the on-site review. Based on a review of those forms, 69 of 70 (99%) of the staff hired during this time period had signed the statement acknowledging their reporting obligations. An additional sample of 33 employees was selected randomly to determine if annual statements had been signed. Of the 33 employees, 33 (100%) had signed these statements at the time of their annual refresher training. The Facility was asked for a list of staff identified as having failed to report abuse and/or neglect. In response, it was documented that there was no process in place at this time to track this information. However, a lack of a tracking system did not appear to be preventing the Facility from taking "appropriate action in response to any mandatory reporter's failure to report abuse or neglect." In the Monitoring Team's review of investigations files, due to DFPS's policy of not identifying the reporter, it could not be determined whether or not staff made the allegations, or individuals, visitors, or family members. This also made it impossible for the Monitoring Team or the Facility to determine if staff who witnessed an incident had, in fact, reported it. Anonymity in reporting is standard practice, and is necessary to encourage reporting. However, it makes assessment of whether or not mandated reporters have fulfilled their obligations difficult. Extensive discussions with the Director and key staff at LBSSLC confirmed their strong commitment to enforcing the reporting obligations mandated by policy and the Settlement Agreement. As noted above, the Director had raised serious concerns about the failure of DFPS investigators to confirm abuse or neglect, when an employee fails to intervene during an abusive or neglectful situation. Three videotape segments were reviewed during the course of this monitoring visit. In each of the three incidents, employees assigned to the living units were present and failed to intervene, and potentially failed to report these incidents. These employees were not cited for their failures to protect individuals from harm in the final investigations submitted from DFPS. The Director appealed those decisions. This is discussed in further detail with regard to Section D.3.f.	
	(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	A review was conducted of the materials used to educate legally authorized representatives (LARs), or others significantly involved in the individual's life. The brochures provided for review were condensed, but informative. A copy of the letter prepared by the Incident Management Coordinator was included in the information packet. The letter contained some confusing instructions. First, the LAR was invited to contact the Incident Management Coordinator, if there were any questions or concerns and, then, the LAR was told "…I want to discourage you from calling me and asking me if I	Noncompliance

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	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.	think it is abuse/neglect, etc. If you suspect it is, please call the DFPS hotline." For the sake of clarity, it was recommended that this letter be rewritten. Although the point appeared to be that the LAR should always feel empowered to call the hotline, it also is important to ensure they feel they are able to call the Facility if they have questions. Also, it was not clear how many LARs actually received this letter and the accompanying information. The Facility stated that it utilizes annual PSP meetings to educate primary correspondents and LARs about the means to identify and report unusual incidents including allegations of abuse, neglect and exploitation. However, based on a review of six individuals' PSPs, there was evidence that only three individuals (Individual #201, Individual#220, and Individual #284), their LAR, and/or other significantly involved individual (50%) received a copy of the Recognizing Signs of Abuse Resources Guide. The PSPs for Individual #203, Individual #316, and Individual #121 did not indicate that similar information had been provided to them, their LARS, or significant others. A review was conducted of two serious incidents reported by individuals residing at LBSSLC. In both instances, there was evidence that Facility staff provided adequate support to the reporter. In the cases of Individual #154, who was the only LBSSLC individual on the "streamlined caller" list, and Individual #251, who had a history of unfounded calls, a training session was conducted by the APS Supervisor for their entire living unit to explain the nature of abuse, how to manage anger towards staff, and how to develop trusting relationships. This sensitive approach to a challenging issue should be considered for replication in other units, as appropriate.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The "Incident Management: Abuse, Neglect or Exploitation" policy LBSSLC promulgated required the posting and supplying of information on individual rights in a "visibly, accessible area on each living unit and day program site." The Facility had printed a poster that used pictures/symbols to describe an individual's rights. The poster included information about how to exercise such rights, and how to report any violations. The Human Rights Officer's photograph and contact information were included on the poster. The Monitoring Team's observations of all residences, and the workshop showed that each of those areas (100%) had postings of individuals' rights in an area to which individuals regularly had access. However, in two residences, the posters were partially obscured by furniture. When asked, employees working in the residences and the workshop were able to describe, in general terms, how the posters were used to teach individuals about their	Substantial Compliance

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		rights. Individual #121 was able to locate the poster in the hallway of her living unit and was knowledgeable about its content. The Facility had organized a Self-Advocacy Group that met monthly to address rights issues and to participate in activities that would facilitate the exercise of rights. Its membership appeared to be drawn primarily from those individuals who participated in the workshop program. The Human Rights Officer supported the members, and was working to facilitate the group's election of a slate of officers. It was important that the members assume leadership of this group. Installation of officers should be a priority, and opportunities should be provided for them to develop leadership skills through attendance at statewide and national forums. It was positive that at each of the monthly meetings, the group discussed a particular right, and its applicability to the members. In addition, efforts were being made to involve the group in activities that facilitated the exercise of their rights. For example, the group had raised with the Facility's Administration the question of why some residences on campus had cable television, and others did not. The role of the Assistant Ombudsman continued to require clarification and support if this position was to be effective in supporting the exercise of rights at LBSSLC. This issue had not been resolved satisfactorily since the last monitoring visit. Although the Settlement Agreement does not address specifically the role of the Assistant Ombudsman, clarification of the role will be important to ensuring overall that individuals are adequately protected from harm. This office provides an independent forum for individuals to enforce their rights. As noted above, two individuals in one residence had histories of filing unfounded reports. In 2/11, the APS Supervisor conducted a training session for the individuals in this residence. Eleven individuals attended. The training focused on the nature of abuse, ways to manage anger, and the development of trust. This approach appeared to be both sensitive and responsive to the experiences and needs of these individuals. It was an effective strategy for teaching rights and responsibilities and should be considered for replication in other residences. For this provision, the Facility had met the requirements of the Settlement Agreement, and was engaging in other activities that supported the intent of this provision. As a result, the Facility was found in substantial compliance with this provision.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to LBSSLC policy "Incident Management: Abuse, Neglect or Exploitation," within one hour upon discovery or notification that an allegation might involve criminal activity, the Director or her designee were to notify DFPS who was then responsible for notifying law enforcement agencies. Allegations involving "sexual exploitation"	Substantial Compliance

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		committed by a mental health services provider were to be reported by the Director or her designee to the prosecuting attorney and the appropriate state licensing board. DFPS referred one of the incidents in Sample #D.1 to law enforcement officials. This was an appropriate referral. In the incident that was the subject of Investigation #38493890, two direct support professionals watched one individual hit, choke, and throw ice at a second individual. The staff did not intervene to stop the aggression. The incident was captured on videotape. The OIG investigated and found criminal intent. Both alleged perpetrators were terminated from employment. None of the Facility investigations reviewed in Sample #D.2 were referred to a law enforcement agency. Referral was not necessary in any of these incidents.	
	(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.	According to LBSSLC's policy "Incident Management: Abuse, Neglect or Exploitation," retaliation against a person for reporting abuse, neglect or exploitation was prohibited. Any person, who believed he or she was being subjected to retaliatory action upon reporting an allegation, or who believed an allegation had been ignored, was directed to immediately, within one hour, contact the Director or her designee. The Office of the Attorney General, the Office of the Inspector General, and DFPS also could be contacted. The Whistleblower Act, Texas Civil Statutes, Article 6252-16a, permitted prosecution of a supervisor who suspended, or terminated a public employee for reporting a violation of law to law enforcement authorities. Any employee or agent found to have engaged in retaliatory action was subject to disciplinary action. Based on interviews with the Director, the Incident Management Coordinator, and one of the Facility Investigators, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ Prompt access to the Director or her designee for reporting any retaliatory action; ▪ Explicit discussion/instruction regarding the prohibition on retaliation during orientation and annual refresher training on the reporting of abuse, neglect and exploitation; and ▪ Decisive action to investigate any report of retaliation and to discipline anyone confirmed of committing retaliation. Based on informal interviews with 15 staff, all reported they were confident that retaliation would not be tolerated. There were no concerns expressed during these conversations. Based on a review of investigation records, there were no concerns noted related to potential retaliation.	Substantial Compliance

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		The Facility was asked to identify any employee disciplined due to his/her involvement in retaliatory action against another employee who had in good faith reported an allegation of abuse, neglect or exploitation. One such incident was reported during this monitoring visit. The employee confirmed of retaliatory action was terminated from employment.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to the Facility's policy "Incident Management: Abuse, Neglect or Exploitation," all injuries must be treated and documented. It also required the Incident Management Coordinator to "review and make use of audit reports that evaluate whether significant resident injuries are reported for investigation, at least semi-annually." The Facility acknowledged that it was just beginning to implement a reliable system for auditing whether significant resident injuries were reported for investigation. The turnover in the Incident Management Coordinator position appeared to have delayed efforts to achieve compliance with this requirement. Campus Coordinators were now conducting random sampling, on a monthly basis, to determine whether the information in the individuals' notebooks was reflected in the Progress Notes nursing staff entered. When discrepancies were found, the Campus Coordinators were required to notify Incident Management, the Personal Support Team, the Unit Director, and the Chief Nursing Executive. Examples of the documentation prepared by the Campus Coordinator were included in Presentation Book D. On 8/16/10, Individual #58 caught his finger in the door of the staff restroom in 526. The tip of his finger was amputated. The recommendation from the daily meeting was "DSS [direct support staff] will redirect [Individual] from doorways when doors are opening or closing." There was no reference to safety inspections of others doors on that living unit or throughout the Facility to ensure that doors opened and closed properly. It should be noted that this set of circumstances was reviewed state surveyors on 9/23/10. Their report cited the failure to conduct safety checks of self-closing doors throughout the Facility. According to their report, as a result, two other Individuals were injured.	Noncompliance
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		

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	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 012: Protection from Harm-Abuse, Neglect and Exploitation, dated 6/18/10, established procedures for the identification, reporting, trending, analysis of incidents, and prevention of abuse, neglect and exploitation at State Supported Living Centers. DADS Policy Number 002.2 specified the training required for investigators, and the expectation that they not be in the direct line of supervision of an alleged perpetrator. LBSSLC's policy "Incident Management: Abuse, Neglect or Exploitation" described in a detailed manner how investigations would be conducted by the Facility or referred to DFPS. The policy required that investigators be qualified through training, including completion of specific courses: Comprehensive Investigator Training, People with Mental Retardation, Conducting Serious Incident Investigations or Fundamentals of Investigation, and a class in root cause analysis. The policy also stated that the investigator must not be in the direct line of supervision of the alleged perpetrator. None of the DFPS or Facility investigators were within the direct line of supervision of alleged perpetrators. Training curricula were reviewed for DFPS and Facility investigators. This review revealed the following: ▪ DFPS provided transcripts regarding the training provided to its investigators. According to the information provided, all investigators had received training in fundamentals of investigations, and in working with people with mental retardation. DFPS training for investigators included Instructor Led Skills Development (ILSD) and Instructor Led Advanced Skills Development (ILASD) for anyone employed from 2008 to the present. According to DFPS, prior to 2008 these courses had different names, but essentially the same content. The provided curricula included modules 1 through 4 of the ILASD training, and Modules 7, 8, and 10 of the ILSD training. These two courses included segments on interviewing persons with developmental disabilities, as well as overviews of the laws and policies governing the conduct of investigations, causes of abuse and neglect, evidence collection, analysis of evidence and report writing. The ILSD and ILASD training appeared to be adequate with regard to the conduct of investigations in that they provided useful information about interviewing skills, writing reports, detecting deception, and collecting and analyzing	Substantial Compliance

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		evidence. What was not as clear was whether the training included instruction on how to complete the DFPS report, how to review and use information from past investigations, and how to determine when recommendations would be warranted and develop appropriate recommendations. Again, although the training covered the basics of investigations, ongoing training should cover additional topics, such as these listed. The training was not competency-based. Although it included training on topics tied to job performance, and included opportunities for discussion and practice, it was not clear that the training included any methods for evaluating performance as a result of the training. While these modules were instructive and included opportunities for discussion and practice, there was no information about the standards for satisfactory performance or how performance was actually rated. Although the Settlement Agreement does not require competency-based training for this provision, it is suggested that DFPS ensure that its training includes demonstration of knowledge and performance competencies. ▪ Both Facility Investigators had direct experience in working with individuals with mental retardation/developmental disabilities. Their training transcripts indicated that they had been trained in the courses required by the LBSSLC policy. Furthermore, since the last monitoring visit, both investigators had been trained in root cause analysis.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Both State policy and policy governing LBSSLC required cooperation with outside entities conducting investigations of abuse and neglect. This included deferring the interviewing of alleged perpetrators of abuse, neglect, or exploitation to the outside entities. Case files reviewed during this monitoring visit documented that LBSSLC staff followed these policy directives consistently. As described above with regard to Section D.2.a of the Settlement Agreement, two samples of investigation files were selected for review. These included Sample #D.1 and Sample #D.2, which consisted of DFPS investigations and Facility investigations, respectively. ▪ Review of the investigation files in both samples showed that in all investigations (100%), Facility staff cooperated with DFPS investigators. Additionally, Sample #D.3 included one investigation (#11-11-072, theft of medication) completed by the OIG. There was evidence of cooperation in this investigation, and the OIG provided two recommendations for greater oversight of prescription drugs. In an effort to increase interagency collaboration, on 2/8/11, the Director of LBSSLC	Substantial Compliance

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		convened a meeting with DFPS, DADS Regulatory, and the OIG to review issues related to investigations and the requirements of the Settlement Agreement. During interviews with the Director, the Incident Management staff, and the Risk Manager, the working relationships with DFPS and the OIG were described in positive terms.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Minutes from an interagency meeting held on 2/8/11 included attendance by representatives from LBSSLC, DADS Regulatory, the OIG, and DFPS. The discussion included the timeliness of DFPS investigations, and the conflict between some DFPS and OIG investigation outcomes. Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 15 investigation records from DFPS (Sample #D.1), one (38493890) had been referred to law enforcement agencies. In this instance, there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the 7 investigation records from the Facility (Sample #D.2), none, by nature of the incidents, were required to be referred to law enforcement agencies.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The LBSSLC policy on "Incident Management: Managing Unusual Incidents" provided instruction on the safeguarding of physical evidence. It required that the evidence be handled as little as possible to prevent destruction, labeled clearly, and secured in the Incident Management Office. Based on a review of the investigations completed by DFPS (Sample #D.1) and by the Facility (Sample #D.2), there were no incidents requiring the safeguarding of physical evidence. LBSSLC had the capacity to videotape common areas in the residential units. Two staff under the supervision of the Risk Manager monitored these areas through the video cameras. Surveillance was 24 hours a day. The videotapes had been used successfully to identify and document abusive or neglectful practices. The tapes had provided	Substantial Compliance

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		important evidence that resulted in disciplinary action, including termination from employment. In addition, the videotapes had been used to analyze behavioral episodes, in order to develop appropriately individualized interventions and to ensure that any restraint was implemented correctly. LBSSLC also used photographs to document injuries. These photographs were included in the investigation report files. The LBSSLC policy on "Incident Management: Managing Unusual Incidents" contained instructions on the use of photographs to document injuries.	
	(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 policies cited above required that investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. In order to determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Ten out of 15 (67%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. o The following were the investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: Investigation #38479002; Investigation #37844520; Investigation #38410344; Investigation #38493487; Investigation #38503299; Investigation #37948260; Investigation #38479980; Investigation #38150061; Investigation #38492722; and Investigation #38493890. o The following were investigations for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary,	Noncompliance

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		based on the documentation provided: ▪ Investigation #38521434, an allegation of physical abuse, was commenced two days after notification to DFPS; ▪ Investigation #38619448, an allegation of neglect, began two days after DFPS was notified; ▪ Investigation #385101155, an allegation of neglect, was initiated 28 hours after notification was provided; ▪ Investigation #38559456, an allegation of physical abuse and neglect, was initiated 25.5 hours after notification; ▪ Investigation #38543580, allegation of neglect, was initiated three days after notification. Based on the Monitoring Panel's discussion with DFPS in December 2010, DFPS is in the process of developing a format to better document activities that occur within the first 24 hours of the investigation. The Monitoring Team looks forward to reviewing such additional information during upcoming reviews. ▪ Four out of 13 (31%) were completed within 10 calendar days of the incident, including sign-off by the supervisor, or had appropriate extensions granted. Two of the 15 had been returned to the Facility for investigation. The timely signed investigations included: Investigations #38493890 and #37884520. Another two investigations had signed written extensions. These two investigations met the extension timeline: Investigation #38503299 and Investigation #38492722. Documentation was included in each of these reports explaining why additional time was needed. A more accurate word than "extraordinary" might be "reasonable." For example, the delays were attributed to unavailable witnesses, or the identification of an additional alleged perpetrator. These were reasonable requests, and each request for an extension was granted. Signatures from the APS Supervisor were not evident in the other nine DFPS investigation reports and, therefore, they were not considered to be timely or complete submissions. ▪ All investigations resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In two of the investigations reviewed (#38492722 and #38619448), recommendations for corrective action were included. In both of the investigations, the recommendations were adequate to address the findings of the investigation. The following are example of an investigations that included appropriate recommendations:	

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		○ Investigation #38492722 involved pica behavior. The DFPS investigator made a sensible recommendation that a place to store the individual's coins be designated and used consistently by staff as a teaching aid. The PST adopted the recommendation, and a lock box was to be purchased. In addition to this recommendation, the PSP Addendum outlined a number of other actions that were to be taken to reduce the behavioral risks. The majority of the DFPS investigations did not offer any recommendations. Although it might not always be in DFPS' purview or area of expertise to offer recommendations, recommendations are key to ensuring issues noted in the investigations are addressed. At LBSSLC, the PSP teams were responsible for designing and implementing corrective actions. Discussions of this nature took place in the residences, with the clinical disciplines, and, to a much lesser extent, in the daily Incident Management Review Team meeting. In some of the investigation files, there was evidence that PSP Addenda were developed or that in-service training was provided to staff. However, it was of concern when these actions happened after the fact, rather than in a proactive manner. For example, for Investigation #38493487, the feeding tube of Individual #225 was dislodged. The investigation did not find neglect, because the staff was not trained in the maintenance of a Jejunostomy tube (J-tube). Although in-service training was initiated, there was no question raised as to why inexperienced personnel were given such a responsibility in the first place. This would have been necessary to ensure that a comprehensive set of recommendations was developed to prevent recurrence. DFPS and DADS should work together to determine the best process for ensuring appropriate recommendations are developed and implemented. <u>Facility Investigations</u> The Facility provided information about the follow-up to any incident in the investigation file itself. The following summarizes the results of the review of seven Facility investigations: ▪ Seven out of seven (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. The following are examples of investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: ○ Investigation #11-12-080 regarding a fall; and ○ Investigation #11-09-003 regarding an unauthorized departure; ▪ Five out of seven (71%) were completed within 10 calendar days of the	

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		incident, including sign-off by the supervisor. One investigation (#11-10-045) was four days late, and one investigation file (#11-11-066) was not returned after a mock survey was completed at the Facility. ▪ For the one investigation that was not completed within 10 days, for which information was available, there was no documentation of a written extension request that had been approved by the Facility Director. ▪ Six out of seven investigations (86%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In six of the 7 investigations reviewed (86%), recommendations for corrective action were included. ▪ In all of the investigations (100%) in which recommendations were present, the recommendations were adequate to address the findings of the investigation. The following are examples of investigations that included appropriate recommendations: o In-service training was provided to staff in three cases (#11-11-049, #11-10-045, and #11-11-054) involving injuries or aggression towards peers.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material	The State and LBSSLC policies regarding Abuse, Neglect, or Exploitation, and Incident Management referenced above required that: ▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion; ▪ The report utilize a standardized format that set forth explicitly and separately: o Each serious incident or allegations of wrongdoing; o The name(s) of all witnesses; o The name(s) of all alleged victims and perpetrators; o The names of all persons interviewed during the investigation; o For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o All documents reviewed during the investigation; o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o The investigator's findings; and o The investigator's reasons for his/her conclusions. The investigators have been trained in the preparation of the investigation report, and, in general, there was a thorough response to each of the required sections. Although	Noncompliance

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	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.	previous incidents or investigations involving the victim and alleged perpetrator were cited in the narrative, there was not any analysis of past findings or the recommendations that were to have been implemented. In considering ways to strengthen the investigation process, more in-depth analysis about previous incidents involving both the victim and the alleged perpetrator would helpful to the formulation of conclusions and the development of recommendations. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ With the exception of four investigations, as described below, in 11 out of 15 investigations reviewed (73%), the contents of the investigation reports reviewed were sufficient to provide a clear basis for its conclusion. The investigations for which concerns were noted included: o The investigation of Incident #38521434 included a review of the video footage. The investigator concluded that there was inconclusive evidence of abuse, even though the footage showed the alleged perpetrator holding the door closed with both hands. The staff member did not shout out for assistance from co-workers. The Director asked for a methodological review of this finding, but DFPS refused. In its response to the Monitoring Team's draft report, DFPS indicated: "The basis for the requested methodological review was not appropriate since it was based on the comparison of the outcome (not the methodology) to another DFPS investigation, which contained a totally different set of facts. However, a request for review of findings by state office would have been appropriate for any concerns the facility may have had about the finding. This was a very complex case, and the facility chose not to request a review of finding." However, this response did not resolve the Monitoring Team's concerns about the adequacy of the investigation, or the conclusions drawn by the investigator. o The investigation of Incident #38150061 did not question how Individual #34 could have swallowed a hearing aid battery while she was on an Enhanced Level of Supervision. There was no in-depth interview of the staff person assigned that responsibility. In its response to the Monitoring Team's draft report, DFPS indicated: "DFPS	

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		state office agrees that the incident should have been investigated for neglect rather than referred back to the facility for further action. DFPS will discuss this referral with the regional office to clarify that the intake and subsequent documentation indicated a full investigation was warranted." o In Incident #38410344, Individual #293's knee was fractured. It was alleged that the injury was a result of neglect. Staff denied knowledge of how the injury happened. The investigator found their statements to be credible because, "they state that they did not know how (the Individual) was injured." There was no further analysis. In its response to the Monitoring Team's draft report, DFPS indicated: "Incident #38410344 - DFPS state office agrees that the investigator's credibility statement should have been based on the internal consistency of the individual statements with the statement given by the physician indicating the cause of the injury was not due to abuse or neglect. DFPS state office feels the finding that was reached was the correct finding given the physician's statement." o In Incident #38503299, the Director appealed the finding because the investigator failed to interview two witnesses, the investigator made a subjective statement about motivation, and there was a lack of corroboration of information provided by one of four staff. The finding was upheld. However, in reviewing the investigation, the Monitoring Team concurred with the Director, and questioned the thoroughness of the investigation, and the justification for the findings. One employee was confirmed of emotional/verbal abuse. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 15 out of 15 (100%), each serious incident or allegations of wrongdoing; o In 15 out of 15 (100%), the name(s) of all witnesses; o In 15 out of 15 (100%), the name(s) of all alleged victims and perpetrators; o In 15 out of 15 (100%), the names of all persons interviewed during the investigation; o In 15 out of 15 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 15 out of 15 (100%), all documents reviewed during the investigation; o It could not be determined whether all sources of evidence were considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the	

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		investigating agency. In a meeting in December 2010, DFPS indicated that investigators reviewed previous investigations electronically and only commented in the investigation report if there was relevance. However, this did not provide a mechanism for the Monitoring Teams to ascertain whether this had been done. DFPS agreed to include a statement that would describe the results of these reviews in future investigations. DFPS has indicated that it is in the process of drafting policy to instruct investigators to document the review of prior case history in each investigative report; o In 15 out of 15 (100%), the investigator's findings; and o In 15 out of 15 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations involving serious incidents: ▪ In seven out of seven investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately o In seven out of seven (100%), each serious incident or allegations of wrongdoing; o In seven out of seven (100%), the name(s) of all witnesses; o In seven out of seven (100%), the name(s) of all alleged victims and perpetrators; o In seven out of seven (100%), the names of all persons interviewed during the investigation; o In seven out of seven (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In seven out of seven (100%), all documents reviewed during the investigation; o Although the previous histories of both the individual and the alleged perpetrator were listed, it was uncertain as to how much analysis was included in the review of the facts. As a result, in none of the seven (0%) was there evidence that all sources of evidence were considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In seven out of seven (100%), the investigator's findings; and o In seven out of seven (100%), the investigator's reasons for his/her	

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		conclusions.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Based on review of the DADS and LBSSLC policies referenced above, there was a clear expectation that investigations would be reviewed, and that recommendations would be acted upon in a timely manner. Ultimately, it was the Director's responsibility to ensure that the investigation was complete, and that the report itself was accurate, complete, and coherent. The Director was responsible for addressing any deficiencies, and might interview witnesses and/or speak with the investigator. In order to implement these responsibilities, the Director had to rely on the Incident Management Coordinator and his staff, and on the members of the Incident Management Review Team, which was a team comprised of leadership staff that met daily, except on weekends or holidays. The Incident Management Coordinator played a critical role in this process of review. Unfortunately, there had been turnover in that position at LBSSLC, and, as a result, mandated responsibilities had not been implemented to the extent necessary to eliminate risk in this environment. The Director considered recruitment for this position a priority. With the exception of this current problem, LBSSLC had a comprehensive process for the review of investigations. Although there were instances where there was not a prompt or complete review documented in the record, the overall structure for an appropriate review had been implemented at this Facility. The Incident Management Coordinator was responsible for ensuring that investigations were completed according to policy. The deadlines for investigations were tracked in the minutes of the daily Incident Management Review Team meetings. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In four out of 15 investigation files reviewed (27%), there was evidence that the supervisor had conducted a review of the investigation report. These included: #38493890, #38492722, #37844520, and #38619448. ▪ In none of the investigations was there evidence of any changes being recommended and/or completed. Based on the deficiencies noted in some of the reports, it did not appear that the DFPS supervisor's review had resulted in these being identified, or in changes being made to correct deficiencies. However, as cited above, there was evidence of the Facility Director's review, and of her attempts to clarify or correct certain conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations:	Noncompliance

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		▪ In four out of seven (57%) investigation reports reviewed, there was evidence that the supervisor had conducted a timely review of the investigation report. There were no signatures included for Investigation #11-10-045. The review of Investigation #11-11-054 was late.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility's compliance with the completion of investigations for serious incidents is discussed in detail with regard to Section D.3.f.	Noncompliance
	(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.	According to the State and LBSSLC policies cited above, disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence was to be taken promptly and thoroughly. In addition, the Facility was to have a system for tracking and documenting such actions and the corresponding outcomes. As part of the documents that were provided after the onsite review, the Facility provided information documenting the disciplinary action taken as a result of investigation findings confirming abuse, neglect, or other serious incidents. According to the documentation provided, since 10/1/10, 12 employees had been terminated; four resigned prior to any action being taken; six received letters of reprimand; one disciplinary action was appealed and overturned; and four actions were pending. The details of the disciplinary action that was overturned were not probed during the monitoring visit, but it is hoped that the Director's attempts to strengthen the workforce were not undermined by personnel actions outside the control of the Facility. In order to determine compliance with this provision of the Settlement Agreement, each of the investigation files and other supporting documentation was reviewed for evidence that follow-up to any recommendations had occurred. This task was expedited by the Facility's practice of including any relevant follow-up information in the investigation file. Most frequently, the information focused on the disciplinary action taken, or the development of a PSP addendum. At its daily meeting, the Incident Management Coordinator or his designee informed the Incident Management Review Team of the investigations' findings and any recommendations. The minutes of these meetings reflected these discussions. In the case of injuries, the Client Injury Assessment form also had a section to document discussion at the daily meeting. Recommendations were referred to the PSP team, or to other appropriate staff for implementation. The Incident Management Coordinator was responsible for tracking the completion of recommendations. As described with regard to Section D.4 of the	Noncompliance

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		Settlement Agreement, the analysis of recommendations on a Facility-wide basis appeared to be insufficient at the time of this monitoring visit. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. There was evidence that follow-up had occurred in 12 of 15 (80%) investigations completed by DFPS: ▪ In case #385101155, training on pica precautions was implemented as recommended. ▪ In case #38479002, there was a meeting of the PST on the same day as the fall incident. Safety precautions were instituted, including an increase in the level of supervision. ▪ After the incident occurred in case #38492722, the level of supervision was increased and training in pica precautions was given to staff. ▪ In case #37948260, there was documentation that the PST for each individual involved in the incident met to discuss and implement protective measures; ▪ Following the incident in case #38543580, a PSP Addendum was approved for the individual involved. ▪ Victim's counseling was offered in case #38503299. ▪ The alleged perpetrator was discharged from employment in case #38559456; ▪ In case #38410344, a PSP Addendum was developed within two days of the incident causing a fracture, in order to ensure that physician's orders were followed. ▪ The PST convened within one day to develop a PSP Addendum for the individual who swallowed a hearing aid battery in case #38150061. ▪ Following the incident in case #38521434, the involved staff person was retrained in PMAB techniques. However, the training took place two months after the incident. ▪ The PST met the same day as the incident in case #38493487, and staff were to be trained in proper care of the feeding tube. However, this training should have occurred before the Individual was entrusted to their care. ▪ In the aftermath of Investigation #38493890, one of the two alleged perpetrators was dismissed. In five out of seven (71%) of the Facility investigations reviewed, there was evidence that follow-up had occurred. For example: ▪ In relation to Investigation #11-09-003, the PSP team met to discuss the	

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		unauthorized departure on the same day as the incident. Within seven days, the team met again to review Individual #240's level of supervision. ▪ In relation to Investigation #11-10-045, in-service training was held three days after the incident, while Individual #213 was hospitalized with a fractured leg. The training was focused on the revised Safety Plan for this individual. ▪ Investigation #11-11-054 involved peer-to-peer aggression. In-service training on reflective listening and completing bed checks was completed as recommended, and the supervision of both individuals was revised. ▪ Following the incident related to Investigation #11-11-049, during which Individual #106 fell from a van injuring her leg, her PNMP was revised. ▪ In relation to Investigation #11-12-080, the PSP Addendum for Individual #4 was formulated after his fall to ensure the use of a gait belt and other supports. The Facility did appear to collect injury assessment data, as evidenced by the records reviewed for a sample of individuals. These forms included documentation that review of the injury incident occurred at the daily Incident Management Review Team meeting. A review of a number of the forms raised questions, however, as to the extent of preventative or remedial actions. For example: ▪ On 8/16/10, Individual #58 caught his finger in the door of the staff restroom in 526. The tip of his finger was amputated. The recommendation from the daily meeting was "DSS [direct support staff] will redirect [Individual] from doorways when doors are opening or closing." There was no reference to safety inspections of others doors on that living unit or throughout the Facility to ensure that doors opened and closed properly. It should be noted that this set of circumstances was reviewed state surveyors on 9/23/10. Their report cited the failure to conduct safety checks of self-closing doors throughout the Facility. According to their report, as a result, two other individuals were injured. ▪ On 10/22/10, this same Individual fell against the wall while strapped in a shower chair due to the shower chair wheel falling off. The recommendation for further action stated: "DSS will inspect [Individual's] shower chair for malfunctioning parts before usage." Adequate supervision was not referenced. ▪ On 1/9/11, Individual #58 was scratched on a sharp point on his wheelchair. The recommendation stated that: "DSS will monitor [Individual's] wheelchair and contact HT(L) [Habilitation Therapies] if repairs or a replacement is (sic) needed." There was no indication in the documentation provided that these accidents provoked Facility-wide inspections of shower chairs and wheelchairs. ▪ The failure to correct the causes of injuries was noted also in the reports regarding Individual #203. This individual had repeated documentation of numerous scratches. In fact, review of the months from 10/10 to 2/11 indicated that this individual was scratched at least once a month, and three times in 12/10, by one of three known peers. Yet, his living situation was not changed to	

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		a more risk-free environment. The Risk Manager was working to analyze the patterns of injury across the Facility. The findings from her intensive review should be supplemented by corrective actions that do not focus solely on the individual who was injured. It is critical that environmental and peer-related risks be examined, and that reliable remedial actions are instituted without delay. Although appropriate action was taken to protect the individual involved in the specific incidents described in this monitoring report, after reviewing the list of incidents by individual, there was a concern that certain individuals had been at the center of repeated incidents, some of the identical type. The question must be raised whether or not sufficient attention had been paid to causation, and the removal of environmental and other known risks. For example: ▪ Individual #203 had been the subject of three confirmed cases of neglect or physical abuse in the last eight months; ▪ Individual #109 had been the victim of confirmed neglect twice in the last two months; and ▪ Individual #135 had been confirmed as having been neglected in four separate incidents since 8/10. The Facility might find it useful to establish other initiatives, similar to the Pica Reduction Committee, to explore risks in the residences, and to propose remedial actions from both the individual and systemic levels.	
	(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.	Based on review of LBSSLC's policy "Incident Management: Managing Unusual Incidents," records of every investigation were to be maintained in a manner that permitted investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, records from the current year and one year past were stored in the office of the Incident Management Coordinator. This storage space was confirmed by observation. After two years and for up to five years, records were stored in a container in the Maintenance Department's space on the Facility grounds. After this time, records were transferred to an off-site storage space controlled by Iron Mountain. Neither the Incident Management Coordinator, nor his staff reported any problems with access to records. DFPS files appeared to be maintained electronically to allow access to their authorized personnel. It appeared that their official reports were transmitted to LBSSLC in hard copy, where they were filed in the Facility record.	Substantial Compliance

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D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The LBSSLC policy "Incident Management: Managing Unusual Incidents" required the Incident Management Coordinator to complete monthly and quarterly analyses of unusual incidents, including deaths, injuries, restraints, and allegations/confirmations of abuse, neglect or exploitation. During the monitoring visit, the Facility acknowledged that the system for trending and tracking of unusual incidents and investigations was incomplete. The turnover in the Incident Management Coordinator position had delayed completion of this requirement. Although the occurrence of unusual incidents and the results of investigations were discussed at the daily Incident Management Review Team meetings, the patterns of events and their causation were not analyzed sufficiently enough to permit consistent and reliable corrective actions. Some examples of this are provided with regard to Section D.3.i of the Settlement Agreement. The Facility had begun to collect the data required for a thorough analysis. The Incident Management Office had developed a spreadsheet that described the type of incident, the staff alleged to have caused the incident, the individuals directly involved, the location of the incident, the date and time of the incident, and the probable cause. The spreadsheet also included the outcome of the investigation process. The Risk Manager had been instrumental in the collection and distribution of incident-related data. She was noted to be of invaluable assistance in supporting the work of the Incident Management staff.	Noncompliance
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	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 15 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. Background checks were confirmed for a sample of 15 volunteers.	Substantial Compliance

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	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.	Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of September 2010. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history 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 the Facility. The Facility submitted documentation indicating that there was a 12.15% failure to pass criminal background checks in FY10, and a rate of 6.22% in FY11 to date. The significance of this data will be discussed with the Director during the next monitoring visit, but it was interpreted to mean that preliminary screening of applicants had become more stringent. There were no active employees terminated based on the results of background checks conducted in the Fall of 2010.	

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

1. To alleviate the potentially risky congregation of individuals who required, and were entitled to, effective individualized supports, the admissions at LBSSLC should be examined in light of the policy expectations and the responsibility to protect individuals from harm.
2. In addition to increased efforts to remind staff of their responsibilities with regard to intervening and the timely reporting of abuse and neglect, ongoing in-service training should focus on delineating the less obvious or frequent forms of abuse (such as tipping a person off a couch), and reinforcing with staff their responsibilities to intervene and report these allegations in addition to more blatant abuse (e.g., hitting an individual).
3. With regard to mechanisms to educate individuals, guardians, and other people significantly involved in the lives of individuals on identifying and reporting unusual incidents, including abuse, neglect, and exploitation:
    a. The letter sent to guardians should be rewritten to clarify that the LAR should always feel empowered to call the hotline, but also should feel free to call the Facility, if they have questions.
    b. Efforts should be made to ensure that QMRPs discuss and provide the abuse, neglect, and exploitation handouts to individuals at PSP meetings. In addition to reminding, QMRPs about this responsibility, the monitoring tool for PSPs should include an indicator to check to ensure it is done consistently. The provision of this information to the individual should be documented in the PSP.
4. The training the APS Supervisor conducted in one residence focused on the nature of abuse, actions to take when feeling angry with staff, and the development of trust should be considered for replication in other residences.
5. With regard to appropriate follow-up for investigations:

a. The State, including DADS and DFPS, and the Facility should focus on improving the identification of issues and appropriate recommendations in investigation reports so that recommendations address all possible aspects of the situation.
b. The Incident Management Coordinator should review DFPS reports and ensure that all concerns raised are addressed through recommendations in the Incident Management Report that accompanies each investigation.
c. If concerns are not identified or raised in a DFPS report, the IMC should identify them and raise them.
d. Expected outcomes for the corrective actions identified should be set forth.
e. In addition to reviewing documents, as appropriate, the Facility should physically confirm that changes expected as a result of the implementation of recommendations resulting from investigation reports have occurred.

6. More in-depth analysis about previous incidents involving both the victim and the alleged perpetrator should be completed to the formulation of conclusions and the development of recommendations.
7. The Facility should continue its efforts to finalize a tracking and trending system.
8. The Facility should expand its efforts to conduct critical analysis of the trend data collected to determine if any actions should be taken, or action plans developed to address any underlying causes of trends identified. This should be a priority for the Facility.
9. The findings from the Risk Manager's intensive review of incidents should be followed with corrective actions that do not focus solely on the individual who was injured. It is critical that environmental and peer-related risks be examined, and that reliable remedial actions are instituted without delay. The Facility might find it useful to establish other initiatives, similar to the Pica Reduction Committee, to explore risks in the residences, and to propose remedial actions from both the individual and systemic level.

The following are offered as additional suggestions to the State and Facility:

1. The Self-Advocacy Group was an important initiative that warranted additional training and support. Steps should be taken soon to facilitate the group's election of a slate of officers. These individuals should be assisted in developing their leadership skills through participation in state and national forums focused on self-advocacy. A self-advocate should chair the meeting, rather than staff. Although it should be the group's decision where to meet, the Facility should offer the use of space that is conducive to meetings (i.e., quiet space with fewer distractions than the work center). The role of staff advisors to the group should be defined clearly, as well as etiquette for other staff who are visitors to the meetings.

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 Presentation Book for Section E; o LBSSLC Policy "Communication Process: Quality Assurance and Improvement Council," dated 10/11/10; o LBSSLC Policy "Review Processes: Quality Assurance Process/Plan," dated 2/24/11; o Quality Assurance/Quality Improvement Council meeting minutes from 10/27/10 to 3/15/11; o Plan of Improvement/Self-Assessment, dated 3/14/11; o Monitoring reports examining follow-up to Incident #s 10-08-0315, 11-09-003, 10-08-319, 10-08-30, 10-06-249, 10-07-281, 11-09-022, 11-10-040, 11-10-037, 11-10-028, 11-11-054; o Quality Assurance Plan for FY 2011; o Supervision Monitoring Forms, for 11/10 to 1/11; and o Consumer Support Observation/Interview Monthly Tracking, for 9/10 to 1/11. ▪ **Interviews with**: o Libby Allen, Facility Director; o Dawn Ripley, Director of Quality Assurance; o Melinda Voight, Risk Manager; o Jim Forbes, M.Ed., C.B.A., Director of Behavioral Services; and o Lola Walker, QMRP Coordinator. ▪ **Observations of**: o Safety Committee meeting, on 3/30/11; o Incident Management Review Team meetings, on 3/28/11, 3/29/11, and 3/31/11; o Quality Assurance/Quality Improvement Council meeting, on 3/31/11.
	Facility Self-Assessment: The Facility's Plan of Improvement/Self-Assessment was dated 3/14/11. For Section E of the Settlement Agreement, there were no areas determined to be in substantial compliance with the requirements of the Settlement Agreement. The Facility provided a narrative description of some of the action steps taken to achieve compliance with the provisions in this section. These descriptions were helpful, but as the self-assessment process progresses, the Facility also should incorporate data to substantiate its findings of compliance or noncompliance.
	Summary of Monitor's Assessment: Based on a review of the minutes of the QA/QI Council as well as the Monitoring Team's observation of a Council meeting during the onsite review, progress was being made in the Council's development. The meetings were being held consistently. The agendas focused on new developments at both the State and Facility levels, as well as on the discrete areas of monitoring required by the Settlement Agreement. The minutes between the time the QA/QI Council was established in October 2010, and the time of the Monitoring Team's review showed increasing use of data and analysis of that data

	to identify and begin to address areas needing improvement. Although there was a clear commitment by the Facility's leadership to improve its performance in this critical area of performance, the findings of the monitoring visit were consistent with the self-assessment conducted by the Facility. While there had been progress in organizing the work of the Quality Assurance/Quality Improvement Council, and while there was evidence of monitoring by the Quality Assurance and departmental staff, the processes and procedures were not yet fully implemented in a consistent and continuous manner. In addition, the Facility was at the beginning stages of collecting, and beginning to analyze this monitoring information for use in improving the quality of care and habilitation at the Facility. Although a Quality Assurance Plan had been drafted, it lacked adequate detail regarding the use of data collected through the various monitoring efforts, and the assignment of responsibility for implementing remedial actions. The Safety Committee was observed to be working diligently to analyze data about injuries. The efforts of the Director of Behavioral Services and other staff to monitor the use of restraint, and to reduce the incidence of pica behavior demonstrated an impressive level of attention to quality assurance processes.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The Facility had developed a Quality Improvement Plan, revised 2/24/11, which included a monitoring matrix used to designate the various responsibilities for monitoring throughout the Facility. The matrix specified that each section of the Settlement Agreement would be evaluated by Quality Assurance staff and staff from each of the departments. The audit tool, the frequency of review, and sample size were identified in this matrix. The results of these monitoring efforts were to be analyzed to identify areas of strength and weakness, and corrective action plans were to be developed, as appropriate. Findings from each department were to be presented at the Quality Assurance/Quality Improvement Council meetings. The question of how to best ensure inter-rater reliability was being reviewed at the time of the monitoring visit. The Plan itself was not clear in outlining the various methods and strategies that would be used to disseminate the results and to formulate remedial actions. These critical points will need to be addressed before the Plan can be considered adequate. In an interview with the Director of Quality Assurance, she reviewed her use of Quality Assurance staff and their areas of respective responsibility. The Program Compliance Monitors each worked on specific topic areas, allowing them to expand their knowledge in these areas, as well as to work closely with the respective program and clinical staff on monitoring and follow-up activities. The intent was to add a second nurse to the Department. At the time of the monitoring visit, the position had been posted, interviews were in their final stags, and hiring was to be completed by 4/1/10. This would be a positive addition to the QA staff, due to the extensive monitoring that needed to be done	Noncompliance

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		with regard to nursing, pharmacy, and dental supports, as well as involvement in activities such as clinical and administrative death reviews. The Quality Assurance staff had documented their monitoring work in several areas, including, for example, incident management and the use of restraints. In both of these areas, the Program Compliance Monitors reviewed samples of either the investigation reports or the restraint checklists to determine whether there was compliance with criteria established by Facility policy and/or the Settlement Agreement. Strengths and weaknesses were documented in the monitoring summary. This work was informative and indicated areas where improvement was necessary. The QA Department had begun to hold monthly meetings with a number of departments. These meetings were used to review results of monitoring that both the QA Department and the programmatic and clinical departments had completed. The meetings provided an opportunity to compare results, and to begin to address the question of inter-rater reliability. As is noted elsewhere in this report, it will be essential for the Facility to develop formal procedures for establishing inter-rater reliability for all of the monitoring/audit tools being used. The results of the monitoring also were reviewed to determine whether or not there was a need to develop a corrective action plan. 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 begun to collect some data, for example, data related to incidents and allegations, 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. 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. At the time of the review, the Facility did not have a complete system such as this in place, however it did have certain critical elements in place or in the development phases.	

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		As noted in the previous report, 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, many of 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 work done by the Risk Manager and the Director of Behavioral Services to identify trends in injuries, and the use of restraint was very informative and merited replication in other key areas of responsibility, particularly the trending of abuse and neglect. The current data regarding incidents of abuse and neglect was flawed, and could not be used reliably to identify trends. However, the Facility Director had prioritized recruitment of an experienced Incident Management Coordinator in order to address this problem. In the documentation provided to the Monitoring Team and based on interviews with the QA 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. These had the potential to be used to determine which programs or departments were having the most difficulty. In the various sections of this report, the Monitoring Team has provided comments, as appropriate, with regard to the monitoring tools and the Facility's implementation of them. As noted above, monitoring tools had originally been adopted based on the tools used by the Settlement Agreement Monitoring Teams. Several of these tools had been modified to reflect Facility-specific needs, and to crosswalk them with ICF/MR requirements to avoid having separate and redundant monitoring procedures. At the time of the review, LBSSLC had begun to implement 13 of the revised tools. The tools now had guidelines to help to assure consistency of monitoring. As noted above, as applicable, the various sections of this report provide commentary on these monitoring tools. Although additional work needs to be done to refine the tools and the processes being used to implement them, progress had been made in this area.	

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		As indicated in the Facility's POI, the Facility was not in substantial compliance on this subsection. However, there was definite progress.	
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.	Although the Settlement Agreement did not anticipate full compliance with this provision until 6/26/12, some data were already being analyzed regularly. The identification of trends was found to be limited. However, examples of data analysis regarding injuries, the incidence of pica behavior, and the use of restraint were examined and discussed during the monitoring visit. There was valuable information available to the Facility regarding these issues, and there was evidence that the information was being utilized to develop and implement corrective actions and proactive strategies. During the last monitoring visit, the Performance Improvement Council was meeting monthly, and was the focal point for presentation and discussion of each discipline's corrective action plans. Since that time, the Quality Assurance/Quality Improvement (QA/QI) Council had replaced the Performance Improvement Council. Based on a review of the minutes of the QA/QI Council as well as the Monitoring Team's observation of a Council meeting during the onsite review, progress was being made in the Council's development. The meetings were being held consistently. The agendas focused on new developments at both the State and Facility levels, as well as on the discrete areas of monitoring required by the Settlement Agreement. Department heads were scheduled to report on the progress being made in their areas of responsibility and were also expected to identify areas of concern. The meeting minutes documented the substantial work underway at the Facility as it strived to come into compliance with policy and Settlement Agreement directives. Also, it was enjoyable to note the way in which this meeting was being used to strengthen working relationships among the staff who participated on a regular basis. For example, a breakfast in which everyone contributed part of the meal was held shortly before the monitoring visit. The minutes between the time the QA/QI Council was established in October 2010, and the time of the Monitoring Team's review showed increasing use of data and analysis of that data to identify and begin to address areas needing improvement. Some of the minutes included sections entitled "Trending Problems," in which issues identified through monitoring were enumerated. Many of these were similar to those the Monitoring Team has found. For example, some of the issues documented in the minutes included Residential Coordinators not consistently completing infection control surveys, inadequacies with nursing quarterly assessments, health management plans not matching identified risks, issues related to missed dental appointments, and a lack of clinical justification in records. It was extremely positive that this forum had been established to review and analyze data, identify where problems existed, and jointly	Noncompliance

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		begin to come up with solutions to address identified issues. Overall, the development of corrective action plans was reported to be underway. During February 2011, the format for the formal corrective action plan was agreed upon, the process for the development of the corrective action plans was submitted for review and approval, and the revised Quality Assurance Process/Plan procedure was disseminated for training. The need for corrective actions plans was discussed during the QA/QI Council meetings, and, as appropriate some were developed. For example, the mock ICF/MR survey resulted in a recent corrective action plan that addressed a number of the deficiencies documented in this report, including consistency and individualization in treatment interventions. This particular corrective action plan was discussed at the Quality Assurance/Quality Improvement meeting conducted during the monitoring visit. According to the Director of Quality Assurance, since the initial document request was produced, two corrective action plans had been developed for Section D and Section F. Review of these showed: ▪ The plan for Section D related to the notification of individuals, and their LARs or primary correspondents of the results of investigations. It set forth a number of sequential or parallel action steps to develop and implement a tracking system to ensure this was occurring. For each action step, a staff person was identified as responsible, and dates for completion were assigned. Evidence also was identified to confirm completion of each action step. ▪ The plan for Section F was not as straightforward. Although it included all of the same elements, the action steps were more amorphous, and did not set forth an actual plan for each desired outcome. Often, the desired outcome and the action step were almost identical. For example, a desired outcome was "Progress note review form to be used during monthly review." The action step essentially repeated the desired outcome, and read: "Implement use of the progress not (sic) review form during QMRP monthly chart review." The responsible persons were the QMRPs and QMRP Coordinator. This did not set forth an "action plan," clearly identifying who would do what to make sure for example, that the new monthly review format was finalized, it was disseminated, QMRPs were trained on its use, monitoring occurred to ensure it was used consistently and correctly, and any concerns related to its use were addressed. In addition to formal corrective action plans, as is detailed in other sections of this report, a number of work groups had been established to address specific issues. For example, due to concerns about pica, a work group had been established to develop and implement strategies to address the many factors surrounding this issue, including, for example, staff knowledge and skills, as well as environmental issues. Likewise, work groups had been chartered to address issues related to timely filing of documents in	

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		records, and the accessibility of records to ensure their availability in the treatment decision-making process. During the QA/QI Council meeting during the week of the Monitoring Team's visit, it was decided that a group was needed to address issues related to individuals' personal appearance. This resulted from the Council's review of the findings of a family/guardian satisfaction survey. Another issue that was identified for resolution was ensuring that individuals' personal possessions were maintained securely and satisfactorily.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The Facility's POI contained limited information about this provision. It indicated, as noted above that during February 2011, the format for the formal corrective action plan was agreed upon, the process for the development of the corrective action plans was submitted for review and approval, and the revised Quality Assurance Process/Plan procedure was disseminated for training. As noted above, the Monitoring Team noted that some corrective action plans had begun to be developed and implemented. For example, the Action Plans associated with the POI set out specific tasks that needed to be accomplished to bring each section of the Settlement Agreement into substantial compliance. The QA/QI Council appeared to have a process in place to determine what corrective action plans were needed, to identify who needed to be involved, and to track completion of the corrective action plans. It also is important to note that not every issue requiring corrective action requires an action plan. The Monitoring Panel has discussed this with the State Office. For example, the QA/QI Council might decide that the Facility Director needs to send a memorandum to staff to correct a particular issue. The memo could be sent, and a copy attached to the next set of QA/QI Council minutes with a notation that the corrective action was completed. Likewise, for individual issues, such as modifications needing to be made to an individual's Behavior Support Plan, documentation in the form of a PSPA would be sufficient to document the occurrence of the necessary change. Based on the Monitoring Team's observation of one QA/QI Council meeting, it appeared that judgment was being used in deciding which issues required the development and implementation of full corrective action plans, and which issues are more appropriately addressed using another format. This should reduce unnecessary paper work, while at the same time ensuring that issues that do need formal corrective action plans have them. Although the Monitoring Team identified a number of corrective action plans, as the Facility recognized, there continued to be a number of areas in which data either had not been analyzed adequately to identify the need for corrective action, or a problem had been identified requiring formal attention, but a corrective action plan had not been developed. For example, much of the monitoring data the Facility had collected had not yet been formally analyzed and appropriate corrective action plans developed.	Noncompliance

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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.	As noted above, this procedure was under development by the QA/QI Council. A tracking form had been designed, and for the action plans developed in relation to Sections D and F of the Settlement Agreement, the status of the plans' implementation were documented on the tracking sheet. This will be reviewed further during future monitoring visits when additional corrective actions plans are available and being implemented.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	As with Section E.4 of the SA, this will be reviewed during future monitoring visits.	Noncompliance

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

1. The Settlement Agreement 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 enhancement of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, consideration of weighting indicators, and development of scoring sheets, as appropriate.
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 data referenced in Recommendation #2 should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors, and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports.
4. It will be essential for the Facility to develop and implement formal procedures for establishing inter-rater reliability for all of the monitoring/audit tools being used.
5. As recommended in previous reports, 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).
6. Once these action plans are developed, they should 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.
7. The Quality Assurance/Quality Improvement Council would benefit from inclusion of a direct support professional representative as a member. This individual could provide an important perspective about the development and implementation of quality assurance/improvement strategies at the individual and residential/day/vocational levels.
8. In its discussions, the Quality Assurance/Quality Improvement Council should broaden its focus from that of the Settlement Agreement requirements to one that is centered on expected, and even, best practices in the field. For example, focusing on eliminating risk in the environment could lead to proactive strategies regarding more individualized programming, the expansion of community-based options for active treatment, such as supported/competitive employment, and the redesign of residential units. Discussions about restraint use, injuries, incidents, etc. would then be linked more clearly and forcefully to the Facility's overall goals.

9. As the Facility moves forward in developing its self-assessment processes, in addition to the important narrative information included in the POI, the Facility should include data, including the results of the analyses of the data, to substantiate its findings of either substantial compliance or noncompliance. This data would potentially come from a variety of sources, including, for example, the results of monitoring activities, and outcome data being collected and analyzed by various departments. Such data should be quantitative as well as qualitative in nature. This data should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors, and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports.

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** 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 Presentation Book for Section F; o LBSSLC Policy " IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11; o LBSSLC Policy "IDT Process: Protocol for Person Directed Planning - Supporting Visions," dated 2/15/11; o LBSSLC Policy "IDT Process-Program Development: Support Personal Support Team," dated 3/15/11; o LBSSLC Policy "IDT Process Program Development: Scheduling Personal Support Team Meetings," dated 3/16/11; o LBSSLC Policy "IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring," dated 2/11/11; o Draft Personal Support Plan Quarterly Review format, undated; o Person Directed Planning Attendance Tracking, from September 2010 to March 2011; o LBSSLC Personal Support Plan Facilitation Checklist, revised 3/21/11; o Active Treatment Organizational Chart, undated; o Blank and completed monitoring forms, including: ▪ LBSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section F; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section F, with guidelines; and ▪ Settlement Agreement Section F: Integrated Protections, Services, Treatments, and Supports; o Curriculum for Leading Successful Meetings, DADS Educational Services, dated May 2009; o Supporting Visions: Personal Support Planning, including lesson plans, dated 7/10; o Workbook "Supporting Visions Tier 2 & 3: Personal Support Planning"; o Alphabetical list of each individual's home address, PSP dates and file date for PSPs, undated; o Monitoring Coaching Forms for Unit III, and for Individual #284, Individual #252, and Individual #143; o Personal Support Plans, and related assessments for: Individual #38, Individual #215, Individual #184, Individual #116, and Individual #37; o Assessments, Monthly/quarterly reviews, and Specific Program Objectives (SPOs) for the following: Individual #149, Individual #251, Individual #165, Individual # #45, Individual #222, Individual #136, Individual #121, and Individual #128; o Medical and clinical records for: Individual #313, Individual #6, Individual #175,

	Individual #66, Individual #135, Individual #168, Individual #192, Individual #78, Individual #156, Individual #146, Individual #264, Individual #37, Individual #204, Individual #213, Individual #43, Individual #15, Individual #56, Individual #199, and Individual #193; o SPOs, as well as associated SPO data for the last three months, as available, for: Individual #51, Individual #75, Individual #94, Individual #100, Individual #103, Individual #118, Individual #127, Individual #140, Individual #161, Individual #242, Individual #254, and Individual #304; and o Plan of Improvement/Self-Assessment for Section F, dated 3/14/11. ▪ **Interviews with**: o Lola Walker, QMRP Coordinator; o Marisol Gonazales, ISP Coordinator; o Shelia Powell, Human Rights Officer; and o Rodshadi Moore, Active Treatment Supervisor. ▪ **Observations of**: o PSP or PSP addendum meetings for the following: Individual #259, Individual #198, Individual #92, Individual #89, Individual #7, and Individual #62; o All residences and the workshop. 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 served.
	Facility Self-Assessment: The Facility's Plan of Improvement provided a narrative description of steps that had been taken to meet the requirements of the Settlement Agreement. The Facility indicated that it was not in compliance with any of the provisions of Section F, which was consistent with the Monitoring Team's findings. In addition to these narrative descriptions, the Facility also provided some data, which appeared to be based on reviews of PSPs prior to their finalization. However, based on the Monitoring Team's findings, the validity of the Facility's findings was questionable. Issues with regard the validity of monitoring data is discussed in greater detail with regard to Section F.2.g of the Settlement Agreement.
	Summary of Monitor's Assessment: The DADS Personal Support Plan Process policy and associated procedures outlined the basics of PSP planning, including the focus on the individual, the role of the QMRP, the use of the Personal Focus Assessment (PFA), and required assessments to be determined by the PFA. The policy addressed PSP monitoring, staff training and quality assurance. Where it fell short was in describing how to design Action Plans, Skill Acquisition Plans, and Service Objectives so that they reflected the interdisciplinary coordination that is required. LBSSLC had completed PSPs in the new format for approximately half of the individuals it served. Although it was clear that teams were trying to identify and incorporate individuals' preferences and work in a more

	integrated manner, the resulting PSPs still did not show an integrated plan that set forth the full array of protections, supports, and services individuals required. In addition, plans did not identify functional, measurable outcomes designed to allow teams to determine if treatment, services, and supports were assisting individuals to live healthier, fuller, productive, and meaningful lives. Integration of individuals into the community was not a priority in the plans reviewed. 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. Since the previous review, LBSSLC had worked with the DADS State Office to provide facilitation training to the QMRPs to assist them in conducting team meetings, and in ensuring that the PST process was person-centered. This was a positive development, as well as the implementation of the Facilitation Checklist. This checklist should be used as the basis for the development of a competency-based checklist and policy/procedure with regard to meeting facilitation. Documentation was not submitted to confirm that monthly reviews of programs and supports were occurring consistently. Specifically, on a monthly basis, each responsible team member should conduct a data-driven review of the assigned program(s) or support(s), take appropriate action based on this review, and document this review and any follow-up. The QMRP, as the team's facilitator, should ensure this occurs. To close the loop, however, the QMRP would need to take action, if any of these requirements were not met. Team meetings also might need to be held to address issues identified. Shortly before the Monitoring Team's onsite review, a PSP monitoring group was established. The reported goal of the group was to support teams with coaching, training, and feedback on integration of the PSP and risk process. The group consisted of the Assistant Director of Programs, QMRP Coordinator, three QMRPs, and the Program Compliance Monitor for Section F. At the time of the onsite review, this process was fairly new. The process was described as two members of the monitoring group attending three PSP meetings each week. A total of six observations had been completed, and two meetings had been held to discuss the weekly observations. As described with regard to Section I of the Settlement Agreement, the Facility was at the beginning stages of implementing the new at-risk process, and some teams were struggling. This initiative was a very positive one, and the Monitoring Team looks forward to reviewing the results during the next review.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	DADS Policy #004 Personal Support Plan Process was issued on 7/30/10. The DADS Personal Support Plan Process policy and associated procedures outlined the basics of PSP planning, including the focus on the individual, the role of the QMRP, the use of the 3Personal Focus Assessment, and required the team to identify the necessary assessments at the PFA meeting. The policy addressed PSP monitoring, staff training and quality assurance. Where it fell short was it describing how to design Action Plans, Skill Acquisition Plans and Service Objectives so that they reflected the interdisciplinary coordination that is required. LBSSLC had developed a number of policies related to the PSP process, including: ▪ LBSSLC Policy "IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11; ▪ LBSSLC Policy "IDT Process: Protocol for Person Directed Planning - Supporting Visions," dated 2/15/11; ▪ LBSSLC Policy "IDT Process-Program Development: Support Personal Support Team," dated 3/15/11; ▪ LBSSLC Policy "IDT Process Program Development: Scheduling Personal Support Team Meetings," dated 3/16/11; and ▪ LBSSLC Policy "IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring," dated 2/11/11. Generally, these policies generally adopted the DADS State Office policy, and provided some additional detail regarding implementation at LBSSLC. These policies are discussed as appropriate in the sections that follow. In order to review this section of the Settlement Agreement, a sample of PSPs was requested, along with related assessments, SPOs, and monthly and/or quarterly reviews. Although the Facility provided a small sample of PSPs, most of the requested PSPs were not provided. This allowed only a limited review of full PSP packages for five individuals, including Individual #38, Individual #215, Individual #184, Individual #116, and Individual #37. As a result, a variety of additional samples were used in reviewing the PSP process in an attempt to provide as complete a review as possible, despite the Facility's oversight in providing the documents requested. These included samples drawn to address specific issues within the Settlement Agreement, including samples of individuals considered to be at-risk, those for whom behavior supports were being provided, and those for whom active treatment and skill acquisition programs were specifically reviewed. As appropriate, these various samples are referenced throughout this section.	
F1a	Be facilitated by one person from	DADS Policy #004 at II.C.1.b indicated that the QMRP would plan and facilitate the PSP	Noncompliance

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	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.	meeting. The LBSSLC Policy "IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11, clearly identified the QMRPs' role in coordinating and facilitating the team's activities. The QMRP Coordinator confirmed that QMRPs facilitated the teams, including team meetings. During the on-site review, at the annual planning meetings the Monitoring Team attended, the QMRP facilitated the meetings. Reviews of PSPs also suggested that the QMRP was the team leader and responsible for ensuring team participation. However, based on review of PSPs as well as during observation of six meetings held the week of the on-site review (for Individual #259, Individual #198, Individual #92, Individual #89, Individual #7, and Individual #62), 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. Based on observations while the Monitoring Team was onsite, the following illustrated examples of good facilitation of meetings: ▪ The QMRP who facilitated the PSP meeting for Individual #92 had the added challenge of having the individual's family member on the phone instead of in the room. Every effort was made to ensure that the family member could follow the meeting, and had adequate opportunities to participate. In fact, very helpful information was solicited from the family member. The team conducted an initial risk assessment for the individual, which was necessarily time consuming. However, the QMRP kept the meeting moving at an appropriate pace, and solicited information from all of the team members. Individual #92 had moved to the Facility fairly recently, and the QMRP and the team did a good job of identifying a growing list of preferences and goals. The risk discussion was integrated with other team discussions about, for example, increasing her involvement in community and recreational activities. ▪ The PSP Annual Meeting observed for Individual #259 included all of the relevant members of the PST. There was a concerted effort by the QMRP to address the individual and to include him in the discussion, even though he did not communicate verbally. Each team member was prepared for the meeting, and offered information obtained through the assessment and evaluation process. The QMRP Coordinator monitored the meeting, and offered suggestions during the discussion about the individual's level of risk. The following were examples of missed opportunities with regard to adequate facilitation to ensure integrated development of plans that addressed the full set of protections, supports, and services needed by an individual:	

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		▪ The QMRP kept the team focused for two (33%) of the PSPs/PSP addendum meetings observed. The individuals' PSPs/PSP addendum meetings where the facilitator did not keep the team focused included: Individual #89, Individual #7, Individual #62, and Individual #259. Without adequate facilitation to maintain the focus of the discussion, teams spent unnecessary time repeating discussions that occurred earlier in the meeting, or discussing topics that were not relevant to the question the team needed to answer. As a result, some of the meetings were lengthier than they needed to be. This has the likelihood of reducing attendance, or having team members attend only a part of the meeting. While it is important to ensure that all team members have the opportunity to contribute to the meetings, one of the QMRP's roles is to redirect conversation as appropriate to either fully discuss a topic when it comes up, even if it is "out of order," or to identify at what point in the meeting the topic will be discussed. The QMRP Coordinator continued to supervise the QMRPs. At the time of the review, there were 14 QMRPs, which was a significant improvement from the ratio during the original baseline review. This allowed one QMRP to be assigned to each residence, and the overall goal of maintaining a ratio of approximately 1:16 generally was being achieved. It was reported that eight out of the 14 homes had a QMRP-to-individual ratio of 1:16. There had been some turnover in QMRP staff. Since November 2010, two QMRPs had left for various reasons. However, the vacancies were open briefly, and, at the time of the review, all QMRP positions reportedly were filled. As is discussed in further detail below with regard to Sections F.2.e and F.2.g of the Settlement Agreement, efforts were being made to provide additional training and technical assistance to QMRPs, as well as to evaluate their performance to identify areas in which additional supports were needed. Areas in which focused efforts had or were in the process of being made included the facilitation of meetings, and the integration of the at-risk process into the PSP process. These were valuable efforts, which should continue. LBSSLC had completed PSPs in the new format for approximately half of the individuals it served. Although it was clear that teams were trying to identify and incorporate individuals' preferences and work in a more integrated manner, the resulting PSPs still did not show an integrated plan that set forth the full array of protections, supports, and services individuals required. In addition, plans did not identify functional, measurable outcomes designed to allow teams to determine if treatment, services, and supports were assisting individuals to live healthier, fuller, productive, and meaningful lives. Integration of individuals into the community was not a priority in the plans reviewed. Based on observations as well as a review of PSPs, while some meetings were much improved, the meetings were not consistently resulting in the adequate assessment of	

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		individuals, and the development, monitoring and revision of adequate treatments, supports, and services. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	DADS Policy #004 described the Personal Support Team (PST) as including the individual, the Legally Authorized Representative (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 noted earlier, the Facility's policies specifically adopted this policy, and included the same definition of a PST. In reviewing PSP sign-in sheets, QMRPs were present at the annual meetings, and the individual almost always was present. Others participating included, at times, nurses, direct support professionals, Legally Authorized Representatives, psychologists, Occupational Therapists (OTs), Physical Therapists (PTs), Speech Language Pathologists (SLPs), and other disciplines, depending on the individual's circumstances. Physicians rarely attended. Often, neither an OT nor PT attended, even in situations in which an individual had OT/PT needs. SLPs also appeared to attend infrequently. Members of the Monitoring Team observed six individuals' PSP or PSP addendum meetings (Individual #259, Individual #198, Individual #92, Individual #89, Individual #7, and Individual #62) while on site. Specifically, the observations of the PSPs indicated that: ▪ All appropriate disciplines were present at three (50%) of the PSPs. The individuals' PSPs/PSP addendum meetings that did not include all appropriate disciplines included: Individual #92 (Dentist, and day/vocational representative), Individual #7 (Direct Support Professional), and Individual #62 (Direct Support Professional). ▪ The staff present at the PSPs/PSP addendum meetings were the actual staff that worked with the individual and not substitute staff sitting in for other staff members for five (83%) of the PSPs. The individuals' PSPs/PSP addendum meeting that did not include the actual staff that worked with the individual included: Individual #259 (Speech Therapist). However, the Monitoring Team noted that the Speech Therapist was informed about the individual. ▪ The individual was present at four (67%) PSPs/PSP addendum meetings. The individuals' PSPs that did not have the individuals present included: Individual #7, and Individual #62. Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. In only one of a subsample of five PSPs reviewed (20%) did it appear that a duly constituted team was in attendance.	Noncompliance

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		For example: ▪ For Individual #37, no OT/PT attended his PSP meeting, despite the fact that he had a PNMP and Range of Motion (ROM) exercises, etc. In addition, his LAR/parents were not present, and no indication was provided as to whether or not efforts had been made to include them. ▪ Individual #184 had multiple physical and nutritional management needs, including a dining/mealtime plan, and a positioning program. In addition, she used a number of pieces of adaptive and assistive devices. She also had issues related to communication. No OT, PT, Registered Dietician, and/or SLP was present at her meeting. Her medical needs were not discussed in any specific fashion, according to the documentation in her PSP. From the limited information, though, it appeared that she had ongoing medical issues, but no PCP was present at the meeting.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration. The LBSSLC Policy "IDT Process: Protocol for Person Directed Planning - Supporting Visions," dated 2/15/11, adopted the DADS policy, and did not comment further on the assessment process. 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, nursing, audiological screening, dental, community living options, vocational or day evaluations, and other assessments based on specific needs. Plans included a Personal Focus Assessment that gathered information on the individual's preferences. Some of the PFAs identified the assessments that the team decided needed to be completed. Assessments that frequently were missing included medical and psychiatric assessments. 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 individuals' PSPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. In none of the five PSP files the Facility submitted (0%), adequate assessments were	Noncompliance

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		present. Often the narrative sections of individuals' PSPs identified issues of concerns for which assessments were not found. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. The following provide examples of PSPs in which concerns were noted: ▪ It appeared no medical assessment was completed and/or included in the PSP, despite Individual #37 having complex medical needs. ▪ Likewise, no medical assessment was found in Individual #184's PSP package. The following provide examples of individuals who had been identified as being at risk, but for whom timely and comprehensive assessments had not been completed: ▪ Individual #6, Individual #199, Individual #193 and Individual #66 received enteral nutrition, and were at risk for aspiration pneumonia, but the PNMT had not evaluated these individuals. ▪ For Individual #6, who was identified as being at high risk for aspiration and osteoporosis, supporting documentation was not found on his risk assessment indicating how the individual was diagnosed with osteoporosis, such as noting the data, and score of a Dexa Scan. In addition, there was no supporting clinical data included on the assessment tool addressing why the individual was at risk regarding aspiration. ▪ Based on a review of 10 individual records for whom assessments had been completed to address the individuals' at risk conditions, one out of 10 (Individual #128) (10%) included an adequate medical assessment to assist the team in developing an appropriate plan. Comments are provided with regard to Section L.1 of the Settlement Agreement concerning gaps in evaluations for Individual #313, Individual #6, Individual #175, Individual #66, Individual #135, Individual #168, Individual #192, Individual #78, and Individual #156. As discussed in further detail below with regard to Section S.2 of the Settlement Agreement, and as reported during the last visit, a new vocational assessment was under development to replace the previous assessment. According to the Director of Vocational and Day Programming, the new assessment was more comprehensive, and included a format (i.e., open-ended questions) designed to elicit responses central to vocational/employment issues and vision. At the time of the Monitoring Team's previous review, it was reported that, once approved, this new assessment would be adopted statewide. However, there were no completed examples available for review. At the time of this most recent review, it appeared that this new assessment format was still not being utilized. According to recent verbal reports from the Director of Vocational and Day Programming, the previous form was currently still being utilized, and the revised form was still under consideration by State Office. Based on the sampled documentation, examples of concerns regarding completed	

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		vocational assessments are described below: ▪ Vocational assessments appeared to estimate work attendance. However, it appeared that this estimate was based on a very brief amount of time. For example, attendance was evaluated for Individual #173 only during the vocational assessment period (i.e., approximately five days). An entire year of data should be utilized to evaluate trends in attendance and other important variables. ▪ Vocational assessments (or Vocational Updates) completed for some individuals appeared inadequate. For example, the update for Individual #100, dated 3/1/10, did not provide any descriptive information regarding vocational skills, employment history, and/or rationale why the PST recommended that he "stay in the programs." If the vocational assessment was referring to his continued participation in day programming (as opposed to vocational), a brief rationale appeared appropriate. ▪ The vocational assessment provided for Individual #306, dated 1/28/08, as well as vocational updates, dated 1/23/09 and 1/15/10, were not current. In addition, each update recommended completing a reassessment prior to the 2010 PSP. This did not appear to have occurred. ▪ At times, the PSP indicated that the "… Assessment of Vocational Development … was used during the PSP discussion." However, a recently updated vocational assessment was not found for several individuals (e.g., the most recent assessment completed for Individual #66 was in 12/09). ▪ Overall, recommendations listed in the Vocational Assessments appeared to be "boiler plate" and not helpful. That is, they did not appear to be individualized or provide direction to the PST regarding specific issues or concerns related to success within an employment or vocational setting. Many of the recommended items pertained to required employment documentation (e.g., proper identification, tax forms) or the potential for re-assessment (e.g., Vocational Assessments for Individual #108 or Individual #94). As recommended in the baseline report, vocational evaluations should focus on work that is potentially 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. One assessment that would prove useful for some individuals would be an annual review	

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		of incidents, and abuse, neglect, and exploitation allegations. This type of assessment was not found in any of the PSPs reviewed. However, for some individuals, it would be beneficial on an annual basis for teams to review aggregate individual data related to incidents, allegations, and restraints. This would ensure that the team considered the need to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. The intent of such a review would be to ensure that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place, and appropriately incorporated into the PSP. Overall, assessments were either not present or inadequate to guide teams properly in developing adequate PSPs. This is an area that will require the concerted efforts of all team members to resolve.	
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.	Although the new PSP process had been designed specifically to be more interactive, and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the PSPs. Based on the review of the newer plans, even when assessments were present, the connection between the assessment results and the PSP were not always clear. In none of the five plans (0%) were recommendations resulting from assessments adequately addressed in the PSPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. For example: ▪ Many of the recommendations in Individual #184's assessments were not referenced in her PSP as either action plans, or as having been discussed, but with justification, not accepted by the team. Just a few examples of these lapses included: o A water safety assessment indicated that she "seemed enthusiastic about being in the thera-pool… She likely would benefit from continued thera-pool sessions for low impact exercise and to improve her balance." The only reference in the action plan section was that she would be given opportunities to participate in thera-pool activities (as well as other recreational activities) once a month. There was no measurable objective related to exercise or improving her balance; o Her psychological evaluation recommended a complete and updated Structural and Functional Behavior Assessment and PBSP. No related action plan or discussion was found in the body of the PSP; and o Her OT/PT update recommended continuation of her PNMP "to maintain walking and transfer skills and to maintain self-feeding skills." The only reference in the action plan section to the PNMP was with regard to communication.	Noncompliance

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		▪ Although it appeared that the Facility might not have provided a complete copy of Individual #215's PSP, no reference was made in her action plans related to the numerous recommendations made in the OT/PT evaluation update. She had numerous physical and nutritional and support needs, assistive equipment, and communication needs. Although the PSP evidenced some discussion of these needs, the recommendations were not adequately incorporated as either skill acquisition or service objectives. In addition, as discussed in the Monitoring Team's previous reports, 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 should address these two issues to ensure that appropriate assessment information is available, and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans required by the Settlement Agreement.	
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		

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	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 LBSSLC Policy "IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11, further indicated that the QMRP should ensure that: "the PST develops and ISP that… [is] prioritized according to 'what is important' to the person and preferences are identified during the Personal Focus Assessment discussion…" As discussed in the previous report, the newer PSPs reviewed generally included more information regarding the individual's preferences and strengths. Documentation showed that the teams utilized information gained about individuals' preferences at the Personal Focus Assessment meetings that were held in the month preceding the annual PSP meeting to focus the initial discussion of the team during the PSP meeting. However, many of these preferences related to the recreational interests or food preferences of the individuals. They were not necessarily comprehensive in nature, indicating individuals' specific preferences related to living environments or jobs. Moreover, some teams had clearly included preferences in the PSPs, but it often was difficult to determine how the identified preferences of the individuals were incorporated throughout their PSPs. In the subsample of five plans reviewed, three plans (60%) had some connection between the preferences and action plans or measurable objectives. These included the PSPs for Individual #116, Individual #184, and Individual #215. Examples of where it was less clear how individuals' preferences were incorporated into their PSPs included: ▪ Individual #184's team identified some clear preference, including the Golden Youth Program, paper, pens, and relationships. Although there was reference to maintaining relationships, including sending cards, the other preferences were not incorporated in any meaningful ways. ▪ For Individual #215, a long list of preferences was identified. It appeared that the team was working towards one related to a providing pleasure foods. However, no aggressive approach to incorporating the many other preferences was found. 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, strengths, or needs, or were designed to overcome barriers to living in the most integrated setting.	Noncompliance

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		As described with regard to Section S.1 of the Settlement Agreement, skill acquisition programs were reviewed for a sample of 12 individuals (Individual #51, Individual #75, Individual #94, Individual #100, Individual #103, Individual #118, Individual #127, Individual #140, Individual #161, Individual #242, Individual #254, and Individual #304). This sample was examined to determine the integration of skill programming within community and vocational/day settings. Of the sample, four (33%) had SPOs that targeted implementation within a community setting. These included, for example, money management programs (e.g., Individual #51 and Individual #100), or healthy food choice/eating programs (e.g., Individual #94 and Individual #103) targeted for completion in the community. This was a lower estimate than determined during the previous compliance review when, at that time, 50% had at least one SPO targeting the community as a potential setting for implementation. While reviewing SPO data sheets associated with these programs, it was challenging to determine if they had been implemented in a community setting. Data collection should include a method for staff to conspicuously record when skill acquisition training was conducted 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 noted in the last monitoring report, PSPs generally included some individualized and measurable goals/objectives, treatment strategies and supports. However, in most of the plans reviewed, the expected outcomes were general and not measurable. In a number of cases, individualized, observable and/or measurable objectives had not been delineated in the PSP, and/or the treatments or strategies to be employed or necessary supports were not stated specifically. None of the five plans (0%) included a full complement of measurable goals or objectives to address the full array of supports and services the individual required. For example: ▪ The objective "[Individual #38] will participate in desired recreational/leisure activities in town or on campus" was to be implemented "as available." Another objective was "[Individual #38] will participate in a community exposure tour" with the "How often or due date" column listed as "as available." ▪ For Individual #37, although many of the objectives were specific and measurable, many were not. For example, many indicated "as available," as opposed to requiring staff to implement them on a regular and specified schedule. Others, for example with regard to the PNMP, said: "will implement," without any detail of what was being implemented by whom. For none of the 13 records for individuals determined to be at risk (Individual #6, Individual #199, Individual #193, Individual #66, Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #43, Individual #15, and Individual #56) (0%) was documentation available to show that appropriate, functional, and measurable objectives had been incorporated into the PSPs to allow the teams to measure the efficacy of the plan.	Noncompliance

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		As is discussed in further detail throughout this report, improvement was needed in this area. For example, nursing plans, which should have been incorporated into the overall PSPs, did not generally contain individualized measurable goals/objectives. This is further detailed in the section of this report that addresses Section M of the Settlement Agreement. Likewise, as is discussed below with regard to Sections O and P of the Settlement Agreement, measurable functional outcomes were not being identified for individuals in need of physical and nutritional supports. At this juncture, behavior support plans and psychiatric treatment plans did not contain all of the measurable goals and/or objectives that they should. 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 beginning stages of this process. As a result, a finding of noncompliance was made.	
	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. PSPs appeared to integrate some, but not all protections, services and supports that individuals required, as this provision of the Settlement Agreement clearly requires. None of the five plans reviewed in depth (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. For example, the PNMP, nursing care plans, and psychiatric treatment plans, frequently still were separate plans that were not integrated in any measurable way into the PSP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Although PBSP objectives often were included in the PSPs, which was positive, they was not evidence that PBSPs were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, etc.). Examples of issues related to the lack of integration were found between nursing and physical and nutritional supports, psychology and speech therapy in relation to communication supports, and dental and psychology with regard to the development and implement desensitization plans. The following provide a few such examples: ▪ As is discussed with regard to Section M of the Settlement Agreement, 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	Noncompliance

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		collaboration between nursing and the PNMT regarding the individuals who had 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, although the Medication Administration Records (MARs) reviewed contained the PNMPs, nurses were not checking the individuals' position prior to administering medications, reported not having been trained on the PNMPs, and, evidently, did not understand that they were responsible for implementing them. This coordination of individuals' supports and services should have begun in their PSPs, but did not. ▪ The Behavior Analyst for Individual #140 sent an email to his SLP, dated 3/16/11, acknowledging the development of a PBSP, and asking to use his communication book and add in a daily schedule board. The Behavior Analyst requested input from the Speech Language Pathologist (SLP) in the development of the daily schedule. A review of his PBSP, pending consent, incorporated the use of his communication book and a daily schedule, but the PBSP did not document collaboration with the SLP. A Habilitation Therapies Consultation, dated 4/6/10, stated: "During [Residence's] Health Status Meeting, 3/25/10, [Individual #140's] home psychologist requested more recognizable symbols for 'I want' and 'I don't want' in his communication book to support his Positive Behavior Support Plan (PBSP)," but there were no consultations to address integration of communication devices into his pending PBSP. ▪ Based on a review of 13 records for individuals determined to be at risk (Individual #6, Individual #199, Individual #193, Individual #66, Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #43, Individual #15, and Individual #56), there was documentation that: o Plans were integrated into the PSPs in none of the (0%) cases. o None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs.	
	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. The Facility's policies did not appear to comment further on this requirement. Generally, for the action items identified by teams, methods, 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
	5. Provides interventions, strategies, and supports that	As identified in other sections of this report, the interventions, strategies and supports offered to individuals at LBSSLC did not consistently and effectively address individuals'	Noncompliance

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	effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	needs, and not many were not practical and functional at the Facility and/or in community settings. Again, such issues are discussed with regard to plans to address conditions that placed individuals' at-risk, psychiatric treatment plans, nursing care plans, PNMPs, OT/PT treatment plans, and PBSPs. The following provides an example of a PSP that did not effectively address the individual's needs, and/or was not practical and functional at the Facility and/or in community settings: ▪ In the narrative under Transportation, it stated that Individual #38 was used to finishing his work quickly, and going back to the residence to watch television. Although the Mental Retardation Authority (MRA) representative said transportation would be available for this in the community, this was not typical for an adult. No objectives were included to increase his tolerance for remaining at the worksite and working all day. Based on a review of 13 records for individuals determined to be at risk (Individual #6, Individual #199, Individual #193, Individual #66, Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #43, Individual #15, and Individual #56), there was documentation that the PSTs: ▪ Implemented a plan that met the needs identified by the PST assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the (0%) cases.	
	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. Likewise, the LBSSLC Policy "IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11, reinforced this. 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. For example: ▪ Based on a review of 13 records for individuals determined to be at risk (Individual #6, Individual #199, Individual #193, Individual #66, Individual #146, Individual #313, Individual #264, Individual #37, Individual #204,	Noncompliance

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		Individual #213, Individual #43, Individual #15, and Individual #56), for none of the individuals (0%) did the plans include the clinical indicators to be monitored and the frequency of monitoring. ▪ For Individual #37, despite reference to many programs/plans (e.g., PNMP, risk plans, ROM, etc.), measurable objectives were not included in his PSP to measure progress, or lack thereof. 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, but efforts were beginning in this regard. There were some indications that the data being collected was not reliable.	
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 Monitoring Team's previous reviews, 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 responsible for implementing it.	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. The major issue related to comprehensibility of the PSPs reviewed was the lack of delineation of responsibility for the implementation of the plans. As a direct support professional, it would be difficult to read the PSPs as written and determine what his/her responsibilities were for the individual during the course of the 24-hour day. This, in large part, was due to the fact that the PSPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., BSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall PSP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members.	Noncompliance

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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 Settlement Agreement. The LBSSLC Policy "IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11, delineated the QMRPs' role in monitoring the PSPs. For example, it stated: "The QMRP must monitor active treatment programming by… Reviewing data, observation notes and the integrated progress notes through monthly active record reviews and quarterly written reports." As is delineated below, the mechanism for doing this had not been firmly established. In addition, it was unclear from the documentation provided whether or not other team members' role had been delineated at the Facility level with regard to assessing the progress and efficacy of the interventions for which they were responsible, as defined in the PSPs. As noted above, one practical issue that remained was that PSPs did not consistently clearly define these parameters. During the onsite review, the QMRP Coordinator indicated that a monthly review format had been developed to facilitate consistent documentation of the QMRP's monthly review. She reported that this new format recently had been rolled out, on 3/18/11. A copy of this format was requested, but two copies of the revised quarterly report format were provided. In the Presentation Book for Section F, a document entitled "Chart Review (Monthly Review) Monitoring Form," undated was included. This document consisted of 20 questions, which was consistent with the QMRP Coordinator's description of the new monthly review format. Therefore, the Monitoring Team assumed this was the document discussed. If this was the correct document, it provided a list of questions that were important to answer, and mainly related to ensuring that documentation relevant to the individuals' treatment, supports, and services were present in the record. While this was important, it did not assist in meeting the requirement in this provision 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." Although the revised quarterly review form appeared to provide a better format for conducting such a review, it did not explicitly ask some of the questions that would be necessary to ask to meet the requirements of the Settlement Agreement. In addition, it obviously was designed to be conducted quarterly versus monthly. Specifically, on a monthly basis, each responsible team member should conduct a data-driven review of the assigned program(s) or support(s), take appropriate action based	Noncompliance

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		on this review, and document this review and any follow-up. The QMRP, as the team's facilitator, should ensure this occurs. None of the indicators on the monthly chart/record review specifically required this, but an indicator(s) could be added. To close the loop, however, the QMRP would need to take action, if any of these requirements were not met. Team meetings also might need to be held to address issues identified. 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 Settlement Agreement. Moreover, due to the fact that many plans, such as PNMPs, nursing care plans, and psychiatric medication plans, were not integrated into the PSPs, no commentary was provided on these in the corresponding monthly reviews. In particular, no data was provided to support the efficacy of these plans, or to indicate if changes needed to be considered.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are	DADS Policy #004.IV addressed staff training on the PSP process that comports with the SA requirements. LBSSLC Policy "IDT Process: Protocol for Person Directed Planning - Supporting Visions," dated 2/15/11, provided some additional requirements related to training. It appeared to have the beginnings of the procedures for determining competency. However, sufficient details were not provided with regard to the tools that would be used, the criteria to be used in deeming competence, or the processes that would be used. For example, it was unclear what the exact competency requirements were, or what the consequences would be for QMRPs or other team members who could not demonstrate the required competencies, after training and technical assistance were provided. As discussed in the Monitoring Team's previous report, QMRPs and PST members had been provided initial training on the new PSP process. The QMRP Coordinator, as well as two other LBSSLC staff has completed the Supporting Visions Instructor Certification Program initiated by DADS, and had been recognized as certified trainers in the Personal Support Planning Process. Supporting Visions: Personal Support Planning, dated July 2010, was the training curriculum for personal supports planning. The document designated this training as competency-based relying on two aspects of the materials, including that in developing the learning objectives, an examination had been completed of what employees needed to know on the job, and that practice events in the instruction curricula related to select learning objectives. The criteria for receiving credit for the course were attendance, participation in competency-based activity, and assessment throughout the course.	Noncompliance

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	revised.	This training did not meet the requirements for competency-based training. 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. The course contained a variety of activities including role-playing, paper and pencil self-assessments, and videotaped demonstrations. A workbook was included so that learners could have a visual prompt and set of activities at hand. As noted above, the training instructors had special training in presenting this course, and were certified to do this training. This training course provided a good introduction to the development of PSPs, the differences between the new and the old processes, the roles of team members and the expectations for individualized and integrated plans. The training explained the "why" behind the changes, but not the "how." There will need to be additional teaching about how to the develop integrated action plans that draw together the information gathered in assessments, how to analyze that information and incorporate the individual's preferences, and how the priorities can be translated into clear directions for those working with the individual. Once the "how" of designing integrated action plans has been taught, there will need to be further training on how to link those action plans with service objectives and skill acquisition objectives, so that considerations of the individual's interests and priorities and vision for his/her living arrangements and work will be reconciled with medical and safety needs. Since the previous review, LBSSLC had worked with the DADS State Office to provide facilitation training to the QMRPs to assist them in conducting team meetings, and in ensuring that the PST process was person-centered. This was a positive development, as well as the implementation of the Facilitation Checklist, which is discussed in further detail below with regard to Section F.2.g of the Settlement Agreement. This checklist could be used as the beginning of a competency-based checklist with regard to meeting facilitation. The QMRP Coordinator indicated that it was in its second revision. A copy of the handouts from the DADS State Office training, entitled Leading Successful Meetings, was reviewed. The training appeared to provide valuable information related to both planning for meetings, and meeting facilitation. It discussed a number of relevant	

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		topics, such as developing ground rules, clearly stating objectives, people skills, and techniques for addressing difficult or non-participatory behavior from participants. According to staff, this training was valuable, but it was recognized that additional training was needed, particularly with regard to conflict resolution. According to staff, the week following the Monitoring Team's onsite review, a train-the-trainer program was being held related to the PSP process, and would include a focus on facilitation. The QMRP Coordinator and one of the QMRPs from LBSSLC were attending the training, and would be responsible for training all of the QMRPs, as well as the Admissions Placement Coordinator, and Post-Move Monitor. This was an area in which progress was being made. However, additional training, and particularly, the competency-based components of training were needed for compliance to be attained. The Facility should be commended for its efforts to reach out to DADS State Office to obtain needed training related to facilitation of meetings, while other training on the topic was in the development phase.	
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.	In order to evaluate this provision, the Monitoring Team requested lists, including the "Total number and list of individuals for whom most recent PSP meeting was held more than 365 days after previous PSP," and "Total number and list of individuals from whom most recent PSP document was completed/filed more than 30 days after PSP meeting." LBSSLC provided a list with individuals' names, and dates of most recent and previous PSP meetings. However, it did not provide the totals requested. This was concerning, because, other than calculating by hand compliance with these due dates, it was unclear if the Facility had an easy mechanism for tracking the timeliness of meetings and document completion. Review of the list indicated that most, if not all, PSP meetings were held within 365 days of the previous meeting. However, few, if any, PSPs were completed/filed within 30 days of the meeting. In many cases, a couple of months elapsed before the final document was prepared and filed. As noted in the Monitoring Team's previous reports, 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. 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	DADS Policy #004.V addressed quality assurance processes to ensure PSPs are developed and implemented consistent with the provisions of the SA.	Noncompliance

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	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.	Based on interview and document review, LBSSLC was conducting various monitoring of the PSP process. This included: ▪ The LBSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist tool was available for review of the PSP document. The QMRP Coordinator was rating some plans using this tool, as were Program Compliance Monitors from the Quality Assurance Department. The two departments had begun to look at inter-rater reliability. ▪ A sample of plans also was being reviewed using tools the State Office had generated based on the Monitoring Team's review tools. (Some concerns about the Settlement Agreement Cross Referenced with ICF-MR Standards Section F: Integrated Protections Services, Treatments and Supports are discussed below.) The QMRP Coordinator and the QA staff were conducting monitoring. The Facility provided some aggregate data to the Monitoring Team for monitoring that the QMRP Coordinator had completed. This raised questions about the validity of the data. The findings were much different from those of the Monitoring Team. Just a few examples of discrepancies included: o Although assessments were reviewed, it appeared that only the presence or absence of an assessment was evaluated, and not the quality of the assessments; o The monitoring had found an 83% compliance rating for the indicator that PSPs "identified the prioritized needs of the individual." It was unclear how this conclusion was drawn. o The same compliance rate was found in relation to the PSPs identifying "supports to overcome barriers to living in the most integrated setting appropriate to his/her needs." Again, this was vastly inconsistent with the Monitoring Team's findings, and it was unclear what criteria were used to draw this conclusion. o A major problem the Monitoring Team has identified in this and previous reviews relates to the lack of integration of protections, supports, and services in individuals' PSPs. However, the Facility identified an 83% compliance rate. Interestingly, the Facility calculated "at least a 90%" rate, when 10 out of 12 files were found to meet this requirement. This appeared to be a mathematical error. ▪ The QMRP Coordinator had been monitoring the QMRPs' facilitation of PST meetings. A monitoring tool had been developed, which she used as she observed the team meetings. During the week of the Monitoring Team's review, the QMRP Coordinator attended the PSP meeting for Individual #259, and was noted to be completing the monitoring tool. Monitoring tools were reviewed for the PSP meetings for Individual #284, Individual #252, and Individual #143 and	

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		for a sample of individuals living in Unit III. Based on interview, this process had assisted the QMRP Coordinator in identifying both QMRPs who required additional training, as well as one QMRP who required additional hand-on technical assistance with regard to the facilitation process. This process had considerable merit. ▪ On 3/15/11, a PSP monitoring group was established. The reported goal of the group was to support teams with coaching, training and feedback on integration of the PSP and risk process. The group consisted of the Assistant Director of Programs, QMRP Coordinator, three QMRPs, and the Program Compliance Monitor for Section F. At the time of the onsite review, this process was fairly new. The process was described as two members of the monitoring group attending three PSP meetings each week. A total of six observations had been completed, and two meetings had been held to discuss the weekly observations. As described with regard to Section I of the Settlement Agreement, the Facility was at the beginning stages of implementing the new at-risk process, and some teams were struggling. This initiative was a very positive one, and the Monitoring Team looks forward to reviewing the results during the next review. The review tool entitled Settlement Agreement Cross Referenced with ICF-MR Standards Section F: Integrated Protections Services, Treatments and Supports contained guidelines, which should be helpful in ensuring that different auditors are reviewing the same information. The Monitoring Team did not review the guidelines in detail. However, an overall comment would be that the guidelines did not always provide enough information to ensure that the quality of various components of the PSP process was being effectively evaluated. For example, indicator F.2.3 addressed integration of services. The guideline correctly referenced that all services and supports the individual needed should be included in the PSP, and gave an example of the need for a PNMP to be "addressed in the PSP." This did not provide sufficient guidance to ensure the integration of services and supports. For example, with a PNMP, an auditor would need to look to ensure components of the PNMP were integrated into other relevant plans, such as nursing care plans and medication administration records, and that clear objectives for the measurement of the efficacy of the PNMP had been incorporated into the PSP. Similarly, in providing guidance about the indicators related to assessments, the quality of the assessments was not addressed. As the Facility gains experience with implementing the review tools, changes should be made, as necessary. A corrective action plan for Section F had been developed to address issues identified. It included the elements that would be expected in an action plan, including anticipated outcomes, action steps, evidence to show completion, responsible person, start dates, target dates, and completion status. However, the action steps were somewhat	

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		amorphous, and did not set forth an actual plan for each desired outcome. Often, the desired outcome and the action step were almost identical. For example, a desired outcome was "Progress note review form to be used during monthly review." The action step essentially repeated the desired outcome, and read: "Implement use of the progress not (sic) review form during QMRP monthly chart review." The responsible persons were the QMRPs and QMRP Coordinator. This did not set forth an "action plan," clearly identifying who would do what to make sure for example, that the new monthly report format was finalized, it was disseminated, QMRPs were trained on its use, monitoring occurred to ensure it was used consistently and correctly, and any concerns related to its use were addressed. Although progress continued to be made in relation to this provision, the Facility needed to continue to improve the validity of the data, as well as to continue to identify problematic issues, and develop and implement adequate corrective action plans to address them.	

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

1. Additional training should be provided on how to the develop integrated action plans that draw together the information gathered in assessments, how to analyze that information and incorporate the individual's preferences, and how the priorities can be translated into clear directions for those working with the individual.
2. As the Facility and State had planned, QMRPs and/or others with responsibility for facilitating team meetings should be provided with competency-based training on group facilitation, particularly as is relates to the interdisciplinary team process.
3. As teams continue to receive training on the new PSP policy and format, a focus should be on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers.
4. 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.
5. 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.
6. 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.
7. 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.
8. Consideration should be given to adding to the PSP process an annual review of incidents, and abuse, neglect, and exploitations allegations. This would ensure that the team considered how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise.

9. PSPs should integrate the recommendations from assessments, not just reference them, and make the health care, and therapeutic plans a part of the PSP, rather than stand-alone documents. Behavior support plans should be integrated further with other protections, supports, and services.
10. 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, and that they clearly delineate the roles of direct support professionals.
11. Specifically, on a monthly basis, each responsible team member should conduct a data-driven review of the assigned program(s) or support(s), take appropriate action based on this review, and document this review and any follow-up. The QMRP, as the team's facilitator, should ensure this occurs. None of the indicators on the monthly chart/record review specifically require this, but an indicator(s) could be added. To close the loop, however, the QMRP would need to take action, if any of these requirements were not met. Team meetings also might need to be held to address issues identified.
12. 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.
13. The LBSSLC Facilitation Checklist should be used as a starting point for the development of formal facilitation competencies, including a policy and/or procedure for their application.
14. 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.
15. With regard to the Facility's monitoring for Section F, efforts should be made to improve the validity of the data. In addition, when issues are identified, the corrective action plans should clearly set forth the sequential steps that need to be taken to achieve the desired outcome.

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 Off campus visits by Specialty from September 1, 2010 to March 15, 2011, with report date of 3/28/11; o All consults and related Integrated Progress Notes (IPNs) for the following individuals: Individual #323, and Individual #147; o Physical and Nutritional Management Team (PNMT) sign in sheets, dated 9/15/10, and 12/14/10; o Enteral Work Group minutes, dated 3/9/11; o Enteral Work Group sign in sheet, dated 3/9/11; o Sample Integrated Risk Rating forms for Individual #82, dated 11/22/10, and Individual #132, dated 3/20/11; o Sample "At risk Individual Report" for Individual #132, dated 3/10/11; o Attendance Roster for PST Risk Meeting for Individual #132, dated 3/10/11; o LBSSLC policy – Dental Services: Policy for Positioning During Dental Treatment, dated 3/1/11; o Medical records for individuals hospitalized for acute illness, including: Individual #258, Individual #261, Individual #175, Individual #210, Individual #109, Individual #225, Individual #171, Individual #114, Individual #269, Individual #7, Individual #135, Individual #253, Individual #323, Individual #154, Individual #276, and Individual #122; and o Sample: Wheelchair Positioning with directions and photographs of correct positioning for Individual #282, dated 4/20/10. ▪ **Interviews with:** o Glenn Shipley, DO, MPH.
	Facility Self-Assessment: According to the LBSSLC's self-assessment, the Facility continued to create systems to ensure integration of clinical services. The Medical Director or his representative began to attend the PNMT meetings to provide medical expertise to the team process. Additionally, an enteral committee was created to deal with the complex issues related to the use of feeding tubes, utilizing the expertise of many departments. Through the interdisciplinary PST, each individual was to have a risk level assessment completed by the end of May 2011. According to the Facility, the Dental Department had increased communication with the PNMT, and utilized the positioning recommendations listed on the Physical and Nutritional Management Plan (PNMP). The medical providers meeting met each business day in an interdisciplinary format, including the Medical Department, Psychiatry, Dental Department, Nursing Department, and Pharmacy Department. The Facility reported that a medical database had been created that tracked processing of consultation reports, including Primary Care Provider (PCP) review, and PCP agreement or disagreement. The Facility considered itself to be noncompliant with Section G, because they were in the early stages of implementing these important steps.

	Summary of Monitor's Assessment: The Facility was in the early stages of developing integrated systems that will enhance the lives of the individuals residing at LBSSLC. There were several forums where integrated services had the potential to have great impact on the individuals, the staff, and the Facility. The following examples provided evidence of progress in this regard: ▪ The morning medical meeting was an interdisciplinary meeting that reviewed the critical health concerns that occurred in the time interval since the last meeting. The meeting was well attended by medical, nursing, dental, and pharmacy staff. These morning meetings remained in early stages of development, and the full value of these meetings had not yet been realized. The time spent reviewing basic informational logs eventually should lead to discussions regarding what work-ups are still needed to provide insight into preventing recurrent Emergency Room (ER) visits and hospitalizations. The discussions were still in their rudimentary phase. It is at these meetings that changes in health status should be discussed and referrals made to the QMRP to convene the PST for a PSPA to review risk status. ▪ The Pica Reduction Committee was another interdisciplinary group that encompassed nearly every department on campus. Its goal was to identify methods to reduce pica events. The group had demonstrated impressive collaboration. Whether the efforts result in the intended effect will be determined through trend analysis. However, it would appear that the steps taken thus far were essential to any pica reduction program, and the committee should continue its efforts to collaborate and grow the process until the goal is accomplished. ▪ The Dental Desensitization Committee had renewed strength with a new chairman and additional members. This was another attempt to provide an interdisciplinary approach to address this challenging area, including the involvement of the Psychology and Dental Departments. Many consultation reports were followed by a dictated PCP summary of the report, but there were many consultation reports for which this did not occur. In addition, further tracking was needed to ensure that if there were recommendations with which the PCP agreed, that there was a follow-up order, and that the order was executed in a timely manner. Due to the fact that many of these integrated efforts were at the beginning stages, and additional efforts were needed, the Facility correctly indicated it was noncompliant in these areas at this time.

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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	LBSSLC continued to make progress toward integrated clinical services through several different mechanisms. However, many of these initiatives were at the beginning stages, and/or required additional refinement. For example: ▪ The PCP morning medical meeting met each weekday morning to discuss health changes in those individuals who were acutely ill, hospitalized, or sent to the ER; Individuals re-admitted to the Facility, pica incidents, and those individuals who required restraints. It included information provided by the on-call physician concerning acute clinical issues that had occurred since the previous business	Noncompliance

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	therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	day. Participation included all the PCPs, as well as psychiatry, dentistry, pharmacy, infection control, and other nursing representatives. Theoretically, the discussion should provide guidance to the PCPs and nursing staff regarding the next steps in interventions to reduce the burden of illness, and prevent recurrences. The Medical Director was the facilitator of the meeting. Discussion was beginning to occur of critical questions, the need for follow-up, and closure of various issues. However, most of the time was utilized conducting a paper review of the daily clinic report, and other clinical logs, and there was little time or attention given to developing action steps to prevent recurrences. Unfortunately, there was no attendance roster, which would be important evidence to show clinical integration of all services. There were no minutes recording important areas of concern, the interdisciplinary discussion, next steps, or closure information. Such minutes would provide essential proof of the process, and provide a mechanism for the group to track progress, and ensure follow-up occurred. Areas of concern addressed at these morning medical meetings included: ER visits, hospital admissions, and restraint data. Data was being collected to determine trends. Included in this database were individuals' diagnoses for the ER visit/hospitalization, the date of the ER visit/hospitalization, any information about procedures, and the primary diagnosis for the admission or ER transfer. Because this database was initiated on 10/1/10, there had been no trend analysis completed. Once available, in a quarterly format or more frequently as needed, this information should be shared at this interdisciplinary morning medical meeting for discussion and training purposes. Trends identified likely will highlight areas of clinical care and oversight requiring improvement to reduce or reverse disease burden. ▪ The PNMT was created on 9/15/10 to assist PSTs in resolving the most critical and complex issues related to individuals' physical and nutritional support needs. The Medical Director was assigned to the PNMT to assist in providing medical expertise. However, given the many other current tasks and multiple meetings that the Medical Director was required to attend, it might be helpful to the PNMT to have a more consistent presence from the Medical Department. This could be accomplished by assigning to the PNMT the PCP with the caseload that included the highest number of individuals who had feeding tubes and severe dysphagia/gastroesophageal reflux disease (GERD) conditions. This PCP already would know the individuals most often discussed at the PNMT and this arrangement would facilitate changes being made to the medical treatment plans for these individuals. This would provide an efficient and effective resource to the PNMT. ▪ The Facility also decided to create an Enteral Feeding Committee to focus on the	

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		unique issues of those being fed by tube, such as feeding tube rates, residuals, and those with aspiration pneumonia on feeding tubes. ▪ The new "at risk" process had been implemented across the campus since approximately January 1, 2011. State policy and guidelines listed areas of potential risk for PSTs to review for each individual. A clinical department was assigned to each area of risk with the expectation that data would be collected and reviewed, and a clinical analysis of that risk factor would be shared with the entire PST. After PST discussion, a final risk rating would be assigned to the individual for that category of risk, and included as part of the PSP. Once the risk rating was established for all categories of risk, then a plan was supposed to be developed to reduce the risk, with focus being placed on high-risk categories. Once the plans were completed, then the implementation stage began, which required the expertise and cooperation of all departments to ensure success. This new system replaced the old Health Status Meeting process. Considerable in-service training was provided to staff throughout the campus. As is discussed in greater detail with regard to Section I, LBSSLC had begun to implement this process, but significant additional work was necessary to ensure that individuals' levels of risk were identified accurately, sufficient plans were developed, thorough implementation of the plans occurred, reviews of individuals' status occurred using objective data to measure individuals' progress, and, as appropriate, changes were made to address either lack of progress, or changes in individuals' status. ▪ There were other areas of collaboration between departments, such as the Dental Department and the PNMT. When possible, the dental hygienist attended PNMT meetings. This collaboration was important, because proper positioning of individuals is critical while providing dental care. ▪ The Dental Director recently had become chairman of the Dental Desensitization Committee. This was an interdisciplinary meeting, but until recently had little success in moving the created desensitization plans to the implementation phase. At the time of the review, the desensitization plans were considered ineffective, and the Dental Director had the goal of creating all new plans. The Monitoring Team continued to identify areas in which the lack of integrated services were having a negative impact on individuals' protections, services, and supports. For example, the Dental Department had numerous missed/no show appointments. The reasons were varied, and, for many missed appointments, the reasons remained unknown. A close working relationship with the QMRP and house manager will be essential in resolving these issues. Based on record review of 16 individuals who had been hospitalized for acute illness (Individual #258, Individual #261, Individual #175, Individual #210, Individual #109,	

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		Individual #225, Individual #171, Individual #114, Individual #269, Individual #7, Individual #135, Individual #253, Individual #323, Individual #154, Individual #276, and Individual #122), many due to aspiration pneumonia, the onsite observation of medication administration, and interviews with the nursing staff, there continued to be no collaboration between nursing staff and the PNMT regarding the individuals who had recurrent pneumonias and aspiration pneumonias. Consistent with the previous reviews findings, nurses were not assessing safe positioning for individuals, when they were administering medications orally or enterally for individuals who were at risk for aspiration. A review of the Life Threatening 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 Department was solely responsible for conducting the medical emergency drills, and no additional emergency scenarios had been developed and implemented by nursing staff.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	A system that tracked off campus appointments was in place in the Medical Department. The medical secretary entered these appointments into a database on a daily basis. When the appointment was completed, and the consultation report was received, the PCPs were supposed to review the report, and then sign and date the document, and if in disagreement with the consultant, then an entry of justification from the PCP was expected. This information was entered into the database. Based on record reviews, many consultation reports were followed by a dictated PCP summary of the report, but there were many consultation reports for which this did not occur. The Medical Director should review this process to ensure the all PCPs take the same steps. In addition, further tracking was needed to ensure that if there were recommendations with which the PCP agreed, that there was a follow-up order, and that the order was executed (especially if it was an additional lab or x-ray test, or referral to a different consultant). A document entitled "off campus visits by specialty from September 1, 2010 to March 15, 2011" was provided. It listed the appointments made for the individuals residing at LBSSLC during this time. It tracked the date the consultation report was received, as well as whether the PCP agreed or not with the consultation report. Before interpreting the data, one had to read through every consultation and remove those consultations for which no information was recorded regarding whether or not they had been received, and remove those consultations that were cancelled due to missed appointments or for other reasons. With regard to those that were cancelled, but had the information that the PCP reviewed and agreed with the information, some level of review and retraining is needed. Those appointments that occurred, or did not occur, but had indications of PCP review and agreement were tallied, and the numbers compared to those consultations	Noncompliance

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		for which the appointment was kept, but there was no indication of a PCP review, and agreement or disagreement. Additionally, some of the comments sections indicated the PCP had reviewed the report, but the agreement box was not checked. Based on the data reviewed, the following represents the determination as to whether PCPs reviewed and agreed or not with the consultation reports. The results are broken down by specialties: ▪ Allergy consults totaled 19, for which it was indicated 16 were reviewed, and there was agreement by the PCP. This represented an 84% review rate. ▪ For DEXA scan results, there were 25 reports, for which there was evidence that 11 were reviewed and agreed upon by PCPs. This was a 44% review rate. ▪ For mammogram results, there were 14 reports, of which 10 were reviewed, and agreed upon by the PCPs. This was a 71% review rate. ▪ There were 18 cardiology consults during this time. Of these, 11 had evidence of PCP review and agreement, which was a 61% review rate. ▪ There were nine dermatology consults, of which seven were reviewed and agreed upon by the PCPs. This was s 78% review rate. ▪ There was only one off-campus endocrinology consult reported, which had no indication of PCP review or agreement, resulting in a 0% review rate. ▪ There were five Ear, Nose, and Throat (ENT) consults, of which four were reviewed and agreed upon by the PCPs. This was an 80% review rate. ▪ A community family physician was utilized in six consults, of which three had evidence of PCP review and agreement, resulting in a 50% review rate. ▪ There were 17 general surgery consults, for which 11 had evidence of PCP review and agreement. This was a 65% review rate. ▪ There were a large number of gastroenterology (GI) consults, totaling 166 during this time period. Of these, there was evidence of review and agreement for 103 consults by PCPs, and evidence of review and disagreement in two consults by PCPs. This was a review rate of 62%. ▪ There was one non-Facility gynecology consult during this time period, and it had evidence of PCP review and agreement, resulting in a 100% rate of review. ▪ There were 37 hematology consults during this time period, for which 18 had evidence of PCP review and agreement, resulting in a review rate of 49%. ▪ There were four hospital reports, for which one had evidence of PCP review and agreement, resulting in a review rate of 25%. ▪ There were five internal medicine consults, for which three had evidence of PCP review and agreement. This was a 60% review rate. ▪ There were 67 consults considered "NA." Of these, there was evidence of PCP review and agreement in 39 cases. There was evidence of PCP review and disagreement in one case. This was a review rate of 58%. ▪ There were 10 nephrology consults during this time, for which 5 had evidence of PCP review and agreement, resulting in a 50% review rate.	

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		▪ There were 17 consults for neurology and neurosurgery, of which eight had evidence of PCP review and agreement. This was a 47% review rate. ▪ There were 12 oncology consultations during this time, for which 5 had evidence of PCP review and agreement. This was a 42% review rate. ▪ There were 16 ophthalmology consults during this time period, for which 11 had evidence of PCP review and agreement. This was a review rate of 69%. ▪ There were 16 orthopedics consults during this time period, for which eight had evidence of PCP review and agreement. This was a 50% review rate. ▪ There were two off site psychiatry consults, for which one had evidence of PCP review and agreement, for a 50% review rate. ▪ There were 11 pulmonary consults during this time period, of which six had evidence of PCP review and agreement. This was a review rate of 55%. ▪ During this time, there were 97 radiology reports, of which 45 had evidence of PCP review and agreement, for a 46% review rate. ▪ There were six rheumatology consults during this time, for which five had evidence of PCP review and agreement, resulting in an 83% review rate. ▪ There were seven sleep study reports during this time period, and all had evidence of PCP review and agreement, for a 100% review rate. ▪ There were 14 surgery consults (the differentiation between this category and general surgery was not clear, and if they were intended to cover the same area of expertise should be combined), and there was evidence in 11 cases that the PCPs reviewed and agreed, resulting in a 79% review rate. ▪ There were 12 urology consults during this time period, for which seven had evidence of PCP review and agreement, resulting in a 58% review rate. ▪ There were 34 wound clinic consults during this time period, for which 12 had evidence of PCP review and agreement, resulting in a 35% review rate. In total, 639 consults were listed during this time period. There was a wide range of variation in review of the consultant reports. It is recommended that further in-service training be provided to the PCPs concerning the requirements of documentation and follow-through. As noted above, the database had a category of NA. Review of each of the 67 consults revealed the NA category did not need to exist, because the different consults could have been placed accurately in their respective specialty. When reviewing the actual consults, 55% were gastroenterology, and 32% were urology. This indicated a need for the Medical Director to review the quality of the data collected and entered into the database. Since this category included 67 consults, its misuse could have a significant impact on the review of consult specialties, as well as compliance with reviews.	

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		To review this process in a different manner, consultations and the physician responses were reviewed for a number of individuals. The following provide some examples: ▪ For Individual #147, the submitted information was evaluated to determine if a PCP note indicating review of the report followed consultant reports, if there was an indication of agreement/disagreement with recommendations, and/or if there was follow-up to recommendations. The following shows the results of this review: o Vision Clinic consult of 10/1/10, without PCP note; o GI consult of 10/27/10, with typed PCP notes, dated 11/1/10 and 11/2/10; o Podiatry consult of 11/17/10, without PCP note; o Neurology consult of 11/19/10, without PCP note; o Endocrinology consult of 11/24/10, with typed PCP note, dated 12/1/10; o GI consult of 11/24/10, with typed PCP note, dated 12/1/10; o GI consult of 11/25/10, with typed PCP note, dated 12/2/10; o Podiatry consult of 12/22/10, without PCP note; o Urology consult of 1/3/11, with typed PCP note, dated 1/3/11; o Vision consult of 1/7/11, with PCP note in IPN, dated 1/27/11; o Podiatry consult of 1/26/11, with IPN note of 1/27/11; o Podiatry consult of 2/16/11, with typed PCP note, dated 2/22/11; and o DEXA scan report, with typed PCP note, dated 2/18/11. Of 13 consults, nine had a PCP note indicating review and response, for a compliance rate of 69%. ▪ Individual #323 also had a number of consultant reports, and the PCP response was noted as follows: o Neurology consult of 11/3/10, with no other information submitted; o Urology consult, with PCP follow-up note dated 10/13/10, and signed 10/15/10; o Hematology consult, with PCP follow-up note dated 10/25/10, and signed 11/2/10; o GI consult of 11/3/10, with no other information submitted; o Hematology consult with PCP follow-up note dated 11/4/10, and signed 11/9/10; o Urology consult of 11/30/10, with PCP follow-up note dated 11/30/10, and signed 12/1/10; o Urology consult of 1/3/11, with no other information submitted; o Neurology consult of 2/9/11, with no other information submitted; o Hematology consult, with PCP follow-up note dated 2/16/11, and signed 2/18/11; and	

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		o GI consult of 2/22/11, with PCP follow-up note dated 2/24/11, and signed 3/1/11. There were 10 consults that were recorded, and a PCP note following up on these consults in six cases, for a completion rate of 60%. The two methods used to determine PCP review of off-campus consultations showed a need for improvement in this area.	

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

1. Minutes should be maintained for the morning medical meetings, which include documentation of attendance to confirm interdisciplinary participation, as well as identification of clinical questions requiring closure, and tracking of such issues until closure occurs.
2. Quarterly review of trends should be completed based on the medical database, and this information should be discussed at routine intervals (quarterly, or monthly) at the morning medical meeting. As problematic trends are identified, analysis should be completed, and action plans developed and implemented to address underlying issues. Again, closure of these issues should be documented.
3. The Medical Director should review the process the PCPs use to review consultation reports and document agreement or disagreement to ensure that all PCPs take the same steps.
4. In addition, a tracking system should be developed to ensure that if there are recommendations with which the PCP agree, that there is a follow-up order, and that the order is completed in a timely manner
5. The Medical Director should ensure the quality and completeness of the medical databases being used. The off-campus consult database had a large "NA" category, which might not need to exist, and, if it exists, should be used appropriately.
6. Further in-service training concerning the requirements of consultation review and follow-through of recommendations should be provided to PCPs.

The following are offered as additional suggestions to the State and Facility:

1. Consideration should be given to assigning to the PNMT the PCP with the caseload that includes the highest number of individuals who have feeding tubes and severe dysphagia/gastroesophageal reflux disease (GERD) conditions. This PCP already would know the individuals most often discussed at the PNMT, and this arrangement would facilitate changes being made to the medical treatment plans for these individuals. This would provide an efficient and effective resource to the PNMT.

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 LBSSLC draft policy: Health Services: At-Risk Individuals, dated 2/4/11; o SSLC Risk Guidelines – Draft; o LBSSLC - Positive Behavior Support: Prevention and Treatment of Pica, revised 12/14/10; o Training attendance roster: individuals that ingest inedible items, dated 3/10/11; o Training roster: Pica – root cause analysis, dated 1/14/11; o Attendance roster: Prevention and Treatment of Pica, dated 12/14/10; o Criteria for inclusion on the Active Ingestion list; o Database table: Individuals that ingest inedible items; o Pica Prevention Critical Incident meeting minutes, dated 1/14/11; o Critical Incident Team Actions topic: Prevention of pica behavior, dated 1/14/11; and o Email correspondence, dated 3/28/ 11 regarding Medicare billing/codes, from Reimbursement Officer/Medical Contracts Manager. ▪ **Interviews with**: o Glenn Shipley, DO, MPH.
	Facility Self-Assessment: Based on the POI, the Facility acknowledged noncompliance in all areas of Section H. A narrative description was given of some of the progress the Facility believed it had made. For example, the Facility indicated that as of 10/1/10, PCPs reviewed the health status of each individual on a quarterly basis, and recorded findings in a quarterly progress note form, which was placed in the integrated progress note section. Those individuals with pica reportedly were tracked closely, and treatments/interventions were implemented in a timely manner. Clinical indicators awaited the approval of various clinical guidelines, but it was the expectation that acute and new problems were treated and follow-up was documented to closure. The POI did not specifically identify the self-monitoring process it was using for Section H, nor did it include any data to substantiate its findings of noncompliance. In addition to monitoring tools, it will be important to include clinical indicators, which can be used as measurement tools to generate data as evidence of progress towards compliance. Several of the subsections of H were awaiting the final approval of a number of clinical guidelines, from which clinical indicators should be derived and used for monitoring of progress in this area. It should be noted that the focus of the Facility's comments was on medical care. A broader approach needs to be utilized in assessing compliance with this section. For example, assessments cover a broad range of topics and disciplines, and the Facility should look beyond its ability to provide timely and appropriate medical assessments.

	Summary of Monitor's Assessment: The Facility continued to move toward a comprehensive system of integrated clinical services to meet the requirements of the SA. Timeliness of evaluations remained a concern, with overdue clinical assessments. However, adequate evaluation also means identifying the problem as well as the potential causes, and methodically analyzing each possibility thoroughly. This is perhaps the greatest challenge in those with frequent hospitalizations for aspiration pneumonia, in those with recurrent pica events, and in those with recurrent escalation of behaviors. For instance, the Medical Department provided excellent care once an individual was diagnosed with aspiration pneumonia, but challenges remained in anticipating and preventing the cause of the recurrence. The morning meeting would be an excellent forum to discuss these critical areas of clinical care. Medical diagnoses that were made appeared to have excellent clinical justification recorded in the medical record. The Facility was awaiting the finalization of many clinical guidelines/pathways that will assist in assuring basic expectations in any clinical work-up and treatment. From these guidelines/pathways, clinical indicators should be extracted, and used to further guide the Medical Department in providing adequate and appropriate care and treatment. The psychiatric diagnoses utilized at the LBSSLC were consistent with the nomenclature in the DSM-IV-TR. The current deficiency in this area was that there was incomplete (or missing) documentation in the individual records, which set forth the specific symptoms that the individual presented with in a manner that would support the validity of the psychiatric diagnosis.

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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.	DADS Draft Policy #005: Minimum and Integrated Clinical Services provided the administrative structure and oversight needed to obtain compliance with Section H of the Settlement Agreement. This policy provided precise guidance concerning such areas as periodicity and timeliness of clinical assessments and evaluations. It provided expectations across a wide range of disciplines, such as quarterly reviews by nurses, annual dental examinations, regular review of drugs, annual physical exams, and periodic assessment of risk status. Changes in status had assessment expectations within 24 hours for non-urgent change, within one hour for urgent change, and immediately for emergent change. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). In addition, it might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of provision H. LBSSLC did not appear to have developed any Facility-specific policies based on this draft policy. Annual medical assessments and physical examinations continued not to be consistently completed in a timely manner (further discussion on this is found with regard to Section	Noncompliance

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		L1). Physicians completed a quarterly Medical Doctor (MD)/PCP progress note on each individual and reviewed medication orders at that time. Individuals were sent to the ER in a timely manner. However, at times, important clinical information might not have been provided to the ER MD. The Facility should ensure the ER MD receives accurate and timely information about those being transferred to the ER. Upon return, there appeared to be good follow-through of findings and recommendations. When the ER report was not returned with the individual, the PCP opted to call the ER MD for a review of findings and recommendations. In response to an ER visit or hospitalization, the PCP morning medical meeting was the daily forum in which critical thinking should have occurred and inquiries should have been made concerning prevention of future ER visits or hospitalizations. However, there were no formal minutes in which critical questions asked or follow-up was documented. When an individual returns after an ER visit or hospitalization, there should be a determination made regarding what work-up should be done, or the next step to prevent a reoccurrence. Examples of unrecognized and untreated GERD, recurrent dislodging of the feeding tube, recurrent pica habits, acute choking, and recurrent constipation are further reviewed with regard to Section L1. The State Office's completion of clinical guidelines will be essential in standardizing the approaches used to address many of these concerns. Since the last review, there was an At-Risk Individuals Policy Training webinar provided to the medical staff as well as all clinical staff, and this was mandatory training. The focus was on the reduction of aspiration pneumonia. The new system in place for prevention of aspiration pneumonia was importantly dependent on early recognition of health status change by the direct support professionals. It also provided direction related to the roles of the other clinical disciplines. The process was at the beginning stage of implementation, and sufficient time had not passed for data collection, interpretation, and adaptation of the process to have occurred. As is illustrated throughout other sections of this report, there were issues with regard to assessments and evaluations being completed regularly, and performed in response to development or changes in an individual's status. Some examples of this included nursing assessments, particularly with regard to individuals who experienced acute illness; individuals who might benefit from communication systems; and individuals being considered for enteral nutrition.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year,	The DADS Draft Policy #005 also set forth expectations for Facility clinical staff, specifically stating "Diagnoses must clinically fit the corresponding assessments or evaluations and be consistent with the current version of the Diagnostic and Statistical	Noncompliance

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	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.	Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems." Diagnoses on both the active and inactive problem lists continued to be based on the criteria of the International Classification of Disease. There continued to be 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. A number of specialists assisted in the care of the individuals, and there were a number of on-site specialty clinics, which by proximity encouraged clinical care that was guided by appropriate specialties. The policy "LSS-Health Services Coding Requirements" continued to be followed. According to the policy, each diagnosis was to be in compliance with current International Statistical Classification of Diseases and Related Health Problems (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) Manuals. The Dental Department was to follow the codes per the American Dental Association (ADA) guidelines. The Reimbursement Officer/Medical Contracts Manager subsequently billed according to the contents of the dictated notes and clinic notes, using the ICD-9 codes. If there were rejections by Medicare or other billable sources, the Reimbursement Officer notified the PCP for clarification of the most appropriate diagnosis based on documented information in the record. As is illustrated with regard to Section J of the Settlement Agreement, the assessment processes used to determine diagnoses were not always consistent with DSM criteria or generally accepted standards of practice. The psychiatric diagnoses utilized at the LBSSLC were consistent with the nomenclature in the DSM-IV-TR. The current deficiency in this area was that there was incomplete (or missing) documentation in the individual records, which set forth the specific symptoms that the individual presented with in a manner that would support the validity of the psychiatric diagnosis. According to the Plan of Improvement of 3/14/10, a revised coding policy was drafted and awaiting approval by the Operating Procedures Manual (OPM) committee.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The development of clinical guidelines/pathways will provide the medical guidance and criteria necessary to assess and diagnose clinical conditions, as well as provide appropriate options for further evaluation and treatment. This necessarily will include serial changes of treatment or further testing until the problem is clearly defined and optimally treated. Many of the clinical pathways were in draft stage of completion, such as aspiration pneumonia, anticoagulation, and seizure management. Once the guidelines are finalized and staff are trained on them, a variety of measures based on the guidelines can be used to determine compliance with the Settlement Agreement.	Noncompliance

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		As part of the system to ensure timely diagnosis/assessment, a risk assessment was being completed on each individual (by 5/11, for all individuals, and then prior to each subsequent annual review). A table entitled "Risk Guidelines" identified criteria for teams to use in determining the level of risk for many of the risk factors common to the Intellectual/Developmental Disability (IDD) population. A plan to reduce the severity of each risk was then supposed to be developed, with further assessments as needed to guide treatment, and the plan was to be implemented. The guidance for this system approach to risk management was reflected in the following policies: LBSSLC – Health Services draft policy: At-Risk Individuals, dated 2/4/11, and SSLC draft Risk Guidelines. The Facility was at the beginning stages of implementing this process. The policy entitled "Lubbock SSLC Positive Behavior Support: Prevention and Treatment of Pica" outlined the assessments, screenings, and evaluations that staff were expected to complete for those individuals at risk for pica. This was to include a structural and functional assessment, screening for medical and nutritional causes, and psychiatric screening/evaluation. Based on these results, a PBSP was to be developed, or other actions taken, as appropriate. The policy provided guidance to the teams in addressing the needs of an individual with pica. In addition, the Pica Committee met on 1/14/11 to discuss pica prevention, and initial steps were outlined in a document entitled: "Critical Incident Team Actions." Several important steps occurred. A table that listed individuals that ingest inedible items was created (updates were ongoing and reflected any new pica incidents). A document was implemented entitled "Criteria for inclusion on the Active Ingestion List." There was training focused on pica across disciplines. This approach was an ambitious attempt at assessing and diagnosing pica, as well as providing timely treatment, and monitoring of effectiveness.	
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.	In DADS Draft Policy #005, the expectation/requirement was set forth that: "clinical indicators of the efficacy of treatments and interventions are determined in a clinically justified manner." The State Office then provided guidance for several areas of healthcare by referring the clinical departments to specific guidelines, which national organizations with expertise in specific areas of healthcare had developed and continued to update. The scope of practice covered by these guidelines was wide ranging, including preventive care, immunizations, cardiac care, diabetic care, breast cancer, cervical cancer, pneumonia, depression, and other guidelines available through the US Agency for Healthcare Quality and Research. The State Office clearly had identified a framework and level of expectation with regard to the quality of care. Based on these guidelines, the policy further stated "the facility must develop a system to identify which guidelines to follow …"	Noncompliance

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		The clinical guidelines, currently in draft form, were in various stages of completion. Once completed, clinical indicators then should be determined, or directly included in the guidelines as target goals for an illness, or lack of acute care interventions (i.e., reduction in use of "as needed," or prn, medication, reduced ER visits, etc.). Additionally, clinical indicators could be extracted from the risk guidelines. For instance, for a clinical indicator of diabetes management, lack of documented hypoglycemia is a clinical indicator that should be readily found in documentation. Another clinical indicator is an Hgb A1C level of six or lower. Lastly, clinical indicators might have face validity, especially if the indicator is whether an event occurred or not, for example, whether a pica incident occurred, or a fracture occurred. To be compliant with the Settlement Agreement, valid and reliable clinical indicators must be developed and tracked for a range of common illnesses or health parameters (for prevention and wellness), which can be measured across time for trend analysis and interpretation. As is illustrated in various sections of this report, clinical indicators often were not identified. For example, when psychiatric medications were prescribed, the target symptoms were generally not tracked. Tracking these symptoms would assist in determining the efficacy of the treatment. Likewise, nursing plans did not identify what clinical indicators would be tracked, by whom, or when. Many PNMPs also did not identify the functional outcomes to be measured. The at-risk plans that had been developed also did not include measurable clinical indicators to determine improvement, or lack thereof, in individuals' at-risk status.	
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.	DADS Draft Policy #005 also set the standards and expectations the Medical Director needed to use in creating a health status monitoring system. The expectation appropriately, but ambitiously set the standard as monthly monitoring on a wide variety of domains of health care, including staffing, timeliness, equipment and resources, quality of care, morbidity, clinical indicators, etc. At the time of the Monitoring Team's onsite review, many of these expected monthly monitoring systems were not in place. The PCPs, the Nursing Department, the Psychology Department, the Dental Department, and the PST members completed some level of monitoring of health status. The physicians completed quarterly and annual evaluations. The quarterly evaluations monitored the stability of health, including monitoring of weight change, recent respiratory diagnoses, the number of enemas or suppositories required for constipation, and the number of seizures since the last quarterly evaluation. Many of these parameters reflected changes in health status at an early stage. The "At Risk Individuals" policy also required the ongoing PST evaluation of each of the areas of risk to ensure progress was being made in reducing the burden of risk. As noted above, at the time of the review, this was not consistently a data driven process. The at-risk plans developed should identify	Noncompliance

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		the data that various disciplines should share with the PST during at-risk reviews for each risk category. The team should use this data to make a decision about whether risk is being reduced, or whether additional or different steps need to be considered. It also is important to ensure that data being used to make initial assessment, and ongoing treatment decisions is accurate. This should be a regular quality assurance function. Additionally, specific clinical groups monitor certain diagnoses. For example, the neurologists have on site clinics and follow individuals with seizures closely through this mechanism. Pica events are discussed at the morning medical meeting, as well as followed by the PST.	
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.	DADS Draft Policy #005 also set the standard and expectations for the Medical Department with regard to this provision when it stated: "Clinicians are expected to act on reports from other staff, monitor the individual themselves, note the effects of interventions, and make changes to treatments and interventions in response to clinical indicators and as warranted." As already mentioned, the Facility had not developed and implemented clinical indicators from clinical guidelines that could be used as a measuring tool to identify medical issues and provide interventions. This section is dependent on valid clinical indicators to reflect improvement in health, and each area of health risk. Once established, this becomes the barometer by which all treatments should be measured. As noted above, clinical indicators should be part of the clinical guidelines. If the PCP followed the clinical guideline and the chosen treatment or intervention did not change the health of the individual (i.e., the clinical indicator was not met), then the PCP would again review the clinical guideline for alternative choices of treatments, or consider the need for further testing to refine treatment options. Because the clinical guidelines were not in place, and initial treatment might require days to months to result in a measurable effect, this component of the Settlement Agreement is a future goal. As a follow-up to creation of the clinical indicators, the appropriate department will need to collect accurate and complete data relevant to that clinical indicator being discussed. This information, once shared at the PST meeting, will drive the next step, as to whether the intervention resolved or reduced the risk, or whether additional steps need to be taken. However, at this point, such a system-wide approach was not in place.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish	The policies already mentioned in other sections related to Section H were the first steps in providing a framework for other integrated clinical services policies, procedures, and guidelines to refine the process of assessment and diagnosis, followed by timely quality care. As noted previously, a number of draft clinical guidelines were in various stages of	Noncompliance

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	and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	completion for the most common and problematic health concerns in the IDD population, including: aspiration pneumonia, seizure management, constipation, and osteoporosis. Further clinical guidelines might be needed to address many of the risk categories listed in the "Risk Guidelines" draft. The clinical guidelines should integrate all the disciplines contributing to quality care for the individuals in that identified risk category. For instance, in providing guidance for seizure management, the clinical guideline/pathway should set forth the content of a seizure protocol, which staff directly supporting the individual. A seizure protocol should include guidance to the direct support professionals regarding how to identify the type of seizure for that individual, how to time the seizure, how to position the individual, and who to contact; for clinical staff, guidance should be provided regarding when to administer medication and by what route, as well as what to measure (pulse oximetry, etc.) and when to call 911. This would reflect integrated clinical services in meeting the needs of the individual for this risk category.	

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

1. The Facility should create a monitoring system to ensure the ER medical team receives accurate and timely information about individuals being transferred to the ER.
2. For each individual hospitalized, an important question that should be asked at the morning medical meetings, and the responses documented in the minutes, concerns what evaluation should be completed, or what the next step is in treatment, to prevent a recurrent visit to the ER or hospitalization for that individual.
3. The State Office should finalize, distribute, and implement clinical guidelines, especially for pathological conditions common to the IDD population residing at LBSSLC.
4. The at-risk plans developed should identify the data that various disciplines should share with the PST during at-risk reviews for each risk category. The team should use this data to make a decision about whether risk is being reduced, or whether additional or different steps need to be considered.
5. Monitoring the quality of the information provided in the "rationale" section of the integrated risk review documents should be an ongoing quality assurance process.
6. Once clinical guidelines are developed, the Medical Director should develop clinical measures (clinical indicators) that reflect success in treating the illness. It is recommended that for each clinical guideline, two or more clinical indicators be defined that can measure success of treatment (improved laboratory test results, functional improvement, reduction in medication, improvement in chest x-ray, improved findings on physical examination, etc.).
7. Once priority clinical guidelines/pathways are developed, the State Office should create clinical guidelines for the many other risk categories listed in the Risk Guidelines draft.

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 Plan of Improvement/Self Assessment, dated 3/14/11; o Sample of At-Risk Individual Report; o Sample of Integrated Risk Rating Form; o Sample of PST Risk Meeting - Attendance Roster; o DADS SSLC Policy #006: At Risk Individuals, dated 10/28/10; o At-risk tracking form: "At risk high risk 14 day Implementation;" o SSLC – "Risk Guidelines" laminated record; o Presentation Book for Section I; o The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) Evaluation, Aspiration Pneumonia/Enteral Nutrition (APEN) Evaluation, Nutrition Evaluation; OT/PT/SLP consultations for the last year, Personal Support Plan and PSP Addendums for the last year including PSPA for PSP Risk Assessment and Physical Nutritional Management Team Evaluation/Action Plan, Physical and Nutritional Management Plan with pictures, Integrated Risk Rating Form, Action Plan for Risk Assessment, person-specific monitoring for the past year, PNMP Clinic Notes for the past year, competency-based training for staff, dining plan with pictures, supporting documentation for PST Risk Assessment and Action Plan and PNMT Action Plan implementation, PNMT Evaluation and PNMT Action Plan Update(s) documentation for the following 16 individuals: Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, Individual #258, Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139; o The following documents: Integrated Risk Tracking Form and Action Plan for Risk Assessment for the following 12 individuals: Individual #253, Individual #29, Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #6, Individual #43, Individual #15, and Individual #56; o Medical records for the following individuals, most recent PSPs and PSPAs, including the most recent submitted risk assessment rating tools (at risk individual reports, integrated risk rating forms, risk action plans): Individual #6, Individual #33, Individual #66, Individual #130, Individual #168, Individual # 253, Individual #313, Individual #175, Individual #135, Individual #29, Individual #192, Individual #128, Individual #78, and Individual #156; o LBSSLC At Risk Individuals policy, dated 2/4/11; o LBSSLC Pneumonia Profile Report, dated 2/28/11;and o At-Risk Ratings for multiple health risk indicators, dated 2/9/11. ▪ **Interviews with**: o Informational meetings reviewing the "integrated risk rating form," and "risk action plan" with Monitoring Team and PSTs of the following individuals: Individual #33, Individual

	#29, and Individual #253. ▪ **Observations of**: o PSP Meeting for Individual #7, on 3/28/11; o PSP Meeting for Individual #62, on 3/28/11; o PSP Meeting for Individual #89, on 3/30/11; o PSP Meeting for Individual #198, on 3/28/11; o PSP Meeting for Individual #92, on 3/28/11; and o PSP Meeting for Individual #259, on 3/30/11.
	Facility Self-Assessment: According to the Facility's self-assessment, since the last Monitoring Team visit, the Facility had begun the new risk process. A committee was formed that prioritized those needing risk rating reviews most urgently, and all individuals on campus were expected to have a risk rating review completed by May 2011. Teams had used the risk guidelines developed by the State Office in determining the risk for each of the categories based on criteria in the guidelines. A risk action plan was then created, often at the time of the risk-rating meeting with the PST. Implementation was then expected. The Facility was just beginning this process, and recognized that it remained noncompliant with this section of the Settlement Agreement.
	Summary of Monitor's Assessment: In January 2011, LBSSLC had implemented the new risk system and State policy regarding At-Risk Individuals. The policy included Risk Guidelines, which were specific criteria to assist teams during individuals' PSP meetings to determine the appropriate risk levels for each risk indicator. To ensure that all individuals had been screened for their at-risk status, and plans developed to address risks by the end of May 2011, a number of PSP addendum meetings were being held. The Facility was methodically completing the risk rating process. Overall, in observing a number of meetings while onsite, the Monitoring Team noted improvements in the clinical discussions and the use of supporting clinical data when the PSTs were determining the risks levels. However, the quality of the results of this process was dependent on each member being prepared to contribute his or her area of expertise, for the teams to work in an integrated fashion to develop new solutions to address areas of risk identified, for critical reviews to occur of the actions taken and their results, and for teams to aggressively pursue additional options when risks factors were not ameliorated, or reduced, to the extent possible. During the onsite review, the Monitoring Team met with three teams to review their risk rating, and plan development and implementation processes. Although the Monitoring Team recognized that the teams were in the beginning stages of learning this new process, an array of concerns were identified related to a lack of adequate analysis of information with the result being inadequate risk determinations, incomplete action plans, as well as lack of follow up. There remained communication gaps between departments. The process will require strong QMRP leadership, and collaboration and cooperation from all medical and clinical departments. It will require extensive preparatory work on the part of all PST members, and the PCPs will need to take a lead role in this area.

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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.	In January 2011, LBSSLC had implemented the new risk system and State policy regarding At-Risk Individuals. The policy included Risk Guidelines, which were specific criteria to assist teams during individuals' PSP meetings to determine the appropriate risk levels for each risk indicator. On 2/2/11, the Facility "at risk" policy was completed, and was synchronous with the state "at risk" policy. According to the POI, a high-risk committee was formed to identify individuals that were given priority in completion of the risk rating process. At the time of the review, the Facility had scheduled additional PSP addendum meetings to ensure that all individuals would have their risks reviewed and risk levels assigned in alignment with the new At–Risk policy by the end of May 2011. The following describes the documentation trail: The PST, during the PSP process, completed an "Integrated Risk Rating Form," which included each risk category. Each risk category identified the team's risk rating, followed by a rationale for the rating, especially if the rating indicated high or medium risk. A signature sheet was attached to the PSP or PSPA in which the risk(s) were rated. An "At Risk Individual Report" was generated, which included a column with the risk categories, and the risk score for each category. This allowed team members to quickly obtain a perspective of the risk profile. There was a recommendation section at the bottom of the list reiterating the high-risk categories that needed an action plan. To assess the Facility's risk screening process, members of the Monitoring Team observed six individuals' PSP or PSP addendum meetings (Individual #259, Individual #198, Individual #92, Individual #89, Individual #7, and Individual #62) while on site. Specifically, the observations of the PSPs indicated that: ▪ All appropriate disciplines were present at three (50%) of the PSPs. The individuals' PSPs/PSP addendum meetings that did not include all appropriate disciplines included: Individual #92 (Dentist and day/vocational representative), Individual #7 (Direct Support Professional), and Individual #62 (Direct Support Professional). ▪ The staff present at the PSPs/PSP addendum meetings were the actual staff that worked with the individual and not substitute staff sitting in for other staff members for five (83%) of the PSPs. The individuals' PSPs/PSP addendum meeting that did not include the actual staff that worked with the individual included: Individual #259 (Speech Therapist), however, the Monitoring Team noted that the Speech Therapist was informed about the individual. ▪ The individual was present at four (67%) PSPs/PSP addendum meetings. The individuals' PSPs that did not have the individuals present included: Individual #7, and Individual #62. ▪ The PST used the Risk Level Guidelines when determining risk levels at five	Noncompliance

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		(83%) of the PSPs/PSP addendum meetings. The individual's PST that did not use the Risk Level Guidelines when determining risk levels included: Individual #259. ▪ The PST used supporting clinical data when determining risks levels for all the PSPs observed (100%). Although the Monitoring Team noted that there was improvement for this indicator, specific supporting clinical data needs to be consistently used when determining risks levels and future compliance scores will reflect consistency for this indicator. ▪ The risk levels the PSTs designated were appropriate for each category for three individuals (50%). The individuals' PSTs that did not appropriately designate risk levels included: Individual #259 (PST not able to come to consensus regarding risk level for weight issues, and ended up taking a vote to assign the risk level), Individual #198 (the PST assigned dental risk level as medium, which was not appropriate given the clinical issues discussed), and Individual #92 (the PST assigned the risk level assigned for constipation as low, which was not in alignment with the guidelines, based on her clinical issues). ▪ There was clinical discussion among appropriate team members in decisions regarding risk levels in all (100%) PSPs/PSP addendum meetings observed. Although the Monitoring Team noted improvement for this indicator, the PSTs need to continue to expand the depth and scope of the clinical discussions related to the risk indicators and levels, and future compliance scores will reflect the adequacy of the clinical discussions. ▪ Team disagreements regarding risk levels were noted in two PSPs (Individual #259 and Individual #89), and were appropriately resolved in one (50%). The PST for Individual #89 was not able to come to consensus regarding risk level for weight issues, and ended up taking a vote to assign the risk level. ▪ The PSP facilitator kept the team focused for two (33%) of the PSPs/PSP addendum meetings observed. The individuals' PSPs/PSP addendum meetings where the facilitator did not keep the team focused included: Individual #89, Individual #7, Individual #62, and Individual #259. Overall, the Monitoring Team noted improvements in the clinical discussions and the use of supporting clinical data when the PSTs were determining the risks levels. In addition, other positive observations from the Monitoring Team included: ▪ The PST for Individual #92 arranged for the individual's mother to participate via conference call, which enabled the team to conduct an extensive review of past medical and clinical issues. This resulted in the team discovering a history of past episodes of heat exhaustion. ▪ The physician for Individual #198 was very knowledgeable and vocal during the PSP meeting, and integrated her information into the team's discussions of risks and risk levels without taking over the PSP meeting. In addition, the direct	

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		support professional provided excellent input regarding the individual's preferences. The team also discussed the possibility of a future transition to the community for the individual, despite differences of opinions amongst team members. ▪ The PST for Individual #7 appropriately changed the risk level regarding aspiration, based on additional clinical discussions regarding dental risks. ▪ The PST for Individual #259 knew the individual well and directed conversations toward the individual during the PSP meeting. In addition, the physician on the team was well informed about the individual, and played a critical role during the PSP meeting. The psychologist on the PST appeared to have the best understanding of the at-risk process. To further assess the risk rating and follow-up process, during the on-site visit, the Monitoring Team met with three teams to review three individuals' risk ratings, and the plans that had been developed to address at-risk issues. These individuals included: Individual #33, Individual #29, and Individual #253. The following provides information related to these individuals: ▪ On 12/2/10, Individual #33 had a Risk Action Plan completed during a PSPA meeting. This was before the several in-services that were provided to the staff at LBSSLC. Several areas were identified as either high or medium risk, including polypharmacy, constipation, behaviors, and osteoporosis. Follow-up was to be in three months, but no follow up meeting had yet been held. The actual risk factors generally appeared to follow the state office guidelines, with some exceptions. For example, the team had rated Individual #33 as "low" with regard to infections, despite a diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA). Team members indicated that with the additional training they had, they likely would have rated this as "high." For dental, her rating was medium, despite the fact that she required general anesthesia for work to be completed. ▪ On 3/30/11, at an informational session between the PST and the Monitoring Team, Individual #29's current at risk report and action plan were discussed. The integrated risk rating form was completed on 1/6/11. There were several high-risk categories identified, including: Aspiration, respiratory, and polypharmacy. Although the individual met the criteria for polypharmacy, the polypharmacy involved different types of breathing treatment. Due to the limited side effect profile of nebulizer treatments, although it technically met the high risk by definition, this was an example in which critical thinking should have been applied to determine that assignment of a "high" risk rating was inappropriate. It had the potential to distract the team away from other high-risk areas, as well as medium risk areas that would likely have more negative effect than the polypharmacy use of three nebulizers. Another concern related	

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		to the risk rating was that the team had rated Individual #29 as "low" for infections, despite three hospital admissions for pneumonia in 2010. ▪ On 3/31/11, at an informational session between the PST and the Monitoring Team, the current at risk report and action plan for Individual #253 was discussed. The integrated risk rating form was completed on 3/4/11, but no copy was submitted for review. A PSPA meeting had been held to review Individual #253's risk ratings. At the time of the Monitoring Team's review, this individual remained hospitalized with abdominal complications, resulting from an attempt to create a functional J-tube. When teams convene, the departments responsible for each risk category should be sufficiently knowledgeable about that category to explain the risk to the remainder of the team. The surgery for this individual was complex, and varied from the original request for a fundoplication. It remained unclear why that procedure was not completed, but a Roux-en-y type procedure for a J-tube placement was completed. Unfortunately, there appeared to be considerable confusion about the reasons for the type of surgery, until the PCP called the surgeon, and the surgeon returned the call during the informational session with the Monitoring Team. Areas discussed included the challenges of positioning the individual, which aggravated GERD. An Esophagogastroduodenoscopy (EGD) in 12/10 indicated esophagitis. If the gastroesophageal (GE) junction were patulous, the gastric acid would still reflux and cause esophagitis, and, if severe enough, aspiration. The team would need to monitor the individual to determine if GERD symptoms continued. It was important to note that the Dental Department considered his medical problems too high a risk to undertake dental care at LBSSLC, and he was referred to the hospital for procedures, where he could be monitored more extensively. A risk ratings for which there was a discrepancy between the team decision, and the State Office Guidelines, and for which there was not adequate justification included: for constipation/bowel obstruction, the team assigned a "low" risk, despite the fact that Individual #253 was taking routine medication for constipation, which should have placed him in the medium risk category. Ten individuals' records also were reviewed to determine the quality of the PST meeting concerning risk identification, and adherence to the risk guidelines as defined by State Office criteria. These individuals included Individual #313, Individual #6, Individual #175, Individual #66, Individual #135, Individual #168, Individual #192, Individual #128, Individual #78, and Individual #156. The following summarizes the results of this review: ▪ The PST meetings at which the risk ratings were discussed were attended by the appropriate disciplines for seven out of 10 individuals (70%). ▪ The individual was present at the PSP meeting in two out of 10 risk rating meetings (20%).	

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		▪ The PST used the risk guidelines when determining risk for six out of 10 individuals (60%). The guidelines were not used for one individual (Individual #6). There were three individuals for which the rating was still based on the old system, and was completed in 2010 (Individual #168, Individual #78, and Individual #156.) ▪ The PST used supporting clinical data when determining risk in seven out of 10 individual ratings (70%). Three were rated prior to the new risk system being implemented. ▪ The risk levels were appropriate for each category in five cases (71%), and were not appropriate for each category in two cases. For three, this could not be determined, because the risk level was determined according to the old Health Status Meeting system. The following provides details about the ten individuals reviewed: ▪ On 1/14/11, Individual #313 had an Integrated Risk Rating form completed. High-risk areas identified were constipation, osteoporosis, polypharmacy (taking four medications for constipation), and fluid imbalance due to having to be constantly encouraged to take fluids. These areas met criteria included in the risk guidelines. However, there was no risk action plan submitted, including what steps were to be taken to encourage fluid intake, monitoring of input and output of fluids, as well monitoring for use of prn constipation medications and ER visits for constipation, and/or consideration of additional evaluation for surgical options in treating constipation, such as bowel motility studies. ▪ On 12/21/10, Individual #6 had an integrated Risk Rating form completed. High-risk areas included aspiration, respiratory compromise, GI problems, osteoporosis, and infection. He had not been worked up further for his GI problems, and there were many factors that should have been taken into consideration. He had a history of Barrett's esophagus, and had a fundoplication in the past. Whether the G-tube was coiled and the end pointing back up the esophagus or at the EG junction was not considered despite his frequent vomiting. Given his history of Barrett's esophagus, an EGD would be important to consider, as well as assessment of the fundoplication to determine if it was still wrapped. It did not appear he had been worked up to ensure a gastric outlet obstruction was not occurring. He was considered high risk for osteoporosis, based on long-term use of valproic acid. There did not appear to be a DEXA scan completed on this individual, or referenced in the submitted documents. Depending on the score, he would be a candidate for osteopenia or osteoporosis treatment. However, he was not currently prescribed medication for osteoporosis, although the team considered him high risk for this health issue. Incidentally, he had a set of computerized orders, dated 11/30/10 to 2/30/11. Pharmacy might need to review the quality of the computer programming for	

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		orders, because 2/30/11 is not a date that exists on calendars. Monitoring for optimal positioning was not found in the documents received. If there was a consideration that positioning aggravated his vomiting, then unannounced monitoring on all shifts should be documented. The team rated him high risk for respiratory compromise based on nodules on a Computed Tomography (CT) scan, although the findings did not require treatment, and did not appear to be interfering with respiratory function. The physician only rated respiratory compromise as moderate. The rationale for overriding the physician's recommended rating was not documented. With regard to complex medical conditions, the physician or PCP on the team brings education and expertise that other team members do not have. Although all members of the team should be involved in the decisions related to risk, for any risk ratings that diverge from the recommendations of the clinical discipline specifically assigned to that risk area or from the State Office guidelines, the rationale should be well documented. The physician was at the 12/21/10 PSPA where the risk rating was completed, and the team would have been able to gain an understanding from the physician regarding the reason a moderate risk level was recommended. Individual #6 did meet the criteria for high risk, having had aspiration pneumonia on 6/20/10, but that was not the rationale listed in the document. ▪ The most recent risk assessment for a PSP Addendum was reviewed for Individual #175. It was dated 1/5/11. She had several hospitalizations over the prior year, with pneumonias and other episodes of acute onset hypoxia. She was also constipated. She choked shortly after the PSP Addendum was written. On 1/27/11, a PSP addendum was written, but did not include the episode of choking. Because the PST only met quarterly to review the risk rating protocol, developments between the meetings were not addressed in the PSPA. For instance, choking should have been moved to the high-risk level. Aspiration from GERD was probable, given the episodes of hypoxia and respiratory distress, which resolved quickly and were not related to pneumonia. However, until the work up for GERD and potential fundoplication was done, this should remain a high-risk rating. ▪ On 1/12/11, Individual #66 had an Integrated Risk Rating Form completed, and a Risk Action Plan also was completed. She was considered high risk for aspiration and respiratory compromise, and had been followed by the PNMT. She had repeated aspiration pneumonias. Although the risk action plan addressed GERD precautions, it did not address the need to determine and prevent recurrent aspiration pneumonias, which might be due to GERD. Further work up/evaluation was indicated. From the most recent orders dated 3/24/11, she was not prescribed a proton pump inhibitor or other medication despite concerns for GERD. Upon further review, the Risk Action Plan deferred	

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		evaluation of GERD to the RN case manager and physician on 1/12/11, but there was no information as to whether a work-up was ordered. She might benefit from either a medical or surgical approach (or both), if she had a confirmed diagnosis of GERD, but the next step could not be taken without an adequate evaluation. Due to the severe T score, she was considered high risk for osteoporosis. She was medium risk in several areas, and cardiac disease was one of these. With her recent resuscitation, again a thorough evaluation was indicated. After the resuscitation and hospitalization, there did not appear to be an urgent meeting of the PST to update the risk profile of this individual, or to assure assessment was completed, or was being carried out in a timely manner. Risk action plans need to be followed to completion in a timely manner, and are dependent on complete assessment of the high-risk areas identified. ▪ For Individual #135, the risk assessment rating was not submitted, but a PSP addendum of 2/10/11 listed the high-risk categories as challenging behavior, constipation/bowel obstruction, and infections. The challenging behavior of pica was high risk. The risk guideline under constipation/bowel obstruction included the criterion: "pica, episode within past year requiring removal of a foreign object," which occurred twice in 2010. Additionally, he had a series of infections of his skin (hands, abdomen, and chest wall with bacterial resistance to antibiotics), which would be categorized as high risk according to the risk guidelines. The PST risk rating appeared appropriate. ▪ For Individual #130, the most recent risk-rating tool submitted was dated 9/2/10, and was the result of a Health Status Meeting. The new risk criteria guidelines were not available at that time. All categories were rated low concerning risk. He had been diagnosed with osteoporosis, and treatment included Alendronate for osteoporosis. He would have been high risk for osteoporosis according to the new criteria. ▪ For Individual #168, the last submitted health risk assessment-rating tool submitted was dated 10/14/10. It rated seizures and "respiratory" as medium risk, and other categories as low risk. The PSP from 4/29/10 indicated he was high risk for seizures, and medium risk for aspiration and constipation. Based on the history of seizures, he would be categorized as high risk according to the new risk guidelines. He would be considered moderate risk for constipation as he was taking routine medication for this. He was on thickened liquids and pureed diet of pudding consistency, with a diagnosis of dysphagia, which placed him at medium risk for aspiration and choking. For osteoporosis, which was not mentioned in the risk rating, he was considered high risk due to the markedly abnormal T score. ▪ On 1/6/11, the PST met and completed an integrated risk rating for Individual #29. He met the risk guidelines criteria for high risk for aspiration and respiratory compromise. Polypharmacy with three inhaler/nebulizer	

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		medications made this area high risk, although clinically, his polypharmacy would not be prioritized compared to the other areas. Areas such as constipation and GERD (gastrointestinal problems) were considered medium/moderate risk. However, the importance of a timely completed GERD work up has already been mentioned. Constipation might cause ileus, and vomiting or high feeding residuals. The moderate risk categories for this individual were important, because they might have been contributing to attacks of respiratory distress. These areas should not be considered less significant because they were considered moderate/medium level risk. If the individual had GERD, and had not been evaluated for potential severity such as reflux aspiration, then GERD could actually be high risk and one of the most significant risks on the list. Additionally, he had a diagnosis of osteoporosis, which according to the risk guidelines should have placed him in a high risk rating for this category. The team had rated him a medium risk for osteoporosis. ▪ For Individual #192, an earlier risk rating of choking indicated low risk. Aspiration was also considered low risk. A later risk rating indicated that choking was a medium risk, based in part on a potential choking episode on 6/16/10. However, she had two more choking episodes since that time, on 10/27/10, and 3/5/11. There would appear to be the need for further review to determine the etiology, if possible, and review the dining plan. She also would appear to be at heightened risk with three choking spells within a year. This category might be more appropriately considered high risk, according to the risk guidelines. She continued to have recurrent stage 1 and 2 pressure areas of her back, and according to the risk guidelines, this would place her in medium risk, which was consistent with the current rating by the team. ▪ Individual #128 was considered high risk for osteoporosis and dental, because she met the criteria for these through the risk guidelines. She did not have other areas of risk, and the PST's Integrated Risk Rating form of 2/16/11 appeared to be accurate. ▪ For Individual #78, no updated risk assessment rating was submitted. The only one submitted was from 10/21/10. It listed respiratory as high risk, and all other categories were low risk. As her DEXA scan of 4/5/06 indicated a T score of negative 2.8 at the left femur, she also would be considered high risk for osteoporosis. If another DEXA scan had not been ordered, it would be indicated. As she was listed in the "combined list for risk discussion meetings (enteral feeding, pneumonia, and PICA)" as being on continuous feeding via G-tube, she would be considered high risk for aspiration. However, comparison of this information to the team rating decisions was not possible. ▪ For Individual #156, no recent health risk assessment rating was provided. The one submitted was dated 9/7/10, and listed injury as high risk, and weight as medium risk, but all other categories were low risk. From the risk guidelines,	

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		injury was not listed as a category, but he would have fit into the category of fractures, as he had a fracture in the past year. Additionally, he would have met the high-risk criteria for constipation, because as he required several enemas over time, and some of those administrations were associated with a fecal impaction. Comparison to any current PST risk rating was not possible. According to the POI, to initiate a need for risk review, the daily morning medical meetings were to be one route through which this process would be initiated. The process included communicating with the QMRP the need to schedule a PSPA meeting to assess the risk and create a plan for that risk. Although the clinic lists, campus log, and daily clinic report were reviewed at each morning meeting the Monitoring Team attended, this active referral process was not observed. There was no instance in which a risk was identified requiring a PSPA. The Monitoring Team would agree with the Facility's assessment included in the POI that this step was still "in process." Areas needing focus or improvement included: ▪ The PSTs should continue to consistently use objective clinical data when determining risk levels; ▪ Some team members were not aware of significant medication changes; ▪ PSTs were uncertain whether or not to rate risk levels based on if supports were in place, or to rate the risk as if the supports were not already implemented; ▪ Some rating of risks was based on "institutional" standards rather than how a community practitioner would rate the risk level (i.e., a lower standard was used, for example, with regard to dental health); and ▪ The facilitation of some of the PSPs lacked structure and focus. Although the Monitoring Team noted some positive improvements in the at-risk process from the previous reviews, the Facility should consider additional training for PSTs. This is necessary to ensure that the at-risk process adequately identifies these critical issues, so that appropriate and clinically sound action plans can be developed to address the risks identified.	
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	According to the POI, after development of the risk ratings for an individual, the PST met within five working days, or sooner, if the risk reflected acute care issues. The Facility created a tracking system for these various administrative steps. This occurred on 11/1/10. The database tracked all the PST risk meetings, the risk areas identified at each risk meeting, completion of the risk action plan, and the frequency of follow up agreed by the PST. As noted above, during the week of the onsite review, the Monitoring Team met with a sample of teams to discuss the process used for risk review and plan development, as	Noncompliance

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	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.	well as the results of those reviews for a few individuals. Based on these discussions, the following provides some examples of the Monitoring Team's concerns related to assessments completed for the individuals teams' responses to individuals' risk areas: ▪ For Individual #33, the development of an action plan appeared to be hindered by delays and lack of tracking/follow-through. As mentioned, despite her hospitalization and ongoing severe psychiatric and behavior problems, there was no timely follow-up from the 12/2/10 meeting. Given that staff had completed additional in-service training, it would have been important to meet again and review the prior risk ratings, because the new training likely would have led to new insights and concerns. A number of tests also appeared to be delayed. The team had identified a number of areas of risk, but the interdisciplinary assessment and next steps for treatment, supports, changes in the environment or programming, etc., were lacking. For example, she was sent to a gastroenterologist, but the consult report had not been received promptly, but there was no follow-up of this. A GI work up was eventually done, but it took many months to schedule. Additionally, she was scheduled for a DEXA scan, because the last one was completed in 2005. It was scheduled for 2/11, but she was hospitalized during this time. There was a delay of several weeks before it was rescheduled. The Risk Action Plan process did not seem to be integral to the PSP process, but rather seemed to be an additional task, which did not have the intended goal of directing the team's response through the development of an action plan that was based on risk factors, and resulted in the timely assessment and treatment of these risk need areas. ▪ For Individual #29, the team did not appear to identify the potential important contribution of reflux and aspiration on bronchospasm and recurrent pneumonias. The team appeared to believe the risk from GERD was "stable" as identified in the rationale. However, there was no work-up to prove GERD was considered stable or under control. The team members needed to challenge each other in ensuring their rationales were evidence-based, and not based on assumptions. Ideally, there should be evidence to confirm the team's rationale for each category or risk reviewed. Based on a further review of 15 records for individuals determined to be at risk (Individual #253, Individual #29, Individual #6, Individual #199, Individual #193, Individual #66, Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #43, Individual #15, and, Individual #56), there was documentation that the PST started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these (0%) individuals. Examples of records that did not contain documentation of this requirement included: ▪ Individual #29's PNMT Evaluation, dated 10/21/10, acknowledged that prior to	

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		being referred to the PNMT, he had been hospitalized and/or had visited the emergency room seven times during the previous six months for respiratory distress and pneumonia. Individual #29's was at risk for respiratory concerns, but his PNMT assessment was not initiated within five working days of the individual being identified at risk of respiratory concerns. ▪ Individual #253's Integrated Risk Rating Form, dated 3/4/11, identified him as being at high risk for aspiration, respiratory compromise, osteoporosis, and dental. He had been diagnosed with pneumonia, on 5/20/10, 5/24/10, and 8/11/10, and aspiration pneumonia, on 12/16/10. However, he was not assessed for these risk indicators within five days of his first hospitalization for pneumonia. ▪ For the following records, there was not adequate documentation to determine exactly when the Individuals were identified as being at risk and what assessments were actually conducted: Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #6 Individual #43, Individual #15, and Individual #56 <u>Physical and Nutritional Management, and/or OT/PT/SLP Assessment</u> Based on a review of six individuals records for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate physical and nutritional management, and/or OT/PT/SLP assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #253, Individual #29, Individual #6, Individual #199, Individual #193, and Individual #66. The following provides examples of assessments that were not comprehensive: ▪ Individual #6, Individual #199, Individual #193 and Individual #66 received enteral nutrition, and were at risk for aspiration pneumonia, but the PNMT had not evaluated these individuals. <u>Nursing Assessments</u> Based on a review of ten individuals records for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #6, Individual #43, Individual #15, and Individual #56. The following provides examples of assessments that were not comprehensive: • No Risk Assessment Tools-Nursing were found for Individual #313, and Individual #264. • In addition, the Risk Assessment Tool for Individual #6, who was identified as being at high risk for aspiration and osteoporosis, did not include any supporting	

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		documentation indicating how the individual was diagnosed with osteoporosis, such as noting the data, and score of a Dexa Scan. In addition, there was no supporting clinical data included on the assessment tool addressing why the individual was at risk regarding aspiration. • Dates when the Risk Assessment Tool was completed were missing on some of the tools, and there were a variety to tool forms used that were missing some of the health indicators such as hypothermia, falls, and fractures. Based on a review of the At-Risk policy, there was no indication as to what type of nursing assessment was to be conducted on individuals with status changes related to their risk factors. Although the Facility had been using the Risk Assessment Tool-Nursing, and the CNE reported that they continued to use the tool when the new risk process was implemented, the tool itself was only a screening tool, not a comprehensive nursing assessment. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals. <u>Medical Assessments</u> Based on a review of 10 individual records for whom assessments had been completed to address the individuals' at risk conditions, one out of 10 (Individual #128) (10%) included an adequate medical assessment to assist the team in developing an appropriate plan. Comments are provided with regard to Section L.1 concerning gaps in evaluation for Individual #313, Individual #6, Individual #175, Individual #66, Individual #135, Individual #168, Individual #192, Individual #78, and Individual #156.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical	According to the Facility policy, the PST was expected to implement the plan, once completed, within 14 days. Additionally, a copy of the final plan was placed in the record within 30 days of finalization of the plan. A document entitled "At Risk High Risk 14 Day Implementation" recorded a number of individuals who had had risks rated, assessments completed or in progress, and a plan of implementation completed. For each individual listed, there was verification that the action plan was received, there was a follow-up meeting scheduled, and high risk and medium risk categories were defined. The submitted document included individuals for whom the date of the risk meeting occurred between 10/29/10 and 2/8/11. Based on a review of 13 records for individuals determined to be at risk (Individual #6, Individual #199, Individual #193, Individual #66, Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #43, Individual #15, and Individual #56), there was documentation that the Facility: ▪ Established and implemented a plan within fourteen days of the plan's	Noncompliance

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	indicators to be monitored and the frequency of monitoring.	finalization, for each individual, as appropriate, in none of the (0%) cases. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the (0%) cases. ▪ When the risk to the individual warranted, took immediate action in none of the (0%) cases. ▪ Integrated the plans into the PSPs in none of the (0%) cases. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ For none (0%) of the plans were appropriate, functional, and measurable objectives incorporated into the PSP to allow the team to measure the efficacy of the plan. ▪ Plans included the clinical indicators to be monitored and the frequency of monitoring for none of the individuals (0%). The following are examples of plans that were inadequate to address the at-risk factors identified for the individuals: ▪ Individual #199's APEN Evaluation, dated 2/9/11, was completed "due to aspiration pneumonia on 4/29/10 and 7/24/10." On 9/11/09, he had a PEG tube placement. His Integrated Risk Rating Form, dated 2/16/11, placed him at high risk for aspiration, gastrointestinal problems, osteoporosis, and polypharmacy/side effects. The objective for aspiration pneumonia in the Action Plan, dated 2/16/11, was "over the next 12 months [Individual #199] will have less episodes of aspiration." The Action Step stated: "strategies for reflux precautions and positioning will be outlined in the PNMP." The monitoring frequency was to occur quarterly. His Action Plan objectives were not adequate to minimize his risk for aspiration pneumonia, because the implementation of his PNMP did not prevent recurrent episodes of aspiration pneumonia in April and July 2010. His Action Plan should have identified specific clinical data collection such as scheduled recording of lung sounds and oxygen saturation levels to ensure Individual #199 was not aspirating. Quarterly monitoring was not sufficient for an individual identified at high risk for aspiration pneumonia. There were no PSPA updates to address the status of his Action Plan. Per established criteria, the PNMT should have evaluated Individual #199. ▪ Individual #66 was hospitalized with discharge diagnosis of aspiration pneumonia on 2/19/10, and 9/10/10. Individual #66's Integrated Risk Rating Form, dated 1/12/11, showed that he had a high-risk status in the areas of aspiration, respiratory compromise, and osteoporosis. A Risk Action Plan objective stated: "[Individual #66] will have fewer respiratory issues over the	

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		next 12 months." The Action Steps were: "1) staff will follow the strategies outlined in her PNMP in order to prevent respiratory issues, 2) will remain in upright positioning for 1 hour following her meals, and 3) when laying in her bed/daybed she will maintain the recommended elevation." When she was hospitalized for aspiration pneumonia, these strategies were present on her PNMP, but did not prevent recurrent episodes of aspiration pneumonia. The PST and/or PNMT members should have completed an evaluation to determine if PNMP strategies remained effective, and/or why these strategies were not being implemented. The monitoring frequency on the Risk Action Plan was "every 90 days," which was not sufficient for an individual identified at high risk for aspiration. ▪ Individual #253, Individual #29, Individual #6, and Individual #193 also were enterally nourished and at risk for aspiration pneumonia, but the PNMT had not evaluated them. As a result, an adequate action plan had not been developed or implemented to minimize and/or reduce their high-risk health indicators. No functional, measurable outcomes had been developed to measure the efficacy of interventions. Their PNMPs were not integrated into nursing care plans and/or PSPs. The PNMPs did not address staff strategies for bathing/showering and personal care. ▪ Although Individual #146, Individual #313, Individual #204, Individual #213, Individual #6 Individual #43, Individual #15, and Individual #56 were identified as being high risk for a number of health indicators, there was no indication that action plans had been developed addressing their health risks. ▪ The action plan, dated 1/18/11, for Individual #264 indicated that he was at high risk for dental. However, the Integrated Risk Rating form, dated 1/18/11, indicated that he was at moderate risk. There was no documentation found indicating why his risk level for dental had been increased. In addition, the action step addressing his dental risk indicated that he had been on a formal program for tooth brushing that would be continued without mention of the progress of the current program or how often it would be reviewed to determine when modifications would be needed in alignment with the health risks his dental status posed. In addition, there were no interventions addressing an increase in oral assessments by nursing or dental to evaluate any positive or negative changes in his dental status. Thus, there were no aggressive or proactive interventions included in the action plan. Consequently, the action plan for this high-risk health indicator was inadequate. Records for 10 individuals were requested and reviewed to determine whether the development of an action plan had occurred in a timely manner. This included the records for: Individual #128, Individual #313, Individual #6, Individual #175, Individual	

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		#66, Individual #135, Individual #168, Individual #192, Individual #78, and Individual #156. An emphasis was placed on the content of the plan, as well as in ensuring the work-ups were thorough, consultations were made, etc. There was only one individual for whom a risk action plan was submitted (Individual #66). Copies of the risk action plans were requested for all 10 individuals. Some of the documents mentioned the risk action plan existed. However, comparison of findings to the risk action plans was not possible. The Risk ratings highlighted areas of clinical critical concern, but there were significant gaps in most records reviewed concerning adequate work-ups that would guide the team to appropriate treatment. For example: ▪ In the one Risk Action Plan submitted for Individual #66, there was no discussion of any further work-up for recurrent pneumonias, no discussion of the role of GERD and the need to further evaluate and treat/prevent, no further questioning or diagnostic evaluation for her recent coding in the home for which she was resuscitated successfully, and there was only an outdated DEXA scan in the record. The action plan did not address these issues. A number of barriers rendered it difficult, if not impossible in some cases, for the Monitoring Team to assess some of these requirements reflected by the indicators listed in Sections I.2 and I.3, such as: ▪ The lack of dates on documents; ▪ The lack of documents such as PSPs, Action Plans, and Integrated Risk Assessment Rating forms either not completed, or not included in the document requests; ▪ Lack of clarification regarding "assessments," included in the At-Risk Individuals policy; and ▪ Discrepancies between documents regarding risk ratings. As the Facility progresses in developing the At-Risk System, monitoring and tracking systems should be developed addressing the Facility's compliance with the requirements of the Settlement Agreement for Section I that includes the specific indicators noted above. Due to the critical nature of the At-Risk System to the health and wellbeing of the individuals at LBSSLC, continued development of this area should be considered a priority.	

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

1. Additional training on the at-risk process should be provided to the PSTs. This is necessary to ensure that the at-risk process adequately identifies the critical issues, and that appropriate and clinically sound action plans are developed to address the risks identified.

2. To standardize the team process, one nurse and one behavior analyst should be trained on implementation of the new risk rating process, risk action plan development, and plan implementation process. These staff could then act as mentors for the risk process implementation, and attend as many of the PST meetings as possible to ensure basic aspects of the new policy and procedure are followed.
3. The Facility should monitor the PSPs to ensure the risk ratings become part of the plan.
4. The risk category of polypharmacy might need further refining to include polypharmacy with certain classes of medications, which have the greater likelihood of a negative impact.
5. When the team convenes about an individual, the departments responsible for background information concerning a risk category should be sufficiently knowledgeable about that category to explain the risk to the remainder of the team.
6. Each PST member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating.
7. There should be evidence to confirm the team's rationale for each category of risk reviewed.
8. When there is a change in health status, the PST should reconvene to rate the categories of risk, and incorporate any changes in health into the risk categories and into a risk action plan.
9. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals.
10. The PCPs should ensure complete and timely assessments are ordered, and results incorporated into the individual's treatment and care. The risk action plan requires critical clinical thinking on how to prevent recurrences such as ER visits or hospitalizations to improve the quality of life by improving the health of the individual.
11. If an action plan item is deferred to a member of the team, that team member should have a document trail for implementation of the plan, and should document closure of the issue.
12. As individuals' risks are identified, and risk action plans are developed, teams need to review the steps taken to ensure they are completed in a timely manner they actively reduce risk. In order for this to occur, measurable objectives or indicators need to be established to allow the team to measure whether or not the individual is better or worse, and if his/her risk level is reduced. If a plan is not working, the team needs to reevaluate it, and potentially revise it.
13. As the Facility progresses in developing the At-Risk System, monitoring and tracking systems should be developed addressing the Facility's compliance with the requirements of the Settlement Agreement for Section I.

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 from the 3/19/11 Pharmacy and Therapeutics (P&T) Committee Meeting; o List of individuals who are receiving Reglan; o Alphabetical list of individuals psychiatrically hospitalized during the last year; o Reiss Screening instrument spreadsheet, dated 3/28/11; o Completed Reiss Screening instrument for a random sample of 20% of the individuals screened; o A table entitled, "Comparative on Polypharmacy," which provided frequencies for the following time points: 6/05, 9/08, 9/09, 3/10, 9/10, and 2/11 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 Behavioral Desensitization Plans for dental/medical appointments for the following individuals: Individual #264, 1/11; Individual #127, 10/10; Individual #35, 3/09; Individual #160, 11/10; Individual #33, 8/10; Individual #175, 8/10; Individual #322, 2/1/10; Individual #16, 1/11; Individual #183, 3/09; and Individual #182, 5/10; o The supporting documents, including the Internal Quality Enhancement Monitoring results, which were distributed at the Quality Assurance/Quality Improvement Council Meeting, on 3/31/11; o Review of the supporting documentation related to the Positive Behavior Support Committee Meeting, on 3/31/11; o The following documents that were in the Presentation Book related to Section J of the Settlement Agreement, dated 3/11: ▪ The Plan of Improvement/Self-Assessment for the Psychiatry section, dated 3/14/11; ▪ Quality Assurance Monitoring Reports, with results for 9/10, 10/10, 11/10, 12/10, and 1/11; ▪ Document entitled "Psychiatry – Section J: Progress Since Monitoring Visit, 3/10; ▪ A spreadsheet entitled "MOSES/DISCUS Monitoring Form for Nursing/Psychiatry/Pharmacy;" o Alphabetical list of all individuals receiving psychotropic medication, with diagnosis, target symptoms, derivation of target symptoms as behavioral, psychiatric, or both, and

	list of the specific medications with current dosages, revised 3/8/11; o List of individuals prescribed benzodiazepines, dated 2/22/11; o State Supported Living Center Policy: At-Risk Individuals, dated 11/2/10; o Restraint Report for LBSSLC from 8/8/10 to 1/31/11; o Report on the use of Chemical Restraints at LBSSLC, from 8/1/10 to 1/31/11; o List of employees who have received MH/MR dual diagnoses training, provided twice a month by Dr. Weddige, from 3/11/10 to 3/11/11; o Policy for prescribing psychoactive medication, revised 6/8/10; o Policy for psychiatric assessments, dated 9/1/10; o Policy for MOSES and DISCUS monitoring, dated 12/9/10; o List of individuals prescribed anticholinergic medication, dated 2/22/11; o List of individuals prescribed intra-class polypharmacy, dated 2/22/11; o List of individuals monitored for tardive dyskinesia, dated 2/22/11; o List of individuals being prescribed an anticonvulsant medication for psychiatric reasons, dated 2/22/11; o List of meeting and rounds attended by the Psychiatrists, undated; o Curriculum vitae of Richard Weddige, M.D.; o Overview of Psychiatrists' weekly schedule, undated; o Job description of Psychiatrist III, undated; o The minutes, supporting documents and attachments for the "Monthly Facility Review of Psychoactive Medication Polypharmacy" Meetings, dated 8/15/10, 9/28/10, 10/26/10, 11/18/10, 12/21/10, and 1/25/11; o The Pre-treatment Sedation Checklist for Dental Appointments; o The newly developed Desensitization Plan for Dental Appointments for Individual #119; o The new policy for Dental Desensitization, dated 3/20/11; o The minutes and attendance sheets of the Dental Desensitization Committee Meetings, dated 1/31/11, 2/10/11, and 3/18/11; o The following sections of the medical record Demographic Information (e.g., Profile Sheet – Photograph and Identifying Information Sheet); Social History Evaluation; the PSP section; the Positive Behavior Support Plan (PBSP) section, including Addendums; the Psychological Assessment; the Functional Analysis; Annual Medical Summary; Active Problem List; Inactive Problem List; Psychiatric Problem List; Hospital Admission section; Health Risk Assessment Rating – tool and team meeting sheet (only most recent); Psychiatry section, inclusive of the most recent Comprehensive Psychiatric Assessment; MOSES/DISCUS Side Effects Screening section; Quarterly Drug Regimen Reviews; Neurology Consultation section; any documentation and consultations regarding the use of pretreatment sedation medication [i.e., Treatment Plan, Guardian Approval, Human Rights Committee (HRC) Approval, etc.]; the Human Rights section, including a copy of the signed Consents, for the following individuals whose names were randomly selected from the list of individuals who were receiving psychotropic medication at the time of the review: Individual #146, Individual #276, Individual #235, Individual #147, Individual #284, Individual #25, Individual #162, Individual #38, Individual #318, Individual #65,

	Individual #271, Individual #240; o The same set of records was requested for the following individuals, as they had recently been admitted to LBSSLC: Individual #321, Individual #131, Individual #201, Individual #173, Individual #61, Individual #221, and Individual #92; o The same set of records was requested for the following individuals due to their clinical acuity: Individual #190, Individual #288, Individual #33, Individual #25, Individual #4, and Individual #242. ▪ **Interviews with**: o Dr. Richard Weddige, Director of Psychiatry, on 3/28/11; o Mr. John McCullen, Psychiatric Assistant, on 3/28/11 and 3/29/11; o Ms. Martha Castilo, Lead File Clerk, on 9/14/10; o Dr. James Forbes, Director of Psychology Services, on 3/29/11; o Dr. Russell Reddell, Director of Dental Services, on 3/30/11; o John Todd, R.PH., Clinical Pharmacist, on 3/30/11; o Glen Shipley, D.O., Medical Director, and Don Minnis, RN, Chief Nursing Executive, on 3/30/11; o Ms. Marisol Gonzales, ISP Coordinator, on 3/31/11; and o Mr. John McCollum, Psychiatric Assistant, and Mr. Bob Robbins, Program Compliance Monitor, on 3/31/11. ▪ **Observations of**: o The following individuals were observed in the context of the Psychiatric Clinics, on 3/29/11 and 3/30/11: Individual #131, Individual #273, Individual #276, and Individual #92; o The following individuals were seen in the context of the Neurology Clinic on 3/30/11: Individual #258, Individual #4, Individual #284, Individual #115, Individual #62, Individual #171, Individual #55, Individual #282, Individual #205 o Morning Provider Meeting, on 3/29/11; o Pharmacy & Therapeutics Committee Meeting, on 3/29/11; o Risk Assessment Process Meetings, on 3/29/11, 3/30/11, and 3/31/11; o Psychiatric Clinics, on 3/29/11 and 3/30/11; o Human Rights Committee Meeting, on 3/30/11; o Quality Assurance/Quality Improvement Council Meeting, on 3/31/11; o Positive Behavior Support Committee Meeting, on 3/31/11; o Neurology Clinic with Dr. Daniel Hurst, on 3/30/11; o During visits to the residential living units at LBSSLC, the following individuals were observed: Individual #116, Individual #198, Individual #53, Individual #161, Individual #179, Individual #73, Individual #74, Individual #257, Individual #269, Individual #265, Individual #33, Individual #60, Individual #61, Individual #288, Individual #221, Individual #240, Individual #300, Individual #140, Individual #279, Individual #155, Individual #237, Individual #112, Individual #119, Individual #8, Individual #310, Individual #106, Individual #82, Individual #233, Individual #34, Individual #159, and Individual #322.

	Facility Self-Assessment: 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 that are enumerated in the Settlement Agreement. These materials were reviewed during the onsite review with the Psychiatry Assistant and the Program Compliance Monitor for Psychiatry, on 3/31/11. During that meeting, the methodology and results of the internal Facility reviews of the Psychiatry Department were discussed. The materials in the Presentation Book indicated that the internal auditing reviews had involved the review of medical records by more than one rater. Typically, each review included the assessment of nine to 11 records by the Psychiatry Department, and five records by the Quality Assurance (QA) Department. The evidence included in the Presentation Book was based on a review of the medical records of 25 (20%) of the residents who were receiving psychotropic medications. As might be expected, a number of the improvements described in narrative form in the Presentation Book were not fully reflected in the analysis of the random sample, due to the time that is required for positive changes in the provision of psychiatric services to be fully reflected in practice patterns. In addition, to the degree that there was a divergence between the results of the internal audits of medical records and the current Monitoring Team's review, this appeared to be related to the focus of the internal audit on whether a specific piece of documentation was present or absent, whereas the Monitoring Team also closely reviewed the degree to which the clinical documentation met the quality standards set forth in the Settlement Agreement. LBSSLC "Plan of Improvement/Self-Assessment" dated 3/14/11 provided a brief synopsis of each provision of Section J of the Settlement Agreement, the Facility's self-assessment compliance rating, and a discussion of the rationale for that rating under the heading of "Comments/Status." There were obvious discrepancies between the results of the internal audits described in the "Plan of Improvement/Self-Assessment" under the column labeled "Comments/Status," and the global compliance self-rating of "Substantial Compliance" or "Noncompliance." These discrepancies were apparent for the following Provisions: J.2, J.3, J.8, J.9, J.10, J.11, J.13, and J.14. For example, for Section J.2, which requires 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," the Facility indicated it was in noncompliance with this provision. However, in the Comments/Status column, the Facility stated: "For the time period 9/10 to 1/11, ten individuals records were reviewed by the Psychiatry Department, which showed 100% compliance; and five were reviewed by the QA Department with 92% compliance." These findings would be indicative of substantial compliance, but the Facility included a finding of noncompliance. These observations were discussed with the Psychiatry Assistant and Program Compliance Monitor in a meeting on 3/31/11. The rationale provided at that time was that although they were aware that a significant number of records contained documentation related to these provisions, there were concerns about the quality of this documentation. Although these concerns were not reflected in the narrative comments related to each provision, they were considered in the Facility's overall compliance self-rating for each section. In conducting monitoring, the Facility should be reviewing the quality of treatment provided, and the related documentation. The ratings should reflect the findings of these qualitative reviews.

	Given that the Facility was not relying solely on the data, which did not account for issues related to quality, the Facility's overall compliance were generally in alignment with those of the Monitoring Team. However, the corresponding percentage completion results were significantly different for many of the provisions. The two provisions for which there was a discrepancy in the compliance findings were for J.6 and J.12. In both cases, the Facility assessed itself as being in compliance, which was not consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The observations made during the onsite review and the subsequent review of documents indicated that LBSSLC had thoroughly reviewed the content of the Monitoring Team's prior reports, and had made incremental progress in many of the 15 provisions in Section J of the Settlement Agreement. This progress, including examples, is described in detail below. Areas where some progress had been made related to the identification of the symptoms that support the psychiatric diagnosis of record, and the delineation of the derivation of the target symptoms of the psychotropic medications with regard to whether they are related to a biologically-based psychiatric disorder, or are precipitated by environmental and/or behavioral factors. Although the Facility was at the beginning stages of this process, there had been concerted efforts to attempt to make improvements for a number of individuals. The Facility also had made incremental progress in the area of polypharmacy. The statistics tracking polypharmacy dated back several years, and the longitudinal perspective this information provided was quite helpful. In the report that follows, the Monitoring Team has raised the possibility of separately tracking the polypharmacy related to individuals who were admitted from the community, because their pharmacological regimens skewed the Facility's polypharmacy statistics in a negative manner. It also might provide the State with important information about psychiatric supports currently available to individuals with Intellectual/Developmental Disabilities (IDD) in the community. During the onsite review, the Psychiatric Reviews of four newly-admitted individuals were observed, and it was clear that the teams had already begun to formulate strategies to begin to carefully reduce medications that might be unnecessary. The observation of the Psychiatric Reviews that were attended during the onsite review ranged from 20 minutes in length for a simple follow-up review, to 45 to 60 minutes for a more complex newly-admitted individual. The topics covered in these meetings included, not only the behavioral data, but also the interpersonal and family issues, as well as any relevant medical concerns. A difficult area that will require further work is the matter of actually being able to demonstrate that the burden of the side effects presented by the psychotropic medications is justified by the clinical benefits of the medication. This is a difficult problem not only from a clinical standpoint, but also from a mathematical perspective. As the number of prescribed medications for a given individual increases, the task of proving efficacy becomes exponentially more complex. Conversely, to the extent that polypharmacy can be decreased, these problems become simpler. The risk-benefit considerations were discussed in some of the Psychiatric Notes.

	The issue of pre-treatment sedation for medical and dental appointments is also referenced in Section J of the Settlement Agreement. The lead discipline for that initiative had recently been identified as the Dental Department, with support from the Psychology Department. A newly revised template for individual Desensitization Plans had begun to be implemented, but it was too early to assess whether this process would be effective. Empirical evidence that the prescribed psychotropic medication was effective in diminishing the identified behavioral symptoms of the psychiatric disorder could be definitively identified in only one of the 25 (4%) records reviewed. The primary factors that made it difficult to determine if the psychotropic medications had been effective for other individuals were the lack of adequate baseline data, and the co-existence of multiple psychotropic medications, which made it impossible to discern differential effects. The Neurology Clinic was observed during the onsite review, and an active dialogue was noted between the Neurologist, the Psychiatrist, and the PCP. Although progress was noted in many areas, improvements were not uniformly distributed throughout the relevant sections of the individuals' records. A prime example of this related to identifying the derivation of the target behaviors of the psychotropic medications as being present on a behavioral basis, due to a psychiatric disorder, or a combination of factors. The work in this area had progressed to the point that a column was added to the master spreadsheet, which listed the individual's name, psychiatric diagnosis, and psychotropic medications. However, this information was not uniformly reflected in the Positive Behavior Support Plans in the sample of individual records reviewed. At the time of the previous review, the Facility had hired a second full-time Psychiatrist. This Psychiatrist had since resigned, leaving the Director of Psychiatry with responsibility for the entire population at LBSSLC. In speaking with the Medical Director about this, and there was an active recruitment process underway to hire another full-time psychiatrist.

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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. The second full-time Psychiatrist, identified in the prior report, resigned near the end of 2010. Thus, Dr. Weddige resumed the clinical responsibility for all individuals at the Facility who were receiving psychotropic medication.	Substantial Compliance

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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.	The Psychiatrist had reviewed each individual at LBSSLC who was receiving psychotropic medication monthly, and directly observed the individuals at the time of the Quarterly Reviews. The evidence related to the requirement that: "No individual shall receive psychotropic medication without having been evaluated and diagnosed in a clinically justifiable manner…." was primarily contained in the Comprehensive Psychiatric Assessments (CPAs), as well the Monthly and Quarterly Psychiatric Review Notes. The review of the medical records of 25 individuals (20%), who were receiving psychotropic medications at the time of the review, found that a CPA that had been completed within the past two years for 21 of the 25 individuals (84%). The four individuals for whom a current CPA was not present were: Individual #38, Individual #65, Individual #271, and Individual #276. However, of the 21 individuals for whom a recent CPA could be identified, 10 (48%) met the quality standards specified in Appendix B of the Settlement Agreement. The quality standards were not met for the following individuals: Individual #318, Individual #156, Individual #94, Individual #240, Individual #25, Individual #4, Individual #162, Individual #147, Individual #284, Individual #146, and Individual #33. Although these CPAs did not meet the specific requirements outlined in Appendix B of the Settlement Agreement, they did contain a great deal of useful information, which could be expanded upon and updated to meet the requirements specified in the Settlement Agreement. The deficiencies that were identified in the CPAs that did not meet the quality requirements of the Settlement Agreement were primarily related to not fully conforming to the format described in the outline contained in the Settlement Agreement. For example: ▪ The "Psychiatric Assessment/Consultation" for Individual #25, dated 2/9/10, did not contain the following sections: Family History, Substance Use History, Medical History, Developmental History, Social History, Physical Examination, and Laboratory testing. There was a reference in the "Past Medications and Past History" section to prior documents dated 9/28/07, 9/2/09, and 1/6/10 for "past family history, medical history, and social history." The entire Past Medications and Past History section contained five lines of text, including the reference to the prior documents. A more recent document labeled "Annual psychiatric Review/Assessment," dated 2/2/11, referred the reader to unspecified prior documents for the Family, Medical and Developmental History, and was also lacking any reference to a recent Physical Examination. In addition, the Mental Status Examination did not conform to the outline contained in the Settlement Agreement.	Noncompliance

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		Ten of the 25 individuals' records (40%) contained CPAs that were both current and conformed to the outline contained in Appendix B of the Settlement Agreement. They were as follows: Individual #61, Individual #321, Individual #131, Individual #221, Individual #190, Individual #201, Individual #42, Individual #235, Individual #288, and Individual #92. Documents that could be construed as representing a CPA were not consistently labeled in the individual records and included titles such as "Psychiatric Assessment," "Psychiatric Consultation/Assessment," and "Annual Assessment." It would be useful if the psychiatric team could identify uniform nomenclature, such as "Comprehensive Psychiatric Assessment" with an indication of either "initial," for newly-admitted individuals, or "revised" (with current date), for updates related to individuals who have had a prior CPA. The current policy of the Psychiatry Department at LBSSLC was to update the individual psychiatric assessments on an annual basis. In the future, this annual review should provide an opportunity to ensure that: 1) the pertinent historical information in any prior CPA is carried forward; 2) the current relevant clinical information has been added; 3) the format conforms to that outlined in the Settlement Agreement, with each subheading in the outline accounted for; and 4) the resulting document is clearly identified as a revised CPA, which also includes a revision date.	
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 Positive Behavior Support Plan (PBSP), or as punishment. All of the records reviewed indicated that individuals receiving psychotropic medication had an active PBSP. There was no indication that psychotropic medication was being used as a punishment at LBSSLC. As discussed in further detail below with regard to Section J.9, the description of a behavior that was listed as a target of psychotropic medication and also being 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, the Director of Psychiatry and the Director of Psychological Services indicated that the efforts to address this issue had been expanded in the months that followed the Monitoring Team's previous review. Specifically, this initiative had included joint reviews of relevant individuals by the Psychiatry and Psychology Departments, case-based discussions at the meetings of the PBSP Committee, and inclusion of this information on the master spreadsheet, which listed the individuals' names, psychotropic medications and psychiatric diagnosis. However, as indicated in the discussion related to Section J.9 of the Settlement Agreement, several instances of this problem continued to be identified.	Noncompliance

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J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	Discussions with the Facility's Dentist and the Director of Psychological Services indicated that significant changes had occurred since the prior visit with regard to the implementation of Desensitization Plans to reduce the reliance on pre-treatment sedation medication for dental and medical procedures at LBSSLC. At the time of the previous review, this initiative was the responsibility of the QMRPs. In the months following the last review, the Dental Department had become the lead discipline in coordinating the initiative, with primary support from the Psychology Department. The Director of Psychological Services further indicated that the template for the development of individualized Desensitization Plans that were being developed at the time of the prior review had been abandoned, because they were too formulaic in nature, and lacked sufficient individual-specific detail. Thus, the Desensitization Plans for the ten individuals, which the Facility submitted in response to the pre-onsite review document request, were no longer considered to be valid. Both the Director of Dental Services and the Director of Psychological Services indicated that the new format for the development of individualized Desensitization Plans had benefitted from consultative input from a Board Certified Behavioral Analyst. On 3/30/11, the Director of Dental Services further stated that, to date, only one of the newly formatted Desensitization Plans had been completed for Individual #119. A copy of this Plan was requested and reviewed. The Plan was described on a form labeled "Strategy Sheet," with a notation that it was "Revised 12/07/10." However, this date appeared to relate to the date the form was revised, and not the date of the Desensitization Plan itself. The date this specific document was completed could not be located on the form. The plan for Individual #119 described four discreet behavioral interventions with a corresponding "strategy" for each "step." The details of these behavioral interventions appeared to be individualized. The final phrase concluded with "Once the two minutes is up, allow you and A to get up [from the dental chair] and leave, if she wishes." Thus, the goal of this sequential plan appeared to conclude with the individual sitting quietly in the dental chair, and did not include an actual or sham intervention by the dentist that would involve physical probes inside her mouth, which is the most anxiety-provoking step for many individuals. Presumably, this would be accomplished in a subsequent plan, which would be developed after this initial plan proved successful. LBSSLC also had developed a "Desensitization Committee." The minutes and attendance sheets for the 1/13/11, 2/10/11, and 3/18/11 meetings were reviewed. The content of these meetings focused on developing the components of the desensitization plans, as well as the policies and procedures for the implementation of the new Desensitization Plans. For example, the minutes from the 3/18/11 Meeting indicated that the new	Noncompliance

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		behavioral strategy for Individual #119 was reviewed during this Meeting, as was the new "Dental Desensitization Policy." A copy of this Policy also was requested and reviewed. The Policy was dated 3/20/11, and clearly described the four-phase process, which was identified in the newly developed Desensitization Plan for Individual #119. In summary, the leadership for developing Desensitization Plans for dental procedures had recently been transferred to the Dental Department. It was too early to assess the success of this initiative. Its progress will be monitored in future reviews. Documentation of a similar process with regard to the development of Desensitization Plans for medical procedures could not be identified. Discussion of this topic with the Medical Director indicated that Desensitization Plans for medical procedures were required less frequently than those for dental procedures. Thus, a parallel process to develop Desensitization Plans for medical procedures had not been developed yet. However, the principles derived from the development of the Dental Desensitization Plans could be applied to medical procedures in the future. This issue will also be reassessed during future monitoring reviews.	
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.	At the time of the previous review, the Facility employed two full-time Psychiatrists to provide psychiatric services to the 120 individuals who were receiving psychotropic medication at that time. The Psychiatrists had evenly divided the caseloads into manageable levels of 60 individuals per Psychiatrist and, thus, were found to be in substantial compliance with this provision of the Settlement Agreement. In the months following the previous review, one of the Psychiatrists had resigned, leaving only one Psychiatrist to provide psychiatric services to the 126 individuals at LBSSLC who were receiving psychotropic medication at the time of the most recent onsite review. Thus, the Facility was no longer in substantial compliance with this provision of the Settlement Agreement. The Medical Director indicated that the Facility was continuing its efforts to actively recruit additional Psychiatrists.	Noncompliance
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.	LBSSLC relied upon the Director of Psychiatry for psychiatric assessment, diagnosis, and case formulation. However, this process involved active consultation with Psychology. The previous monitoring reviews 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 their psychiatric staff had actively addressed this issue. The degree to which this effort had contributed to the improvement in individuals' treatment and the documentation in the medical records of individuals who were receiving psychotropic medication was	Noncompliance

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		assessed through the review of the medical records of the sample of 25 (20%) of the individuals receiving psychotropic medication. This review indicated that symptoms that were congruent with the psychiatric diagnosis of record could be identified in 13 of the 25 records (52%). The 12 individuals for whom the symptoms of the psychiatric diagnosis could not be identified were as follows: Individual #38, Individual #318, Individual #65, Individual #27, Individual #156, Individual #14, Individual #321, Individual #276, Individual #284, Individual #146, Individual #147, and Individual #4. For example: ▪ Individual #276 had a long standing Axis 1 Psychiatric Diagnosis of an "Impulse Control Disorder." However a Psychiatric note, dated 11/18/10, for the purposes of "Diagnostic Clarification" noted that since May of that year "it has become abundantly clear that his diagnosis of impulse control disorder has been complicated with an underlying seasonal affective mood disorder." The note went on to refer to periods during the year when he had increased energy and diminished sleep, although specific dates or seasonality were not defined. The Axis 1 Psychiatric Diagnosis of record was changed to "Mood Disorder due to congenital or acquired brain injury" at that time. However there was no description of the specific symptoms that would support that diagnosis, other than the aforementioned general reference to periods during the year when he seemed to have had more energy and decreased sleep. The "Psychiatric Evaluation/Annual review," dated 12/7/10, carried forward this Axis 1 Psychiatric Diagnosis, and also listed under the heading for Axis 1 "SSRI induced mood disorder symptoms with manic features." This diagnosis would imply that he had developed affective symptoms of mania related to prior treatment with a Selective Serotonin Reuptake Inhibitor (SSRI) antidepressant, which could have explained some of the symptoms of increased energy and decreased sleep that were alluded to in the prior notes. Additional diagnoses listed in this category were " History of impulse control disorder," and "History of Dysthymic disorder." The Biopsychosocial/ Spiritual Formulation section of this document made a general reference to a possible contribution from his Genetic Disorder of "Sotos syndrome," as well as behavioral contributions to his maladaptive behaviors, but did not list any specific symptoms that would support the above referenced Psychiatric Diagnoses, nor was there a narrative description of a Psychiatric Formulation that would explain the support for these diagnoses and explain their co-existence. The individuals whose records contained documentation that supported the psychiatric diagnosis of record were as follows: Individual #61, Individual #131, Individual #201, Individual #240, Individual #25, Individual #235, Individual #162, Individual #190, Individual #288, Individual #33, Individual #92, Individual #42, and Individual #221.	

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		In the previous reviews it was noted that the documentation that would substantiate the psychiatric diagnosis of record were not identified in a cohesive manner, but rather were located in disparate sections of the record. During this review, the explanation of the rationale for the psychiatric diagnosis was more apt to be found in the bio-psycho formulation sub-section of the CPA, which followed the psychiatric diagnostic section in the format outlined in Appendix B of the Settlement Agreement.	
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. The individuals who were prescribed psychotropic medication should have received a psychiatric assessment, as specified in the Settlement Agreement (as discussed with regard to Sections J.2, J.6, and J.13). Thus, the Reiss Screen should have been administered to those individuals who were not receiving psychotropic medication. The spreadsheet that was revised on 3/28/11 entitled "Reiss Screen for Maladaptive Behaviors" listed individuals who had been administered the Reiss Screen beginning in 2008. At the time of the onsite review, there were 126 individuals receiving psychotropic medication at LBSSLC. The census of the Facility was 227 individuals. The Reiss spreadsheet contained the names of 97 individuals who had been administered the Reiss Screen, indicating that 223 individuals (98%) either had had a psychiatric assessment or a Reiss Screen. In order to assess the validity of the information contained in the spreadsheet, a random sample of 20% (every fifth individual, N=20) was selected, and the copy of the actual Reiss Screening Protocol was requested. Documentation to show that the Reiss Screen had been completed was submitted and verified for 100% of the random sample. The individuals for whom this information was requested, and the date the Reiss Screen was administered was as follows: REISS – RANDOM SAMPLE <u>Individual #</u> <u>Date Completed</u> Individual #258 3/4/09 Individual #43 4/27/09 Individual #293 3/4/09 Individual #15 1/14/09 Individual #203 4/27/09 Individual #74 1/14/09 Individual #296 4/27/09 Individual #17 3/14/09	Noncompliance

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		Individual #172 4/13/09 Individual #211 3/4/09 Individual #170 3/4/11 Individual #308 3/25/09 Individual #139 3/14/09 Individual #132 8/25/09 Individual #19 1/14/09 Individual #80 2/14/09 Individual #29 3/14/09 Individual #253 2/14/09 Individual #128 4/13/09 Individual #252 4/30/09 The assessment of the validity of the information contained in the Reiss Screen for Maladaptive Behaviors described above was the first step of many that was involved in the assessment of compliance with this provision. This first step involved checking the reliability of the spreadsheet by requesting the random sample of 20% of the individuals who were identified has having been administered the Reiss screen, and then verifying that the instrument had been administered on the corresponding date listed on the spreadsheet. As documented above, this assessment indicated that the screening instrument had been administered on the date that was indicated for 100% of this random sample. The second step was to assess the integrity of the scoring of the Reiss protocols, because the Facility did not utilize the commercial computer-scoring program for the Reiss Screens, but instead relied upon manual scoring of the protocols, followed by a review of those results by members of the Interdisciplinary Team (IDT). The review of the scoring forms utilized to assess the data contained in the actual Reiss Scoring Sheets indicated that each individual scoring form contained the following information: ▪ Date; ▪ Individual's name and LBSSLC case number; ▪ Residence ▪ Name of Scorer who completed the protocol ▪ Identification of members of the Personal Support Team who were present at the meeting during which the results were obtained; ▪ The results of the Reiss Screen, which were comprised of two possible answers: o According to the test booklet, there were no problems regarding maladaptive behaviors; or o According to the test booklet, the following maladaptive behaviors were scored as: "Problem" or "Major Problem;" ▪ The Personal Support Team agreed/disagreed with the results of the Reiss Screen; ▪ Comments;	

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		▪ Recommendations: o Continue to monitor; or o Refer for psychiatric assessment; and ▪ Signatures and titles of those team members present at the meeting. The review of the documentation described above indicated that the scoring results for the following individuals identified "no problems regarding maladaptive behavior:" Individual # — Date Completed Individual #258 — 3/4/09 Individual #43 — 4/27/09 Individual #293 — 3/4/09 Individual #74 — 1/14/09 Individual #17 — 6/25/08 Individual #211 — 3/4/09 Individual #308 — 3/25/09 Individual #139 — 3/4/09 Individual #132 — 8/25/09 Individual #29 — 3/14/09 Thus, the scoring of 50% of this random sample (N=10) indicated that no behavior problems were identified on the Reiss Screen. It was also noted that the Director of Psychiatry was present at the review of the Reiss Screening for two of these individuals, including Individual #43 and Individual #308. The scoring of the protocol for the following individuals indicated that one or more areas were identified as being positive for a "problem," but not a "major problem:" Individual # — Date Completed Individual #252 — 4/30/09 Individual #15 — 1/14/09 Individual #172 — 4/13/09 Individual #19 — 1/14/09 Individual #253 — 2/14/09 The documentation related to these reviews indicated that the Director of Psychiatry was present for the reviews of the following individuals: Individual #252, Individual #172, and Individual #253. The scoring documentation identified the following individuals as having positive results that qualified in both categories of "Problem" and "Major Problem" behaviors:	

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		Individual # Date Completed Individual #203 4/27/09 Individual #296 4/27/09 Individual #170 3/4/11 Individual #80 2/4/09 Individual #128 4/13/09 The scoring sheets indicated that the Director of Psychiatry was present for all of the above individuals and/or reviewed the Reiss protocol: Individual #203, Individual #296, Individual #80, and Individual #128. The Comments section of the scoring sheets for the individuals for whom problem and major problem behaviors had been identified indicated that the team had carefully reviewed each protocol with regard to whether a behavior program should be developed, and/or whether they should be referred for a formal CPA. These handwritten comments appeared to have been prepared by the Psychiatrist, but the specific team member who prepared the Comments section was not identified. The signatures of all team members who attended were present. At the time of this review, the total census at LBSSLC consisted of 227 individuals. Of those, 126 were receiving psychotropic medication, and had undergone a CPA as part of that process. Thus, the number derived by subtracting the number of individuals who were receiving psychotropic medication (126) from the total census (227) should have equaled the total number of individuals who were administered the Reiss Screening Instrument (101). Comparison of these numbers indicated a discrepancy of four, as the spreadsheet indicated that 97 individuals had been administered the Reiss Screening Instrument. This meant that a small number of individuals (four) who should have been assessed with the Reiss Screen had been overlooked. However, manual comparison of the names in the respective lists identified three specific individuals (Individual #59, Individual #272, and Individual #130) who had received a CPA, because they were receiving psychotropic medication and, thus, would not have been screened with the Reiss Instrument. These three individuals had subsequently been tapered off of their psychotropic medications, and, thus, no longer appeared on the list of individuals receiving psychotropic medication. A fourth person (Individual #321) was not receiving psychotropic medication at the time of admission to LBSSLC, and, thus, would have been administered the Reiss Screen. However, this individual received a CPA, and was not screened with the Reiss. These observations and the related calculations effectively resolved the problem with the apparent numerical discrepancy described above. This provision also discusses the importance of a thorough psychiatric assessment.	

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		Thus, the psychiatric documentation related to the four individuals described above (Individual #59, Individual #321, Individual #272, and Individual #130) was requested. The review of this documentation indicated that a CPA had been performed on these individuals on the following dates: Individual # — Date Performed Individual #59 — 4/23/07 Individual #272 — 7/14/08 Individual #130 — 7/21/08 Individual #321 — 7/12/10 A CPA had been performed on Individual #321, because he had recently been admitted, even though he was not receiving psychotropic medication. The CPAs for the other individuals were not current, as they were no longer receiving psychotropic medication. All four of these CPAs conformed to the requirements outlined in the Settlement Agreement. The final step in the review of this Provision involved the request for documentation related to individuals who had undergone a CPA as a result of the review of the Reiss Screening Protocol. The Facility identified Individual #97. Related documentation indicated that the clinical meeting to review the results of the Reiss Screen for Individual #97 was held on 4/27/09, and was attended by the Psychologist, QMRP, RN Case Manager, Residential Support Staff, and the Director of Psychiatry. The Recommendations section of the "Review of Reiss Screen" identified above indicated that the plan at that time was to "Continue to Monitor," as opposed to "Refer for Psychiatric Assessment." The CPA that was subsequently performed on 2/25/11, noted that: "He is referred because of increased frequency and intensity of pinching and grabbing behaviors…" Thus, the referral for the CPA did not appear to have been directly related to the Reiss Screening evaluation that was performed almost a year earlier, but rather due to a change in his status. This was consistent with the recommendation in the Review of the Reiss Screen that the staff would continue to monitor his status. The format of this CPA met the criteria identified in the Settlement Agreement. The Recommendations section of the CPA indicated that the plan would be to continue to collect baseline data, while implementing a PBSP, to ascertain the effect of behavioral interventions before pharmacological strategies would be considered. A structured Functional Assessment was completed on 4/13/10, and a PBSP was then implemented on 5/17/10. The PBSP included a reference to a trial of Paxil, which was the pharmacological intervention identified in the CPA to be utilized, pending the results of the behavioral assessments.	

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		To summarize the process for the implementation of the Reiss Screen, LBSSLC utilized manual scoring of the Reiss Screen Protocol, rather than the commercially available computer scoring. Members of the IDT, utilizing the formula described above, reviewed the results of the manual scoring. The Director of Psychiatry did not attend all of these meetings, but did attend those for whom the scoring results were indicative of a more problematic presentation. However, regardless of the number of "Problem" and "Major Problem" areas that were identified by the manual scoring of the Reiss Screening Instrument, the recommendations section in the entire sample of Reiss Screen Reviews indicated that the plan was to "Continue to Monitor," and not "Refer for Psychiatric Assessment". The mechanism by which the PSTs made these decisions will be discussed in future monitoring reviews, as they directly relate to the requirements of this provision. During the 3/29/11 interview, the Director of Psychological Services indicated that a plan currently was in place for a specific Psychologist to be assigned to update the Psychological Assessment on all of the individuals living at LBSSLC who required such an assessment. As part of this process, the Reiss Screen was to be re-administered to individuals who were not receiving psychotropic medication and, therefore, would not have undergone a CPA. The discussions between the Director of Psychiatry and the Psychiatry Assistant indicated that new admissions to LBSSLC primarily were individuals who could not be safely maintained in community residential programs, and were usually receiving psychotropic medication at the time of admission. Accordingly, they would receive a CPA, and be assimilated into the ongoing Psychiatric Clinic review process. Individuals who were not receiving psychotropic medication at the time of their admission would be screened with the Reiss Screening Instrument. Evidence that these procedures are in place will continue to be assessed during future monitoring reviews. Specifically, the screening of individuals who are newly admitted to LBSSLC with either the Reiss Screen or a CPA will be assessed, as will the progress of the initiative described by the Director of Psychological Services to re-administer the Reiss Screen to individuals who had previously been screened in the past.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case	Interviews with the Facility Psychiatrist and the Director of Behavior Services indicated that there was a close working relationship between the Departments of Psychiatry and Psychology. During the onsite review, this collaboration also was apparent in the observations of the individuals' psychiatric team reviews. Those meetings ranged in duration from 20 minutes (for a follow-up review of an individual who was relatively stable), to 60 minutes (for a newly admitted individual, or an individual with a complex presentation). Observations of these meetings indicated that the Psychiatrist relied on the Psychology	Noncompliance

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	formulation.	Staff for both data that related to the behaviors, or symptoms, that were thought to be responsive to psychotropic medication, as well as the impact of environmental and interpersonal factors that might be effecting the individual's behavioral presentation. The review of the sample of individual records indicated that 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 Settlement Agreement. 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. However, both the Psychiatry and Psychology Departments had actively addressed this problem, and although problems with this issue continued to exist, noticeable progress had been made.	
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 as a problem in the previous reviews. To the extent that this issue continued to exist, it represented a deficiency 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 regarding the rationale for its appearance in both categories. During the previous review, the Director of Psychiatry indicated that he and the Director of the Psychology Department had allocated the time to review the records of several individuals in an attempt to develop strategies to address this problem. There also were clinical examples in the Presentation Book that indicated that the Psychiatry and Psychology staff members were actively addressing this issue. This initiative had continued and had been expanded to include relevant discussions in the meetings of the Positive Behavior Support Committee. The Psychiatry Department also had added a column to the master spreadsheet that addressed the derivation of the identified target behaviors. The spreadsheet also listed the individual's name, their psychotropic medication, and their psychiatric diagnosis, and was completed for each individual who was receiving psychotropic medication. By reviewing the records for the sample of 25 (20%) individuals receiving psychotropic medication, the degree to which these efforts	Noncompliance

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		had produced meaningful changes in the treatment provided and the documentation contained in the individual medical records was assessed. The co-existence of the same behavior in both categories was identified in 17 (68%) of the records reviewed. The records in which the dual description of a specific behavior as being both present on a behavioral basis, and as an identified target of psychotropic medication without adequate rationale included those for the following individuals: Individual #38, Individual #318, Individual #65, Individual #271, Individual #156, Individual #94, Individual #321, Individual #20, Individual #276, Individual #25, Individual #4, Individual #162, Individual #284, Individual #146, Individual #221, Individual #33, and Individual #190. This overlap was more apt to occur in individuals who were functioning in the Severe to Profound range of intellectual disability, and 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 disability and to have a discreet Axis I psychiatric disorder (such as Schizophrenia or Bipolar Disorder). For these individuals, clear examples were recorded of behaviors related to the underlying psychiatric disorder. Clear delineation between the symptoms that were identified as target behaviors of the psychotropic medication, and those that were present on a behavioral basis were identified in eight (32%) of the individual records reviewed. This included the following individuals: Individual #61, Individual #131, Individual #240, Individual #235, Individual #288, Individual #147, Individual #92, and Individual #42. 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 PBSP of Individual #147, dated 3/22/10: *RELATIONSHIP OF PLAN AND FUNDAMENTAL OUTCOMES:* *This plan has been developed to increase [Individual #147's] use of his communication skills, to show and teach [him] how to participate in training, and to help him learn appropriate ways of refusing an activity. [He] currently takes Zyprexa to address the symptoms of an Impulse Control Disorder and Zoloft to help with the apparent symptoms of depression. His behavioral stability will be maintained with the lowest effective dose of Zyprexa and Zoloft. The procedures in this plan are designed to maintain low rates of aggression, which will maintain a lower risk of injury to [him] and others. The plan should allow for increased social interaction and improve [his] ability to participate in and benefit from active treatment and leisure activities.*	

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		The structural and Functional Analysis for Individual #147 was assessed on 3/11/11. This note addressed the effect of his psychiatric disorder on his behavioral presentation in the following paragraph: *It was also stated that [Individual #147] could go weeks and at times months without engaging in aggression. Precursors for aggression is laughing, singing, clapping hands, spitting on the floor, yelling, and plucking at hair. Consequent events were redirection to stop hitting and moving him away from others. Particular setting events for aggression is his diagnosis axis I diagnosis, and staying up for several nights. An EO (sic) that was identified is being tired. One staff identified getting to close to [him] as an antecedent for him aggressing. No other antecedents were identified by staff. The staff interviewed have worked with [Individual #147] for several years and know him very well.* This example was chosen as it illustrated the Facility's effort to differentiate between the biological determinants of a specific maladaptive behavior, and those that are more purely behavioral in nature. Although there was still some overlap in this treatment plan between the definition of aggression that is addressed in his behavior support plan and that related to the Psychiatric Diagnosis of an Impulse Control Disorder, the paragraph cited above identified "precursors for aggression" that would appear to be psychiatric in nature, and also clarified that his Psychiatric Diagnosis served as a "setting event" for the aggressive episodes that were responded to through the interventions described in his behavior support plan. During the PBSP Committee Meeting on 3/31/11, there was an extensive discussion of Individual #82, whose PBSP was in the process of being revised. The Director of Psychiatry and the Director of Psychological Services also attended this meeting. This discussion served both as an example of a PBSP that did not provide adequate differentiation of the target behaviors of psychotropic medications, as well as structural changes that could be implemented to correct these deficiencies. During the 3/31/11 meeting, there was an extensive discussion between the Psychiatrist and the Psychologists regarding the impact of Individual #82's psychiatric diagnosis. Specifically, it was noted that Individual #82's psychiatric diagnosis was "Schizoaffective Disorder and Dysthymia," and that the psychotropic medications prescribed to address these psychiatric disorders were Divalproex, Zyprexa, and Luvox. The risk of not providing this medication was identified in the PBSP, as described below: *RISKS OF NOT PROVIDING THIS TREATMENT* *The risks of not providing the medication treatment as outlined by the staff psychiatrist*	

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		would be the risk of increased aggression, SIB [Self-Injurious Behavior], outbursts, and suicidal threats/gestures, injury to staff and peers, and psychological instability. During the detailed discussion of this plan, it became apparent that although the psychotropic medication was effective in treating the Axis I diagnosis of Schizoaffective Disorder and the related symptoms of depression with psychotic features, there were residual symptoms that were more behavioral in nature. These behavioral symptoms included suicidal threats for manipulative purposes. This important differentiation was not apparent in the draft of the PBSP that was reviewed during the meeting. However, as the discussion between the Director of Psychiatry and the Psychologist progressed, it became apparent that the symptoms that were more indicative of the Axis I Psychiatric Disorder could be differentiated from those that were more behavioral in nature. Although this process was labor intensive and consumed approximately 40 minutes of the meeting, it was extremely productive in resolving this issue. As indicated above, the Psychiatry Department had added a column that identified the derivation of the individual's psychiatric symptoms (as behavioral, psychiatric, or both) to their primary spreadsheet. The review of the sample of individual records indicated that, although progress had been made in elucidating the derivation of these symptoms, deficits still occurred throughout the individual's record. For example, the information included on the spreadsheet was not uniformly reflected in the Positive Behavior Support Plans in the sample of individual records reviewed. The clinical example described above would suggest that the PBSP Committee Meeting, which was attended by the Staff Psychologists, as well as the Director of Psychology Services and the Director of Psychiatry, would be the most efficient forum to review the derivation of the target behavior of the psychotropic medication, and then integrate this information into the PBSPs as they are being reviewed and revised. Additional clinical examples that illustrate the issues discussed with regard to this provision are contained below in relation to Section J.10, which relates to risk versus benefit analysis, because there was significant overlap between these two areas of concern.	
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	Risk-benefit analysis as it relates to the use of psychotropic medication in individuals with developmental disabilities involves a number of inter-related steps. The first of these steps is to assess the severity of the behavioral symptom of the psychiatric disorder in terms of physical harm to the individual or others. Second, this risk of physical harm is 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	Noncompliance

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	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.	physical harm produced by the behavioral symptoms of the psychiatric disorder that the medication is intended to address. In those situations in which the individual is currently receiving medication, these considerations can be based on actual perceived side effects and realized benefits, rather than hypothetical probabilities. In 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 the sample of records of individuals receiving psychotropic medication was similar to the prior reviews, in that the risks of the psychotropic medications were usually put forth in very general terms, such as the possible increase in maladaptive behaviors if the individual did not receive the psychotropic medication, and the benefits were described as simply decreasing these behaviors. The risk-benefit discussion regarding 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. 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 had been reported to occur in large populations. In addition, the benefits of the medications were usually described simply as a general reduction of the frequency of the identified target behaviors of the medication. The overall construction of the discussion was formulaic in nature, and suggested 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. As a result of these pervasive, systemic deficiencies the Monitoring Team concluded that none of the 25 plans reviewed (0%) complied with the requirements of the Settlement Agreement. An example of this process was contained in the HRC review of the PBSP for Individual #146, dated 5/12/10. The relevant sections of this document were as follows: *<u>Program Summary (to include restrictive/intrusive components)</u>:* *The plan is being reviewed based on completion of a new functional assessment. Zyprexa was added to [Individual #146's] psychoactive medication regimen in June 2009. At that time, Dr. Weddige had ordered to begin Zyprexa due to reported increased aggression by [him]. It seemed that intensity of his behavior had worsened. [Individual #146] not only was hitting people but also biting them, and had attacked several members of staff and injured them. He also exhibits food seeking behavior and often will not be deterred from his determination to get into the kitchen. This plan will seek to make the living room an enriched area by frequent reinforcement. It is hypothesized that this will reduce [his] food seeking behaviors and thereby reduce his aggression. Historically, [he] has been prescribed*	

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		Valproic Acid (Depakote) for a seizure disorder. He was seen in the Neurology Clinic in May, and since he had been seizure free for the previous ten years, the neurologist stated, "At this point the Valproic Acid should be considered to be therapeutic for his psychiatric problems." This PBSP will also include the Valproic Acid. *<u>Justification</u>:* *This plan has been developed to increase [Individual #146's] use of communication skills to decrease aggression and sleeplessness. It also involves enriching [his] environment so food foraging is less attractive. Success in these areas will increase his ability to learn new functional skills, and will increase work opportunities and lead to greater community inclusion. Attainment of the goals of his psychoactive medication plan will result in a reduction of psychoactive medication.* *<u>Less intrusive approaches previously attempted</u>:* *Procedures have included social reinforcement, edible reinforcement, verbal redirection and protective surveillance in [his] room, techniques for continuing his training and contingent restraint. Previous medications prescribed have included Ritalin, Buspar, Trazodone, and Risperdal.* *Risk vs. Risk Analysis* *<u>Potential Risks/Discomfort</u>:* *There are no inherent risks with the behavioral aspects of the PBSP. [Individual #146] may experience some frustration when his behaviors are interrupted. The possible side effects of Remeron may include: dizziness, tremors, confusion, nausea, increased appetite, dry mouth, constipation, urinary frequency, weight gain, swelling, or flu like symptoms. The possible side effects of Valproic Acid may include: 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. The possible side effects of Zyprexa may include: 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, lip puckering, rapid eye blinking, and rapid movements of the arms, legs and trunk).* *<u>Benefits</u>:* *This plan has been developed to increase [Individual #146's] use of communication skills to decrease aggression and sleeplessness. It has also been developed to establish an enriched*	

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		area for [him] in the living room in order to reduce food foraging behaviors. Success in these areas will increase his ability to learn new functional skills, to increase work opportunities and greater community inclusion. Attainment of the goals of his psychoactive medication plan will result in a reduction of psychoactive medication. These outcomes are consistent with his current PSP. <u>*Risks of Not Providing this Treatment*</u> *Absence of programming can lead to an increase in target behaviors, increased possibility of injuries, decreased training time and possibly more restrictive procedures.* This treatment plan illustrated several points related to the general approach to risk-benefit analysis at LBSSLC. The first of these was that the Program Summary did not clearly link the use of the Zyprexa to an underlying psychiatric disorder. The narrative history included in this paragraph could be construed to imply that the Zyprexa was prescribed to treat a behavioral disorder, rather than a psychiatric disorder; and further, that adjustments in dosage would be titrated according to negative or positive changes in the status of that behavioral disorder. The last three sentences of the Program Summary suggested that the Valproic Acid was originally begun to address a seizure disorder. However, since the individual had been seizure-free for ten years, it was being reclassified as "therapeutic for his psychiatric problems," and, thus, was now being included in the PBSP. The "Justification" section primarily addressed the behavioral aspects of the PBSP. The only reference to psychoactive medication appeared in the last sentence, which stated: "Attainment of the goals of his psychoactive medication plan will result in a reduction of his psychoactive medication." The side effects listed in the "Potential Risks/Discomfort" section were general in nature. The possible risks related to Zyprexa were listed primarily as motor side effects, which are more commonly seen with the first-generation antipsychotic agents, although they can occur with Zyprexa. The potential primary problematic side effects related to Zyprexa are weight gain and other metabolic side effects, such as an increase in lipids and altered glucose metabolism. This listing of potential side effects made only one brief reference to "weight gain," and did not mention the metabolic side effects. Individual #146 was currently receiving three psychotropic medications, but the risks of this polypharmacy were not addressed. There also was no mention of any side effects that he might actually have experienced. The "benefits" described primarily were those that would have been expected to result	

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		from his PBSP. The only sentence that pertained directly to his psychotropic medication was a verbatim repetition of the last sentence in the "Justification" sentence that read: "Attainment of the goals of his psychoactive medication plan will result in a reduction of psychoactive medication." The "Risk of not providing this treatment" section simply referred to an increase in "target behaviors," and the risks related to that. In order to provide the complete context for the sections of the HRC review of the PBSP, which were quoted above, the final two paragraphs of this document are reproduced below: *HRC REVIEW OF PBSP* *<u>Determination by Personal Support Team</u>:* *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 [him]. 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.* *Plan to remove restriction/intrusive component* *<u>Medication Plan</u>:* *The use of psychoactive medications is evaluated at health status reviews and psychiatric clinics. The reduction of these psychoactive medications will be reviewed at these meetings as indicated by his current behavior rates and intensities. Upon 3 consecutive months of meeting the plan objective rates for targeted behaviors, the PST will schedule a psychiatric clinic to assess a possible medication reduction/discontinuation. Dr. Weddige, Psychiatrist, has stated that if [Individual #146's] sleep increases, he will most likely reduce the Remeron and taper to hold; if his sleep stabilizes, he will taper and hold; if it worsens, he will prescribe alternate medication. In regard to aggression, Dr. Weddige has stated that should it improve, he will reduce the Zyprexa by 2.5 mg per month; should aggression stabilize, he will keep the medications the same; should aggression worsen, he will most likely increase the Zyprexa in 2.5 mg increments.* The focus of these final sections continued the overall theme that Individual #146 primarily had a behavioral disorder, and that the dosage of the antipsychotic agent	

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		Zyprexa would be titrated according to the frequency of aggression. The following handwritten comments appeared at the end of this document in the HRC Comments section: "Due to changes in procedures – added food foraging – has hyperglycemia – possible Prader Wili without facial feature – will turn living room into enrichment area for [Individual #146] – not restricting his going into the kitchen area – sleeplessness still being targeted." The hyperglycemia (increased blood glucose) appeared to be linked to the increased food consumption in this paragraph. As noted in the comments above, this also could be a metabolic side effect of the Zyprexa, which is not mentioned in the side effect listing that appeared in the Risk versus Risk Analysis section of the plan. An increase in hunger and related food seeking also could be a side effect of Zyprexa, but it did not appear to have been considered as a potential contributor to his food-foraging behavior. There was evidence in some of the records that more comprehensive risk versus benefit considerations had occurred. The following "Psychiatric Review" of Individual #201, who was admitted on 7/8/10, provides an example of this. This document, which was prepared by the Director of Psychiatry, and dated 8/13/10, is quoted below: *This is a psychiatric review on this individual with reference to the rationale for using an antipsychotic medication, Zydis at 30 mg in his treatment. Consideration was given to the characteristics of his symptoms prior to admission, which included the very high frequency, rather long duration, high intensity, and high symptom severity of his incidents. Prior to transfer to the Big Spring State Hospital he had had over 50 reported serious incidents, which included a variety of aggressive behavior directed at others, himself, and property. During this group home stay he had been on a combination of clonazepam, Risperdal, Paxil, and valproic acid. He continued to have many problematic behaviors. Prior to this his medication included Zyprexa, Strattera, Concerta, and Risperdal. On this combination the father stated [Individual #201] was very uneasy, unable to sit still, mildly agitated and hyperactive.* *We would prefer to use a medication with a more benign side effect profile such as a beta blocker or an alpha agonist with him. However, the risk of personal and or self injury continues to be quite high with him historically. There was also an increased likelihood that the atypical antipsychotic medication would be effective in reducing his problematic behavior for now, even though there are not definitive, discrete psychotic symptoms. We feel that the likelihood that this medication will continue to work versus a side effect profile still warrants the use. In the future if he stabilizes we could decrease it and try a class of medication with a more benign side effect profile. It does appear that the psychostimulants might have been activating for him in that the SSRI (Selective Serotonin Reuptake Inhibitor Antidepressant) Paxil and the benzodiazepine Klonopin, as well as the mood stabilizer, were*	

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		not particularly effective in decreasing his target symptoms. We are continuing to evaluate the past history, as well as baseline data in determining what would be the safest medication for him, both in terms of his past behavior as well as the side effect profile. This clinical note clearly reflected a careful risk versus benefit analysis related to the pharmacological treatment prescribed for Individual #201. The PBSP, dated 12/30/10, did not reflect this thoughtful analysis in the psychoactive medication subsection of that document, which stated: *Psychoactive Medication* *<u>Medications Prescribed</u>: Zypreza, 30 mg per day* *<u>Diagnosis and Symptoms</u>: Axis I: Autism* *<u>Target Variable or Marker Being Tracked for Each Medication</u>: Zyprexa – aggression and SIB* *<u>Medication Plan</u>: [Individual #201] is currently taking Zyprexa and he has been taking it for a sufficient time for it to have reached therapeutic effectiveness. In a communication from Dr. Weddige dated 11/19/2010, Dr. Weddige indicated that if the behaviors increased he would add another psychoactive medication and decrease the Zyprexa. If the behaviors decreased, he would gradually taper the Zyprexa by 2.5 to 5 mg per month. If there is no change in behaviors he would still attempt a slow taper of 2.5 mg per month.* As illustrated by the following excerpt from the "HRC Review of PBSP" dated 12/1/10, for Individual #242, there was also an indication that the risk versus benefit discussions related to the use of psychotropic medication were more individualized and relevant for individuals who presented with more typical Axis I psychiatric disorders: *<u>Potential Risks/Discomfort</u>:* *[Individual #242] is prescribed Ativan and Lamictal. Side effects for the medications are as follows: Ativan (lorazepam) – drowsiness, sedation, sleep disturbances, headache and mild depression. Lamictal – drowsiness, cough, weakness, back pain, fatigue, runny nose, chest pain.* *<u>Benefits</u>:* *This plan has been developed to increase [Individual #242's] ability to have a greater quality of life, as outlined in her PSP goals, when she is not experiencing symptoms of her*	

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		Bipolar disorder. [She] will attempt to participate in activities, as outlined in this program, in an attempt to alleviate discomfort from symptoms of her bipolar disorder and minimize manic phases. It was also written to offer her consistent supports in times of rapid cycling. This plan also supports the use of psychoactive medication to decrease the probability of agitated behavior that is caused by hypomania and insomnia. There are steps taken when challenging behaviors are seen that give notification to professional staff that [she] may be entering a stage of mania. Success in these areas will increase her ability to participate fully in her daily life and maintain her self-help skills. Reduction of her psychoactive medications will continue to occur when [she] is not experiencing symptoms of bipolar disorder, or if sedation is seen. However, data has proven that increases in psychoactive medication are crucial for her to remain at the Lubbock State Supported Living Center versus psychiatric hospitalization. Data has indicated that [Individual #242] is incredibly dosage sensitive to psychoactive medication. <u>*Risks of Not Providing this Treatment*</u>*:* *The risks of not providing the psychoactive medication treatment outlined in this plan are increased mania, injury, and further emotional distress for [her]. The risks of not providing the preventative and responsive actions in this behavior support plan is not providing [her] with the supports needed to aid her in having the highest potential quality of life.* The discussion contained in this plan of potential and acknowledged side effects of the psychotropic medications was inadequate. However, the overall review of the general risk versus benefit considerations related to the utilization of psychotropic medication was straightforward and well documented. This discussion was also amplified in other sections of this document. In summary, although significant deficiencies in the Facility's approach to risk versus benefit analysis and documentation continued to exist, evidence of progress was noted in some of the individual records reviewed. In addition to expanding on the limited progress that had been made in this area, it will also be important that the Psychiatry Department documentation, the Psychology section of the record, and those sections related to the Human Rights Review and Guardian Consent process clearly document an adequate risk versus benefit analysis.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly	This provision relates to the degree of inter-class and intra-class polypharmacy, as well as the attempts to reduce polypharmacy. LBSSLC had maintained tabular data 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. The current version of this document illustrated additional progress in reducing the frequency of polypharmacy with psychotropic medication. The number of individuals	Noncompliance

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	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.	receiving six or more psychotropic medications has been maintained at zero since 2008, and the number receiving five psychotropic medications had decreased from one in 9/08 and 3/10, to zero in 9/10. However, as of 2/11, the number receiving five psychotropic medications had increased to two. The number receiving four psychotropic medications had remained in the same range over the past two years: seven in 9/09, six in 3/10, and seven in 9/10. As of 2/11, the number had decreased to four. The number of individuals receiving three psychotropic medications had gradually decreased to 14 as of 9/10, and 15 as of 2/11, from 44 in 6/05, when monitoring began. The number of individuals receiving two psychotropic medications (62 in 2/11) was in the same range as the prior three reporting periods (56 in 9/09; 53 in 3/10; and 56 in 9/10). 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, 44 in 9/10, and most recently 41 in 2/11. The data also substantiated improvement with regard to intra-class polypharmacy. Six individuals were receiving two antipsychotic agents as of 6/05, and this had stabilized at three for the most recent four reporting periods, including 2/11. 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 the 9/09 and 2/11 reviews. The number of individuals receiving two antidepressants also had gradually declined from six in 6/05, to zero in 9/10, and one as of 2/11. The review of the documentation from the "Monthly Facility Review of Psychoactive Medication Polypharmacy Meetings," dated 8/25/10, 9/28/10, 10/26/10, 11/18/10, 12/21/10, and 1/25/11 indicated that a thorough review of multiple individuals who were receiving polypharmacy with psychotropic medications occurred each month. The members of the professional staff who routinely attended these meetings were as follows: The Medical Director, Clinical Pharmacist, Director of Dental Services, and the Director of Psychiatry, the Program Compliance Monitor, and the Psychiatric Assistant. The Facility continued to make consistent progress toward meeting this requirement of the Settlement Agreement. Although the minutes of these meetings described detailed discussions, they need to include clinical information, which provides the rationale for each specific medication for those individuals who are receiving multiple psychotropic medications. LBSSLC had continued to admit individuals from community-based residential programs, and/or psychiatric hospitals, that were deemed to require a more structured environmental setting, due to the acuity of their psychiatric and behavioral presentations. These individuals were often prescribed multiple psychotropic medications while in the community. For example:	

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		▪ Individual #92, who was admitted on 2/28/11, was receiving the following psychotropic medications at the time of admission: Xanax 1 milligram (mg) twice a day (BID); Tegretol 400 mg BID; Clonidine 0.1 mg three times a day (TID); Lithium 1200 mg per day; Zyprexa 40 mg per day; and Geodon 80 mg per day. ▪ Individual #131, who was admitted on 1/4/11, was being prescribed Clonidine 0.2 mg per day; Depakote ER 500 mg per day; Lexapro 10 mg per day; Seroquel 400 mg per day; and Trazodone 100 mg per day. The Facility might want to consider developing a parallel polypharmacy tracking system for these individuals, as their polypharmacy regimens of psychotropic medications negatively skew the Facility's statistical progress in reducing polypharmacy. This suggestion is not meant to imply that the psychiatric team is not responsible for decreasing these complicated pharmacological regimens, once the individual has been admitted to LBSSLC. Observations of the psychiatric reviews of newly admitted individuals indicated that the Director of Psychiatry, working in conjunction with the IDT, formulated initial plans to decrease the multiple psychotropic medications that had been prescribed for these newly admitted individuals from the community soon after their admission to LBSSLC. Information related to the medications regimens of individuals admitted to the Facility, in conjunction with the successful reductions of these medications over time also might provide the State Office with important information about the quality of psychiatric and/or behavioral supports in community settings. There are two components to this provision. The first is that the Committee meets on a regular basis, and reviews the clinical status of individuals whose psychotropic medications meet the criteria of polypharmacy. The second component relates to the clinical justification for those regimens that fit the description of polypharmacy, and further, that those medications whose efficacy cannot be established be eliminated. The Facility has not yet complied with the second component of this provision's requirements.	
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	The Director of Psychiatry indicated that nursing staff performed the Monitoring of Side Effects Scale (MOSES), and the Psychiatric Assistant performed the Dyskinesia Identification System: Condensed User Scale (DISCUS). 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) was conducted. A current DISCUS (within the last three months), and evidence of quarterly evaluations over the past year were identified in 23 of the 25 records reviewed (92%). The exceptions were the	Noncompliance

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	and/or changing needs, but at least quarterly.	records of Individual #321 (most recent evaluation dated 8/6/10), and Individual #25 (gap between 3/3/10 and 9/1/10). The DISCUS also was 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 similar to those produced by antipsychotic agents. In order to assess for the completion of these exams, a spreadsheet, dated 2/22/11, was obtained which listed all individuals who were prescribed Reglan. This list was then compared and cross-referenced with the list of individuals who were receiving psychotropic medication, and those individuals who were receiving both Reglan and psychotropic medications were then deleted. The compilation of names that resulted from this process of elimination contained only individuals who were receiving Reglan for GERD. A random sample of this list (20%) produced the following individuals: Individual #312, Individual #199, Individual #225, Individual #62, and Individual #263. A copy of the current DISCUS, as well as those for the last year, was 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 #263, whose most recent evaluation was on 10/15/10. The record of Individual #225 only contained one DISCUS, dated 1/31/11. However, this was a baseline evaluation related to initiation of treatment with Reglan. Thus, there would have been no need for prior evaluations, and the next quarterly evaluation was not yet due. 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 for all of the individuals, with the exception of Individual #162, whose record only contained documentation of a MOSES evaluation on 1/11/11; and Individual #92, whose record did not contain a MOSES evaluation, although she had been admitted a month earlier (on 2/28/11) and was receiving multiple psychotropic medications. Thus, the MOSES had been completed as specified for 23 of the 25 individuals in the sample (92%). The same methodology as described above, with regard to developing a sub-sample of individuals who were prescribed Reglan to assess for the completion of the DISCUS, was also included in the analysis for the MOSES review. Accordingly, the sample consisted of the following individuals: Individual #312, Individual #199, Individual #225, Individual #62, and Individual #263.	

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		This review indicated that the MOSES was current and had been completed as specified for 100% of this sample. However, as discussed in detail with regard to Section N.5, which also addresses the completion of these screenings, significant issues were noted with regard to the timeliness of the prescribers' review of the completed screenings. This is an essential component of ensuring that individuals' side effects are appropriately monitored and managed.	
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 a number of factors related to the appropriate use of psychotropic medications for individuals with intellectual and developmental disabilities. 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. In order to assess the Facility's compliance with this provision, an analysis of the 25 records, which comprised a random sample (20%) of those receiving psychotropic medication, was carried out. The degree to which a description of the specific symptoms that justified the psychiatric diagnosis of record could be identified was discussed above with regard to Section J.6 of the Settlement Agreement. The discussion related to Provision J.2 also relates to this provision, as it reviews the Facility's compliance status with regard to Comprehensive Psychiatric Assessments. The next analysis related to this provision involved 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, which 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 would not be 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 definitively identified in only one of the 25 (4%) records reviewed. Specifically: ▪ This evidence was found in the documentation related to Individual #162. The target symptom of the psychotropic medication for this individual was Self-Injurious Behavior, and the etiology of this behavior was linked to the psychiatric diagnosis. The individual was only receiving two psychotropic medications in the form of Haldol and Naltrexone. The history indicated that	Noncompliance

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		prior trials of Zyprexa and Risperdal had not been effective in decreasing the frequency of the SIB. The tabular and graphic presentation of the behavioral data documented the efficacy of these medications. The data did not make it possible to differentiate between the two medications. However, the Haldol dosage was being gradually decreased. Thus, a methodology was in place that would make it possible to differentiate the relative contribution of each of these medications to the individual's stability. The primary factors that made it difficult to determine if the psychotropic medications had been effective for other individuals were the lack of adequate baseline data, and the co-existence of multiple psychotropic medications, which made it impossible to discern differential effects. The observation that the percentage of individuals whose records provided empirical evidence of efficacy was considerably lower in this review (4%), as compared to the prior review (32%) should not necessarily be construed as regression in the Facility's status in this area. The negative change more likely represents a change in the manner in which the sample of records to be reviewed was constructed. At the time of the prior review, this sample of individuals was constructed on a random basis. As detailed above, in the introductory "Review of Documents" section, approximately 50% of the sample for this review was composed of individuals who had been recently admitted to LBSSLC, or who were selected because of their clinical acuity, as reflected in high rates of chemical and/or mechanical restraint, or an external psychiatric hospitalization. As indicated elsewhere in this report, the individuals who were admitted from the community tended to have been receiving multiple psychotropic medications with little or no evidence of efficacy. However, both the 32% rating of the prior review, and the 4% compliance rating for this review illustrate a significant deficit in this area that needs to be addressed. The final stipulation contained in this provision of the Settlement Agreement discusses the need for ongoing monitoring of the psychiatric treatment "based on the individual's current status and/or changing needs, but no less often than quarterly." As discussed above with regard to Section J.2, the review of the sample of 20% of the records of individuals who received psychotropic medication indicated that there had been monthly and quarterly psychiatric reviews of the clinical status of the individuals who received psychotropic medication. There was also documentation that the Psychiatrist had the ability to assess individuals on an as-needed basis throughout the week. During the onsite review, both Nurses and Psychologists spontaneously commented on the responsiveness of the Director of Psychiatry, when a precipitous change in an individual's status necessitated an urgent consultation that was outside of	

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		the routine schedule.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Documentation that the individual had a Legal Guardian was located in 15 (60%) of the individual records reviewed. LBSSLC served a number of individuals whose teams had identified 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 Facility Director (or their designee) made the decision, and signed the necessary Consent Form. The documentation available in the records suggested that the Facility Director or the LAR had signed off on the necessary documentation. However, the consent process at LBSSLC raised concerns similar to those related to the risk-benefit analysis described above with regard to Section J.10 of the Settlement Agreement. The specific concerns were 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. Although there was evidence of progress made in a number of the provisions of Section J of the Settlement Agreement, there did not appear to have been any significant effort to address the concerns that had been expressed regarding the consent process.	Noncompliance
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 Director of Psychiatry, the Medical Director, two Physicians, the Physician Assistant, and the Clinical Pharmacist attended the Neurology Clinic on 3/30/11. The format was consistent with that observed during the prior reviews. A nurse from the residential unit accompanied each individual reviewed. The nurse presented the relevant history, and the individual's clinical files also were available to the Neurologist. A discussion followed the review of each case presentation. These discussions were quite detailed, involved the Psychiatrists and Primary Care Provider (PCPs), and, where appropriate, there was a discussion of the relevant published literature. During the 3/30/11 Neurology Clinic, two individuals (Individual #284 and Individual #4) were reviewed who had both a seizure disorder and a complicated psychiatric presentation. There was an extensive discussion of the issues related to both of these individuals that included the Neurologist, Psychiatrist, and the PCP.	Substantial Compliance

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		The presence of the Psychiatrist, and a brief synopsis of the discussion were documented in the Neurologist's Note. The consistency of this process was verified through a review of the Neurology sections of 16 out of the 25 individuals within the random sample who required and received neurological consultation (64%). The review of records indicated that the following individuals were periodically reviewed by the Neurologist: Individual #318, Individual #61, Individual #156, Individual #94, Individual #321, Individual #240, Individual #25, Individual #4, Individual #235, Individual #162, Individual #147, Individual #284, Individual #146, Individual #242, Individual #33, and Individual #190. The Neurology Consultation Note documented the attendance of the Psychiatrist, as well as the PCP, in 15 of the 16 individual records (94%). The Notes also summarized the relevant clinical issues involved. The individual's record that did not consistently provide documentation of the Psychiatrist's presence was that of Individual #318. Specifically, the Neurology Consultation Note of 12/3/10 did not mention the presence of the Psychiatrist at that meeting, although the corresponding Neurology Consultation Note from 1/15/10 did specifically note the presence of the Psychiatrist at that meeting. The PCP and the Medical Director were present at both meetings. In summary, the collaboration between Neurology and Psychiatry was documented through direct observation of the Neurology Clinic during the current and prior onsite reviews. The review of the related documentation confirmed the presence of the Psychiatrist at these meetings in all but one instance in the sample of records reviewed.	

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

1. The Facility should continue the interdisciplinary work that had begun to identify the derivation of the target behaviors of the psychotropic medication, to determine if they are related to a psychiatric or behavioral disorder.
2. The Facility should continue its efforts to provide adequate documentation of the symptoms that confirm the psychiatric diagnosis for each individual, and ensure that this information is integrated into each section of the individual's record, as indicated.
3. Annual psychiatric reviews should be used as an opportunity to ensure that: 1) the pertinent historical information in any prior CPA is carried forward; 2) the current relevant clinical information has been added; 3) the format conforms to that outlined in the Settlement Agreement, with each subheading in the outline accounted for; and 4) the resulting document is clearly identified as a revised CPA, which also includes a revision date.
4. A plan should be developed to implement the newest version of the Desensitization Plans for dental procedures in a timely manner.
5. The Facility should ensure that individuals who are newly admitted receive either a Comprehensive Psychiatric Assessment, or are evaluated with the Reiss Screening Instrument.
6. A process that mirrors the initiative to develop Dental Desensitization Plans for dental procedures also should be developed for medical

appointments.

7. 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 psychotropic medication when more than one is prescribed, as well as the dosage range;
    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.
8. For those individuals who are receiving multiple psychoactive medications, it would be useful to provide the rationale for each medication.
9. Efforts should continue to decrease the number of individuals who are prescribed polypharmacy with psychotropic medications.
10. 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 might have been started multiple years ago should be investigated and implemented.
11. 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.

The following are offered as additional suggestions to the State and Facility:

1. The Facility might want to consider developing a parallel polypharmacy tracking system for newly admitted individuals, as their polypharmacy regimens of psychotropic medications negatively skew the Facility's statistical progress in reducing polypharmacy. Information related to the medications regimens of individuals admitted to the Facility, in conjunction with the successful reductions of these medications over time also might provide the State Office with important information about the quality of psychiatric and/or behavioral supports in community settings.

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 LBSSLC Policy – Positive Behavior Support: Positive Behavior Support Practices, dated 8/31/10; o LBSSLC Plan of Improvement/Self Assessment, dated 03/14/11; o Lubbock SSLC – IDT Active Treatment: Competency Based Individual Support Plan for Direct Support and Program Staff, dated 3/1/11; o Summary document of Behavioral Services Staff, including Credentials/Development of Credentials, as of 2/17/11; o Packet of information including copies of diplomas, educational, training and/or conference certificate of attendance, and Behavior Analyst Certification Board certificates, and field; o Interagency Cooperation Contract between LBSSLC and Texas Tech University; o Curriculum vitae of Jim Forbes, M.Ed., BCBA, Director of Behavioral Services; o Behavior Support Peer Review Committee (BSC) meeting minutes, from 10/8/10 to 3/16/11; o Emails regarding external peer review of Structural and Functional Assessment Reports (SFARs) for Individual #316, Individual #23, Individual #79, and Individual 109; o Examples of standardized Daily Summary of Target Behaviors; o Summary of progress and examples related to the development and implementation of the new Excel behavioral data, graphing, and progress note system; o LBSSLC Behavioral Services Tracking Grid of BSC, Human Rights Committee (HRC), and Consent Expiration for Positive Behavior Support Plans, updated 2/23/11; o LBSSLC Behavioral Services Tracking Grid of BSC, HRC and Consent Expiration for Safety Plans: 1) updated on 2/16/11; and 2) updated on 2/23/11; o Tracking grid for behavioral services 2010 Progress Notes across months; o [Section K.4] Positive Behavior Support Plans (PBSPs) for: Individual #33, Individual #190, Individual #4, Individual #124, Individual #156, Individual #315, Individual #240, Individual #242, Individual #304, Individual #75, Individual #94, Individual #38, Individual #318, Individual #271, Individual #108, Individual #173, Individual #125, Individual #174, Individual #306, and Individual #118; o Safety Plans for Crisis Intervention (SPCIs) for: Individual #33, Individual #190, Individual #288, and Individual #240; o Inter-observer Agreement (IOA) Instructions and Inter-observer Agreement Event Recording Data Sheet; o Behavioral Services meeting minutes, dated 2/16/11; o Raw data sheets reflecting IOA data collection at Rose (525) on 3/15/11, Birch (514) on 3/15/11 and 3/16/11, and Fir (516) on 2/22/11 and 2/23/11; o Psychological Assessments, including the Inventory for Client and Agency Planning (ICAP)

	Evaluations, when available for: Individual #103, Individual #118, Individual #127, Individual #66, Individual #271, Individual #108, Individual #173, Individual #125, Individual #174, Individual #306, Individual #304, Individual #75, Individual #94, Individual #38, Individual #318, Individual #161, Individual #100, Individual #51, Individual #242, Individual #140, Individual #254, and Individual #240; o Summary listing of Psychological Assessment Updates, not dated; o [Section K.5] Structural and Functional Assessment Report, when available for: Individual #4, Individual #38, Individual #51, Individual #66, Individual #75, Individual #94, Individual #100, Individual #103, Individual #108, Individual #118, Individual #124, Individual #125, Individual #127, Individual #131, Individual #140, Individual #156, Individual #161, Individual #173, Individual #174, Individual #240, Individual #242, Individual #254, Individual #271, Individual #304, Individual #308, and Individual #318; o 30-day Psychological Assessments and Positive Behavior Support Plans for new admissions, including Individual #173, Individual #131, and Individual #124; o Treatment Plans, as available, from external community-based counseling centers for: Individual #124, Individual #125, and Individual #94; o Billing invoices for recipients of individual psychotherapy through community-based counselors, including for: for January 2011, for Individual #36, Individual #82, Individual #34, Individual #125, Individual #106, and Individual #132; October to November 2010, for Individual #240 and Individual #237; and October 2010 to February 2011, for Individual #61 and Individual #143; o Requesting Counseling Protocol: Guide for PST Members, reissued 2/24/09; o Email, dated 3/11/11, describing team discussion regarding counseling services for: Individual #82, Individual #159, Individual #94, Individual #197, Individual #121, and Individual #34; and an email, dated 3/22/11, describing team discussion for Individual #36 and Individual #125; o Integrated Progress Notes and/or Monthly PBSPs Progress Notes, as available, for: Individual #33, Individual #190, Individual #4, Individual #124, Individual #156, Individual #315, Individual #240, Individual #242, Individual #304, Individual #75, Individual #94, Individual #38, Individual #318, Individual #271, Individual #108, Individual #173, Individual #125, Individual #174, Individual #306, and Individual #118; o Safety Plan Progress Notes, as available, for: Individual #33, Individual #190, Individual #288, and Individual #240; o Email regarding the re-organization of clinical caseloads, dated January 26, 2011; o Summary data and graph of current caseloads, with one position testing, as of 1/21/11; o Excel Behavioral Data/Progress Note Spreadsheet descriptive summary, staff instructions, and staff training documentation on 12/16/10, 12/17/10, 12/20/10, 12/27/10, and 1/21/11; o Behavioral Services Meeting minutes on 1/20/11 and 3/8/11; o Purchase orders of new standardized psychological testing instruments; o Excel spreadsheet to track completion of standardized tests of intelligence and adaptive skills;

	o Sample of Completed PBSP Assessment-Guided and Observation-Guided Staff Instructions; o Summary data of Responses to PBSP Assessment-Guided and Observation Guided Staff Instruction for Aspen, Birch, Canna, Elm, Fir, Iris, Maple, Sparrow, Willow, Tulip, Rose, and Oak; o PBSP Assessment-Guided Staff Training and Observation-Guided Staff Training rubric; o Positive Behavior Support Plan Checklist; o Structural and Functional Assessment Monitoring Checklist; o Sample of completed Structural and Functional Assessment Self-Monitoring Checklist; o Behavioral Services Meeting minutes, dated 2/16/11, describing implementation of the new Structural and Functional Assessment Self-Monitoring Checklist; and o Human Rights Committee meeting minutes, from 3/3/10 to 8/25/10. ▪ **Interviews and Meetings with the following**: o Tracy Murphy, Residential Services Coordinator, two Unit Directors, exploring potential on-campus placements to reduce PICA, on 3/28/11; o Jim Forbes, Director of Behavioral Services on 3/28/11, 3/29/11, and 3/30/11; o Lola Walker, QMRP Coordinator, Marisol Gonzales, ISP Coordinator, Rodshadi Moore, Active Treatment Supervisor, and Melissa Moore, Psychologist, on 3/29/11; o Residential Coordinator, Active Treatment Supervisor, and Active Treatment Coordinators, including: Tracey Murphy, Roshadi Moore, Erica Flores, Adrain Richards, Stepanie Gamie, and Kimberly Scott, on 3/30/11; o At-Risk Process Meeting for Individual #33, on 3/29/11; o At-Risk Process Meeting for Individual #241, on 3/30/11; o At-Risk Process Meeting for Individual #253, on 3/31/11; o Psychologists including: Carolyn Milton, Philip Kite, Melissa Moore, Lamecca Abduljaami, Teresa Balawejder, Christina Sosa, Ronald Flint, Michelle Hutton, Krista Leubner, and Beckie Crawford, on 3/30/11; o Psychology Assistants including: Nicole Johnson, Anna Shackelford, Amber Flores, Blake Perez, and Jamie Trevino, on 3/30/11; o Inter-disciplinary meeting with psychology, speech and OT staff, on 3/30/11; o Teresa Balawejder, BCBA and Melissa Moore BCBA, on 3/30/11; o Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 3/31/11; o Sheila Powell, Human Rights Officer, on 3/31/11; o Mary Ortiz, Director of Competency Training and Development, on 3/31/11; and o Laura Anciso, Director of Vocational and Day Programs, on 4/1/11. ▪ **Observations Conducted**: o PICA Reduction Committee Meeting, on 3/28/11; o Restraint Reduction Committee Meeting, on 3/29/11; o Behavior Support Committee Peer Review Meeting, on 3/31/11; o Onsite direct observation and/or interaction with direct support professionals, and other professionals including, for example, Residence Coordinators, Psychologists, Psychology Assistants, Home Team Leaders and Assistant Home Team Leaders, Active Treatment

	Staff, and/or QMRPs were conducted throughout the day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Estacado Industries Residential Services (EIRS), on 3/28/11; ▪ Aspen (513), on 3/28/11 and 3/29/11; ▪ Birch (514), on 3/28/11 and 4/1/11; ▪ Elm (515), on 3/29/11; ▪ Fir (516), on 3/29/11; ▪ Maple (517), on 3/29/11; ▪ Oak (518), on 3/29/11; ▪ Violet (523), on 3/30/11 ▪ Willow (520), on 3/31/11; ▪ Zinnia (528), on 3/31/11; ▪ Iris (527), on 4/1/11; ▪ Estacado Industries Workshop (EIWS), on 4/1/11, and; ▪ Tulip (526), on 4/1/11.
	Facility Self-Assessment: The Facility had developed a Plan of Improvement with regard to Section K of the Settlement Agreement. The POI contained outcomes, action steps, required evidence, Facility target dates, completion status, a determination of non-compliance (N) or substantial compliance (S), and additional comments. The POI included thirteen action plans and the associated action steps, evidence, start/target dates, and completion status. According to the POI, the Facility reported the completion of nine out of thirteen action plans identified within the POI. These activities are discussed as appropriate throughout the remainder of this section. The Facility developed a self-assessment tool based on the Monitoring Teams' Section K rubric. Verbal reports, as well as documentation indicated that Director of Behavioral Services, and the Program Compliance Monitor (PCM) conducted reviews, and had subsequently been meeting regularly to facilitate improved inter-rater reliability. That is, compliance scores from reviews using the previous monitoring tool for December and January, as well as February, for which the new monitoring tool was used, were 76%, 75%, and 71% for the PCM, and 93%, 88%, and 63% for the Director of Behavioral Services, respectively Inter-rater agreement between the PCM and the Director of Behavioral Services for December and January were 90% and 91%. It was reported that behavioral services staff required additional training on accurately utilizing the monitoring protocols. Based on reports, it appeared that increases in accuracy were desired before the results of any monitoring were utilized to support decision-making. According to the POI, LBSSLC indicated that it was in substantial compliance with Sections K.2 and K.3, and in noncompliance with all of the remaining sections. These findings were consistent with the Monitoring Team's review with one exception. Based on the Monitoring Team's review, the Facility was in noncompliance with Section K.3. More specifically, although the current internal and external peer review systems had shown great progress, both systems needed to continue to improve, and demonstrate consistent contributions from active membership over time for the Facility to be found in substantial

	compliance with this component of the Settlement Agreement.
	Summary of Monitor's Assessment: Progress had been made with Psychological Services since the previous monitoring visit. An additional BCBA was hired within behavior services, and eight of the nine current psychologists had completed previous classes and were enrolled in Spring 2011 coursework. The majority of staff taking classes also had begun necessary supervision. One staff member had completed all coursework and supervision, and was expected to take the exam in April 2011. The foundation for current and future internal and external peer review had been established. Behavior Support Peer Review Committee (BSC) meetings were held regularly, and appeared to be helpful in improving that nature of behavioral services. Participation by critical members of the committee could be improved. A formal interagency cooperation contract was developed and signed between LBSSLC and Texas Tech University. Progress had been made in the area of data collection and monitoring of Positive Behavior Support Plans (PBSPs). That is, a new data management system had been developed allowing weekly data monitoring, as well as more standardization across graphs. Improvement in the monitoring and graphing of replacement behavior also was noted. Specific guidelines are needed to identify the nature of data display (when and where to include). Inter-observer agreement (IOA) data collection has been initiated in a small sample of residential programs, and efforts to measure and improve treatment integrity had continued. However, these efforts had been just initiated, and did not provide sufficient data to establish accurate estimates. In addition, concerns regarding the timeliness and adequacy of data collection remained. Structural and Functional Assessment Reports (SFARs) continued to be an area of strength within psychological services. Substantial progress had been made in the format, content, and quality of the SFARs. Progress in developing a system to update standardized tests of intelligence and adaptive behavior also had been made. Progress in improving the quality of PBSPs continued to be observed. However, specific areas for continued improvement remained. Training of and staff competency in implementing PBSPs also remained a concern. In addition, the adequate provision of other psychological services (e.g., counseling services) appeared problematic.

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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	At the previous monitoring visit, the Director of Behavioral Services, as well as a Psychologist I, and all Associate Psychologists (N=9), had at least a Master's degree. Two of the psychology staff (i.e., the Director and Psychologist I) were Board Certified Behavior Analysts (BCBAs). Since the previous review, an additional BCBA (Psychologist	Noncompliance

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	individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	I) has been hired. Consequently, three staff, including the Director of Behavioral Services and two Psychologist I positions, were BCBAs. Progress continued to be made in supporting staff in pursuing credentialing. At the time of the previous review, 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, and six of the nine had completed multiple courses toward certification. Since the previous visit, eight of the nine had completed coursework toward certification. At the time of the most recent review, eight were enrolled in Spring 2011 coursework. The remaining Associate Psychologist had completed all necessary coursework and required supervision, and was preparing to take the BCBA exam in April 2011. At the previous monitoring visit, six of the Associate Psychologists had started receiving the necessary supervision toward certification. At the time of the most recent review, seven of the nine Associate Psychologists were receiving BCBA field supervision (one has completed requisite supervision). One of the Psychological Assistants and Psychologists completed additional training in Verbal Behavior this past November 2010. Currently, it appeared that the initial plan addressing the recruitment, training, and retention of BCBAs – that was developed and implemented following the baseline review, has been successful in recruiting and training BCBA-level professionals. At the time of the current review, all Psychologist and Associate Psychologist positions had been filled. According to staff verbal reports, questions remained regarding salary and ongoing certification costs (renewal) implications once staff become certified. At the previous monitoring visit, there were eight Psychological Assistants compared to the five that were employed at the time of the baseline visit. Currently, there were six Psychological Assistants, including four with bachelor degrees. According to verbal report from the Director of Behavioral Services, following the most recent restructuring within the department, there were currently no open Psychological Assistant positions. As of March 21, 2011, a formal Interagency Cooperation Contract (IAC) was developed and signed between LBSSLC and Texas Tech University. This contract outlined the provision of services of Texas Tech Doctoral-level Board Certified Behavior Analyst (BCBA-Ds) and graduate students. At the time of the most recent onsite review, a BCBA-D from Texas Tech (faculty member) provided approximately 16 hours a month (four and 12 hours of onsite and off-site consultation, respectively) of case and peer review (discussed below with regard to Section K.3 of the Settlement Agreement). In the future,	

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		an additional external consultant (i.e., another faculty member with a BCBA-D from Texas Tech), as well as graduate students might be contracted to provide consultative services, including peer review. 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 of the Settlement Agreement.	
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 previously reported, Jim Forbes, M.Ed., BCBA, Director of Behavioral Services, held a Master's degree in School Psychology, and received his BCBA in March 2009. He had been employed in his current position for over eight years, and had extensive experience (over 32 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. 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 aligned the Director of Behavioral Services to directly supervise all staff within behavioral services. Reports at the previous monitoring visit as well as current verbal reports from behavioral services staff continued to endorse this change (i.e., to a discipline-based administrative structure), as preferable to the previous unit-based model. The challenge of adequately supervising behavioral services staff following this restructuring, however, prompted a recent change (February 2011) in the provision of professional and administrative supervision. More specifically, two behavior analysts (i.e., BCBAs; Psychologist I positions) had been repositioned within the current structure to provide professional and administrative supervision to the Associate Psychologists. At the time of the Monitoring visit, these two professionals were providing professional supervision to assigned members of the Behavioral Services staff, and, as reported by the Director of Behavioral Services, would begin to provide administrative supervision in the near future. Based on recent verbal reports, this change appeared necessary and acceptable to both Director of Behavioral Services, as well as the two behavior analysts. At the time of the review, given the described reorganization within Behavior Services, the Facility appeared positioned to better respond to the reported demands and challenges associated with the provision of psychological care throughout the Facility. This new structure will likely facilitate improved support and supervision to all Behavior Services staff. The Monitoring Team looks forward to examining the effectiveness of these recent changes in supporting all members of the Behavioral Services at the next	Substantial Compliance

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		monitoring visit.	
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.	Previous baseline and initial monitoring reviews established that LBSSLC supported a rigorous peer review system. At the previous monitoring visit, this system had been refined through the inclusion of specific peer review process criteria within the Positive Behavior Support – Positive Behavior Support Practices policy. At that time, procedures regarding both internal and external peer review had been added. At the time of the most recent review, these procedures did not appear to have been changed, and were still in place. As previously noted, internal peer review occurred primarily through the Behavior Support Peer Review Committee Meetings, and evidenced progress through greater diversity of regular meeting attendees including Psychologists, Psychology Assistants, medical representatives (RN or MD), a Psychiatrist, a QMRP, a Speech Language Pathologist (SLP), a human rights officer (HRO), and quality assurance staff (QA). Review of a sample of BSC meeting minutes (from 10/8/10 to 3/16/11) revealed that the committee met 23 times during this 24-week period, and Psychologists, at least one medical representative, an SLP, a QMRP, and a QA staff consistently attended. Although the committee met consistently, according to this documentation, the HRO, Psychiatrist, external BCBA-D consultant, and Psychology Assistants were in attendance in only five (22%), five (22%), two (9%) and three (13%) of the 23 documented meetings, respectively. The limited involvement by the BCBA-D consultant as well as any Psychology Assistants was particularly concerning. Improving the frequency and consistency of their involvement likely would facilitate improved critical review in the future. In addition, because the Psychology Assistants are likely to be involved in conducting assessments, as well as in staff training on PBSPs and SPCIs, this meeting would offer an opportunity for continued development of professional competencies that are integral to effective behavioral programming. The Monitoring Team's direct observation of the BSC, during the recent onsite visit, evidenced good attendance, very active participation of committee members, presentation of plans by their authors, and data-based review and decision making when evaluating assessments and/or potential interventions. The interaction between committee members reflected critical review of assessments and interventions within a nurturing, positive, and educative atmosphere. At the previous monitoring visit, progress had been noted in the area of external peer review. At that time, an independent consultant, a Doctoral-level Board Certified Behavior Analyst (BCBA-D) from Texas Tech University with expertise in Special Education and Applied Behavior Analysis, was contracted (since 5/12/10) to provide peer review and in-depth case review on selected individuals. This relationship was	Noncompliance

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		recently formalized through the completion of an Interagency Cooperative Contract between LBSSLC and Texas Tech University (signed 3/21/2011). This contract appeared to provide potential supplemental supports and services though the similar consultation of an additional BCBA-D as well as up to two Texas Tech graduate students. Documentation as well as verbal reports from the Director of Behavioral Services also indicated additional external support and review by colleagues from other Texas State Facilities (i.e., State Central Office, Austin State Supported Living Center). Review of documentation reflected external peer review (via email) of four SFARs within the month of March 2011. The current internal system as well as the building of external systems to provide critical peer review had shown great progress. Consideration should be given to developing a system, which tracks, monitors, and summarizes the involvement of external supports in providing peer review over time. Both systems need to continue to improve and demonstrate consistent contributions from active membership over time for the Facility to be found in substantial compliance with this component of the Settlement Agreement.	
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 initial baseline and previous Monitoring Team review, a high percentage of PBSPs, Psychological Assessments, SFARs, Safety Plans, Integrated Progress Notes, and SPCI monthly notes contained data on target and replacement behaviors, as well as restraint data. This data was presented 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. In an attempt to examine the nature of data collection, a sample of 20 PBSPs implemented since the last visit were selected and reviewed. This sample reflected fifteen percent of the total PBSPs currently in place (N=132). Of this sample, 18 (90%) displayed data, either in graphic and/or table format. Two PBSPs revised within the last two months did not include any data display at all (e.g., Individual #124 and Individual #173). Replacement behavior data was not included within four (20%) of the sampled PBSPs (i.e., Individual #33, Individual #156, Individual #242, and Individual # 306). In at least one case, it appeared that replacement data was intentionally not collected due to the presence of an underlying mental health disorder (i.e., Individual #242). Further clarification as to why an underlying mental health disorder would preclude data collection on a more adaptive response will need to be obtained during the next monitoring visit. In addition, 15 (75%) PBSPs included information on psychotropic medications either displayed within tables or bar graphs. Overall, there was considerable variability across	Noncompliance

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		PBSPs in how data was displayed. That is, some PBSPs only displayed a single table (e.g., Individual #33 and Individual #304) or single graph (e.g., Individual #271), while other PBSPs displayed multiple graphs (Individual #190 and Individual #127). Of the 20 individuals whose PBSPs were reviewed, 17 (85%) had target and replacement behaviors reported in graphic form within Integrated Progress Notes or Monthly PBSP Notes. The monthly reports for three individuals did not include data on replacement behaviors (i.e., Individual #242, Individual #75, and Individual #173). In addition, of these individuals, 19 (95%) evidenced recently completed Monthly PBSPs Notes. As a result, it appeared that for most of the individuals sampled, the new format for monitoring behavioral progress had been implemented. In an attempt to estimate the completion of monthly progress notes for all individuals with PBSPs, the 2010 Progress Notes tracking form was reviewed. Based on this summary, it appeared that one or more monthly notes were missing for 29 (22%) of individuals with PBSPs throughout the 12 months of 2010. It is unknown, however, the reason for these missing notes (e.g., hospital admission, etc.). Unfortunately, data display continued to evidence examples where information on replacement behavior was either not available or not graphed for substantial amounts of time. For example, review of provided Integrated Progress Notes (September to November 2010), as well as Monthly PBSP Progress Notes (November to March 2011) for Individual #75 did not evidence any collected replacement behavior data, with only the description within the clinical note indicating that "… behaviors continue to remain absent or unreported." Data on replacement behaviors also was not included within Monthly Reports for other individuals as well (e.g., Individual #242 and Individual #173). Surprisingly, replacement data was not reported in any documentation (until very recently) for Individual #33, who might be one of the individuals at LBSSLC at greatest risk for injury from SIB. That is, data on replacement behavior was not included in the PBSP, SFAR or Psychological Assessment. Months of progress notes indicated: "limited progress on replacement behavior," although no actual data was ever included. However, in the most recent PBSP Progress Note (January to February 2011), six weeks of replacement behavior (all at zero level of responding) were reported. But, as discussed below, it was unclear if this reflected a zero level of responding, or the unavailability of data. There appeared to be a trend toward removing excessive data displays, including tables, from monthly progress documentation. This was based on the fact that all of the Monthly PBSP Progress Notes only included graphic display of data. Given the removal of data tables from documentation, it appeared likely that viewers of graphed data would be unable to discriminate between zero levels of responding (i.e., reflecting of the actual absence of behavior) and the lack or unavailability of data. That is, when looking at some	

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		data displays (e.g., Individual #75), it was unclear if a specific behavior was at a zero level of responding, or if it was not included in the display. Therefore, clinicians should clearly state in their weekly progress note if data is missing. Not only will this ensure a more accurate interpretation of the graph, it is likely to prompt more timely resolution of data collection issues. Four sampled Safety Plans for Crisis Intervention, representing 44% of the total SPCIs currently in place (N=9), were reviewed to estimate how data related to restraint was collected and displayed. These included SPCIs for Individual #33, Individual #190, Individual #288, and Individual #240. In 100% of the sampled SPCIs, the frequency of restraint, total duration of restraint, and injuries related to restraint were displayed either in table or graphic format. In one case, the average duration of restraint also was included (i.e., Individual #288). There was variability in how the data was displayed. That is, some SPCIs displayed a single table (Individual #33), a single graph (Individual #190 and Individual #240), or both table and graph (Individual #288). Safety Plan Progress Notes for the four individuals identified above also were reviewed to determine the adequacy of restraint data collected, displayed, and summarized. All of the monthly progress notes contained tables and line graphs illustrating data on the frequency of restraints, total duration of restraints, average duration of restraint, and number of injuries related to restraint per month. Current review of graphs displayed within documents described above evidenced improvement compared to those reviewed during the previous monitoring visit. That is, data display of target and replacement behaviors, as well as the use of restraint appeared to be improved. Documentation evidenced the use of a new format, called the Monthly PBSP Progress Note that appeared to more clearly and efficiently display data on target and replacement behaviors on a weekly basis. This change was an improvement over displays of monthly data within previous Integrated Progress Notes. However, clinical notes within these new formats should offer potential explanations of changes in behavioral responding, and not simply restate the graphed data in written form. For example, descriptions of weekly progress for Individual #190 (Monthly Progress Note for January 2011) primarily included redundant description of information easily derived from the data display. As found during the Monitoring Team's previous visit, there continued to be room for improvement. More specifically, the quality of the graphic display discussed in further detail with regard to Section K.10 of the Settlement Agreement could still be improved. Direct observation and brief chart/data review during brief onsite visits reflected mixed findings regarding staff's knowledge of PBSPs and data collection. This finding was consistent with observations made during the baseline and previous compliance visit.	

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		Discussion with direct support professionals reflected variability in knowledge regarding PBSPs and inconsistencies about where and when data should be collected. For example: ▪ Strategies outlined in the PBSP for Individual #103, including a replacement behavior, appeared to be integrated within his work setting. However, when questioned about the PBSP, a staff member in the work setting was unsure if Individual #103 actually had a PBSP (although the staff member was able to describe some of challenging behaviors), and could not locate his "All About Me Book," when attempting to answer additional questions. ▪ A similar experience was observed when a direct support professional was asked if Individual #161 had a PBSP. The staff answered "No," and was surprised to find that a PBSP was in place when she checked the record. When asked about data collection, this staff member also was not aware of the use of data cards within the residence. ▪ A direct support professional accurately explained where data was recorded for Individual #118 while at the residence. However, she was unable to accurately describe the targeted behavior (identified in the PBSP) being measured, and described an additional way to collect data that, according to site psychologist, was incorrect. ▪ A direct support professional did not know definitively whether or not Individual #100 had a PBSP, and did not know the specific targeted behaviors that were being tracked. This staff member was able to find the appropriate record, and correctly answer the initial questions. I n addition, this direct support professional was able to generally describe one of Individual #100's skill acquisition programs. ▪ Direct support professionals were unaware of the use of the data card for tracking data related to the PBSP for Individual #103 at the residence. ▪ A direct support professional working closely with Individual #33 did accurately indicate that data was to be taken using the data card in addition to the home notes. ▪ Two direct support professionals interviewed about PBSPs at 527 (Iris) were unsure which individuals had PBSPs. Review of data collection with regard to PBSPs also appeared to evidence inconsistency across settings. For example: ▪ Data appeared to be completed appropriately when reviewing the home shift log at Birch, when completing brief onsite review of Individual #60. ▪ Data appeared to be completed accurately for the 6 a.m. to 2 p.m. shift for Individual #4. However, staff were unaware that the data card was missing a shift interval (in which to collect data). ▪ On 4/1/11, the data card stapled to the shift home log at 526 (Tulip) was not completed at all.	

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		▪ On 4/1/11, the data card appeared to be completed at 514 (Birch) for the 6 a.m. to 2 p.m. shift. Since the previous visit, it appeared the use of a structured data card, a new standardized format that utilized frequency recording and allowed staff to record data for all individuals on a single sheet, had been implemented across all sites. This sheet was designed to collect frequency data across shifts each day. Recent verbal reports from staff, however, indicated that not everyone recognized that this card had been implemented and direct observation evidenced that some cards were not completed as expected. In addition, although many observations revealed several incidents of target behaviors demonstrated by several individuals, timely data collection was not observed. As previously reported, the Monitoring Team recognizes the rationale for a consistent and standard format to "simplify" data collection across sites. However, the system would still need to be flexible enough to allow individualized data collection systems, when warranted. The new format prescribed data collection across shifts and, consequently, might continue to inadvertently support the collection of data at the end of the shift rather than recording the behavior soon after its occurrence (which might be more likely if staff members were required to complete data recording more frequently). Consideration should be given to how the design of the data collection system will enhance more timely data collection. Since the Monitoring Team's last visit progress had been made in the area of collecting inter-observer agreement data. This was an improvement over earlier monitoring visits, when IOA had not been collected. Documentation indicated that instructions and a structured data sheet had been developed to assist staff with collecting IOA on target and replacement behaviors. Behavioral Services Staff Meeting minutes, dated 2/16/11, indicated that the collection of IOA was initially targeted as part of a pilot to examine its success within three residential programs, including Rose (525), Birch (514), and Fir (516). Raw data sheets evidenced completed IOA data collection at Rose on 3/15/11, Birch on 3/15/11 and 3/16/11, and Fir on 2/22/11 and 2/23/11. Data indicated that one, eight, and six IOA observations were completed at Rose, Birch and Fir, respectively, with IOA estimates ranging from 66 to 100% across programs. Only one of the fifteen conducted observations targeted a replacement behavior for assessment of IOA. As many of the observations recorded "0" for occurrence of selected target behavior, it is recommended that more than one target behavior, as well as the replacement behavior be selected while conducting IOA observations. This is discussed in further detail with regard to Section K.10 of the Settlement Agreement.	
K5	Commencing within six months of the Effective Date hereof and with	The underlying expectation of Behavioral Services staff, as determined during previous reviews, was that each individual residing at LBSSLC was required to have a current	Noncompliance

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	full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	psychological assessment. More specifically, a psychological assessment would be completed, updated, and/or reviewed at least annually for each individual served. This included reviewing and including summary data from the 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 individual must have a current psychological evaluation. A sample of 22 psychological assessments was selected for the current review. This sample represented approximately 10% of the total number of individuals (N=227) expected to have a psychological assessment. Within this sample, 20 (91%) had a psychological assessment that, at the time of the onsite review, was updated within the last 12 months. More specifically, psychological assessments were outdated by more than one year for two sampled individuals (i.e., Individual #174 and Individual #51). It should be noted that the previous psychological assessment for Individual #51 expired (exceeded the one year criteria) the week prior to the onsite monitoring visit. A more current assessment might have been completed, but was not available at the time of the visit. Documentation provided indicated that 100% of those sampled above had had an ICAP evaluation completed within the last three years. More specifically, all of the reviewed psychological assessments detailed dates of ICAP completion within the last three years. However, this was challenging to verify, because some of the dates on provided documentation (ICAP booklets and scoring summaries) were not consistent with cross-referenced information found within psychological assessments, or the ICAP assessment and/or summary sheets were not available as requested. In addition, some of the most recent assessment data did not appear to be reported in the documentation provided, or documentation was missing not allowing confirmation that the most recent assessment information was adequately reported. For example: ▪ Although ICAP data was reported in psychological assessments, actual ICAP assessments were not provided as requested for five (23%) individuals sampled (i.e., Individual #271, Individual #108, Individual #38, Individual #318, and Individual #242). ▪ Provided documentation for Individual #174 evidenced completion of the ICAP in January 2011, but because the provided psychological assessment was previously completed in January 2010, confirmation that it was adequately recorded within the most recent assessment was not possible. ▪ Data provided within the psychological assessment, dated 3/25/10, for Individual #51 included information on a previously completed ICAP, dated	

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		4/17/08. Documentation provided revealed the more recent completion of a subsequent ICAP, on 5/01/09. It is unclear why, if a more recent ICAP was scheduled for completion, it was not completed concurrently with the psychological assessment, thereby ensuring the inclusion of the most recent assessment data. ▪ Data provided with the psychological assessment for Individual #304 indicated that the ICAP was completed on 7/31/09, but the actual dates listed on the ICAP data sheet, as well as the computer summary printout reported a completion date of 8/7/09. Of the psychological assessments reviewed, 20 (91%) contained results of previously completed standardized tests of intelligence. These tests included the use of the Wechsler, Slosson, TONI, Stanford Binet, and/or Leiter, and were completed, on average, approximately 18 years ago (completion dates ranging from six to 23 years ago). Sixteen (80%) of these IQ tests were conducted over 10 years ago, with none (0%) being completed within the last five years. Additional examination of those completed over 10 years ago indicated that 25% and 75% completed over 11 to 20 years, and over 21 years ago, respectively. The Facility's plan to improve its compliance with regard to the timeliness of intelligence testing is discussed with regard to Section K.7 of the Settlement Agreement. The two sampled psychological assessments that did not provide summary information on standardized tests of intelligence including the following: ▪ Psychological Assessment for Individual #304 indicated that: "… due to profound… deficits in adaptive functioning and sensory impairments, standardized formal intelligence testing was not appropriate." ▪ Psychological Assessment for Individual #100, after reporting scores from the Vineland Adaptive Behavior Scales, indicated that: "Due to the severity of [Individual #100's] cognitive deficits, more formal intelligence testing is not indicated at this time." As consistent with the Monitoring Team's previous findings regarding psychological assessments, it was unclear which standardized assessments were utilized without success, 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 factors were considered when selecting the test (i.e., how it was most applicable to the person), or, given the situations described above, 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.	

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		Of the psychological assessments currently reviewed, 16 (73%) 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 six (27%) remaining psychological assessments included the use of the ICAP as the initial measure of adaptive behavior. All of the psychological assessments appeared to adhere to a standardized format. This format included content areas including: rationale; previous assessment findings; current assessment procedures and findings; history, mood and affect; cognitive and adaptive functioning, which typically included scores on the most recent ICAP; review of behavior, including data in tables and/or graphs; diagnosis; level of functioning; and recommendations. There was considerable variability in whether or not (and how) behavioral data, and, in some cases, information on medication was displayed. Overall, review of LBSSLC Summary Listing of Individuals for whom a psychological assessment had been completed (i.e., Psychological Assessment Updates, not dated) revealed that 225 had been completed (i.e., using the document scan date of 2/23/11). Based on this summary listing, it appeared that nine (4%) were out-of-date, as of 2/23/11. When comparing dates of outdated psychological assessment sampled with this listing, it appeared that Individual #174 might have had a psychological assessment updated on 1/3/11. However, this was not provided with requested documentation. As previously reported, 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. Twenty-six individuals were currently sampled, reflecting 20% of the total number of individuals (N=132) with PBSPs. Of the individuals sampled, 20 (77%) had a SFAR that was updated within the past 12 months. It should be noted that three of the individuals sampled were recently admitted to LBSSLC, and had interim PBSPs in place while the SFARs were completed (i.e., Individual #124, Individual #131, and Individual #173). The remaining five SFARs (for Individual #304, Individual #140, Individual #161, Individual #174, and Individual #66) were outdated (dated more than 12 months before the recent onsite monitoring visit). Of these, two SFARs appeared to be outdated for only a few days (i.e., Individual # 140 and Individual #161). Overall, review of LBSSLC listing of Individuals with Functional Assessments, completed 2/1/10 through 2/1/11, revealed that 111 SFARs were completed within the last year. Based on this documentation and provided data on the total number of PBSPs currently in place (N=132), it appears that 21 (16%) individuals with PBSPs did not currently have a SFAR (i.e., they were missing from this list). According to this list, only two (2%) of the SFARs were outdated (i.e., recorded completion date exceeded 12 months as of	

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		2/14/11). This was an improvement over previous estimates. Based on previous data on the Behavioral Services tracking grid, 20% and 14% of the total SFARs were out-of-date during the baseline and the Monitoring Team's previous reviews, respectively. However, according to the current behavioral services tracking grid, dated 2/23/11, four (3%) individuals with PBSPs did not have a SFAR. In addition, current dates on the behavioral services tracking grid indicated that 26 (20%) SFARs were currently outdated. It should be noted that data on the most recent behavior services tracking grid reflected dates when the required signatures on SFARs were received. Consequently, SFARs could have been completed, but not yet signed. It is unclear if this criterion in establishing whether or not an SFAR is "completed" is a new alteration since the Monitoring Team's previous visit. It should be noted that the Monitoring Team was unable to resolve the discrepancy in the number of missing SFARs between the listing of individuals with Functional Assessments completed (2/1/10 to 2/14/11), and the behavioral services tracking grid, dated 2/23/11. This is important information for the Director of Behavioral Services to review as well. Consideration should be given to developing summary data that identifies the number and percentage of current, as well as missing (or outdated) psychological assessments, SFARs, and PBSPs based on the current census. Since the Monitoring Team's previous review, significant progress had been made in the format, content, and the quality of the SFARs. A new Structural and Functional Assessment Self-Monitoring Checklist was developed and appeared to be quite helpful. Documentation provided reflected active use of this checklist by psychologists and behavior analysts while developing or revising SFBAs, and, as described below, the outcome was very positive. Because the new format appeared to be implemented quite recently, 10 individuals with SFARs completed in the last five months were selected (from the original sample) for closer review, these included: Individual #271, Individual #108, Individual #308, Individual #94, Individual #38, Individual #318, Individual #75, Individual #240, Individual #4, and Individual #156. Of these plans, it appeared that eight were completed using the new format (i.e., the older format was utilized within SFAR for Individual #75 and Individual #4). Based on review of this limited sample (N=8), it appeared that the Facility had actively responded to previous recommendations. The following information is based on the review of these eight SFARs. As found during the Monitoring Team's previous reviews, the SFARs were very comprehensive and included methods widely accepted as standard practice within the field of Applied Behavior Analysis (ABA). These included structured interview formats (e.g., Functional Assessment Interview Form, The Problem Centered Interview), rating	

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		scales [e.g., Motivation Assessment Scale (MAS), Functional Analysis Screening Tool (FAST)], event recording and permanent product review [e.g., Antecedent-Behavior-Consequence (ABC) behavior recording, scatter plot, etc.], and direct observation. Currently, these methods were still evident and were found in all of the SFARs reviewed. However, the majority of the raw assessment data was removed from the reports, and replaced with summary descriptions and examples. This change was viewed as a significant improvement, and likely will facilitate a more effective and efficient review of assessment findings. The new SFAR format contained the content areas found during the Monitoring Team's previous reviews, but these sections had been reorganized. All of the newly formatted SFARs had content areas including: 1) personal attributes and interests; 2) applicable history and review of status, including medical, psychiatric, neurological, psycho-social, and developmental; 3) previous and current behavioral programming; 4) assessment procedures and findings, including interviews, behavior rating scales, and direct observation and observation notes; 5) preferences and potential reinforcers; 6) potential replacement behaviors; 7) conclusions; 8) recommendations; and, 9) references. Review of this limited sample evidenced an emphasis by behavioral services staff to: 1) operationally define target behaviors; 2) identifying potential setting events and establishing operations; 3) identify functions of target behavior(s); 4) identify potential replacement behavior(s); 5) integrate background information with findings from assessments; and 6) integrate findings and hypothesized functions with research-based intervention strategies (i.e., link interventions with hypothesis). Indeed, the progress made in developing effective SFARs was notable. Since the baseline review, this limited review reflected substantial progress in the quality of SFARs. As new and revised SFARs are completed in the future, the Facility is strongly encouraged to remain focused on continuing its emphasis on quality. Although improvement in all assessments was obvious, current review of sampled assessments continued to reflect variability across SFARs. This variability was a natural consequence of the many authors with different levels of experience. The following illustrates some of the concerns noted: ▪ SFARs adhering to the new format did not include behavioral data displayed in tables or graphs. This was an improvement, as long as the author provides a summary of behavioral progress, including progress of target and replacement behavior, and describes how interventions or other important changes have supported (or not) each individual's success. o The nature of data display of behavioral data and medication information on the SFAR for Individual #75, for example, did not appear to facilitate interpretation beyond what could be completed in a few	

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		summary sentences. Consequently, the new format will improve the efficiency of developing and reading future SFARs for this individual. o Good examples of summarizing behavioral progress were found, for example, in the SFARs for Individual #108 and Individual #156 o A critical analysis of the adequacy and sufficiency of data collection was offered, for example, in the SFARs for Individual #271 and Individual #308. Both of these were good examples of where authors described, interpreted and expanded upon issues related to data collection. ▪ Although all plans typically provided objective definitions for target behaviors, most did not provide specific definitions for replacement behaviors. To be clear, all of the SFARs identified or provided descriptions of potential replacement behaviors. However, plans did not provide specific definitions in a similar fashion as provided for target behaviors. o A good example of where a replacement behavior was objectively defined was found in the SFAR for Individual #75. o The author offered a critical analysis of previous replacement behavior and potential necessary changes in revised programming for Individual #240. ▪ SFARs clearly identified potential underlying functions of each target behavior. And, in many cases, interventions were linked to those functions and target behaviors. However, some plans continued to overlook one or more function of a target behavior(s). Authors should provide a rationale for why a potential function is not being addressed through intervention strategies. o The SFAR for Individual #108 identified "escape" as the primary function of aggression. Although appropriate replacements were included to address other identified functions, there did not appear to be a functionally equivalent replacement behavior identified for aggression maintained by escape. This was a significant oversight, because, according to data in the SFAR, it appeared that aggression was likely the most problematic target behavior. o The SFAR for Individual #38 identified the potential underlying functions of escape and access to tangibles as maintaining a number of target behaviors. It was unclear from the included description how the proposed single replacement behavior (i.e., "using a visual schedule") would address all of the identified target behaviors and related functions. ▪ It appeared some authors continued to struggle with identifying, integrating, and/or addressing potential setting events or establishing operations within intervention recommendations. Ongoing training should be provided on these concepts, how they relate to the development of hypothesis, and their implication on identifying and implementing appropriate intervention	

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		strategies. o It would be helpful if, for example, the author of the SFAR for Individual #38 explained or expanded upon how "the diagnosis of intermittent explosive disorder" and "deprivation of a scheduled event" might act as potential setting events or establishing operation. o A number of potential setting events and antecedents were identified, for example, in the SFAR for Individual #318 (e.g., a badge, fleets, constipation). These were, however, not specifically and conspicuously integrated into intervention recommendations in the SFAR or included as strategies within the current PBSP as stated. As observed during the Monitoring Team's previous reviews, in addition to the above assessments, screening for psychopathology, emotional and behavioral issues continued to be completed either through the psychiatric clinic's completion of a psychiatric assessment or the completion of the Reiss Screen for Maladaptive Behavior to screen for the need of a psychiatric assessment. The Reiss screenings had been completed to examine individuals who were not receiving psychiatric services. The Facility's compliance with the implementation of the Reiss Screening process is discussed above with regard to Section J.7 of the Settlement Agreement.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The current LBSSLC Psychological Evaluations policy indicated that each individual residing at LBSSLC must have a current psychological evaluation. This expectation, that a current psychological evaluation would be completed, updated, and/or reviewed at least annually for each individual served, had not changed since the Monitoring Team's previous visit. The information below is also described earlier with regard to Section K.5 of the Settlement Agreement. To determine whether or not psychological assessments were based on current, accurate and complete clinical and behavioral data, a sample of 22 psychological assessments was selected for review. This sample represented approximately 10% of the total number of individuals (N=227) expected to have a psychological assessment. Within this sample, 20 (91%) had a psychological assessment that, at the time of the onsite Monitoring visit, was updated within the last 12 months. Sampled documentation also indicated that 100% of those sampled had an ICAP evaluation completed within the last three years. Of the psychological assessments reviewed, 20 (91%) contained results of previously completed standardized tests of intelligence. These tests included the use of the Wechsler, Slosson, TONI, Stanford Binet, and/or Leiter, and were completed, on average, approximately 18 years ago (completion dates ranging from six to 23 years ago). Sixteen (80%) of these IQ tests were conducted over 10 years ago, with none (0%) being completed within the last five years. In addition, 16 (73%) of the sampled psychological	Noncompliance

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		assessments 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 six (27%) remaining psychological assessments included the use of the ICAP as the initial measure of adaptive behavior. Review of sampled psychological assessments revealed considerable diversity in the type of data collected as well as the format used to display collected data. For example, 50% contained both table and graphs (line and/or bar graphs), with the remaining assessments containing either data displayed in only tables, only graphs, or did not display any data at all. The data displayed also continued to vary across individuals with some plans including data on replacement behaviors, and some not (i.e., no replacement data was reported for Individual #161, Individual #51, Individual #242, Individual #254, and Individual #306), as well as the reporting of psychiatric symptoms, and data on the use of restraint (e.g., Individual #94). In addition, most of the sampled psychological assessments, 17 (77%), included bar graphs illustrating medication and associated dosages. As previously recommended, the Facility should examine the type of data collected and displayed within the psychological assessment. 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. The Facility should provide 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 Sections K.5 and K.6 of the Settlement Agreement, 20 (91%) of the individuals sampled (N=22) had a psychological assessment that was updated within the last 12 months. Sampled documentation also indicated that 100% of those sampled had an ICAP evaluation completed within the last three years. Of those sampled, 20 (91%) contained results of previously completed standardized tests of intelligence that were completed, on average, approximately 18 years ago (completion dates ranging from 6 to 23 years ago). Sixteen (80%) of these IQ tests were conducted over 10 years ago, with none (0%) being completed within the last five years. According to documentation provided (i.e., emails dated 1/13/11 and 1/26/11, and behavioral services meeting minutes, dated 1/20/11) and verbal reports from the Director of Behavioral Services, a re-organization of clinical caseloads of psychologists and behavior analysts occurred on February 1, 2011. The rationale for this change in responsibilities was to eliminate the majority of the current clinical caseload of one psychologist to allow her to begin completing standardized assessments of intellectual and adaptive abilities. Indeed, at the time of the current Monitoring visit, progress already had been made in ordering new standardized intelligence tests and adaptive	Noncompliance

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		behavior scales, as well as in developing an Excel monitoring system to track completion of completion of these assessments. This change appeared thoughtful, as an examination of current caseloads (i.e., number of individuals, PBSPS, and SPCIs) was completed. The Monitoring Team looks forward to assessing outcomes associated with this organizational change, and progress on standardized testing during the next visit. As evident from the previous and current Monitoring Team reviews, efforts to ensure the timely completion of behavioral services documentation (e.g., psychological assessments, SFARs, PBSPs, consents, etc.) had been facilitated by the ongoing use and monitoring of the behavioral services tracking grid. It appeared that a similar system was utilized to track completion of monthly progress notes (i.e., Integrated Progress Notes). These systems should be examined to determine if they could support monthly summary of missing or outdated documentation, and be utilized as a form of performance feedback for behavioral services staff with the aim of increasing timely completion of necessary assessments, interventions, and consents. LBSSLC policy stated that one month from the date of an individual's admittance, a psychological assessment was required to be completed. At the time of the previous Monitoring visit, provided documentation for three new arrivals, including Individual #36, Individual #235, and Individual #190, was reviewed and a 30-day psychological assessments was completed for each individual within one month of the date of their arrival. In addition, according to the behavioral services grid, dated 2/23/11, a SFAR was completed approximately four, three, and five months after admission for Individual #36, Individual #235, and Individual #190, respectively. Documentation also revealed that a PBSP was implemented for each individual either the day that they were admitted, or within a few days. Since the last compliance review, four additional individuals were admitted to the Facility. Sampled documentation for three (75%) of these individuals (i.e., Individual #173, Individual #131, and Individual #124) was reviewed to ensure that psychological assessments had been completed within 30 days of their arrival. Documentation indicated that 30-day psychological assessments were completed for each of these new individuals within one month of admittance to LBSSLC. More specific information regarding each assessment is provided below: ▪ The 30-day psychological assessment for Individual #173 appeared to review and summarize findings from previous assessments completed prior to his arrival, describe initial observations, review background history, and identify diagnoses. In addition, the report identified timelines for ICAP and SFAR completion, and provided recommendations and definitions of target behaviors for data collection. ▪ The 30-day psychological assessment for Individual #131 also appeared to	

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		review findings from previously completed assessments, review past history, describe initial observations during the first month, list and review recently completed ICAP scores, display and review behavioral data collected since admission, identify diagnoses, identify a timeline for completion of a SFAR, and provide recommendations and definitions of target behaviors for data collection. ▪ The 30-day psychological assessment for Individual #124 also appeared to review findings from previously completed assessments, review past history, describe initial observations during the first month, list and review recently completed ICAP scores, display and review behavioral data collected since admission, identify diagnoses, identify a timeline for completion of a SFAR, and make recommendations for a PBSP, as well as psychiatric clinic consultation. Additional information will be requested at the next visit to monitor whether or not the identified timelines discussed above were successfully completed.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	The baseline review of counseling services provided to 14 individuals residing at LBSSLC by community-based agencies evidenced a lack of measureable goals or objectives, sufficient descriptions of interventions (to determine if the intervention was rooted in evidenced-based practice), and inadequate identification and integration within the PSP and psychological assessments. During the Monitoring Team's September 2010 visit, it appeared that the community-based counseling providers had been encouraged to address noted concerns, and the documentation reviewed evidenced some initial improvement. Previous recommendations included an emphasis on: 1) defining objective measureable goals that could be monitored weekly or monthly; 2) identifying a level of performance (e.g., lack of progress, failure to attend appointments) that would trigger review and revision of interventions; 3) identifying attendance at counseling sessions as a specific goal in the PSP, counseling treatment plans, skill plans, and/or PBSPs for individuals that miss one or more appointments per month; and, 4) through collaboration with associate psychologists, integrating therapeutic objectives and skills into skill acquisition programs within the residential program. In an effort to examine progress toward previous recommendations, a sample of progress notes and treatment plans were reviewed to determine if progress continued to be made and whether or not the above concerns were adequately addressed. According to provided documentation (i.e., January 2011 billing invoices and February 2011 treatment notes), it appeared that there were 14 individuals receiving individual psychotherapy from three community-based therapists. However, this was difficult to estimate given that treatment plans were not provided for one individual listed on January billing invoice (i.e., Individual #143), some individuals with February 2011 treatment plans were not listed on provided billing invoices, and, most importantly, a comprehensive list of individuals currently receiving counseling services was not	Noncompliance

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		provided as requested. Of this sample, three individuals, representing approximately 21% of the total number of individuals receiving counseling, was chosen for review. This included Individual #124, Individual #125, and Individual #94. The following summarizes the findings of these reviews: ▪ According to a Diagnostic and Treatment Plan, dated 2/24/11, Individual #124 received individual counseling services to address aggression, hallucinations, and previous trauma. However, the provision of counseling services was not recommended within the current psychological assessment, dated 3/2/11. Because this individual was admitted recently, a PSP was not currently available (i.e., the PST meeting might not have been completed yet). Billing invoices were not provided. Consequently, the expectation for and attendance at scheduled appointments could not be determined. The identified goals of the treatment plan, including "reduce/prevent future aggressive behaviors," "assess for and understand role of reported hallucinations," and "process and understand influence of childhood abuse and witnessing of violence," were not objective or measureable. Also, there was not sufficient information regarding targeted interventions, for example, "trust building, externalization of hallucinations" or "journaling, education," to determine if they were founded in evidenced-based practice. The planned number of sessions was estimated at between 12 and 16. ▪ According to a Treatment Plan, dated 2/23/11, Individual #125 received individual counseling services to assist in making good behavioral choices in response to his environmental circumstances. Identified treatment goals were objective and measureable. However, the included goals were rather "long-term," as they included a date of 12/31/2011. The primary therapeutic orientation was described as "enhanced cognitive behavioral therapy" and "family systems therapy." Treatment progress was described as limited due to inconsistent therapy attendance. January 2011 billing invoice indicated that Individual #125 missed three, and cancelled one appointment. It did not appear that counseling was recommended within the current psychological assessment, dated 8/16/10, or recommended within the current PSP, dated 8/23/10. However, the PST discussed counseling supports following aggressive behavior toward peers. For example, a PSP Addendum, dated 12/10/10, indicated: "[Individual #125] will be encouraged to attend scheduled counseling sessions," and the PSP Addendum, dated 1/4/11, stated: "The Psychologist will assess [Individual #125] for counseling and will counsel with him if deemed necessary." It was unclear, though, if the PST attempted to problem solve regarding his poor attendance at therapy appointments, or to determine the effectiveness of those supports. ▪ According to a Treatment Plan, dated 2/26/11, Individual #94 received individual counseling services to address long-term goals, including "elevate self-esteem" and "demonstrate improved self-esteem through more pride in	

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		appearance and self-care." More specification was provided in associated objective and measureable short-term objectives for each long-term goal. However, the Monitoring Team viewed these short-term objectives as more long-term objectives, because they included a criterion date of 12/21/11. The identified therapeutic interventions appeared based in cognitive-behavior therapy, and were clear and straightforward. It did not appear that counseling was recommended within the current psychological assessment, dated 10/3/10, or recommended within the current PSP, dated 10/13/10. Although, the PST did recommend that Individual #94 "… continue to follow-up with outside counselor …" following a suicide threat. Her attendance at counseling could not be determined, because billing invoices were not provided. Given the above observations, it appeared that previous recommendations continued to remain appropriate. Behavioral services staff should work closely with community-based providers as well as PSTs to ensure emphasis on: 1) defining objective measureable goals that are monitored weekly or monthly; 2) identifying a level of performance (e.g., lack of progress, failure to attend appointments) that would trigger review and revision of interventions; 3) identifying attendance at counseling sessions as a specific goal in the PSP, counseling treatment plans, skill plans, and/or PBSPs for individuals that miss one or more appointments per month; and 4) through collaboration with associate psychologists, integrating therapeutic objectives and skills into skill acquisition programs within the residential program. This last item was not examined, because integrated skill training programs were not yet developed utilizing the new format being piloted. This is discussed in further detail with regard to Section S.1 of the Settlement Agreement. Based on billing invoices provided, it appeared that the majority of individuals identified to receive counseling services did not attend their scheduled appointments. Concern regarding attendance at therapy appointments was initially identified in the Monitoring Team's previous report. Based on the current review, it appeared that non-attendance had remained a problem, and potentially had become worse. A closer inspection of a limited number of invoices (i.e., for one or more months for 11 individuals) revealed that individuals attended approximately 11 (20%) of their scheduled appointments. In addition, it appeared that only four (36%) of the 11 individuals attended one or more appointments during this time period. Indeed, one individual (Individual #143) missed or cancelled 15 appointments in a three-month period. The fact that the majority of individuals missed or canceled the majority of their counseling appointments reflected a significant problem with regard to the non-provision of (or inaccessibility of) therapeutic services. In addition, this represents a waste of limited resources and money. An informal estimate of invoice charges for missed or cancelled appointments (based on invoices provided) reflected an approximate loss of over $1,400.00.	

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		There was some evidence that the Facility had been working to overcome attendance issues, and other concerns regarding counseling services. A team meeting (email dated 3/11/11, describing team discussion for Individual #82, Individual #159, Individual #94, Individual #197, Individual #121, and Individual #34) was held to discuss the effectiveness of current community-based counseling services for seven of the individuals currently receiving individualized therapy. In the majority of the cases, the team determined that the individual was not benefiting from counseling. It was unclear from the documentation provided, however, if these decisions were data-based, or if these decisions were documented within the PSP. For example, Individual #94 was one of the individuals whom the team determined was "… not benefiting at this time" from counseling services. However, review of requested documentation (e.g., PSP and PSP addendums) did not evidence a summary of this meeting, and/or the PST's recommendation regarding the continuation of counseling services. Other evidence (e.g., email dated 3/22/11, describing team discussion for Individual #36 and Individual #125; listing of community-based counseling providers, etc.) also reflected ongoing efforts to ensure attendance at counseling appointments as well as identify more appropriate services based on individual need). In general, the use of counseling services as well as any other identified psychological treatment or interventions, should be held to the same standards typically associated with PBSPs. More specifically, behavioral services staff must ensure that psychological supports and services, in this case community-based counseling services, adhere to rigorous standards, and are implemented as designated. The necessity and nature of these services should be closely examined, as well as monitoring each individual's utilization of these services and related progress. If not already completed, the Facility should identify potential barriers to provision of these services and develop potential solutions. In addition to the counseling services, several other types of therapeutic services were identified and observed during the baseline and previous Monitoring visits. These additional 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. In some cases, these experiences appeared to be recommended as part of ongoing therapy. Previous Monitoring Team recommendations encouraged the Facility to identify specific outcomes for individuals receiving such experiences, collect data and determine if these services were effective for individuals for whom they were prescribed. At the previous visit, the Director of Behavioral Services had begun to develop a plan to identify and assess non-evidenced based interventions that were currently being promoted as therapeutic (or therapy) within the Facility. At the time, the plan appeared to be in the development	

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		phase. Further discussions with the Director of Behavioral Services during the most recent Monitoring onsite visit indicated that an effort to remove all non-evidenced based interventions from PBSPs was in place, and that the previously discussed plan was no longer necessary.	
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.	It was evident that progress has continued to be made with regard to the development of PBSPs. A sample of 16 (12% of the total number) PBSPs, implemented since the last Monitoring visit, were reviewed to assess compliance with the Settlement Agreement. Overall, as found during the previous review, the PBSPs were comprehensive and typically adhered to a standard format. Since October 2010, according to verbal report, psychologists had been encouraged to follow the PBSP Checklist, and their adherence to this format was monitored through the behavior support peer review committee. Sampled plans demonstrated good adherence to the format with only a few showing slight divergence, as is discussed below. In general, the sampled PBSPs continued to demonstrate improvement toward meeting the requirements of the Settlement Agreement. Sections within the PBSPs that continued to demonstrate consistency included: 1) the treatment rationale, including references of evidenced-based practices and description of how these were integrated within the PBSP; 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 (although, replacement behavior data was not always presented); 7) information on psychiatric diagnosis, medications, and potential side effects; and 8) brief staff instructions, expected treatment outcomes. In addition, improvement was noted in the area of identification of one or more replacement behaviors. 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. Indeed, good correspondence generally was found between assessment findings and the rationale for approaches described in the PBSP (exceptions are discussed below). There were still areas within some sampled PBSPs that were somewhat limited or insufficient, and did not appear to meet the requirements of the Settlement Agreement. These included: 1) specification of previously attempted interventions, descriptions of changes to behavioral programming and explanations why these changes were made (other than medication changes); 2) operational definition of replacement behaviors; 3) complete behavioral objectives that facilitated efficient and accurate progress determination; 4) detailed procedures for how/when to use (or not use) identified reinforcers; and, 5) overlooking identified functions of target behavior or not providing a rationale for why a potential function was not addressed. Examples of these are	Noncompliance

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		described below: In general, all the PBSPs reviewed followed a similar format. There were some exceptions, although, for interim PBSPs, this might be appropriate. An interim PBSP was noted for Individual #124, who was recently admitted, and Individual #156, who, although all the components were included, had a PBSP that was organized differently than the other plans reviewed. In most cases, identified functions underlying target behaviors, as well as replacement behaviors outlined in SFARs were consistently integrated within current PBSPs. However, there were some exceptions or issues for consideration found in a few cases. For example: ▪ Although behavioral objectives and intervention strategies were included to improve work attendance, this was not identified as a replacement behavior, or sufficiently defined in the PBSP for Individual #94. ▪ The primary function of the seemingly most challenging target behavior (aggression) for Individual #108 was identified within the SFBA as escape. The PBSP appeared to include communication strategies aimed at this function. However, there did not appear to be a related replacement behavior targeted to estimate if this alternative skill was demonstrated. Although all of the plans reviewed identified one or more replacement behaviors, some plans did not identify a replacement behavior or definitions provided for replacement behaviors were often inadequate. For example: ▪ Communication was identified as the replacement behavior for Individual #156. Although the use of the picture communication book was generally described, a clear measureable definition of "communication" was not specified. ▪ Problem solving training was identified for Individual #240. This skill, while seemingly appropriate and worthwhile, was not objectively defined or measureable. Similar limitations were noted with regard to how functional communication was defined for Individual #73, and participation in an activity of choice for Individual #174. ▪ It appeared that a replacement behavior was not identified within the PBSP for Individual #242, because the challenging behaviors were "directly related to [Individual #242]'s Bipolar disorder …" This was not an oversight and appeared to be the result of a thoughtful clinical assessment. Indeed, the SFAR reflected a very complicated case with unclear assessment results. However, to the fact that the plan described several adaptive responses (e.g., participation in activities, self-help skills, relaxation techniques, etc.) that were reported to potentially "… alleviate discomfort from symptoms …" These adaptive responses likely could be objectively defined, measured, and reinforced in an attempt to examine their	

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		combined effectiveness with psychoactive medication. Although objectives were typically included in PBSPs, they often did not provide sufficient detail to determine whether or not the objective was met. In addition, although plans stated objectives for replacement behaviors, data on replacement behaviors was not included in the PBSP. For example: ▪ The objectives outlined in the PBSP for Individual #38 did not include sufficient detail to adequately determine if the objective had been met. That is, some objectives did not indicate how many weeks or months (i.e., between the implementation and criterion dates) the criteria had to be obtained in order to judge the objective as met. For example, it was unclear if the objective for aggression referred to every month between now and February 2012, or perhaps an unidentified percentage of months. The same issue was evident with scheduling (i.e., did he need to be successful at least five times in the next eight consecutive weeks, or eight weeks sometime this year?), and accepting "no" (i.e., did he need to be successful for 30 out of 40 trial this month or this year?). In addition, with the new data management system in place, behavioral services staff should examine how weekly data summaries will impact current objectives. With more frequent weekly data summary, a shorter criterion might be more appropriate to ensure more timely review and revision, if necessary. ▪ Objectives that appeared to provide sufficient information to facilitate accurate determination of success included those outlined in the PBSP for Individual #108 and Individual #156. ▪ Although baseline data was provided in graphic form for Individual #271, data on replacement behavior (i.e., functional communication, etc.) was not included. It was unclear why data on the target behavior, but not replacement behavior, would be included. Similar missing data on replacement behavior was reflected within the PBSP for Individual #306. ▪ Graphic data on replacement behaviors indicated that the response did not occur 11 months out of the year for Individual #304. However, closer examination of data included on the table within the PBSP indicated that data was not collected. Each PBSP included a section on "reason for review." In some cases, more specific information might be helpful in tracking changes in programming over time. For example: ▪ Description in the PBSP for Individual #94 indicated that the plan contained revised behavioral interventions, but did not specify what the changes included. ▪ An example where helpful information regarding changes was described was found in the PBSP for Individual #108.	

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		In some cases, it was difficult to assess whether or not approvals (HRC and BSC), and/or consent had been obtained prior to the implementation of the most recent revision of a PBSP. In one case, it was due to the lack of a date recorded on a PBSP. ▪ The PBSP plan for Individual #4 had been revised multiple times over the course of the last year, most recently in March 2011. It was unclear if the BSC, HRC, and Consent expiration dates provided on the BSC tracking grid (all in December 2011) corresponded to the current plan. The Monitoring Team assumed that these consent dates were not for the current plan, because the PBSP number on the actual document and the one on the BSC grid did not match. Similar findings were found for the current PBSP of Individual #75. ▪ According to the BSC tracking grid, it appeared that the HRC and BSC approval had been received, but the Consent was outdated (i.e., dated 1/31/11), for the most recent PBSP for Individual #94. ▪ The number on the PBSP did not match the number on the BSC tracking grid for Individual #118. Therefore, it was unclear if the BSC and HRC approval dates, as well as Consent date were for the current PBSP, dated 2/23/11. The current plan appeared to have been revised recently due to a medication change. ▪ There was no implementation date recorded on the PBSP for Individual #318, and the identification number listed on the PBSP did not match the number listed on the BSC tracking grid. ▪ The initial implementation date of the PBSP for Individual #174 was in April of 2010, and the listed approvals and consents appeared to expire in March 2011. However, the plan was more recently revised in November 2010, and the approvals and consents did not appear to be updated as well. In most cases, PBSPs included information on identified preferred activities, items, etc., but did not specifically prescribe their use when attempting to teach and reinforce alternative behavior. ▪ Although verbal praise was identified and prescribed, the planned use of identified preferred items as reinforcers was not included within antecedent or consequent based interventions for Individual #38. ▪ Similarly, it appeared that cigarettes were being integrated within a pre-determined schedule, but it was unclear if other identified preferred items (to-go coffee cup) was prescribed for use to reinforce alternative/replacement behaviors for Individual #75. As reported with regard to Section K.7 of the SA, interim PBSPs were implemented for individuals on the day (or within a few days) of their admission. These brief plans appeared to offer initial direction to direct support professionals to ensure the individual's safety while necessary assessments (SFARs) were completed, and a more comprehensive PBSP, including assessment-linked strategies, was developed and	

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		implemented. For example: ▪ Individual #124 had an interim PBSP implemented on the day he was admitted. This plan was similar in format to other PBSPs reviewed. Although because an SFAR had not yet been completed, many important components of the plan were missing (e.g., identified function, replacement behaviors, etc.). It was interesting to note that enough information was known about Individual #124 to identify target behaviors, but not replacement behaviors. Behavioral services staff should attempt to identify and measure an adaptive response(s) in addition to the response targeted for decrease. This would allow collection of baseline data across multiple responses, which might be helpful in determining the effectiveness of future intervention. The Monitoring Team recognizes that the PST might not initially identify the most salient responses to measure for a new individual. The effort, however, might assist in identifying and/or refining more important responses to measure in the future. As indicated above, determination of whether or not necessary approvals and consents were obtained prior to the implementation of the sampled PBSPs was a challenging undertaking. In an attempt to estimate adherence to the Settlement Agreement, a closer examination of the BSP tracking grid for all PBSPs was completed. It should be noted that this indirect assessment was limited by the fact that corresponding permanent products were not available for review. According to BSC and HRC approval expiration dates as well as Consent expiration dates listed on the BSC tracking grid, 13 (10%) and 12 (9%), and seven (5%) were outdated, respectively. The previous estimate, determined at the time of the last review (i.e., using the BSC tracking grid, dated 9/18/10), indicated that the BSC, HRC, and/or guardian approval/consent had expired in approximately 10% of the total number of PBSPs. Currently, it appeared that the BSC, HRC, and/or guardian approval and/or consent had expired in approximately 12% of the total number of PBSPs. Similarly, in an attempt to estimate adherence to the Settlement Agreement, a closer examination of the BSP tracking grid for all SPCIs was completed. It appeared that the BSC, HRC, and/or guardian approval and/or consent had expired in approximately one (11%) of the total number of SPCIs. That is, documentation indicated that the consent was "pending" for Individual #298. Previous reviews of the LBSSLC Human Rights Committee evidenced concern regarding the composition of the committee members. More specifically, during the baseline review, it appeared that the majority of attendees were employed by LBSSLC. At the time of the last review, it appeared that participation by individuals not employed by LBSSLC had improved. A review of a five-week sample (meetings from 7/28/10 to 8/25/10) reflected a range of 25 to 50% of attending members who were not employed by the	

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		Facility. Recent verbal reports from the Human Rights Officer indicated a concerted effort to increase the number of community members on the committee. Indeed, verbal reports indicated that four new community members had been identified. Review of recent HRC meeting minutes (from 11/10/10 to 3/9/11) reflected a mean (and range) of 35% (17 to 44%) per week of attending members who were not employed by the Facility.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	As previously discussed with regard to Section K.4 of the Settlement Agreement, progress had been made in the area of collecting inter-observer agreement data. This was an improvement over earlier Monitoring Team visits when IOA had not been collected. Documentation indicated that instructions and a structured data sheet had been developed to assist staff with collecting IOA on target and replacement behaviors. In addition, Behavioral Services Staff Meeting minutes, dated 2/16/11, indicated that the collection of IOA was initially targeted for three residential programs, including Rose (525), Birch (514), and Fir (516). Raw data sheets evidenced completed IOA data collection at Rose on 3/15/11, Birch on 3/15/11 and 3/16/11, and Fir on 2/22/11 and 2/23/11. Data indicated that one, eight, and six IOA observations were completed at Rose, Birch, and Fir, respectively, with IOA estimates ranging from 66 to 100% across programs. Only one of the fifteen conducted observations targeted a replacement behavior for assessment of IOA. As many of the observations recorded "0" for occurrence of selected target behavior, more than one target behavior, as well as one or more replacement behaviors should be selected while conducting IOA observations. The Monitoring Team was encouraged with the progress the behavioral services professionals had made in initiating this pilot to examine the accuracy of the current data collection systems. The Monitoring Team looks forward to learning more about the effectiveness of this pilot, including any implications for a more comprehensive system-wide implementation, at the next Monitoring visit. As found during previous baseline and compliance reviews, PBSP data was typically collected and summarized on a monthly basis within the Integrated Progress Note. This monthly 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 within 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 of the Settlement Agreement, across previous and current Monitoring visits, considerable variability was observed in how data had been displayed across monthly reports and other documentation (psychological assessments, SFARs, PBSPs, and SPCIs). As previously described, a sample of individuals (N=20; with PBSPs that were updated since the last Monitoring review) was identified,	Noncompliance

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		and their monthly progress notes (e.g., "old" Integrated Progress Notes and/or "new" Monthly PBSP Progress Note) were reviewed. Of these, 17 (85%) reported target and replacement behaviors in graphic form; the monthly reports for three individuals did not include data on replacement behaviors (i.e., Individual #242, Individual #75, and Individual #173). Of these individuals in the sample, 19 (95%) evidenced utilization of the new Monthly PBSP Progress Notes. Consequently, it appeared that for most of the individuals sampled, the new format for monitoring behavioral progress had been initiated. The new Monthly PBSP Progress note appeared to be an improvement over the previous Integrated Progress Note format (a good example of this was seen in the PBSP Progress Note for March 2011 for Individual #4). Graphic display was used within the new format, and the data displayed typically included both target and replacement behaviors (with the exception of those noted above). In addition, this new format displayed data by week (not month), which will likely be a more sensitive indicator of variability of responding, and, hopefully, provide more informative when attempting to identify or examine variables related to target and replacement behaviors. In addition, these graphs could display varying ranges of data, phase change lines, and other information (medication changes, etc.). Verbal reports from the Director of Behavioral Services indicated that the new automated Excel spreadsheet (data management system) facilitated the new graphing format, and allowed behavioral services staff to quickly generate updated graphs for inclusion within monthly reports or other required documentation. Written guidelines were developed for the utilization of this new system, including specific instructions for how to input data into Excel, how to determine the ranges of data to display, and the necessary content of weekly clinical notes. Behavioral services staff, including behavior analysts, psychologists, psychology assistants, received training on this new system (in December 2011). This revised data management system appeared to be a significant improvement, and will likely improve the efficiency and effectiveness of data display, as well as data-based decision making. Although this new format for monthly progress reports appeared to be an improvement, challenges within the data collection system, in general, remained. For example, data display continued to evidence examples where information on replacement behavior was either not available or not graphed for substantial amounts of time. For example: ▪ Review of Integrated Progress Notes (September to November 2010), as well as Monthly PBSP Progress Notes (November to March 2011) for Individual #75 did not evidence any collected data on replacement behavior, with only the description within the clinical note indicating that "… behaviors continue to remain absent or unreported."	

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		▪ The reporting of replacement behavior data was very inconsistent within previous Integrated Progress Notes or current Monthly Reports for other individuals as well (e.g., Individual #4, Individual #161, Individual #190, Individual #242 and Individual #173). ▪ Replacement data was not reported in any documentation (until very recently) for Individual #33, who might be one of the individuals at LBSSLC at greatest risk for injury from SIB. Data on replacement was not included in the PBSP, SFAR, or Psychological Assessment. Months of progress notes indicated: "limited progress on replacement behavior," although no actual data was ever included. Six weeks of replacement behavior (all at zero level of responding) was reported, however, only in the most recent PBSP Progress Note (January to February 2011). ▪ No replacement behavior was targeted for collection or displayed in current documentation for Individual #124. This was likely due to his recent admission to LBSSLC. However, weekly progress notes indicated that staff identified multiple seemingly appropriate responses (i.e., "telling staff," "using a card," or a "code word" instead of displaying target behaviors) that, at least initially (albeit perhaps temporarily), could have been utilized and measured as replacement behaviors. As discussed previously with regard to Section K.4 of the Settlement Agreement, there appeared to be a trend toward removing excessive data displays (i.e., including the use of multiple tables and graphs) out of monthly progress documentation. This is based on the fact all of the sampled Monthly PBSP Progress Notes included only the graphic display of data. Given the removal of data in tables from documentation, it appeared likely that viewers of graphed data would be unable to discriminate between zero levels of responding (i.e., reflecting of the actual absence of behavior), and the lack or unavailability of data. That is, when looking at some data displays (e.g., Individual #75), it was unclear if a specific behavior was at a zero level of responding, or if data was not available, but still graphed within the display. In this example, although an entire year of replacement behavior data was labeled "NA" within the table, zero rates of responding were displayed across months in the graph in the Integrated Progress Notes for Individual #75. Therefore, clinicians should clearly state in their weekly progress note if data is missing. In addition, zero rates of responding should not be graphed when data is missing. Not only will this ensure a more accurate interpretation of the graph, it is likely to prompt a more timely resolution to data collection issues. Overall, data display with graphs appeared improved since previous Monitoring visits. However, consideration should be given to the items described below as well as vigilance with regard to previously stated recommendations in the Monitoring Team's earlier reports regarding graphing conventions to ensure that progress in improving the quality	

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		of graphic display of data continues. ▪ Ensure that the vertical (Y) axis is of sufficient range to adequately allow effective interpretation of the included data. For example, the number of physical restraints for Individual #33, for one month, exceeded the range of the vertical axis (i.e., Safety Plan Progress Note, dated February 2011). ▪ Information describing the vertical axis should be clearly indicated. Often, the axis label and/or numbers on the axis were difficult to read (e.g., Safety Plan Progress Note for Individual #190, or PBSP for Individual #304). ▪ Ensure that all legends markers are identifiable when integrating graphic displays into documents (e.g., PBSP for Individual #190). ▪ Data display within documents should reflect previously collected data and not empty cells of upcoming months (e.g., Safety Plan Progress Note for Individual #190). The point of this information is to examine current behavioral responding compared to previous behavioral responding. ▪ Remove additional legend markers if not in use (e.g., Monthly PBSP Progress note for Individual #33 and #70). ▪ When progress notes suggest that data is missing, the note should contain sufficient detail to establish which data specifically is missing (e.g., Monthly PBSP Progress note for Individual #33). ▪ Ensure that the description of data within weekly progress review notes matches the data displayed on the graph (e.g., Monthly PBSP Progress Note for Individual #156). ▪ When graphic displays are incorporated into documents, ensure that their size facilitates effective interpretation. For example, the graphs included in the PBSP for Individual #70 were too small to read. A good example of a graph well integrated was in the PBSP for Individual #306. ▪ Ensure that the data displayed on graphs matches the raw data displayed in tables. For example, the replacement behavior data displayed within the table reflects better performance than would be potentially attributed to graphed data (e.g., PBSP for Individual #118). This may be a case where a second Y-axis is required to adequately display percentage data associated with the replacement behavior to allow a more representative and/or accurate interpretation. As previously recommended, the Facility should continue to examine the data collected as well as the nature of how this data is displayed (e.g., how, where, etc.) within current assessments (Psychological Assessments and SFARs) and plans (PBSPs and SPCIs). As discussed earlier and in previous reports, it appears that some of the data presented might be redundant or unnecessary (e.g., table and multiple graphs with the PBPS for Individual #318). Behavioral services staff should continue to monitor to ensure that staff are adhering to specific guidelines related to when and where to include certain types and formats of data.	

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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.	Efforts to systematically measure and increase treatment integrity had continued since the last Monitoring visit. At that time, a new spreadsheet had been developed to assist behavioral services staff in the monitoring of data derived from the completion of assessment-guided and observation-guided staff training rubrics in residential and work settings. These assessments were designed to estimate staff knowledge and competencies through direct interaction (e.g., asking staff questions or asking staff to demonstrate a component of a PBSP) or unobtrusive direct observation of staff implementing PBSPs. Data from the Monitoring Team's previous visit indicated that data derived from the initial completion of assessment-guided measures over the course of three weeks (at Aspen) estimated staff knowledge of select PBSPs to be between 72 to 84%. This was the first attempt at collecting this data. However, at that time, observation-guided probes estimating staff's ability to implement PBSP strategies had not yet been initiated. At the time of this most recent review, documentation indicated that assessment-guided and observation-guided measures were initiated within 12 residential programs and the Workshop. The summary data displayed the percent correct for each item, as well as an overall percent correct per week for both the assessment-guided and observation-guided items. It should be noted that data was not provided for Quail or Violet, but some of the data sheets did not identify a specific residential setting. Data indicated that assessment-guided probes were conducted for an average (and range) of six (one to 12) weeks per residence, since the Monitoring Team's last visit. Estimates of overall percentage correct (per week) across residences ranged from 60.8% to 100%. Data indicated that observation-guided probes were conducted for an average (and range) of two (one to four) weeks per residence, since the Monitoring Team's last visit. It should be noted that this average was based on only the seven residences in which observation-guided probes were conducted (i.e., no observation-guided probes were conducted in Elm, Iris, Maple, Sparrow, and Tulip). Estimates of overall percentage correct (per week) across residences ranged from 66.7% to 100%. The above data reflected the initial attempts at estimating how well direct support professionals understood and could implement PBSPs. In general, it appeared that the majority of residential programs had collected probe data across five or less weeks, since the last Monitoring visit in September 2010. The limited amount of data collected, especially for observation-guided measures, was insufficient to establish an accurate estimate of treatment integrity across residential settings. In addition, it was not possible to determine how many probes were conducted each week. That is, based on the sample of raw data sheets, it appeared that probe data was collapsed per week. This made it impossible (without all of the raw data sheets) to determine how many probes were conducted each week. Lastly, assuming that data was collapsed across probes per	Noncompliance

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		week (i.e., if there was more than one probe), it was unclear how items that were not scored "yes" or "no" were included in the scoring. More specifically, some items scored "NA," "most of them," or "with prompting" did not appear to fit the current scoring rubric. Consideration should be given to monitoring and displaying the number of probes conducted each week by shift. In addition, clarification will be sought during the next Monitoring visit regarding how multiple probes are scored each week, especially when one or more of the items are scored atypically. Findings from the Monitoring Team's recent onsite visit were consistent with previous baseline and compliance reviews. That is, verbal reports from direct support professionals produced mixed results regarding staff's knowledge of PBSPs. More detailed information is provided with regard to Section K.4 of the Settlement Agreement. Since the previous Monitoring visit, continued efforts at examining the PBSP format and considering potential changes had occurred. Documentation provided revealed ongoing peer support to assist psychologists in writing and revising PBSPs that were shorter and simpler, avoided unnecessary jargon, and were written at or below a sixth-grade reading level. Indeed, the topic of streamlining PBSPs was actively discussed during the most recent onsite Monitoring visit. As previously observed, behavioral services staff utilized the last few pages of PBSPs, labeled "staff instructions," when conducting staff training. These pages, typically between two to four pages long, were designed to provide a concise summary of antecedent and consequence-based strategies in the hopes of promoting effective training. At the time of the Monitoring Team's most recent visit, verbal reports indicated that consultation with State Office as well as other SSLCs regarding the format of PBSPs would continue.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	Since the last Monitoring visit, progress in the area of competency-based training had been observed. A new training policy called "Competency Based Individual Support Plan Training for Direct Support and Program Staff," dated 3/1/11, was completed. This policy required trainers to utilize role-playing and other training strategies to ensure that each direct support and program staff demonstrated competence in implementing skills targeted during training sessions. Employees who did not demonstrate competence were required to complete additional training, and any staff still not meeting competency measures would be referred to supervisory staff for corrective or administrative action. To facilitate sufficient training, staff members were released from all other duties during training sessions. Currently, it appeared that most onsite group training sessions occurred during transitions times (i.e., just prior to a shift or just following a shift). Staff receiving the training and the staff member conducting the training now had to complete training documentation. The Competency Training and Development Department (CTD) now maintained this documentation. Documentation	Noncompliance

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		provided evidenced multiple examples of signed completion of competency-based training certifications. According to recent verbal reports, the curriculum for New Employee Orientation (NEO) training, specifically related to psychological services, was recently revised, and was currently taught by a BCBA from Behavioral Services. According to the new competency-based training policy, once direct support or program staff members had completed NEO, they must receive unit or program-specific training within five working days. If staff required extended time (e.g., to review multiple PBSPs), additional training dates and times were supposed to be allocated. It appeared that this policy supported administrative action for staff who demonstrated a pattern of non-attendance at trainings. Follow-up assessment and training, if necessary, was facilitated through the use of the PBSP assessment-guided and observation-guided training forms. As previously presented (i.e., with regard to Section K.11 of the Settlement Agreement), these were developed to assist with measurement and improvement of staff competency, as well as ultimately improve treatment integrity of PBSPs. Documentation provided revealed that they had been initiated across most residential programming. Based on recent onsite discussions with behavioral services staff, concerns continued to be voiced regarding the adequacy of training for direct support professionals. These concerns included: 1) the challenge of trying to monitor and ensure new and pulled staff were sufficiently trained; 2) the competency of the trainers; 3) adequate staff attendance at scheduled trainings; and, 4) the amount of training covered within single training sessions. Several of the behavioral services staff interviewed commented on the difficulty of trying to identify new or pulled staff and schedule sufficient training sessions. This appeared to be a very challenging task, because the Facility continued to be plagued with considerable turnover in staffing. In addition, Psychology Assistants voiced concern about conducting trainings on PBSPs that they did not develop, and, in some cases, they might have interpreted differently than the plan's author. Verbal reports also highlighted challenges associated with inconsistent, and, at times, poor attendance by direct support professionals at scheduled in-services training. Lastly, behavioral services staff viewed the number of PBSPs reviewed in a single training session as less than effective. Documentation evidenced that, in some cases, a direct support professionals was trained on 12 PBSPs and two SPCIs in one training session (e.g., new staff in-service training at 516 S. Cedar, dated 1/6/11). Similar examples with other direct support professionals were observed in other documentation as well. Progress had been made in the area of competency-based training. However, questions and concerns remained. For example, it was unclear when a new staff was judged to be	

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		competent on a PBSP. More specifically, it was not clear if a determination of competence required: 1) attendance at an initial training (and annual updates thereafter), and successful demonstration of all the skills targeted during that session (e.g., strategies outlined within a specific PBSP or skill acquisition plan); and/or 2) demonstrated 100% competence on assessment-guided and observation guided measures on this PBSP at some follow-up date. It was not clear if a staff member must successfully undergo the two steps listed above for each PBSP for each individual that they might encounter within their work setting. Lastly, it also was unclear if the staff member must then successfully undergo the two steps listed above for each skill acquisition plan for each individual that they might encounter within their work setting. If this was the expectation, given the current turnover and time allocated to training, successful adherence to this expectation appeared unrealistic. Based on staff verbal report, the approximately three hours currently allocated for onsite training of specific PBSPs (last day of NEO) was inadequate, and likely ineffective, given the number of plans at some residences. This training, however, might be supplemented by additional learning experiences offered during the recently extended "on-the-job" training. However, it did not appear that psychologists or psychology assistants had been integrated into this supplemental onsite training. Further review of the CTD, including a more specific examination of the roles of trainers, including review of actual trainings, and allocation of training resources (time, etc.) as related to psychological services will be completed during the Monitoring Team's next review. The Facility should ensure that the key professional and support staff (e.g., psychological assistants, home team leaders, assistant home team leaders, residence coordinators, QMRPs), who are most likely to be in positions to model accurate and effective programming (i.e., skill acquisition plans, PBSPs, SPCIs, data collection, etc.) to direct support professionals, are trained first. Given the current nature of turnover and inconsistency in staffing, the Facility might more greatly benefit from ensuring that the most reliable and experienced staff have the competencies to model and provide performance feedback to the many staff they support. This indirect service delivery model might offer a temporary, albeit partial solution, to the seemingly insurmountable challenge of ongoing training of new staff. It appeared that behavioral services staff continued to actively collaborate with other disciplines, and within settings beyond residential settings (e.g., day and vocational environments). As observed during the Monitoring Team's last visit, an experienced psychologist had been assigned to partner with professional staff within day and vocational programs to ensure the successful integration of behavioral services within these settings. At that time, effective integration of psychological services also was	

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		observed within psychiatry. Since the last visit, additional psychologists had worked closely with other disciplines (e.g., active treatment, speech language, and dental) to improve the provision of services. In addition, very active collaboration between psychology and other disciplines was evident during the observed Pica Reduction Committee. This integration across disciplines should increase the likelihood of improvements in the quality of services.	
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.	Consistent with the Monitoring Team's previous visits, progress continued to be made in the composition of staff within psychological services. At the time of the Monitoring Team's last visit, in addition to the Director of Behavioral Services, LBSSLC employed one Psychologist (with a BCBA), nine Associate Psychologists, and seven Psychological Assistants. At the time of the most recent review, an additional BCBA (Psychologist) had been hired. In addition, a reduction was noted in the number of Psychology Assistants, however, from seven to six. Recent reports, as of 3/28/11, indicated that LBSSLC currently served 227 individuals. Based on this census, and the recognition that the Director of Behavioral Services as well as one Associate Psychologist (who will be tasked with only completing standardized test of intelligence and adaptive behavior) will not carry a caseload, an approximate average ratio of 1:23 psychologist-to-individual served was determined. With six Psychological Assistants currently employed, the Facility exceeded the ratio of one Psychological Assistant for every two Psychologist/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, as evidenced by the absence of professional certification, as well as by the overall 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 ensure adequate attendance by external BCBA-D and other key members (e.g., psychology assistants), in accordance with established expectations (monthly attendance), at BSC meetings.
2. As previously recommended, the Facility should examine the type of data collected and displayed within all psychological documentation. This should include adhering to specific guidelines regarding which documents will contain which types of data and in which form (table, graph, and/or summary). Based on current documentation, it appeared that the new graphic format was appropriate for PBSPs, whereas summary of assessment data might be more helpful than graphic or table displays in SFARs.
3. With the new data management system in place, behavioral services staff should examine how weekly data summaries will impact current objectives. With more frequent weekly data summary, a shorter criterion might be more appropriate to ensure more timely review and revision, if necessary.
4. With the use of the new Monthly PBSP Progress Note, with data graphed by week, was an improvement, the Facility should ensure that relevant

information is described and that the included narrative reflects potential explanation(s) of the data and not merely a written, redundant description of the data.

5. Given the removal of data tables from documentation, it appears likely that viewers of graphed data will be unable to discriminate between zero levels of responding (i.e., reflecting of the actual absence of behavior) and the lack or unavailability of data. Therefore, clinicians should clearly state in their weekly progress note if data is missing. Not only will this ensure a more accurate interpretation of the graph, it is likely to prompt more timely resolution of data collection issues.
6. Data collection systems should continue to be trained, evaluated and improved, when necessary to ensure data collection is timely, reliable and valid. As previously presented, the system should be flexible enough to allow individualization, when necessary. For example, when appropriate measures should reflect the frequency, duration, and/or intensity of problem behavior and corresponding replacement behavior, data collection systems should be revised to allow collection of these data.
7. The pilot examining inter-observer agreement (IOA) should continue, and be thoughtfully expanded to include additional settings. More specifically, behavioral services staff should closely examine the success and/or challenges associated with this pilot demonstration and evaluate implications for subsequent system-wide implementation. In addition, when conducting probes, observers are encouraged to attempt to estimate agreement on one or more target and replacement behavior. This is likely to increase the probability that staff observe at least one response that may be used to estimate agreement.
8. To optimize the progress made in establishing the resources necessary to complete outdated standardized tests of intelligence and adaptive behavior, a monitoring system should be implemented to track the progress of their completion.
9. The behavioral services tracking grid or another mechanism should be used to produce a monthly summary regarding upcoming, outdated, or missing documentation. This summary information should be utilized as a prompt, as well as performance monitoring and feedback for behavioral services staff with the aim of increasing timely completion of necessary assessments, interventions, approvals and consents. This system, for example, could be used to identify the number and percentage of current as well as missing (or outdated) psychological assessments, SFARs, PBSPs, SPCIs, and Monthly PBSPs Notes across a number of variables (e.g., month, residence, psychologist, etc.).
10. Emphasis should remain on identifying appropriate replacement behaviors, adequately defining these responses, integrating specific teaching strategies to prompt and reinforce their use with PBSPs, and ensuring adequate measurement/monitoring over time.
11. For interim PBSP, attempts should be made to identify and measure an adaptive response(s) in addition to the response targeted for decrease. This would allow collection of baseline data across multiple responses, which might be helpful in determining the effectiveness of future intervention.
12. Priority should be given to identifying individuals who have not had standardized intellectual assessment completed. Consideration should be given to identifying potential standardized tests that might be more appropriate, given the rationale for not completing the testing in the past.
13. Ongoing training should be provided on identifying, integrating, and/or addressing potential setting events or establishing operations within intervention recommendations; how they relate to the development of hypothesis; and their implication on identifying and implementing appropriate intervention strategies.
14. With regard to counseling sessions:
    a. Recommendations and/or support for these services should be described and integrated within the PSP, including the Psychological Assessments, and ongoing evaluation as well as any proposed changes should be based on collected objective data.
    b. 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. Community-based therapists should continue to be provided support in writing measureable goals/objectives.
    c. Objective measures of anticipated behavior change should be collected with accompanying data analysis to determine the effectiveness (or lack thereof) of the recommended practice. The determination of the effectiveness of counseling should be data-based.
    d. A system should be developed for monitoring attendance at counseling sessions as well as evaluating ongoing individual progress.
    e. The necessity and nature of these services should be closely examined, as well as monitoring each individual's utilization of these

services and related progress. If not already completed, the Facility should identify potential barriers to provision of these services and develop potential solutions.

15. Monitoring of and follow-up on the behavioral services tracking grid should continue to ensure closer adherence to the completion of necessary consents and approvals prior to their expiration as well as ensure that PBSPs are not implemented prior to receipt of consent.
16. In addition to reviewing related recommendations in previous reports, the Facility should consider the following as it revises its graphing procedures:
    a. Ensure that the vertical (Y) axis is of sufficient range to adequately allow effective interpretation of the included data;
    b. Information describing the vertical axis should be clearly indicated
    c. Ensure that all legends markers are identifiable when integrating graphic displays into documents;
    d. Data display within documents should reflect previously collected data and not empty cells of upcoming months;
    e. Remove additional legend markers if not in use
    f. When progress notes suggest that data is missing, the note should contain sufficient detail to establish which data specifically is missing
    g. Ensure that the description of data within weekly progress review notes matches the data displayed on the graph;
    h. When graphic displays are incorporated into documents, ensure that their size facilitates effective interpretation; and
    i. Ensure that the data displayed on graphs matches the raw data displayed in tables.
17. The Facility should continue to emphasize competency-based training and the ongoing monitoring of treatment integrity. This includes the continued utilization of PBSP Assessment-Guided and Observation-Guided Staff Training rubrics, and summary data systems. Regular examination of this system should occur and performance feedback (regarding adequate completion), as well as critical evaluation and refinement of the process (i.e., how these probes/observations are conducted and how staff training is implemented) should be completed.
18. If not already in place, a system should be developed to ensure adequate oversight and appropriate assignment of regular, relief, or pulled staff to ensure that they are adequately trained to support the individuals to whom they are assigned to work. In addition, consideration should be given to identifying a pool of relief, part-time or "floating" direct support professionals that are adequately trained in targeted settings. This might increase the availability of competent staff to address unexpected variability in staffing ratios.
19. The Facility should examine strategies to encourage better attendance at trainings (e.g., use of incentives), and closely monitor and respond (in accordance with prescribed policy) when staff miss multiple trainings.
20. The Facility should ensure that all new staff receive the revised, initial Positive Behavior Support training. In addition, the Facility should closely examine the time and resources necessary to adequately training new staff during on-the-job training on site specific PBSPs.
21. The Facility should continue to promote the integration of behavioral services within day vocational/employment, habilitation services, psychiatry, dentistry, etc.

The following are offered as additional suggestions to the State and Facility:

1. More specific feedback should be provided to staff regarding financial implications of becoming certified. For example, staff questioned whether or not certification would prompt increases in salary and whether or not costs associated with continued certification annual renewal, including costs of continuing education credits, would be reimbursed.
2. A system should be developed to track and summarize the nature of external peer review. That is, an ongoing list should be created of case consultation and peer review completed by external peer reviewers including the individuals targeted, associated dates, and the nature of the consultation/review (e.g., conducting functional analysis, participation in BSC, document review, etc.). This system might be even more necessary as the diversity and intensity of the support increases over time (i.e., addition of Texas Tech graduate students).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Complete History and Physical, from September 1, 2009 to March 15, 2011, report date of 3/28/11; o Annual medical summary and physical examination for the following individuals with dates of reports: Individual #63, dated 2/12/10, 1/27/11; Individual #77, dated 2/26/10, 1/13/11; Individual #222, dated 2/3/10, 1/13/11; Individual #317, dated 2/25/10, 3/10/11; Individual #35, dated 2/4/10, 1/26/11; Individual #100, dated 2/24/10, 2/4/11; Individual #74, dated 1/5/10, 2/4/11; Individual #147, dated 2/5/10, 1/27/11; Individual #296, dated 1/13/10, 1/11/11; Individual #50, dated 1/28/10, 2/10/11; Individual #275, dated 2/26/10, 2/11/11; Individual #86, dated 2/4/10, 1/11/11; Individual #120, dated 2/4/10, 2/10/11; Individual #134, dated 2/16/10, 2/10/11; Individual #121, dated 3/5/10, 1/27/11; Individual #115, dated 1/14/10, 1/12/11; Individual #84, dated 2/17/10, 1/25/11; Individual #215, dated 2/11/10, 1/10/11; Individual #89, dated 3/16/10, 2/24/11; and Individual #90, dated 2/26/10, 2/22/11. o List of individuals age greater than 50, date of last colonoscopy, and reason if not completed; o Colonoscopies for individuals over age 50, from January 1, 2001 to February 15, 2011; o Pneumonia Profile Report January 1, 2010 to January 1, 2011; o Individuals newly diagnosed with pneumonia with date for prior year; LBSSLC Pneumonia Report 2/1/2010 through 1/31/2011; o Incidence rates for prior year for pneumonia; o Incidence rates (prior year, by month) decubitus ulcers; o Incidence rates for prior year for UTIs; o List of females, list of males ages 50 to 90, from 9/1/10 to 3/29/11; o List of females age greater than 50, mammograms done in past two years; o Visits by type: Emergency Room by individual, from 1/1/10 through 2/9/11 with reason for visit, and date of visit; o Neurology consultation reports for the following: Individual #290, dated 9/15/10; Individual #290, dated 10/20/10; Individual #290, dated 11/17/10; Individual #290, dated 1/12/11; Individual #290, dated 2/9/11; Individual #171, dated 9/1/10; Individual #171, dated 10/6/10; Individual #171, dated 10/20/10; Individual #171, dated 11/17/10; Individual #171, dated 12/15/10; Individual #171, dated 1/26/11; Individual #171, dated 2/9/11; Individual #190, dated 10/6/10; Individual #190, dated 11/3/10; Individual #190, dated 1/12/11; Individual #190, dated 1/26/11; Individual #269, dated 9/1/10; Individual #269, dated 12/15/10; Individual #269, dated 2/9/11; Individual #120, dated 9/15/10; Individual #120, dated 10/20/10; Individual #120, dated 12/1/10; Individual #120, dated 1/12/11; Individual #120, dated 1/26/11; Individual #120, dated 2/9/11; Individual #182, dated 9/15/10; Individual #182, dated 10/6/10; Individual #182, dated 11/17/10; Individual #182, dated 1/12/11; Individual #182, dated 1/26/11;

	and Individual #182, dated 2/9/11; o Individuals sent to ER for seizures; o Seizure medications, dated 2/10/11; o Individuals with status epilepticus, since last monitoring visit; o Individuals with refractory seizure disorder; o List of individuals seen by neurologist in past six months; o Individuals with refractory seizure disorder being evaluated for Vagus Nerve Stimulators (VNS); o Percentage of individuals on seizure medications taking two, three, four, and five anti-epileptic drugs (AEDs); o Percentage of individuals on seizure medications taking older AEDs; o Individuals with VNS; o Individuals with fractures and type within past six months: Ortho profile report from September 1, 2010 to February 22, 2011; o Individuals with injuries requiring ER/hospitalizations; o Individuals with osteoporosis and osteopenia, medications and dosages; o Dual Energy X-ray Absorptiometry (DEXAs) done for individuals over the age of 50 within the past six months; o Individuals with Down Syndrome, with thyroid test date; o Individuals with pica, with ingestion date and object; o List of Medical Department staff: January 2011, signed timesheets; o List of new PCPs to Facility; o PCP Continuing Medical Education Credits; o Medical Department completing Cardiopulmonary Resuscitation (CPR) and dates: active employee course participation report 2/10/09 to 2/10/11; o Number of individuals on each PCP's caseload; o State draft medical guidelines: Interdisciplinary Aspiration Pneumonia Prevention Algorithm, Clinical Pathway: Medical Management of Seizure Activity, Anticonvulsant monitoring pathway, Flow record: Seizure Management, Clinical Pathway: Anticoagulation, Clinical Pathway: Venous Thromboembolism (VTE) Screening and Prophylaxis Protocol; VTE risk assessment screening form, Clinical Pathway: Bowel Management and Constipation Prevention and Treatment; o LBSSLC policy: Health Services: Choking; o Clinical guidelines developed since last visit: LBSSLC- Health Services: Medical Care; o ER visits with discharge orders and follow up on following individuals: Individual #258; Individual #199; Individual #322; Individual #290; Individual #191; Individual #182; Individual #174; Individual #132; Individual #202; and Individual #253; o Skin Integrity Meeting minutes, dated 10/27/10; o Texas Department of state health services standard out-of-hospital do-not-resuscitate (DNR) order and Resuscitative status form (II or III) for the following individuals: Individual #52; Individual #63; Individual #195; Individual #199; Individual #15; Individual #138; Individual #14; Individual #269; Individual #167; and Individual #161;

	o Current DNR list, updated 2/2010; o Individuals with rescinded DNR: PSPA 10/22/10 for Individual #281; o Rate of autopsy completion; o Specialty clinics for past six months; o Provider morning meeting notes, dated 1/28/11 to 2/25/11; o Most recent non-Facility physician review for the following individuals: Individual #70 undated; Individual #204, dated 2/10/11; Individual #82, dated 2/9/11; Individual #193, dated 2/9/11; Individual #100, dated 2/9/11; Individual #138, dated 2/9/11; Individual #322, dated 2/10/11; Individual #237, dated 2/10/11; Individual #130, dated 2/9/11; and Individual #2, dated 2/10/11; o Blank copy of the non-Facility review form; o Sample of 90-day medication order review, and physician quarterly progress notes for the following: Individual #313; Individual #111; Individual #119; Individual #135; and Individual #128; o Medical records for the following: Individual #313; Individual #6; Individual #175; Individual #66; Individual #135; Individual #33; Individual #130; Individual #168; Individual #29; Individual #192; Individual #253; Individual #128; Individual #78; and Individual #156; o Combined list for Risk Discussion Meetings (Enteral Feeding, Pneumonia, and Pica); o Jejunostomy tube (J-tube) and Gastrostomy tube (G-tube) medications; o Clients on enteral feeding; o Antibiotic use per individual for past six months; o Memorandum: Pica List Plans, dated 1/12/11; o Slide presentation: "Prevent Pica!" dated 6/22/10; o Lubbock SSLC – Positive Behavior Support: Prevention and Treatment of Pica, revised 6/29/10, and 12/14/10; o Lubbock SSLC: Preventive Maintenance Work Order – numerous examples concerning environmental improvements that were pica related dating, dated 12/10 to 3/11; o Table format: Individuals that ingest inedible items; o LBSSLC Pica Behavior Reduction Plan, dated 3/10/11; o Pica Reduction Committee Meeting minutes, dated 5/13/10, 9/30/10, and 3/10/11; o Pica Prevention Critical Incident Meeting, dated 1/14/11, 1/20/11, and 1/21/11; o Pica: data from 4/10 to 1/11; o Training roster - Pica: root cause analysis, dated 1/14/11, and 1/20/11; o Pica Awareness/Training Group Meeting, dated 5/20/10; o Environmental Work Group meeting, dated 10/29/10, 1/21/11, and 3/11/11; o Pica workgroup meeting, dated 1/21/11, and 2/3/11; o Housekeeping Department Plan of Correction on pica issue, dated 7/12/10; attendance roster dated 7/12/10; o Housekeeping attendance roster: pica sweeps, dated 12/1/10; o Housekeeping attendance roster: in-service on string pica, dated 3/22/11; o Pica Awareness Workgroup/Pica Sweep Team meeting notes, dated 12/10/10;

	o Housekeeping Department Pica Check List; o Pica Sweep Checklist; o Deep Pica Sweep Checklist; o Two-hour Pica Sweep Checklist; o Prevention of pica behavior competency test; o Pica Sweep Checklist: Hearts and Hands, Estacado Industries Residential Services (EIRS), Estacado Industries Workshop (EIWS), Supported Work, Education, Gym, Lily, and Pine; o Outside peer review consultation – LBSSLC, dated 8/2/10 to 8/4/10; o Criteria for inclusion on the "list of persons requiring pica precautions," undated; o Behavior Support Peer Review Meeting Notes, dated 3/4/11, and 3/11/11; o Campus Coordinator Log Entries, dated 3/11; o Certification of completion of competency based training – behavioral services (several dates of training); o Plant Maintenance Training, dated 3/9/11; o Interagency Cooperation Contract Client Services (with Texas Tech University), dated 3/21/11; o Critical Incident Team Actions, dated 1/14/11, 1/20/11, and 1/21/11; o Physician follow-up log, campus coordinator log, daily clinic report for morning medical meetings of 3/29/11, 3/30/11, and 3/31/11; o Sample Medical Provider QA Audit – Results and Action Plans; o Action Plans follow up by QA; o Medical Provider Quality Assurance Audit Process; o LBSSLC Clinical/Administrative death reports incomplete/outstanding, dated 3/4/11; o Since last onsite review, a list of individuals who have been admitted to the Facility; who have died, including the date of death; and who have transitioned into the community, including the date of transition; o For the last year, a list of individuals who died either at the Facility, or after being transferred to a local hospital or other care setting, including name, age, date and time of death, and cause of death; o List of individuals with tracheostomies; o List of individuals with pneumonias in past six months who eat orally; o At risk – osteoporosis risk rating; o List of individuals during the past 12 months who have had a fecal impaction; o List of individuals receiving sutures or dermabond in the last year; o Clients on enteral feeding: Enteral feeding and frequency report, dated 2/1/11 to 2/28/11; o Individuals with BMI (body mass index) greater than 30, including the individual BMI; o List of individuals for the last year who have had unplanned weight loss of 10% or greater over six months; o List of individuals during the past 12 months who have had skin breakdown and have an active pressure ulcer within the last six months; o List of individuals during the past 12 months who have had a fall;

	○ List of individuals during the past 12 months who have experienced a fracture; ○ List of individuals treated for seizure disorder; ○ List of individuals with diagnosis of constipation and receiving medications; ○ List of individuals diagnosed with malignancy during the past year; and ○ List of individuals newly diagnosed within the past year for cardiovascular disease. ▪ **Interviews with**: ○ Glenn Shipley DO, MPH, Medical Director; ○ Ricardo Rodriguez, MD, staff physician; ○ Kimberly Leighton, MD, MPH, staff physician; and ○ Grazyna Thomas, PA-C. ▪ **Observations of**: ○ Individuals living in the Sparrow residence on 3/30/11, including: Individual #323; Individual #63; Individual #258; Individual #37; Individual #312; Individual #226; Individual #217; Individual #17; Individual #72; Individual #304; Individual #104; Individual #7; Individual #167; Individual #191; Individual #62; Individual #139; Individual #324; Individual #185; Individual #21; and Individual #89; ○ Individuals in Quail residence on 3/30/11: Individual #195; Individual #181; Individual #281; Individual #138; Individual #211; Individual #176; Individual #263; Individual #215; Individual #78; Individual #29; Individual #196; and Individual #283; ○ Morning Medical Meeting, on 3/29/11, 3/30/11, and 3/31/11; and ○ Pica Reduction Committee, on 3/28/11.
	Facility Self-Assessment: The Facility's POI provided a narrative description of steps it had taken to comply with the Settlement Agreement. This information was helpful in identifying progress that had been made. According to the POI, in order to begin to methodically address the scope of quality medical care, a medical database had been created which tracked many aspects of care, such as colonoscopies, mammograms, ER visits, hospital admissions, and restraint use. The system was still in the data collection phase, and it did not appear that there was routine review or analysis for trends, in part due to the small window of time included in the database. Going forward, as more monthly and quarterly information is added, a review process should be developed to measure compliance, and, as appropriate actions should be developed and implemented to improve underperforming areas of medical care. This data also should be used in the Facility's self-assessment process to substantiate compliance findings. According to the Facility's POI, a tracking system was in place to ensure updated licensing information, and that all primary care providers completed necessary Continuing Medical Education (CME) credits. The Facility reported that for the IPN section of the record, PCP quarterly progress notes were developed, and completed every 90 days to review health status, along with review of the renewal of medication orders. The Facility continued to have a quality medical care review by a non-Facility physician and the information was shared with the PCPs. The Facility reported that the QA Department was to follow outstanding issues to track improvement. In this area, the Facility believed itself to be compliant. This was not consistent with the Monitoring Team's findings for the reasons discussed below.

	The Facility reported that the Medical Director or designee was assigned as a member of the PNMT. In addition, the database for medical quality improvement was beginning to track PCP review and agreement/disagreement with outside consultant reports. Clinical guidelines for many health problems remained in draft form and awaited approval. The Facility determined it was noncompliant with sections L.1, L.3, and L.4. The groundwork for compliance continued to be built, but considerable work needed to be done in each of these areas. As the Facility moves forward in its self-assessment process, it will be important to utilize data to assess and substantiate compliance in all of these areas, in addition to the narrative descriptions of actions that have been taken and progress made.
	Summary of Monitor's Assessment: A continuing challenge for the Medical Department was ensuring routine, preventive, and emergency medical care consistent with current professional standards. With regard to Section L.1 of the Settlement Agreement, systems were in place to ensure quality with some aspects of routine assessments, such as the quarterly physician reviews, but there also were areas of concern, such as outdated annual examinations. Preventive care had improved, but remained in need of additional attention. There was a medical database, but concerns existed with regard to the quality of the data being entered, the completeness of the data entered, and the analysis and review of the data for trending purposes. Once several months of data are entered, the Medical Department should begin to trend and analyze the data to assist in ensuring preventive care. Emergency treatment appeared to be appropriate and timely. However, an area of remaining concern related to the prevention of the acute illness event. In other words, the Medical Department needs to move the focus of care to preventing acute illness by determining the causative factors leading to morbidity. The system of clinical death review and administrative death review was efficient and timely. There were no outstanding deaths to review except the most recent cases. All individuals appeared to have been provided quality medical care. A non-Facility medical peer review had been completed, and five percent of the records had been reviewed. For compliance to be achieved, the goal would be a 20% record review, which appeared to be the State's goal, based on a schedule submitted that showed quarterly reviews at each Facility. Additionally, consideration should be given to reviewing clinical quality, as well as the administrative aspects of medical care currently reviewed. The Medical Department's quality improvement initiatives remained rudimentary. This should be assisted with completion of the clinical guidelines. Some important data was being collected, but was not yet being analyzed or acted upon. For example, based on the fact that 27 out of the 33 individuals that had pneumonia had gastrostomy tubes (82%) suggested the need to review any aggravating factors that would

	exacerbate GERD, such as flat positioning, or bolus feeding, and the need to consider diagnostic testing to rule out the presence of GERD as another source of aspiration. Medications and surgical procedures might be indicated depending on the findings.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, mortality reviews, Do Not Resuscitate (DNR) Orders, and mock drills. <u>Staffing</u> There continued to be stability in the Medical Department. There were no new PCPs. The three PCPs were assigned caseloads between 66 and 76 individuals. The Medical Director carried a smaller caseload of 14 individuals. All the PCPs had been certified in Basic Life Support for Health Care Providers [CPR/Automatic External Defibrillation (AED)]. At the time the "Active Employee Course Participation Report" was run, all were current. However, one PCP had "date last taken" listed as 3/11/09. If this was a two-year certification and the PCP had not been recertified, this PCP was not current at the time of the Monitoring Team's visit. The Medical Department submitted a list of continuing education credits for the six months prior to the Monitoring Team visit for each of the PCPs. The list of topics was far ranging, including such topics as childhood mental illness, causes of secondary osteoporosis, critical care, constipation, urinary tract infections, exercise in the practice of medicine, Barrett esophagus, dyslipidemia, and chronic pain. Two of the PCPs had total continuing medical education credits listed. This included one PCP, who had 50 CME credits in the year 2010. Another PCP's documentation listed various totals, but the period of time was confusing. However, the numbers appeared adequate. The documentation for two other PCPs included copied certificates, and there was no final tally of total CMEs. The numbers again appeared adequate. One PCP had what appeared to be an overlap in time with CME credits, which made the totals inaccurate. According to the POI, all CMEs were tracked and kept up-to-date. However, the submitted information appeared to be copies of individual CME certificates. A copy of the database report would have assisted in determining CME credits per PCP per year. To ensure that the Medical Director is able to easily ascertain if PCPs have completed timely and adequate CMEs, if not already in place, the database should be used to summarize the	Noncompliance

#	Provision	Assessment of Status	Compliance
		CME certificates, including the number of CME credits in the given timeframe, along with a simple list of CME topics contributing to those credits. The majority of topics appeared to be appropriate to meeting the needs of the IDD population at LBSSLC. Physician Participation in Team Process Each business day, at the start of the day, there was a PCP morning meeting, attended also by nursing, pharmacy, and dentistry. The purpose was to review three documents: the campus coordinator log, a physician follow-up log, and a daily clinic report/log. Concise minutes should be written, rather than simply having three different forms as evidence of interdisciplinary discussion and communication. Those in attendance should be recorded. There also should be a column or other mechanism for documenting closure, which should include a brief comment on the closure, as well as the date of the closure. Clinical concerns, especially focusing on critical issues, such as preventing recurrence of pneumonia for an individual returning from the hospital, should be asked routinely, with follow-up recorded in these minutes. <u>Routine Care and Preventative Care</u> One measure of quality routine care is the timeliness of annual medical assessments and physical examinations. A document was submitted entitled: "Complete History and Physical from September 1, 2009 to March 15, 2011." The current physicals were highlighted, with prior annual assessments and physical dates provided for comparison and determination of timeliness. Forty-six annual medical assessments and physical evaluations were identified for review. Of these, 33 annual medical assessments and physical examinations were considered timely (365 days, or less, from the prior annual medical assessment and physical examination). These included the following individuals with the dates of the two most recent annual medical assessments and physical examinations: Individual #52, dated 12/9/09, and 11/23/10; Individual #38, dated 12/30/09, and 12/8/10; Individual #226, dated 2/12/10, and 1/13/11; Individual #77, dated 2/26/10, and 1/13/11; Individual #222, dated 2/3/10, and 1/13/11; Individual #82, dated 3/8/10, and 2/28/11; Individual #35, dated 2/4/10, and 1/25/11; Individual #100, dated 2/24/10, and 2/4/11; Individual #210, dated 7/15/10, and 2/8/11; Individual #306, dated 1/26/10, and 12/16/10; Individual #147, dated 2/5/10, and 1/27/11; Individual #296, dated 1/13/10, and 1/11/11; Individual #122, dated 12/29/09, and 11/22/10; Individual #284, dated 2/24/10, and 2/9/11; Individual #176, dated 2/11/10, and 1/10/11; Individual #275, dated 2/26/10, and 2/11/11; Individual #86, dated 2/4/10, and 1/11/11; Individual #60, dated 1/25/10, and 1/12/11; Individual #167, dated 2/12/10, and 1/26/11; Individual #14, dated 1/25/10, and 12/28/10; Individual #324, dated 2/12/10, and 1/26/11; Individual #134, dated 2/16/10, and 2/10/11; Individual #310, dated 1/15/10, and12/14/10; Individual #80, dated 2/10/10, and 1/4/11;	

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		Individual #316, dated 12/17/09, and 11/16/10; Individual #121, dated 3/5/10, and 1/27/11; Individual #115, dated 1/14/10, and 1/12/11; Individual #84, dated 2/17/10, and 1/25/11; Individual #192, dated 12/21/09, and 12/9/10; Individual #215, dated 2/11/10, and 1/10/11; Individual #89, dated 3/16/10, and 2/24/11; and Individual #90, dated 2/26/10, and 2/22/11. There were 13 overdue annual medical assessments and physical evaluations. These included: Individual #317, dated 2/25/10, and 3/10/11; Individual #56, dated 12/17/09, and 12/27/10; Individual #41, dated 12/17/09, and 1/10/11; Individual #74, dated 1/5/10, and 2/4/11; Individual #314, dated 1/7/10, and 1/11/11; Individual #99, dated 12/29/09, and 1/6/11; Individual #66, dated 12/21/09, and 12/23/10; Individual #237, dated 12/18/09, and 12/28/10; Individual #50, dated 1/28/10, and 2/4/11; Individual #178, dated 12/29/09, and 1/6/11; Individual #120, dated 2/4/10, and 2/10/11; Individual #230, dated 1/7/10, and 1/11/11; and Individual #162, dated 12/21/09, and 1/5/11. Compliance was 33 out of 46 (72%). Additionally, data entry irregularities were noted for individuals for whom annual medical assessments and physical examinations were submitted. Individuals for whom annual medical assessments and physical examinations were submitted included: Individual #63, Individual #77, Individual #222, Individual #317, Individual #35, Individual #100, Individual #74, Individual #147, Individual #296, Individual #50, Individual #275, Individual #86, Individual #120, Individual #134, Individual #121, Individual #115, Individual #84, Individual #215, Individual #89, and Individual #90. For seven of these individuals, the documents submitted were inconsistent with the information listed in the document "Complete History and Physical from September 1, 2009 to March 15, 2011," and represented a data entry error. More specifically: ▪ For Individual #63, the exam date was listed as 1/26/11, but the date of the actual annual exam was 1/27/11. ▪ For Individual #222, the exam date was listed as 2/2/10, but the date of the actual exam was 2/3/10. ▪ For Individual #100, the exam date was listed as 2/26/10, but the date of the actual annual exam was 2/24/10. ▪ Individual #50 had the exam date listed as 2/4/11, but the date of the actual annual exam was 2/10/11. ▪ For Individual #86, the exam date listed was 2/4/11, but the actual annual exam was 2/4/10, and 1/11/11 (there was only one date listed for this individual). ▪ For Individual #134, the exam date was listed as 2/10/10, but the date of the actual exam was 2/16/10. ▪ For Individual #215, the listed exam date was 1/12/11, but the actual annual exam was 1/10/11.	

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		These seven data entries occurred in 20 of the individuals for whom annual medical assessments and physical evaluations were submitted. This represented an error rate of 35% for information concerning annual evaluations. The data entry should be reviewed and monitored to ensure accuracy. Routine assessments were completed quarterly. Examples of these were submitted. The quarterly MD progress notes were completed on a typed form indicating allergies, chronic conditions, ER visits, hospitalizations, history of seizures with numbers of medications, date of last seizure as appropriate, presence of a feeding tube or not, respiratory status in last quarter, genitourinary/gynecological status in last quarter, current weight and weight change from prior weight, any consultations or procedures in past quarter, as well as acute care entries. These quarterly progress notes were usually synchronized with the 90-day medication orders, and the 90-day medication review. Individuals reviewed included Individual #313, Individual #111, Individual #119, Individual #135, and Individual #128. Each had these components completed. Reviews of mammogram completion in the eligible population, colonoscopy completion in the eligible population, thyroid tests for adults with Down Syndrome, and DEXA scans for individuals with risk factors were completed to assess preventive care. A list of women over age 50 was submitted, with the date of the last mammogram. Reasons for not completing mammograms in an individual over age 50 also were requested. There were 32 women identified as over age 50. Of these, three had compelling reasons not to pursue a mammogram, or delay the test indefinitely. For the 29 remaining individuals, there were 15 that had mammograms completed in the prior two years. Because the information submitted only included the year, and not the month or day, an assumption was made that those with a mammogram completed in 2011, 2010, and 2009 were in compliance with national standard of two years. Compliance was 15 out of 29 individuals (52%). A separate list indicated there were 34 women over the age of 50. The reason for the discrepancy between the two lists could not be determined. The standard the Monitoring Team used was the United States Public Health Task Force (USPSTF), which was not the standard set in the Facility's policy, "LbSSLC Health Services: Medical Care." The Facility standard according to the policy was a yearly mammogram starting at age 40. Complete information was not available for those individuals under the age of 50, but for those 50 years of age and over the compliance rate dropped. Eighteen individuals would have been considered overdue according to the Facility policy, and this resulted in a compliance rate 13 out of 31 (42%) for those listed. A list of individuals over the age of 50 was submitted, along with the date of the last	

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		colonoscopy. Although some colonoscopies were likely due to diagnostic work-ups/ evaluations due to problematic signs and symptoms, the data could not be differentiated. The data included a colonoscopy for any cause. The total included 84 individuals over the age of 50, but three were just at age 50, and one was a new admission. The Facility likely would not have had time to coordinate such testing, and these four individuals were not counted into the eligible population of 84 for which testing was recommended. There were five individuals for whom an adequate reason justified not pursuing this preventive test. There remained 79 individuals who were recommended to have a colonoscopy. Of those, 15 were found to be overdue, and 64 had completed the colonoscopy. This was a compliance rate of 64 out of 79 (81%). Again, small differences were noted in the number of men and women age 50 and over submitted on different lists, but the difference of two individuals was not considered significant for the purpose of this discussion. Recommendations for adults with Down Syndrome include an annual thyroid test, for the Thyroid Stimulating Hormone (TSH). The Facility submitted a list of individuals with Down Syndrome, and the date of the last thyroid test. Six individuals were identified. Of these, all had a TSH test, along with additional thyroid tests, within the prior year. This resulted in a 100% compliance rate. The Facility submitted the results of DEXA scans for those over the age of 50 that were completed in the prior six months. Eight DEXA scan reports were submitted. Of these, five indicated high risk of fracture, and three indicated low risk. DEXA scans are recommended every two years for those at risk for osteoporosis, and those on treatment for osteoporosis. Given the numbers of conditions at LBSSLC that contribute to osteoporosis, such as seizure medication, it was problematic that only eight DEXAs were completed in six months, for an annual testing rate of only approximately 16 DEXAs per year. It was further problematic that over half of these tested had T-scores (number of standard deviations above or below the young adult mean) indicating osteopenia or osteoporosis. Based on the information submitted, the low numbers of DEXA scans, and the high rate of finding osteopenia and osteoporosis suggested that this test was not ordered in a timely manner for much of the population residing at LBSSLC who were at risk for osteoporosis and osteopenia, or who are on treatment for these disorders. There were 24 individuals prescribed Calcitonin, 47 prescribed Alendronate for osteoporosis, and 14 prescribed Alendronate for osteopenia. National recommendations indicate the need for serial follow up DEXA scans to determine if the treatment is having a positive impact on bone architecture. Based on the information provided, the Medical Department should review this area of medical prevention and treatment/testing to ensure timely DEXA scans are ordered and completed to assist PCPs in the diagnosis of and determining the effectiveness of treatment of osteoporosis.	

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		The POI indicated that as of 9/1/10, the medical database tracked all screening examinations that were completed or attempted. Given the low completion/compliance rate mentioned in some of the preventive tests (mammograms, colonoscopies, etc.), problems continued to exist. The Medical Director should review the database to ensure the quality of data entry, and also have a system of periodic review and follow-up of data. Identification of overdue and persistently overdue evaluations should be discussed with the PCP. The Medical Director played a key role in promoting immunizations with the employees at LBSSLC, to attempt to create a well-immunized work force resulting in a natural barrier to the spread of contagious illness on the campus. This occurred on 3/14/11, through email correspondence from the Medical Director to all employees concerning hepatitis B. However, similar correspondence should have been sent in the fall of 2010, prior to the influenza season, but was not. The Medical Director should discuss with the infection control nurse ways to promote employee vaccination for the upcoming flu season, so that a plan is ready for implementation when the vaccine arrives in the pharmacy. The POI also stated the Medical Director discussed the need for vaccination at providers meetings and IMT. A sign-in sheet with the topic and the Medical Director's signature should be maintained to verify this is ongoing. Additionally, the POI documented that the infection control nurse had created a database for employee vaccinations, which could be a valuable tool in focusing on those employees not vaccinated. <u>Medical Management of Acute and Chronic Conditions</u> The Facility provided a number of on site specialty clinics for the convenience of the individuals. This included Neurology Clinic (on the following dates: 9/1/10, 9/10/10, 9/15/10, 10/6/10, 10/15/10, 10/20/10, 11/3/10, 11/17/10, 11/19/10, 12/1/10, 12/3/10, 12/15/10, 1/12/11, 1/21/11, 1/26/11, 2/9/11, an d2/18/11), Vision Clinic (on the following dates: 9/3/10, 10/1/10, 11/5/10, 12/10/10, 1/7/11, and 2/4/11), Gynecology Clinic (on the following dates: 9/8/10, and 2/16/11), Podiatry Clinic (on the following dates: 9/22/10, 10/20/10, 11/17/10, 12/22/10, 1/26/11, and 2/16/11), ENT Clinic (on the following dates: 9/24/10, 10/22/10, 11/12/10, 12/10/10, 1/7/11, and 2/25/11), Endocrinology Clinic (on the following dates: 9/29/10, 10/27/10, 11/24/10, 12/22/10, 1/27/11, and 2/23/11), and Urology (on 1/3/11). The Medical Department submitted copies of a number of neurology clinic consultation reports. They were concisely written, and included a list of the participants, including the PCPs, psychiatrist, pharmacist, etc., as well as a brief review of the recent seizure record, current anti-epileptic medication regimen, and any recommendations for	

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		changes of medication and lab work to be ordered. The next follow-up interval also was recorded. If there was VNS adjustment, details were provided. Thirty-two consult reports were reviewed, and quality of care and completeness of documentation was consistent throughout the clinic reports. With regard to the treatment of seizure disorders: ▪ Facility information also indicated that five individuals had had a VNS placed. One individual, Individual #120, had a VNS placement since the Monitoring Team's last visit. ▪ The Facility submitted information that 47.1% (49 out of 104) of the individuals on antiepileptic drugs were on "older" antiepileptic drugs. This was not defined, but likely included Phenobarbital and Dilantin. It was not clear if other medications were included in this category. However, the Facility ensured adequate neurology consultations, with oversight of side effects and drug interactions to ensure these medications continued to be appropriate choices. ▪ The percentage of individuals with seizures on one anti-epileptic drug was 45.2%, 28.8% required two AEDs, 14.4% required three AEDs, 7.7% required four AEDs, and 2.9% required five AEDs. ▪ Seven individuals were categorized as having a refractory seizure disorder. Six of these had seen the neurologist in the past six months. One individual, Individual #48, was not listed, and there was no further information provided. Given the category of severity of the individual's seizure disorder, this might be problematic, depending on the type of seizure, and whether she used a community neurologist instead of the on-site clinics. ▪ The Facility reported no status epilepticus requiring ER treatment or hospitalization documented since the Monitoring Team's last visit. However, a separate document indicated that four individuals were seen in the ER for uncontrolled/prolonged/new onset seizures since 9/2010, suggesting some individuals continued to have challenging seizure disorders. Individuals at the Facility had experienced decubitus ulcers. The number of decubiti per month varied from zero to eight. The information did not indicate how many individuals were affected in each month, a statistic that should be used for tracking. However, it was noted that there were more decubiti from August 2010 to January 2011, than in the prior six months (32 versus 18), suggesting the need for increased surveillance and attention to prevention and risk factors. On 10/27/10, a Skin Integrity Committee Meeting was held, and three individual cases were reviewed. A plan of action was included for each of the individuals. An additional individual had a pressure ulcer, but it had healed. It appeared the committee was used as an information-sharing meeting for the members, and the committee provided an	

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		administrative approach to monitoring decubitus care. The Committee appeared to meet infrequently, reducing the ability of the committee to perform this function. To review the clinical care and documentation of acute care, a number of records were reviewed that included documentation of the period(s) of time prior to the ER visits and immediately following the ER visits. The following provide some examples: ▪ Individual #258 was noted not to be voiding, and taking little fluids by mouth. The parents had been asked to consider a feeding tube in the past and refused. He was offered Pedialyte, but took only insufficient amounts. He was referred to the ER on 2/27/11, at which time a Foley was placed for output measurement. He continued to take little by mouth for the remainder of 2/27/11, but did improve with regard to intake on 2/28/11. There was a detailed physician IPN completed on 2/28/11, reviewing the ER visit, recording the fluid intake and urine output. In this IPN, an examination was recorded with observation that the individual was lethargic, with no acute distress. An abdominal exam was recorded, indicating positive bowel sounds, soft, and questionably distended. There was no cyanosis of extremities. The note was continued on the next page, which was not copied, but he was transferred an hour later back to the ER for evaluation. Considerable lab testing was completed. He was given three liters of fluid IV, and his urine output increased, after which he was returned to LBSSLC. The ER contacted the mother about a feeding tube, and she believed his limited intake was behavioral and not permanent, which led to his return to LBSSLC. On 3/1/11, the PCP dictated a note, but the dictation was apparently cut off and did not indicate the plan of how to improve his oral intake, the monitoring steps, or any discussion about a PST meeting to assist in resolving this recurrent problem. These areas might have been documented in the IPN, but were not submitted for review. ▪ On 2/3/11, Individual #199 had a G-tube replaced. On 2/14/11, he pulled out his G-tube. He was sent to the ER for G-tube replacement. He had developed an abrasion at the G-tube site. Local treatment was provided, and an abdominal binder was placed. A consult was ordered for a Mickey button. On 2/16/11, he again pulled the tube out, when his abdominal binder was not in place. On 2/17/11, there was a typed note reviewing the most recent ER visit and current plan. The note called the tube both a J-tube and a G-tube, which was confusing. It was also confusing as to which ER visit was discussed (the date of the ER visit referenced was not listed), as subsequently, there was another typed note specifically in reference to the 2/16/11 to 2/17/11 ER visit. Another typed PCP note indicated that on 2/17/10, he again pulled his G-tube out despite the abdominal binder being in place. It was replaced at LBSSLC. There were no sequelae. The PCP mentioned one-to-one supervision, until the Mickey button was placed, but only used the term "consider." On 2/27/11, an IPN the nurse	

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		wrote indicated the G-tube was replaced with a Mickey button. There was no PCP typed note submitted concerning return to LBSSLC after the outpatient procedure. The Medical Department should create a policy or guideline concerning prevention of dislodging feeding tubes. This might need to include such steps as an abdominal binder, as well as other clothing that makes the tube less accessible, as well as one-to-one supervision at an earlier stage to prevent unnecessary trauma and needless ER visits. ▪ Individual #322 was sent to the ER on 2/8/11 for swelling of her ear. A typed note by the PCP indicated the ER physician had prescribed Augmentin, but already was taking Cipro and Keflex. The PCP believed she had a seroma. Augmentin was not started as the ER physician recommended, but a note indicated continuation of the previous antibiotics. This was a brief, but clear note with a plan outlined, and reasons listed for not placing her on Augmentin (already on two other antibiotics). ▪ On 2/18/11, Individual #290 was sent to the ER, after falling from his bed during a seizure. He sustained a laceration to his head. There was a typed PCP note summarizing the ER visit. There was no ER note available at the time of transcription, and the PCP called the ER physician for a review of the ER visit. There was a follow-up note written on 2/22/11, concerning the healing of the laceration and breakthrough seizures. There should be collaboration between LBSSLC Medical Department and the ER concerning ensuring the ER report is forwarded with the individual back to the campus. If it is sent, it should be tracked to ensure the PCP reviews it in a timely manner. ▪ On 2/15/11, Individual #191 developed abdominal distention with vomiting. He also had a loose bowel movement. Vital signs were taken 30 minutes apart, and pulse oximetry indicated a saturation of 89 to 90% on three liters per nasal cannula. Oxygenation improved to 98% on four liters per nasal cannula. The PCP was contacted, and Individual #191 was referred to the ER. The IPNs documented the nursing review, and appropriate contacting of the PCP for referral, as he was considered unstable at the time of transfer. He returned early on 2/16/11, as the ER recorded normal oxygenation and a non-distended abdomen. On 2/16/11, the PCP had a typed entry reviewing the ER visit. There was a PCP IPN reviewing a 3/4/11 GI office visit for reflux and constipation. ▪ On 2/15/11, Individual #182 was referred to the ER. According to a PCP note, he was lethargic with low blood pressure. He ate breakfast without problems. The PCP contacted the ER physician, and discussed the referral for possible elevated anti-epileptic drug levels or an infection. He returned the same day, because all blood levels and blood work were normal. According to a follow-up PCP note on 2/16/11, he was more alert. In this case, the PCP was able to instruct the ER physician about the concerns, and able to have these concerns ruled out.	

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		▪ On 2/10/11, Individual #174 was sent to the ER due to self-injury to both hands while agitated. A PCP note from 2/11/11 reviewed the ER course, and included a follow-up evaluation of his hands. There was both a hand written and typed PCP entry. In neither note was there a request or consideration for further behavior consultation intervention. Considering he had severe behaviors and fractures had to be ruled out, contacting and documenting communication with the Psychology Department would be important. ▪ On 2/28/11, Individual #132 was sent to the ER for a laceration to his forehead after a fall. A PCP note earlier in the day, on 2/28/11, indicated concerns regarding whether he had completed a neurology visit to an in-town neurologist, because the record was incomplete or confusing. He had three seizures in a 24-hour period, and apparently, it was not clear from the record whether he received Diazepam after the second seizure. There appeared to be no follow-through to resolve these questions and concerns. There was another PCP note reviewing the fall on 2/28/11, which he sustained while getting off the van. In the ER, he underwent a Computed tomography (CT) scan of his facial bones, which indicated a displaced fracture in the bony architecture surrounding the left eye, which was new since the last CT scan of 11/21/09. He was seen in the clinic for follow-up on 3/1/11, but there was no mention of this finding, and whether or not it was related to the recent trauma, or clinically more remote, and if it had been treated. ▪ On 2/16/11, Individual #202 was sent to the ER for a fever. Earlier in the day, a number of tests had been completed to pursue the source of the fever, but there was no source indicated. He returned from the ER with a diagnosis of bronchitis, and was given a prescription of Doxycycline. The ER recorded that the individual was sent in for a work-up of a fever, and the sitter was unable to provide any other information, such as when the fever started, or if there were other signs and symptoms. The sitter stated that the individual was sent in for possible pneumonia. On review of the Integrated Progress Notes and the ER record, it was clear the ER was not certain of the history other than a fever, and there was no information to indicate the ER was informed that the individual had recurrent pustules on his abdomen. On 2/16/11, his temperature was 106. With little history to provide clinical direction, the ER did a urinalysis and chest x-ray, and sent him back to LBSSLC. The PCP at LBSSLC only provided a brief entry on the ER sheet to indicate it was reviewed, and then wrote a brief entry stating the PCP had found two boils in the left axilla, presumably on further physical examination, and ordered Bactrim and Rocephin to address it, rather than going along with the ER recommendation for Doxycycline. What would have improved clinical care was good communication from the PCP to the ER, through either a telephone call or a written summary. This did not seem to occur, as the ER had to rely on the sitter. Additionally, the PCP should have	

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		written a complete note, or better yet, a typed entry (the penmanship was difficult to read), outlining the decision to send Individual #202 to the ER, the ER findings, and the new findings back at LBSSLC, resulting in the change of medication. ▪ On 2/17/11, Individual #253 was sent to the ER, when the nurses noted that his enteral feeding tube had been pulled out about four inches. The ER note did not mention this history, but recorded the history from the staff that the tube leaked when medication or anything else was administered through the tube. The ER radiographically checked for appropriate placement. A PCP note reflected that the ER evaluated his J/G-tube for placement, and that it was adequately placed. The note included a quick review of the vital signs and mental status. On 2/19/11, Individual #253 again was sent to the ER for a dislodged J-tube. This was reinserted by the GI service at the local hospital. The PCP note reviewed this second ER visit, and that he had been placed on enhanced supervision until the following day. The history the ER recorded was different than the PCP reason the individual was sent to the ER. The Medical Department should conduct a review to ensure the ER receives accurate information. Standardization of the process of transferring critical information might not be occurring. It is also recommended that a staff member knowledgeable about the individual's current condition accompany the individual to the ER, at least initially to provide accurate detailed history to the ER. Several records were reviewed of individuals who had risk factors related to chronic conditions, to determine the risks the PST had identified, and to determine if adequate medical treatment was being provided in response to these risks. The following summarizes the results of this review: ▪ Individual #313 had diagnoses of seizures, osteoporosis, and chronic constipation. He was hospitalized from 9/21/09 to 9/24/09 for dehydration, constipation, and pneumonia. On 1/2/10, he was seen in the ER for decreased mental status and found to have an elevated Dilantin level, and the medication dosage was adjusted. He was hospitalized from 3/19/10 to 3/30/10, originally treated in the ER for fecal impaction, but then returning with hypoxia and admitted with health care acquired pneumonia. He had a long history of constipation. On 8/2/07, a colonoscopy revealed a normal exam. An abdominal x-ray on 1/4/11 showed a "large amount of fecal loading throughout the colon." On 2/4/11, he underwent a colonoscopy, but was found to have an inadequate response to the bowel preparation, and this was rescheduled for 3/4/11, and successfully completed. The indication was for possible colitis on an abdominal CT. Findings included mild inflammation throughout the colon. His current medications for constipation included Bisacodyl, magnesium hydroxide, Miralax, and Lubiprostone. He appeared to be on a maximal medication regimen. If the	

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		constipation continued to worsen, consideration should be given to completing bowel motility studies to determine if there is a section of the bowel that has lost peristalsis/motility. A referral to a colorectal surgeon for evaluation might be indicated. A DEXA scan on 10/22/10 indicated decreased bone density, but improved from the prior DEXA of 2008. He received Alendronate, but no calcium because the dietician calculated his calcium requirements were met in his diet. However, no mention was made of Vitamin D supplementation, also essential in osteoporosis treatment. ▪ Individual #6 had GERD; anemia; a history of fundoplication; was hospitalized from 1/8/10 to 1/20/10 for sepsis; from 4/19/10 to 4/24/10 for fever and vomiting, and underwent a cholecystectomy; from 6/12/10 to 6/18/10 for hypernatremia, dehydration, and pneumonitis; from 6/20/10 to 6/24/10 for a urinary tract infection (UTI), hypernatremia, and aspiration pneumonia; and underwent a Percutaneous Endoscopic Gastrostomy (PEG) placement on 6/21/10; was hospitalized from 6/30/10 to 7/6/10 for C difficile colitis and fever; and from 11/26/10 to 11/30/10 for sepsis due to C difficile colitis, acute renal failure, and hypokalemia. He had significant weight loss until the G-tube was placed, and regained 25 pounds in six months. On 1/26/11, he was sent to the ER for a leaking G-tube, and a part of the G-tube was replaced. More recently, he vomited on 2/3/11, 2/22/11, 2/28/11, 3/1/11, 3/2/11, 3/7/11, 3/17/11, and 3/18/11. He pulled out his G-tube on 3/4/11. On 2/28/10, the PCP considered a J-tube extension to his G-tube. There was no further follow-up information about placement of a J-tube extension, or consideration of placement of a jejunostomy tube. Further, there appeared to be no further evaluation of the frequent vomiting. It was not clear whether consideration had been given to determining if the fundoplication was intact or had become unwrapped. Further evaluation of the GERD would have been suggested, due to the frequent vomiting in an individual with a history of dehydration and severe weight loss. ▪ Individual #175 also had been hospitalized for pneumonia from 2/25/10 to 3/3/10. Several months later, on 9/20/10, she was sent to the ER for multiple episodes of vomiting. The GI work up was challenging due to her behavior. She was being evaluated for gastric outlet obstruction, and constipation. The PCP note indicated a general surgery consult for possible fundoplication. She had a history of GERD and hiatal hernia. On 10/18/10, she was then sent to the ER for decreased mental status and hypotension. She returned to the Facility on 10/28/10, with diagnoses of acute respiratory failure and hypotension. She was noted to have intermittent emesis after she returned. During this admission, she had developed a stage II decubitus ulcer on her back. On 11/2/10, she was sent again to the ER for anemia and emesis (an emesis data sheet had been started), and on 11/3/10, returned to LBSSLC with a diagnosis of hypoxia and obstructive	

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		apnea. Reglan was added back at a low dose prior to this hospitalization, because she had an episode of emesis prior to the hospitalization and had a history of gastroparesis. On 1/8/11, she choked on a potato. She was known to be an unsafe eater. It was reported that staff did not believe they were able to intervene and slow her eating pace. She did not have complications from the choking event. Her diet was changed to ground texture until an OT evaluation was completed. On 1/24/11, Individual #175 was admitted to the hospital for respiratory distress and decreased oxygen saturation (86 to 88%), along with a change in behavior. On 1/26/11, she was discharged with diagnoses of decreased mental status, hypoxia, and dehydration. She received a five-day course of Levaquin and Zithromax. The PCP had called the chief radiologist and discussed the x-ray report of pneumonia, informing the radiology department of lack of cough or fever or other symptoms, which would suggest pneumonia. Throughout this time period, there were many adjustments to her psychiatric medications, because her behaviors escalated. This included on 9/2/10, starting Tegretol and Zyprexa was increased, an emergency dose of Ativan on 9/23/10, restarting Klonopin on 9/24/10, increasing her Zyprexa and Tegretol on 9/28/10, decreasing her Klonopin on 10/29/10, and increasing Tegretol on 1/11/11. With a history of GERD, and episodes of respiratory distress and hypoxia, the severity of her GERD should have been determined. There was a note concerning consultation for a fundoplication, but the submitted documents did not include any follow up as to whether the fundoplication had occurred or was scheduled. There was also little documented follow-up concerning the severity of her constipation. The direct support staff also realized the BSP and dining plan to slow her eating rate were not adequate, but the plan(s) was not adjusted to address these concerns. ▪ Individual #66 had a well-controlled seizure disorder. Her DEXA on 2/6/09 was read as a T score of -3.3. There was one scheduled for 2/26/10 but it was canceled as she was hospitalized. There were no further DEXA scan reports submitted. She was prescribed Vitamin D, Calcium, and Alendronate. Due to severe dysphagia, she had a G-tube placed. She had aspiration pneumonia 9/13/09, pneumonia 9/27/09, hypotension with ER visit 10/10/09, aspiration pneumonia 2/19/10, wheezing with ER visit on 4/17/10, decreased level of	

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		consciousness with ER visit 5/25/10, aspiration pneumonia 9/10/10, She had a laparoscopic cholecystectomy on 3/7/11, and post operatively developed lethargy and sent to the ER 3/10/11. She was sent to the ER for acute renal failure and found to have bacterial cystitis on 3/18/11. She was sent to the ER 3/22/11 when she was found unresponsive, not breathing and pulseless. She was resuscitated with rescue breathing. She recovered quickly. There was little further information submitted about the cause or work up of this event. With the continued aspirations despite a G-tube, it is recommended that a work up for GERD be considered. She may be a candidate for further medical or surgical options. From the submitted information, there appeared to be no next step for treatment of her recurrent aspiration pneumonias. There did not appear to be any further DEXA completed after the 2/10 DEXA was cancelled due to hospitalization. ▪ Individual #135 had a history of significant pica, including ingesting coins. There were a number of ingestions over the prior six months. On 3/12/10, he had a colonoscopy to remove coke caps, coins, and plastic paper. On 5/17/10, he had a colonoscopy to remove foreign bodies. He continued to ingest coins and other objects, and serial x-rays were used to track the objects until expulsion. If not already done, it is recommended the team meet to discuss possible precursor behaviors or gestures, which would prompt increased vigilance. Given the frequency of the habit, the level and quality of supervision should be reviewed. Additionally, the environmental safety had not been assured. More frequent sweeps or administrative monitoring might assist in reducing the incidences of pica. ▪ Individual #130 had been stable this past quarter. He had a well-controlled seizure disorder, and active diagnoses of constipation, and GERD/reflux. He also had Chronic Obstructive Pulmonary Disease (COPD), and continued to smoke. Based on a DEXA scan of 2008, he had a diagnosis of osteoporosis. There was no indication of a current DEXA scan, which was due in 2010. Although he took Alendronate and an upper gastrointestinal endoscopy (7/27/10) indicated both gastritis and reflux esophagitis, the record was difficult to follow concerning treatment. He was treated for H pylori infection based on biopsy from the endoscopy. Treatment occurred on 11/2/10. The annual medical summary/physical examination of 10/15/10 indicated he was prescribed Omeprazole, but the order sheets did not included orders for this medication. The PSP mentioned that an electronic cigarette flavor would be attempted, in order to assist in smoking reduction. There was no information submitted to determine if this was accomplished or successful. Considering his diagnosis of COPD, smoking cessation would be an important consideration. The PSP also mentioned continuous counseling on benefits of smoking cessation, but there was no information concerning implementation of this step.	

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		▪ Individual #168 had diagnoses of seizures, osteoporosis, constipation, and GERD. He had pneumonias diagnosed on 1/2/10, and 2/11/11. He was hospitalized in 4/09 for phenobarbital toxicity, and on 4/28/09 for a gastrointestinal bleed. His last DEXA scan from 5/27/08identified a T score of negative 5.2. A repeat DEXA was ordered on 1/13/11, but the results, if completed were not submitted. On 1/27/11, he was switched from Alendronate to IV Reclast. He was also prescribed Miacalcin, Testosterone, calcium, and vitamin D. If one has not been created, a database for tracking DEXAs would be appropriate in this population at risk for osteoporosis. ▪ Individual #29 had several trips to the hospital for respiratory problems: 5/18//10-5/20/10 status asthmaticus, 7/9/10-7/10/10 airway obstruction due to secretions, 8/18/10-8/20/10 left upper lobe pneumonia, 9/30/10 ER visit pneumonia or bronchitis, 10/1/10-10/4/10 right lower lobe and left lower lobe pneumonia, 10/5/10-10/6/10 pneumonia, 1/8/11-1/10/11 pneumonia. He had had a G-tube since 2/88. He had a diagnosis of GERD, but there was no information to determine if this was considered a significant factor in his bronchospasm and pneumonias. If this had not been completed recently, a work up for GERD is indicated to ensure it is not causing aspiration and bronchospasm, or to treat medically/surgically as appropriate. The PNMT had followed him closely, and had contributed a number of recommendations such as a HEPA filter to reduce the potential of environmental allergies as a contributor to his pulmonary disease. There was also extensive focus on positioning. ▪ Individual #192 was hospitalized twice in 2010, from 2/27/10 to 3/5/10 for dehydration and acidosis. She was again hospitalized from 3/6/10 to 3/16/10 for dehydration, acute renal failure due to dehydration, and sepsis. A modified barium swallow (MBS) at that time indicated the need for nothing by mouth (NPO) status. However, this was declined. On 8/2/10, he had an MBS with findings of mild dysphagia, and recommendations for a pureed diet with thin liquids, and honey thickened liquids, if she refused to drink thin liquids. On 3/5/11, she choked on Jell-O, but spontaneously recovered. On 10/27/10, she again choked, although the food item was not identified in the IPN. On 9/3/10, she had skin breakdown on her back. On 10/27/10, she also was noted to have skin redness on her back, which looked like a friction type lesion. It was presumed to be due to an ill-fitting wheelchair, but there was no next step described about ensuring she had a properly fitted wheelchair, which was considered new. Limited documents were submitted, but there did not appear to be an increased concern after the first or the second choking spell. The PNMT would be expected to review these events. Additionally, no information was provided about whether the new wheelchair was going to be reviewed to ensure the recurrent skin breakdown did not occur, if it was from the wheelchair.	

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		▪ Individual #128 had a long history of dysphagia, and was fed via a G-tube. She was hospitalized from 1/22/10 to 1/26/10 for pneumonia (suspicious for aspiration). A nuclear medicine scan for gastric emptying indicated that she had normal function. On 11/16/10, an MBS was completed. She had silent aspiration of nectar liquids. She also had a history of aspiration of vomitus. The vomiting might have been due to poor positioning. Recommendations included pleasure feeding of pureed solids, and teaspoon sips of honey liquids. Only regular experienced staff were to work with this individual. Her main nutrition and hydration were through the G-tube. Given her complex medical care, the team provided quality of life through pleasure feeding. On 9/27/10, Individual #128 was sent to the ER for projectile bowel movements. Findings were negative and she was returned. She recovered uneventfully. On 10/27/10, she also completed a DEXA scan, and the T score was negative 2.9. This indicated osteoporosis, for which she was taking the appropriate dosage of Alendronate. She also was taking calcium and Vitamin D supplements. She had a history of nephrolithiasis and frequent urinary tract infections. She was followed by Urology, and was frequently prescribed antibiotic for recurrent UTIs. Her care appeared to be thorough and well organized. ▪ Individual #78 had a tracheostomy and a G-tube. She was admitted to the hospital for pneumonia form 4/18/10 to 5/3/10, and was admitted to the hospital from 11/16/10 to 11/22/10 for pneumonia. Due to her GERD, on 1/4/11, a hospital bed was ordered to keep the head of the bed elevated 30 to 40 degrees at night. Her medical care appeared to be maximized. According to the PNMP, correct positioning was essential to preventing aspiration and reflux. It would be important to conduct unannounced observations on all shifts to ensure correct positioning. ▪ Individual #156 had a history of SIB and aggression. He was seen in the ER on 3/1/10, sustaining a right wrist fracture. He also had a history of constipation, and took Miralax daily. Despite this, he required a number of enemas during the past six months, including on 9/20/10, 9/24/10, 10/2/10, 10/23/10, 11/6/10, 12/7/10, 12/12/10, 1/3/11, and 2/5/11, and magnesium citrate on 10/23/10. There did not appear to be an attempt to add a second bowel management medication, or to reduce medications with increased anticholinergic activity. It would be expected that when there are serial prn medications given for constipation, consideration be given to adding routine medication for constipation to a medication regimen. ▪ Individual #7 was listed as having a jejunostomy tube. The 183-Day Medication Orders dated 9/1/10 through 2/28/11 listed three categories of tubes, J-tube, and G-tube, and "per" tube. If there was only a J-tube, then the order sheet	

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		needed to be updated to avoid confusion. If there was no G-tube, then nursing should have clarified the administration of those medications listed as per G-tube. Sucralfate should not be administered through a J-tube, as it bypasses the gastric lining for which it is intended. If this individual only had a J-tube, then the order for Sucralfate needed to be reviewed. ▪ Other individuals with J-tubes should routinely have medication orders reviewed to ensure medications remain effective when administered through a J-tube. For instance, Individual #176 and Individual #72 were both prescribed Levofloxacin, but this class of antibiotics is associated with erratic absorption through J-tubes. According to a 2/1/11 through 1/28/11 list, there were a total of six individuals on J-tubes. <u>Mortality Reviews</u> There were four deaths reported from October 2010 to March 2011. There were two autopsies completed, for an autopsy rate of 50%. The following summarizes the review of these deaths: ▪ For Individual #261, a clinical death review was signed on 3/14/11, and an administrative death review was signed on 3/21/11. This individual was initially seen for blood from a colostomy on 5/9/10, complicated by hypertension, and congestive heart failure. The individual developed sepsis, gangrene and wound dehiscence. She underwent a total colectomy. The individual was then placed in a long-term acute care facility for recuperation. The individual returned home on 7/30/10, but was readmitted to the hospital three times in August. One hospitalization was for a UTI, and there were two hospitalizations for dehydration, and there were complications of elevated potassium, pneumonia, and renal failure. In 10/10, a pressure ulcer developed on the right heel. Due to the relentless downhill course, a family member placed the individual on Resuscitative Status III, which is DNR and only palliative care is allowed. The PST and the Ethics Committee agreed with the decision. Hospice then became involved in August 2010 in providing palliative care. The final cause of death was sepsis, pneumonia, and cerebral palsy. The clinical death review committee agreed the care was appropriate. The shortened bowel was considered a contributing factor to her decline. She died peacefully at the hospital. This individual appeared to have had the appropriate diagnostic work-ups, monitoring, and timely treatment. Good clinical judgment was illustrated throughout the medical record. ▪ For Individual #243, a clinical death review was held on 11/9/10, and an administrative death review on 12/13/10. This individual had a rapid decline. There were several days of meal refusals, up to two meals each day, but this might not have been reported to nursing. Her PCP saw her on the morning of her demise, and there were no findings. She increasingly became confused and	

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		combative as the day progressed. She became unsteady on her feet. As she became more agitated and restless, a pulse oximetry reading was obtained. It was low at 82%, at which time EMS was called. She died later that evening. There was no autopsy performed and cause of death remained speculative. Discussion focused on pneumonia with septic shock, or an acute abdomen. The final cause of death was determined to be multi-organ system failure and cardiac arrest. Medical and nursing care appeared to be appropriate and timely, based on information provided to them. The communication between the direct support professionals and the medical staff might have been problematic. ▪ For Individual #228, a clinical death review committee meeting was held on 3/14/11, and the administrative death review committee met on 3/21/11. The clinical death review committee determined care was appropriate. She was admitted to the hospital for aspiration pneumonia. She was noted to have a large opacity of the right lung from a large hiatal hernia or bowel loop. She underwent an esophagogastroduodenoscopy (EGD), and a PEG tube placement could not be completed due to a deformed stomach. An open jejunostomy tube was placed due to the anatomic anomalous positions. She then developed bilious emesis. Further work-up of the J-tube indicated it was correctly placed. She then developed abdominal distention with fever, and aspirated again. This led to hypotension from sepsis, and she did not survive. Prior to the prolonged and terminal hospitalization, there were several episodes of emesis, which appeared not to have been brought to the attention of the physician. After she was hospitalized, she continued to vomit and have additional aspiration. Once the acute care episode began, care was appropriate and timely. ▪ Individual #194 had a cardiac history, including prior mitral valve repair, and pacemaker placement. He developed low back pain and was sent to the hospital for evaluation. In the two weeks prior to his death, he underwent an extensive work-up for his back pain. During the clinical work up, mental status declined. A CT scan revealed a large bleed into his brain. An autopsy was performed, and this was considered a complication of infected heart valves. Because of clinical brain death, care was withdrawn. Care was appropriate and timely. The death was too recent, and the autopsy report became available on 3/11/11. The clinical and administrative death reviews had not occurred. The system of clinical death review and administrative death review was efficient and timely. There were no outstanding deaths to review except the most recent cases. All individuals appeared to have been provided quality medical care. <u>Do Not Resuscitate Orders</u> There were 13 individuals with a DNR status, two of whom had a Level III DNR, and the remainder had a Level II. Level III DNR was defined as palliative measures only, directed	

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		toward reducing or eliminating pain, and enhancing the comfort and dignity of the individual. Level II DNR was defined as conservative therapeutic and supportive measures performed to reduce mortality and morbidity excluding initiation of endotracheal intubation and external cardiac massage. The "Resuscitative Status" form required renewal annually. Those with renewals that were current included: Individual #52, Individual #63, Individual #14, Individual #195, Individual #15, Individual #199, and Individual #138. Those with outdated "Resuscitative Status" forms included: Individual #161, Individual #269, and Individual #167. The form indicated that: "failure to renew or to designate alternate resuscitative status results in Resuscitative status I designation." The reasons provided for the DNRs appeared appropriate. Examples included Stage 3 colon cancer, metastatic breast cancer, end stage renal disease, Alzheimer's dementia, etc. However, some of the DNRs were implemented between 2005 and 2009, suggesting they were not imminently terminal at the time of the DNR order, or that they had stabilized and improved under the Facility's care and treatment, and the status needed to be reviewed by the team. There was one individual for which a DNR was rescinded. A PSP Addendum, dated 10/22/10, documented that her PST had reviewed her Level II DNR that was ordered 8/24/09, and removed it, because she had been healthy over several months. Her status was returned to full code status. The Monitoring Team met with the Medical Director and PCPs to review the current health status of several individuals. The physicians appeared to be knowledgeable about the various cases, but there were times when documents were not filed in the medical record, dating to at least 30 days prior to the meeting. This made it difficult for the PCPs to provide details and clarity to the updates. It also was potentially problematic in that a PCP or covering PCP would have needed information to answer a clinical concern as it occurred. The Facility should review the filing system to ensure timely filing of clinical information into the record. Additionally, the Medical Department estimated that 50% of the time the medical records did not arrive with the individual at the clinic visits, creating potential problems in adequate care of the individual.	
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	A non-Facility physician review was completed by PCPs (two PCPs, each from different SSLCs). This occurred at LBSSLC from 2/9/11 to 2/11/11. A standardized form was used as the tool in reviewing each record. This included 33 items with a yes/no or not applicable (N/A) result, and room for comments. The tool included essential items that were asterisked, and must be met to have an acceptable rating, in addition to achieving an average score of 80%. Essential concerns included a determination of: whether the active problem list was in the correct location, that it was dated, and that it was updated with each new problem and updated as problems resolved; and whether the annual physical exam and summary were current and complete, and whether it included	Noncompliance

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	improvement.	significant medical events of the past and present, as well as records reflecting drug/food allergies, sensitivities, or reactions. These medical peer reviews were completed on Individual #70, Individual #204, Individual #82, Individual #193, Individual #100, Individual #138, Individual #322, Individual #237, Individual #130, and Individual #2. This represented approximately 5% of the population. The Medical Director summarized the findings. The active problem lists needed updating, both to include new diagnoses, and to remove old problems. There was a lack of documentation of smoking history. Not all problems had resolution noted. The Medical Director met with each of the PCPs to review the findings and take corrective action. A couple of observations about the process might assist in ensuring the process meets the needs of the Facility, and complies with the Settlement Agreement. Many of the questions focused on administrative issues, i.e. were progress notes signed, dated, and timed. It would be helpful to review specific problems to determine if treatment was appropriate. This would allow feedback to be provided regarding treatment of specific conditions, such as treatment of pneumonia, UTIs, or GERD, etc. More specifically, Questions #17 and #26 were all encompassing and extremely broad. It would be helpful to have a #26.a, and have the reviewer go through the record to track a specific diagnosis (e.g., GERD, aspiration pneumonia, constipation). It also would help standardize the system, if one diagnosis was the focus for the review across the entire state, during the quarterly review. It was difficult to determine the depth of the review when the answer to #17 and #26 was simply "yes." Additionally, although this was an excellent start to complying with the SA requirement, the sample was only 5%. The State's goal appeared to be a 20% sampling per year, based on a schedule submitted that showed quarterly reviews at each Facility. Once the review was complete, the QA department then followed up on areas needing improvement, and tracked this through a computerized database until outstanding concerns were closed. QA audits were completed weekly until resolution of the concerns. Additionally, to provide support to other SSLCs, one of the PCPs was sent to Lufkin SSLC for a medical peer review. This was positive, because the PCP will return with potentially new ideas and information about different systems that work at another SSLC. Such information might be incorporated if needed into the LBSSLC systems, or even replace a system, if it is considered advantageous to do so.	
L3	Commencing within six months of	The Medical Department's quality improvement initiatives remained rudimentary. This	Noncompliance

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	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.	should be assisted with completion of the clinical guidelines. Some important data was being collected, but was not yet consistently being analyzed or acted upon. The following provides examples of data the Facility had collected, but not yet used to identify areas in which improvements could be made: ▪ The Medical Department submitted a list of those individuals having had a diagnosis of pneumonia during the past year. From January 1, 2010 to January 1, 2011, there were 55 cases of pneumonia identified in 33 individuals (33 out of 227 total census, or 14.5% of the total population). Nineteen were identified as having had aspiration pneumonia, but many of these diagnoses were made before the in-service the State Office provided defining the accurate categories of pneumonia. It was noted that the pneumonias were distributed throughout the calendar year. The months with three or less initial diagnoses of pneumonia occurred in January, June, and July. Four to seven pneumonias occurred in each of the remaining nine months. Trending of this information might prove useful in defining the type of pneumonia. For instance, aspiration pneumonia would likely have a greater chance of occurring during any month of the year, as opposed to seasonal community pneumonia. However, the categories defined during the in-service training should be helpful in determining the cause of the pneumonia, which is a significant contributor to morbidity in the population. A different report documenting pneumonias spanned the time period from 2/1/10 to 1/31/11. It included information as to whether individuals were on a textured diet, and also, if they had a gastrostomy or jejunostomy tube. It is recommended that information be included in the database concerning thickening of fluids, because those requiring pudding thickened fluids are likely to be at high risk for aspiration pneumonia. That 27 out of the 33 individuals that had pneumonia had gastrostomy tubes (82%) suggested the need to review any aggravating factors that would exacerbate GERD, such as flat positioning, or bolus feeding, and the need to consider diagnostic testing to rule out the presence of GERD as another source of aspiration. Medications and surgical procedures might be indicated depending on the findings. ▪ A list of emergency room visits was submitted. From this list, the emergency room visits were reviewed for the time period from 9/1/10 to the time of the printing of the document (2/8/11). This was approximately a five-month span. In this time period, there were 107 ER visits, of which 38 were related to gastrointestinal concerns. This area of health represented 36% of the ER visits. With this baseline information, it would be important to begin to identify frequent and common diagnoses, and develop protocols/pathways to begin to treat at an earlier stage to decrease the need for ER visits, and more proactively to diagnose and treat the common diagnoses to reduce the number of sick days per occurrence and improve the quality of life of the individuals.	

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		▪ A list was submitted indicating individuals that had been sent to the ER or hospitalized for injuries from 9/1/10 to 2/28/11. The list totaled 26 individuals (separating off those who had pica and were sent to the ER), which was about 10% of the population. The list included five fractures. This information could be used as a baseline from which strategies and programs could be implemented (supervision, change in BSP or psychotropic medications, review of side effects of medication, environmental hazards, etc.) to specifically address the rate of trauma necessitating ER visits and hospitalizations. However, the Facility needed to review its data collection and data systems. Another list of fractures that occurred over this same time period included seven fractures, instead of the five previously mentioned. Individuals with fractures named on both lists included: Individual #213, Individual #293, Individual #175, Individual #147, and Individual #109. However, the second list included two other individuals with fractures, including: Individual #106, and Individual #302. If the information is incomplete or conflicting in nature, it will be difficult to determine accurate baselines and follow trends. ▪ The Facility also had a database that tracked several clinical conditions. Each of these could be used in developing a medical QA review focusing on an area of concern. Areas of concerns could be selected either on the basis that they affected a large number of individuals, or that they affected a smaller number of individuals, but the intensity or severity of the concern justifies a medical QA review. Use of these lists of conditions would be in addition to, but as a different approach to identifying clinical indicators from the clinical guidelines/pathways. Several lists were submitted which could be the baseline from which a medical QA audit could follow. These included: o Individuals newly diagnosed within the past year with cardiovascular disease; o Individuals diagnosed with a malignancy within the past year; o List of individuals with a diagnosis of constipation and receiving medications; o List of individuals during the past 12 months that have experienced a fracture; o List of individuals during the past 12 months that have had a fall; o List of individuals during the past 12 months that have had a skin breakdown and have an active pressure ulcer with the last six months; o List of individuals for the last year who have had unplanned weight loss of 10% or greater over six months; o List of individuals with BMI equal to or greater than 30, including the individual's BMI; o List of individuals on enteral feeding; o List of individuals receiving sutures or dermabond in last year;	

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		o List of individuals during the past 12 months that have had a fecal impaction; o At risk osteoporosis risk rating; o Last six months of individuals with pneumonias who eat orally; and o List of individuals with tracheostomies. An example of the Facility's use of data to identify areas in which focused improvements were needed related to pica. Although pica remained a significant challenge at LBSSLC, important steps had been taken to address this issue. A list was created that recorded each incident of pica, including the name, home, date of incident, the item(s) ingested, whether the individual was hospitalized, whether x-rays were ordered, and whether it was a targeted behavior in the PBSP. From 9/1/10 through 2/15/11 (the document entitled "Individuals that ingest inedible items" did not have a date when it was printed, so the last incident date was used as the end date), there were 12 incidents of pica. Two of these individuals required hospitalization, including: ▪ Individual #202 ingested cigarette butts, coins, buttons, toilet paper, plastic and a chicken bone on 1/3/11. ▪ Individual #109 ingested paper and plastic wrapping, latex gloves, house shoes, and a magnet off a decoration on 1/14/11. Of the 12 individuals listed, there was not a PBSP for five individuals. Although one was being created for the individual involved in the most recent pica incident. In nine of the 12 individuals with recent incidents, monthly abdominal x-rays were ordered. The reasoning for this was not clear, especially if the article ingested was not radiopaque, or was small and did not have sharp edges. The Medical Director had discussed this with a local radiologist, and determined that the serial x-rays were associated with minimal radiation exposures. However, they do represent time the individual must spend getting an x-ray, and the Medical Director might need to review this aspect of monitoring to determine if it is effective or efficacious, specifically a review of whether treatment changed based on the results of the abdominal x-rays. Since the last monitoring visit, several steps had been taken to address the problem of pica behavior in the individuals living at LBSSLC. The Pica Reduction Committee met on 9/30/10, and several work groups with membership were listed in the minutes: environmental, policy and procedure, awareness/training, pica list/process, and pica safe home/work, program area. In October 2010, precise criteria were provided to determine those individuals that should be included on the "list of persons requiring pica precautions." This was revised on 1/12/11. On 1/14/11, a Pica Prevention Critical Incident meeting was held, providing initial discussion of issues and goals. Important areas of discussion included that the level of	

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		supervision assigned to an individual with pica needed to be implemented correctly and needed to be more effective. Precursor behaviors needed to be identified. There was a presentation that focused on "common factors checklist" used in the root cause analysis process. A "critical incident team actions" list was then created, including the projected date of completion, evidence to be used, and the responsible person. A training roster was submitted for the "Pica – Root cause analysis." A follow-up meeting was held on 1/20/11. Updated pica data was provided. The "common factors checklist" was reviewed as a fish-bone diagram format. Data indicated that the recording of completed pica increased in December 2010 and January 2011 from prior months. A "critical incident team actions list" also was created at this meeting. Included in these steps was improvement in new employee competency-based training regarding pica behavior. A "pica – environmental work group " met on 10/29/10 and 1/21/11, and reviewed the physical environment of the campus and the impact on pica. A number of "preventive maintenance work orders" were completed. On 1/21/11, a follow up "Pica prevention critical incident meeting" was held. By this time, a root cause analysis had been completed on a number of individuals who were high profile for pica behavior. A "critical incident team action" plan was completed. It was determined that there needed to be competency-based leadership/supervision training completed for those with oversight responsibilities. There were additional pica workgroup meetings on 12/10/10, 1/21/11, and 2/3/11, with focus on environmental sweeps. From this series of meetings about pica, an ongoing list of "individuals that ingest inedible items" was placed in the M drive, and the following documents were created: a "pica sweep checklist" (later amended to a "2 hour pica sweep checklist"), a "deep pica sweep checklist," and a "prevention of pica behavior competency test," "housekeeping department pica check list", and other pica sweep checklists identified by site as "hearts and hands, EIRS, EIWS, Supported Work, Education, Gym, Lily, and Pine." Additionally, at the Behavior Support Peer Review meeting on 3/4/11, it was documented in the minutes that each psychologist/behavior analyst would provide a presentation of information concerning individuals with recent or continuous pica on their caseload. Additionally, psychology peer review was completed of selected cases. Reviewers were from other SSLCs. There also were outside consultants assisting the Facility in reducing pica behavior, as well as a contract for consultation from Texas Tech. Plant maintenance training occurred on 3/9/11. A pica reduction committee meeting was held on 3/10/11 with creation of the "LbSSLC Pica Behavior Reduction Plan." There were 27 action steps listed. The "pica-environmental work group met 3/11/11 and reviewed the status of their current	

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		recommendations as well as additional areas that needed resolution. One item that was not resolved was the development of "pica precaution procedures and environmental checks for transportation department, vehicles, LbSSLC staff accompanying persons served at the hospital and appointments, and materials." A log was set up to document pica sweeps across the campus. An example was submitted for March 2011 entitled "campus coordinator log – entries." Also submitted was a "Lubbock SSLC – Positive Behavior Support: Prevention and Treatment of Pica," revised 12/14/10. All of the above steps appeared to be essential, and should result in a successful pica reduction program. However, the final measure of the success of these efforts will be a reduction in completed pica actions. If pica reduction does not occur, the various pica committees and work groups should continue to assess, modify existing plans, and/or create new action plans until the incidence of pica is reduced.	
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.	Since the last monitoring visit, the Medical Department had developed/revised and implemented the following policies: ▪ Choking, with implementation date of 12/31/10; and ▪ Health Services: Medical Care, dated 2/11/11. Additionally, there were several state policies and algorithms in draft form, including the following: ▪ Interdisciplinary Aspiration Pneumonia Prevention Algorithm; ▪ Clinical Pathway: Medical Management of Seizure Activity; ▪ Seizure Management Pathway with Associated Medical Interventions; ▪ Flow record: seizure management, updated 11/10/10; ▪ Anticonvulsant monitoring pathway; ▪ Clinical Pathway: Anticoagulation, updated 9/21/10; ▪ Clinical Pathway: Venous Thromboembolism screening and prophylaxis protocol, updated 9/10; ▪ VTE Risk Assessment Screening Form; ▪ Draft Clinical Pathway: Bowel Management and Constipation Prevention and Treatment, updated 10/10; and ▪ Draft policy: Management of Hyperlipidemia. The Facility was not yet in compliance with this sub-section of the Settlement Agreement. It continued to incorporate State Office policies and the Health Care Guidelines into existing policies, and/or develop new policies.	Noncompliance

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

1. If not already in place, a system to ensure CPR certification is current should be implemented.
2. To ensure that the Medical Director is able to easily ascertain if PCPs, psychiatrists, and dentists have completed timely and adequate CMEs, if not already in place, the database should be used to summarize the CME certificates, including the number of CME credits in the given timeframe, along with a simple list of CME topics contributing to those credits.
3. 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.
4. Concise minutes should be written for the morning meetings. Those in attendance should be recorded. There also should be a column or other mechanism for documenting closure, which should include a brief comment on the closure, as well as the date of the closure. Clinical concerns, especially focusing on critical issues, such as preventing recurrence of pneumonia for an individual returning from the hospital, should be asked routinely, with follow-up recorded in the minutes.
5. A review should be conducted and efforts made to improve the quality of the data being entered into the medical database.
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. The Medical Department should review criteria for DEXA scan orders for both diagnosis of osteoporosis, and follow-up to determine the efficacy of treatment at recommended intervals.
9. The medical database should be used to identify overdue and consistently overdue testing patterns either on an individual, or a PCP basis. Depending on the reasons for the overdue status, actions should be taken to improve the testing rates, including addressing PCPs' failure to follow routine national recommendations, to ensure quality care.
10. The Medical Director should discuss with the infection control nurse ways to promote employee vaccination for the upcoming flu season, so that a plan is ready for implementation when the vaccine arrives in the pharmacy.
11. Sign-in sheets with the topic and the Medical Director's signature should be maintained to verify ongoing discussion of the need for vaccinations with various groups, including the Incident Management Team, and the providers.
12. For decubitus ulcer tracking, the number of individuals with decubitus ulcers should be tracked per month, as well as the number of decubitus ulcers per month.
13. With the increased numbers of decubiti in recent months, the Medical Department should provide closer supervision and oversight of the management of decubitus care, with focus on prevention of risk factors. Monitoring information about decubiti should be available weekly, and discussed weekly at the morning medical meeting.
14. The Medical Department should create a policy or guideline concerning preventing dislodged feeding tubes. This might need to include such steps as an abdominal binder, as well as other clothing that makes the tube less accessible, as well as one-to-one supervision at an earlier stage to prevent unnecessary trauma and needless ER visits.
15. The system for transport back from the ER should be reviewed, to ensure that an ER report is included in the transfer. A review of such instances might indicate a common reason for the report not returning with the individual. The Facility should ensure that when the report is received, it is routed to the PCP for review.
16. The Medical Department should develop a policy or protocol indicating the level/intensity/threshold of SIB activity, which should lead to a prompt referral to the psychologist, (i.e., fracture, bruise, laceration, etc.)

17. The Medical Department should consider ensuring all documented fractures from ER testing and examinations are recorded in the database.
18. The Medical Director should review the ER records for comments by the ER staff to determine if accurate/complete information was forwarded at the time of the transfer. Revisions of the current protocol/policy might be needed to ensure that the ER receives accurate information. As part of this policy, a staff member knowledgeable about the individual's current condition should accompany the individual to the ER, at least to provide accurate initial information.
19. When constipation continues despite maximal medical therapy, there should be further physiologic/motility testing and referral to a colorectal surgeon/surgeon for evaluation of potential options. The clinical guideline on this topic should assist in providing steps to be taken in these most severe cases.
20. When individuals have a history of recurrent vomiting, as well as a history of bronchospasm, a current GERD evaluation should be included in the record. Additionally, when there is continued aspiration despite placement of a G-tube, a thorough GERD work-up should be completed, with results available in the record.
21. Because proper positioning is essential to prevent complications of aspiration and reflux, the Facility should implement a system for unannounced monitoring that occurs randomly throughout the 24-hourday, seven- day a week.
22. 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.
23. The Medical Department should review orders to ensure the appropriate feeding tube is listed on all documents.
24. Individuals with J-tubes should routinely have medication orders reviewed to ensure medications remain effective when administered through a J-tube.
25. 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.).
26. The Medical Director should consider creating a tracking system to ensure "Resuscitative Status" forms are reviewed and updated annually.
27. Based on the fact that 27 out of the 33 individuals that had pneumonia had gastrostomy tubes (82%), reviews should be conducted of any aggravating factors that would exacerbate GERD, such as flat positioning, or bolus feeding, and the need to consider diagnostic testing to rule out the presence of GERD as another source of aspiration. Medications and surgical procedures might be indicated depending on the findings.
28. Filing of information into the medical record should be accomplished within a timeframe determined by the Medical Department, but should be brief enough as to not delay care.
29. The State should continue to pursue the goal of conducting a 20% review of the population residing at LBSSLC per year as part of the non-Facility medical peer review. Enhancing the clinical component of the review would assist in assessing compliance with the clinical aspects of the HCG, as well as compliance with the clinical guidelines, once they are finalized.
30. 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.
31. 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. Additional information is available regarding this recommendation in the section of the report that addresses Section M.1 of the Settlement Agreement.

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; o LBSSLC's Nursing Supplemental POI; o LBSSLC's Nursing Department Presentation Book; o LBSSLC - Communication Processes: Active Record Check Out/Check In Process (draft); o Minutes of Workgroup filing in the records, dated 2/11/11, 2/17/11, 2/24/11, 3/3/11, 3/10/11, and 3/17/11; o Minutes of Workgroup for Active Record Check Out/In Process, dated 2/14/11, 2/22/11, 3/3/11, 3/10/11, and 3/17/11; o LBSSLC Nursing monitoring data, since January 2011; o QA monitoring data, since January 2011; o Standard Precautions Monitoring Tool for Infection Control, since August 2010; o Monthly Residential Round data; o The revised Infection Control Monitoring tool and data, since January 2011; o Administrative Review Team Meeting minutes, dated 8/10, 10/21/10 and 11/10 (no specific dates listed on minutes for August and November 2010); o Infection Control Committee meeting minutes and data graphs, dated 11/3/10, and 12/2/10; o Pharmacy and Therapeutic Committee minutes, dated 10/14/10, and 12/14/10; o Infection Control course description for new employee orientation; o LBSSLC's Life Threatening Emergency Drills, from August 2010 through January 2011; o The medical records for the following: Individual #258, Individual #261, Individual #175, Individual #210, Individual #109, Individual #225, Individual #171, Individual #114, Individual #269, Individual #7, Individual #135, Individual #253, Individual #323, Individual #154, Individual #276, Individual #122, Individual #206, Individual #54, Individual #11, Individual #268, Individual #44, Individual #56, Individual #210, Individual# 116, Individual #199, Individual #193, Individual #66, Individual #109, Individual #127, Individual #147, Individual #82, Individual #233, Individual #306, Individual #281, Individual #280, Individual #135, Individual #139, Individual #174, Individual #265, Individual #202, Individual #104, Individual #266, Individual #135, Individual #107, Individual #284, Individual #257, Individual #15, Individual #299, Individual #113, Individual #17, Individual #50, Individual #160, and Individual #300; 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 Continuing Education documentation for the IC Nurse and Assistant;

	○ Data Collection and Analysis Process for Infection Control (draft), dated 2/14/11; ○ Outbreak Investigation for scabies; ○ Physical Assessment Competency Guidelines for Evaluation Criteria (draft); ○ LBSSLC's nursing training rosters; ○ Medication Administration Records (MARs) for 504 West for cart A, B, C, and D; ○ Documentation addressing audits for spot checks for MARS; ○ 117 Medication Error Reports for variances found during the review, on 3/21/11; ○ Medication Administration Guidelines, dated 2/11; ○ Minutes of the Medication Error Committee, dated 10/7/10, and 3/9/11; ○ Minutes of the Brainstorming Work Session, dated 3/9/11; ○ Medication Observation Tracking 2009 data sheets; ○ Case Manager Medication Observation Tracking sheets; and ○ Medication Observation audits, from September 2010 through February 2011. ▪ **Interviews with**: ○ Don Minnis, RN, BSN, Chief Nurse Executive (CNE); ○ Jeremy Ellis, RN, QA Nurse; ○ Michelle McElroy, RN, Infection Control; ○ Dawn Ripley, Quality Assurance Director; ○ Katherine Chance, RN, Case Manager; ○ Amy Cohen, RN, Case Manager; ○ Connie Granado, RN, Case Manager; ○ L. Michele Moore, RN; and ○ Connie Horton, APRN, State Office Consultant. ▪ **Observations of**: ○ Medication administration for individuals in Quail Residence; ○ Emergency equipment demonstrations in Sparrow Residence; and ○ PSP meetings for Individual #198, on 3/28/11.
	Facility Self-Assessment: Based on a review of the LBSSLC's POI with regard to Section M of the Settlement Agreement, the Facility found that it remained out of compliance with the all of the provisions, which was consistent with the Monitoring Team's findings. Although the Monitoring Team was in agreement with these findings, it was not clear if the Facility based this conclusion, in part, based on any objective data generated through the monitoring processes implemented since the last review. Since January 2011, the Facility began using seven out of twelve of the newly modified nursing monitoring tools. Although the tools had associated guidelines, they should be reviewed to determine if additional instructions are needed to ensure that the specific criteria that constitute compliance with each item are identified clearly to encourage consistent scoring. In addition, the Facility reported that inter-rater reliability had not been established for any of the nursing tools. This would be crucial, since the Facility had a number of different auditors generating monitoring data for the same areas. At the time of the review, the Facility did not have a written procedure outlining the inter-rater reliability process to ensure it was executed appropriately and consistently. Without accuracy and reliability of the data generated from

	the monitoring tools, the analysis and interpretation of the data could easily be skewed, and trends not accurately identified. Developing and implementing a consistent procedure for conducting inter-rater reliability would ensure consistency in executing the process. Once this is established, the range of percentages of inter-rater reliability should be reported for each tool to allow evaluation of the reliability of the data collected. In addition, the Facility should develop a unified system to present the data from the monitoring tools in a meaningful way, so that it can be easily analyzed and trends identified. A unified system also would allow data to be easily reviewed and interpreted between disciplines and departments. As noted in previous reports, the presentation of data should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured. Once this data presentation system is developed, the Facility will then need to use these data to justify their compliance status for the various monitoring indicators. Regarding the Facility's POI for Nursing, more information was needed regarding the specific actions taken since the last review, including specific dates of implementation, as well as updates on the status of systems. In addition, the Presentation Book addressing the Settlement Agreement requirements should included all of the Nursing Department's specific supporting documentation regarding actions that the POI describes as having been taken, or that supports progress made.
	Summary of Monitor's Assessment: Since the last review, the Facility had maintained a fill-rate of 89% of their total nursing positions. The Facility's extraordinary efforts and strategies were effective in maintaining consistent nursing staff, which ultimately should result in positive clinical outcomes for the individuals residing at LBSSLC. Since January 2011, the QA Nurse and the Nursing Department began using the newly modified monitoring tools for nursing. The new nursing monitoring tools consisted of a total of 12 tools in the areas of Acute Illness and Injury; Annual/Quarterly Nursing Assessment; Documentation; Infection Control; Management of Chronic Respiratory Distress; Medication Administration and Documentation; Nursing Care Plans; Pain Management; Prevention; Seizure Management; Skin Integrity Assessment; and Urgent Care/ER Visits and Hospitalizations. Both the QA and Nursing Departments had implemented the use of seven of the tools, and it was anticipated that by the next review all the tools should have been implemented. As the Facility continues to implement its monitoring systems, a procedure addressing the establishment of inter-rater reliability should be developed and implemented, and staff assigned monitoring duties will need to be trained regarding this process. Consistent with the findings from the previous reviews, there continued to be significant number of problematic issues regarding the nursing documentation addressing complete and adequate nursing assessments of symptoms for acute changes in status, Nursing Quarterly/Annual Assessments, and Nursing Care Plans. However, some of the data from the QA Nurse and the Nursing Department indicated that the Facility was beginning to critically audit the area regarding Urgent Care/ER Visits and Hospitalizations, and

	had identified findings similar to those of the Monitoring Team. However, at the time of the review, no corrective action plans had yet been developed addressing the problematic areas identified from the audit data. Of significant importance, in response to the Monitoring Team's consistent past findings indicating problems regarding nursing competency regarding assessments, in March 2011, the State developed and implemented a competency-based pilot training program at LBSSLC, addressing physical assessment skills, utilizing Nurse Practitioners with development disabilities experience. At the time of the review, the training program recently had been conducted, and had focused on training the RN Case Managers and Nurse Educators. The program consisted of a day of classroom instruction, followed by a day of competency-based demonstrations of assessment skills, which the RN participants performed on each other. Additional competency-based demonstrations of assessment skills were to be conducted for a quarterly assessment, a chronic condition follow-up, and an acute illness review or/or clinic follow-up. These demonstrations would be completed with an individual assigned to the RN Case Manger's caseload, and would be supervised by the Nurse Practitioner trainers. This competency-based training is essential to the forward movement towards compliance with the Settlement Agreement provisions related to nursing clinical issues. The competency-based training program that the State Office had initiated was a very promising step forward for nursing. Although there continued to be serious problematic issues regarding the medication administration and medication variance systems at LBSSLC, the Facility implemented a Brainstorming Work Session meeting that generated a thorough and promising systematic process for reviewing some of the medication issues, such as the number of unexplained returned medications to the pharmacy.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	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, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and the Facility's medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the SA. <u>Staffing</u> Since the last review, LBSSLC continued investing efforts into securing consistent nursing staff at the Facility. At the time of the review, LBSSLC had a total of 100 nursing positions with 14 vacancies. The vacancies were for four Registered Nurses (RNs), and 10 for Licensed Vocational Nurses (LVNs). Since the baseline review, the Facility was able to decrease its use of agency nurses, and had gone from using seven agencies to three	Noncompliance

#	Provision	Assessment of Status	Compliance
		agencies for nursing staff. The Facility had maintained an 89% fill-rate for their total nursing positions. The Facility's efforts and strategies were effective in maintaining a number of consistent nursing staff, which ultimately should result in positive clinical outcomes for the individuals residing at LBSSLC. Since the previous review, the Facility had lost three RN positions from the Nursing Department. Specifically, a Program Compliance Nurse was assigned to the Medical Department, an RN was assigned fulltime to the Physical Nutritional Management Team (PNMT), and an additional RN was assigned to the QA Department. During the past review the Chief Nurse Executive had requested a position for a Nurse Auditor dedicated to the Nursing Department. However, the CNE reported that this position was not approved. At the time of the review, LBSSLC had a census of 227 individuals. Since the previous review, the structure of the Facility's nursing services remained basically the same: ▪ Three of the residential buildings had 24-hour nursing care, specifically the Sparrow, Quail, and Maple residences. At the time of the review, individuals from the Quail residence had been temporarily moved to building 504 West Mesquite Drive, and individuals from Sparrow had been temporarily moved to 528 N Cedar. Once the designated work was completed, they would be returning back to their original residences. ▪ The Facility did not have an infirmary. ▪ During the day, nurses were assigned to each residence. 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 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. From the past reviews, the CNE indicated that his goal was to staff the residences with the most medically compromised individuals, Sparrow, Quail, and Maple, with all RNs. At the time of the review, there continued to be no set plan in place for this transition, however, the CNE reported that this was still the goal for the Department. The findings of the reviews conducted at LBSSLC supported the need for an increase in the clinical skill level of staff working with this population. LBSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement.	

#	Provision	Assessment of Status	Compliance
		Quality Assurance Efforts Since January 2011, the QA Nurse and the Nursing Department began using the newly modified monitoring tools for nursing. The new nursing monitoring tools consisted of a total of 12 tools in the areas of Acute Illness and Injury; Annual/Quarterly Nursing Assessment; Documentation; Infection Control; Management of Chronic Respiratory Distress; Medication Administration and Documentation; Nursing Care Plans; Pain Management; Prevention; Seizure Management; Skin Integrity Assessment; and Urgent Care/ER Visits and Hospitalizations. Both the QA and Nursing Departments had implemented the use of seven of the tools, and had yet to implement the Annual/Quarterly Nursing Assessment, Documentation, Management of Chronic Respiratory Distress, Pain Management, and Skin Integrity Assessment tools. From discussions with the QA Nurse and the CNE, the Facility conducted a total of six audits per month, using seven of the nursing monitoring tools noted above. The QA nurse conducted two of these audits per month, and the Nursing Department conducted four audits per month. However, from review of the raw data from the Nursing Department from October 2010 through February 2011, there were consistently less than four audits for each tool per month. Although the Facility's last POI indicated that the inter-rater reliability process was to be implemented in July 2010, at the time of the review, the Facility had not implemented a process for establishing inter-rater reliability for the monitoring tools. While on site, a number of appropriate questions were asked by the QA and Nursing Departments regarding the process for establishing inter-rater reliability, indicating that they had been trying to determine the process they needed to implement. These inquiries also indicated that the Facility needed to develop a procedure for establishing inter-rater reliability to ensure all disciplines were executing the process consistently. As the Facility continues to implement its monitoring systems, a procedure addressing the establishment of inter-rater reliability should be developed and implemented, and staff that are assigned monitoring duties will need to be trained regarding this process. In addition, auditor competency is essential to ensure the Facility's data accurately reflect the quality of care being provided, and to quickly identify problematic trends and implement timely plans of correction. Also, the data generated from the monitoring tools should be regularly reviewed, addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems. A review of the data generated since October 2010 from the QA and Nursing Departments found that the auditing was becoming more critical in assessing the items on the tools, especially in the area of Urgent Care/ER Visits and Hospitalizations. Although the Facility had a long way to go in the implementation of its monitoring systems, these initial findings from the audits were extremely promising in that they	

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		showed a critical review of essential indicators. From review of the QA Department's audits for Urgent Care/ER Visits and Hospitalizations, some of the findings noted on the tools included: ▪ No copy of the transfer sheet in the active record; ▪ No indication of a physical assessment completed in the Integrated Progress Notes prior to transfer to hospital; ▪ No documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ A Nursing Care Plan was developed, but was not being followed by direct contact nurses; ▪ The acute care plan was not specific enough in giving the frequency of interventions; ▪ No hospital summary found in record; ▪ The individual's Phenobarbital was discontinued on 1/11/11, and a dose was given the following day; ▪ No PSPA found for individuals returning from the hospital; ▪ The Nursing Care Plan stated to assess mental status every shift. However, no assessment was documented for 48 hours after return from the hospital; and ▪ Hospital Liaison notes not found in the records. From review of the Nursing Department's audits for Urgent Care/ER Visits and Hospitalizations, some of the finding noted on the tools included: ▪ Prior to transfer to the hospital, there was not a complete nursing assessment; ▪ Nurse Liaison notes not found in records; ▪ No hospital discharge summary in record; ▪ No documentation that PST met following individual's return from the hospital; ▪ No documentation of nursing assessments completed at the frequency indicated by the care plan; ▪ Blood pressure medication was not resumed after hospitalization. Individual had several elevated blood pressure readings, and the physician was not notified; and ▪ Nurse documented a blood pressure of 174/97, and noted "within normal range for client." Although at the time of the review, the Facility did not have a system in place to aggregate these data into a report for analysis, the raw data from these audits were more in alignment with the Monitoring Team's findings for this area than the Facility's audits from past reviews. At the time of the review, no corrective action plans had yet been developed addressing the problematic areas identified from the audit data. In addition, the QA Nurse reported that the Facility had implemented a QA/QI monthly meeting in November 2010 to discuss findings and issues related to the monitoring process. Again,	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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this was a very positive step forward.

At the time of the review, the Facility had no consistent system in place addressing the structure of how data was presented for interpretation. The Facility should develop a unified system to present the data from the monitoring tools in a meaningful way so that the data can be easily analyzed and trends identified. In addition, a unified system also would allow data to be easily reviewed and interpreted between disciplines and departments. The table below is only one possible example of a system for the Facility to consider as a simple structure for standardizing the presentation of the data.

<table>
<tr><th colspan="8"><u>Name of the Health Care Monitoring Tool
Established Inter-rater reliability percentage range</u></th></tr>
<tr><td>Month/year data collected</td><td>1/11</td><td>2/11</td><td>3/11</td><td>4/11</td><td>5/11</td><td>6/11</td><td>Mean</td></tr>
<tr><td>N</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>n</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>% Sample</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td># ITEM 1 (Item # on tool and the Item being monitored)</td><td>Compliance scores for item #1 by month</td><td></td><td></td><td></td><td></td><td></td><td>Mean Compliance score for item #1</td></tr>
<tr><td># Item 2</td><td>Compliance scores for item #2 by month</td><td></td><td></td><td></td><td></td><td></td><td>Mean Compliance score for item #2</td></tr>
<tr><td># Item 3</td><td>Compliance scores for item #3 by month</td><td></td><td></td><td></td><td></td><td></td><td>Mean Compliance score for item #3</td></tr>
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N = Number of total population being reviewed (for example: Total number of individuals with Hypertension) in the review month.
n = Number of records audited (for individuals with Hypertension)

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<tr><th>Item #</th><th>Mean Previous Review Period</th><th>Mean Current Review Period</th></tr>
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Whatever the format the Facility adopts, information such as the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent
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#	Provision	Assessment of Status	Compliance
		sample is imperative to indicate the relevance of the compliance scores. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured. In addition, it had been previously reported that the State had plans to implement a new statewide database system. This is a very positive step so that the format and presentation of the data can be consistent, and data easily can be reviewed at the Facility and among Facilities. LBSSLC's Nursing Department should continue its efforts in implementing monitoring systems that generate accurate clinical data focused on the quality of nursing services and documentation, and not just the completion of the required documentation. A review of all the raw data generated from the QA Nurse and Nursing Department indicated that they were moving in the direction of critically auditing nursing practices, and were beginning to seriously review the quality of the nurses' documentation. As the Facility continues to define its monitoring systems, the next steps would entail formalizing the inter-rater reliability process, and establishing a unified structure for presenting the data generated from the newly revised Health Care Monitoring tools. The QA Nurse, and the Nursing Department should have regular discussions regarding the data generated from the monitoring process to ensure that all areas are being critically audited, and auditing focuses on the quality of the nursing services. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Although the Nursing Department and the QA Nurse had identified a number of significant problematic issues from the monitoring audits conducted for individuals who experienced an acute illness and hospitalization, no corrective action plans or interventions had been developed or implemented addressing these issues. Consequently, there were no improvements seen in the nursing documentation for this population. A review of 16 individuals' medical records (Individual #258, Individual #261, Individual #175, Individual #210, Individual #109, Individual #225, Individual #171, Individual #114, Individual #269, Individual #7, Individual #135, Individual #253, Individual #323, Individual #154, Individual #276, and Individual #122), who had been transferred to a community hospital, or emergency room found that in every case reviewed, there continued to be significant problems regarding the nurses' documentation in the following areas, which were consistent with the Monitoring Team's findings from past reviews: ▪ The Nurse Liaison notes were missing from every record reviewed; ▪ A lack of documentation regarding the status and appropriate assessment of the individual at the time of onset of the symptoms; ▪ A lack of complete and appropriate nursing assessments in response to changes in vital signs, oxygen saturations, eating habits, or mental status;	

#	Provision	Assessment of Status	Compliance
		▪ Significant gaps in nursing documentation when nurses' notes stated: "will monitor"; ▪ The type of temperatures taken not consistently documented; ▪ 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, size, and location of injuries, bruises or rashes; ▪ 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 or receiving PRN laxatives; ▪ Physician/Practitioner not timely notified of change in status due to nurses' inadequate follow-up; ▪ No documentation that there was 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; ▪ Lack of an adequate updated Nursing Care Plan to reflect changes in status and new interventions; ▪ Many nursing progress notes and signatures were illegible; and ▪ A lack of systematic documentation addressing the care of catheters,	

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		tracheotomies, and G-Tubes. Similar to the findings from the past reviews, there were a number of significant problematic issues found in all 16 records reviewed regarding complete, timely, and adequate nursing assessments, as well as documentation for symptoms for acute changes in status for individuals. For example: ▪ Individual #253, who was hospitalized at the time of the review, had the following medical issues: lethargy and dehydration; was being treated for symptoms of gastro-esophageal reflux; had been hospitalized twice in the past year for aspiration pneumonia, had been hospitalized for a rectal bleeding during the past year; had been diagnosed with tubular sclerosis with a renal mass; had multiple episodes of skin irritation; had a history of falls; had a lower back fracture in January 2011; was diagnosed with osteopenia in 2002 via Dexa Scan; had episodes of MRSA during the past year; had a seizure disorder; was enterally nourished via G-tube; and had only one lung (left). Listed below are some of the problems found in the nurses' documentation prior to a hospitalization from 12/5/10 to 12/14/10: o There were no regular nursing assessments conducted for his respiratory status; o There were no regular nursing assessments conducted regarding skin integrity; o There were no specific descriptions and measurements of reddened areas to his skin, which were documented; o Nurses' notes indicated that a stool sample was needed to rule out C-Diff. However, there was no documentation of episodes of loose stools/diarrhea documented; o There was no documentation found indicating that stool samples were obtained, or the results of the cultures; o There were no assessments for variations in oxygen saturations; o There was no documentation regarding his activities during the day, and his tolerance for activities; o No mental status assessment was found in the documentation; o There was no documentation assessing his tolerance for his G-tube feedings; o There was no documentation of an assessment of the site of the G-tube for skin break down or infection; o There was no indication if he was bed-bound or out of bed during the day; o There was no assessment of daily urine output; o There was no documentation indicating that the physician was notified of changes in vital signs and oxygen saturations;	

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		o Based on the nursing documentation, it could not be determined exactly which health problems were being assessed and monitored; o Significant lack of follow up for any problems noted in the nursing documentation; and o There was no consistent frequency of any nursing assessments to indicate the status of his health issues. This individual's case was an obvious example of the critical need for nursing to develop and implement protocols and procedures to guide the needed clinical assessments, and clearly outline the criteria for nursing documentation. Of the significant medical problems listed above for Individual #253, nursing staff failed to adequately address any of them. They were either not documented on at all, or inconsistently documented. In addition, the nurses' involved in his care did not adequately identify changes in his status as symptoms that needed to be assessed, reported to the physician, and followed. Consistent with the previous reviews' findings, all 16 records reviewed had significant problematic issues indicating deficits in the clinical competency of the nursing staff, a 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 is necessary to notify the physician of changes in status, and an inability to analyze clinical data. Although the State had implemented a pilot competency-based assessment skills training for nursing staff, which is described in detail with regard to Section M.2, it is imperative that the Nursing Department establish appropriate nursing protocols to drive nursing documentation. Such protocols are necessary to build an adequate system that will have a lasting effect on the clinical outcomes for the individuals at LBSSLC, in accordance with the Settlement Agreement. Also consistent with the previous reviews' findings, a review of the 16 individuals listed above found that the documentation from the Hospital Liaison Nurse was present in none (0%) of the 16 records reviewed. This was a consistent finding in the Facility's QA and Nursing Departments' monitoring data as well, but had not been corrected at the time of the review. Due to the significant problematic issues consistently found in the cases reviewed by the QA Nurse, the Nursing Department, and the Monitoring Team, by the next review, the Nursing Department should be generating and implementing plans of correction addressing the problematic issues related to Urgent Care/ER Visits and Hospitalizations. LBSSLC's POI indicated that the Facility was not in substantial compliance with items specific to this requirement of the SA, which was consistent with the findings of the Monitoring Team.	

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		Availability of Pertinent Medical Records From the review of a number of 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 Monitoring Team's findings during the previous two reviews. There also continued to be a number of Nursing Quarterly Assessments, Nursing Annual Assessments, Nursing Care Plans, and Hospital Liaison Nurse's notes that were not found in the records. From discussions with the CNE, there appeared to be two issues related to these findings. Specifically, some of these documents were not being completed, and those that were completed, often were not being filed in the records in a timely manner. Based an interview with the QA Director, the Facility was aware of this issue, and had initiated two work groups in February 2011 to address problematic issues related to the medical records. These consisted of a workgroup for filing in the record, and a workgroup for a Check Out/Check In Process. From review of the minutes of the Work Group for Filing in the Record, the group quickly recognized that each discipline had a different system, or systems were not in place for tracking documents that needed to be filed in the records. The Workgroup noted that there was no common theme, and no accountability at the department level for determining if information was completed and timely submitted for filing. The minutes indicated the team was considering the use of a date stamp and tracking log to ensure that all completed documents were timely filed in the Active Records. The Workgroup for the Check Out/Check In Process developed a draft procedure to track the location of the Active Records. The minutes of these Workgroups indicated that the Facility was aggressively and thoughtfully developing systems to ensure that the Active Records were consistently accounted for, and that documents were timely filed in the records. From discussion with the QA Director, these systems would be implemented by the next review. The Facility should continue to develop and implement systems to ensure that medical records are accessible, and that documents are filed in a timely manner, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. Infection Control (IC) Based on LBSSLC's POI, the Facility reported that since the last review, in-service training regarding multi-drug resistant organisms and isolation; West Nile Virus; MRSA/ORSA, (Oxacillin Resistant Staph aureus) and standing orders were provided to all nursing staff. Overall, the POI indicated that the Facility was not in substantial compliance with any of the items specific to Infection Control, which 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	

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		the IC Coordinator and a full-time LVN, who assisted the IC Coordinator with monthly environmental surveys and other assigned duties. Documentation was provided that indicated that the IC Nurse conducted some competency-based training with the IC Assistant regarding the administration of the Tuberculin Skin Test (TST). In addition, the Facility provided documentation that in January 2011, the IC Assistant attended training entitled "2011 Winter Essentials Of Infection Control & Prevention," provided by the Texas Society for Infection Control and Prevention. In addition, the IC Nurse also had received additional training in March 2011 through attendance at the Texas Society for Infection Control and Prevention 34th Annual Conference. Both the IC Nurse and IC Assistant should continue to receive regular IC training to continue to increase their expertise in this clinical area. Consistent with the findings from the past reviews, the IC Nurse and Assistant 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. Based on discussions with the IC Nurse, she had developed a draft policy entitled Data Collection and Analysis Process for Infection Control, dated 2/14/11. A review of the draft found that there was considerable effort put into its development. Although the draft outlined a number of databases and methods the IC staff use to collect data regarding infectious diseases, it did not adequately address how these systems were to be used to ensure the reliability of the Facility's IC data. With some modifications made to specifically address this issue, the Facility should be able to have this process formalized by the next review. As noted in previous reports, the Facility should develop and implement formal procedures regarding how different systems are used to ensure data reliability. The procedures should address specific information, such as when data are collected from each system, how discrepancies between the systems are tracked and addressed, and where unit reporting falls into the data collection system. If the IC data is not reliable, the Facility cannot accurately identify its trends, identify problematic changes in trends requiring timely corrective interventions, ensure that treatments and treatment plans are clinically sound, ensure that timely and appropriate training is being provided, or initiate proactive interventions from analyses of past data trends. In addition, at the time of the review, the Facility had not developed a schedule regarding when the immunization status of each individual would be evaluated, and updated, if needed. However, discussions with the IC Nurse indicated that the Facility was in the process of developing a database for IC, which would allow aggregation of the data in a number of different ways to produce meaningful reports regarding issues such as immunizations. The IC Nurse reported that she anticipated its completion by the next review period. This would be a very positive step forward for the IC Program. The Facility should continue to develop and implement strategies to ensure that all individuals at LBSSLC are current regarding their immunization status, in accordance	

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		with the requirements of the Settlement Agreement. In addition, a schedule addressing these issues should be developed to ensure individuals are appropriately prioritized and that no one is overlooked. In addition, the IC Nurse reported that the Residential Coordinators were continuing to conduct audits using the Standard Precautions Monitoring Tool. Although the IC Nurse indicated that not all Residential Coordinators were doing the audits consistently as required (one per shift per month for each home), since the last review, a number of the audits had been completed. The data from the Monthly Residential Rounding tracking sheets indicated that the homes that did not conduct consistent audits or any audits included: 516 S. Cedar, 517 S. Cedar, 518 S. Cedar, 521 N. Cedar, 523 N. Cedar, 525 N. Cedar, 526 N. Cedar, 527 N. Cedar, 528 N. Cedar, 504 E. Mesquite, and 504 W. Mesquite. From a review of this data, it was very concerning that the three residences that had the most medically compromised individuals, specifically the Sparrow, Quail, and Maple residences (504 Mesquite and 517 S. Cedar), had not consistently completed the Standard Precautions Monitoring Tools. A review of the audits conducted since August 2010 found that that some of them identified significant issues that could negatively affect IC practices in those homes. Some of the issues identified included the following: ▪ Sinks were messy and had dried toothpaste on them; ▪ A staff member did not wash her hands between individuals' bed checks; ▪ Staff did not change gloves when working with different individuals; ▪ Carts of soiled laundry were left uncovered; ▪ Bathrooms smelled strongly of urine; ▪ Staff needed reminding to sanitize training materials after each use; ▪ A residence had run out of large gloves; ▪ Staff needed reminding to clean up the office; ▪ Soap dispersers were empty; ▪ Bathroom were out of towels; ▪ Observed staff not scrubbing under fingernails when washing hands; ▪ Staff refusing to wash hands appropriately; ▪ Bedroom had dirty clothes on floor; ▪ Staff not washing their hands when reporting for duty; and ▪ Wheelchairs needed cleaning. Although some of the audits noted when corrective actions were taken, this was not consistently documented. In addition, since the last review, there had been no analysis conducted on the data generated from these audits to identify problematic trends. An analysis of these data should be implemented so that problematic trends can be identified and plans of correction timely implemented. Also, the Infection Control	

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		Committee should review these data, in conjunction with the data addressing actual infectious processes. Most of the Residential Coordinators who were completing the audits were doing a good job identifying areas of major concern related to the Facility's IC practices. It is very troubling that all residences were not completing these audits. The Facility should address the lack of completed Standard Precautions Monitoring Tool audits. As noted in previous reports, this monitoring system was a very promising process for ensuring that staff in the residences were using standard precautions, sanitizing equipment, and were not putting individuals and other staff at risk from cross contamination. At the time of the last review, the IC Coordinator had implemented spot check monitoring for hand washing in the homes. However, there continued to be no formal system or structure developed for when and how frequent these spot checks would occur. The system continued to be informal at the time of the review. The Facility should consider formalizing this system to ensure regular spot checks are conducted in different areas to generate additional data regarding the hand-washing practices of the staff. Based on discussion with the IC Nurse, since August 2010, she had been conducting four IC audits a month. However, the Director of QA had randomly chosen her sample, which often resulted in the review of individuals who had no infectious issues. Consequently, most of the monitoring data produced was insignificant regarding infection control practices. Due to the acute nature of infectious diseases and the potential for spread, auditing for this area should be conducted while the acute infection is active. Otherwise, only conducting retroactive auditing does not allow for immediate amelioration of problematic issues. The QA Nurse and/or Nursing Department might better conduct the completion of the some of the IC random assigned audits, while the IC Nurse completes some as well. The audits the IC nurse conducts should be focused audits done in real-time, which include all individuals who have a contagious, infectious medical issue. The expertise of the IC Nurse would be better utilized reviewing these cases at the time they are identified to ensure that the appropriate infection control practices are being implemented. Thus, consistent with the previous reviews findings, there were no IC audits being conducted to ensure that appropriate treatment practices were being implemented regarding infection control issues. Regarding Infection Control policies and procedures, the IC Nurses indicated that in November 2010, a two-day meeting was held with some of the IC Nurses from the SSLCs to develop standardized IC policies and procedures. However, at the time of the review, the Statewide Infection Control Manual had not yet been finalized, and thus the Monitoring Team did not review it.	

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		Since the last review, there had been some very positive modifications made to the structure and format of the IC Committee Meeting minutes, including the addition of the categories of: topic, discussions/conclusions, recommendation/actions, and effectiveness of actions/follow up. This new format provided a clearer picture of the information discussed during the meeting. However, the minutes should be expanded to include an analysis of IC issues, and indicate when issues were actually resolved. For example, the IC Committee Meeting minutes dated 11/3/10, indicated that bronchitis and upper respiratory infections had increased in the past year. However, there was no analysis of possible contributing factors that might have impacted this issue. 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 nurses, in conjunction with the practices on the units. Consistent with the findings of the past reviews, no formal process had been put in place for reviewing Nursing Care Plans addressing infectious diseases. As discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, the records of 16 individuals diagnosed with a variety of infectious diseases were reviewed, and of the 16, only 10 had Nursing Care Plans addressing the infectious issue. Of the 10 Nursing Care Plans reviewed addressing the infectious diseases, none were found to be adequate and individualized. These findings have been consistent throughout the past two reviews, and are very concerning due to the clinical ramifications of this area. Since the last review, the Facility experienced an outbreak of scabies in early March 2011. This outbreak involved four residences, four individuals, and four staff members. From review of the documentation contained in the Outbreak Investigation, once it was discovered that a staff member had been diagnosed with scabies, the Facility took action in a timely manner, and was able to contain the outbreak. In addition, the day the Facility discovered the staff member had been diagnosed, skin checks were implemented immediately for the individuals in the particular building in which the staff had worked. Although all the actions that the Facility implemented after discovering a staff member had been infected with scabies were clinically appropriate and effective in containing the outbreak, there could have been a significantly different outcome had the nurse who overheard that one of the staff members had scabies not notified the IC Nurse about her concerns. From discussions with the IC Nurse, the supervisor who took the call from the staff member had not notified her about the diagnosis of scabies. Thus**,** training needs to be implemented regarding when the IC Nurse should be notified regarding staff illnesses related to contagious/infectious diseases. In addition, the appropriate and effective actions found documented in the Outbreak Investigation were not found in any Facility	

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		policy. To ensure that the positive outcomes related to this outbreak can be replicated in the event of another possible outbreak, the Facility should review the processes that were implemented for the scabies outbreak, and include them in the Facility's policies and procedures. Since the last review, the IC staff clearly had made efforts to implement some of the needed interventions to move Infection Control forward to meet the requirements of the Settlement Agreement. Significant guidance and clear direction should be provided to the Facility and the IC staff so that efforts are focused on priority clinical issues. Much attention is needed in this area to build a solid infrastructure with formal operational procedures that drive the activities for Infection Control. As noted in previous reports, additional expertise in Infection Control is needed to assist in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement. <u>Code Blue Drills</u> From review of LBSSLC's Life Threatening Emergency Drill documentation from August 2010 through January 2011, the CTD Department had been consistently conducting emergency drills on a monthly basis in each home on each shift. The CNE reported that the Facility was in the process of expanding the scenarios used for conducting the drills. However, at the time of the review, there was no draft yet developed indicating what additional scenarios were going to be included in the drills. Although the CNE reported that the Facility had incorporated the use of the emergency equipment during the Life Threatening Drills, there was no indication on the drills conducted that the CTD Department was actually having staff demonstrate the use of the emergency equipment during the drills. From review of the Administrative Review Team (ART) minutes for August, October, and November 2010, there was no indication of who attended the meetings in November and October 2010. Although the pass rates for the drills were noted in the minutes of the ART, there continued to be no actual analysis regarding the content and quality of the drills, trends identified, or plans of correction generated to address any problematic issues. For example, the minutes, dated 10/21/10, indicated that a workgroup would be established to "work out the details of how to create a 'cheat sheet' to identify home by name and number." This was necessary to ensure timely emergency responses to the appropriate areas when a code was called, because most of the staff only knew the residences by their names, rather than by the building number. A review of the ART minutes for November 2010 had no follow up regarding this issue. Although few comments were found on the Life Threatening Emergency Drills, there was no indication that any problematic issues were addressed during the ART. The Facility should include issues found during the Life Threatening Emergency Drills in the ART meetings to ensure	

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		that all problematic issues have been adequately addressed. As noted previously, there was no documentation indicating who attended the ART meetings in October and November 2010, thus it was impossible to determine what disciplines were involved in the discussion of the Facility's emergency response system. In addition, consistent with the findings from the Monitoring Team's last two reviews, from the drills reviewed, there was no indication that the physicians participated in the drills. As noted in the previous two reports, 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 the staff's knowledge of emergency procedures Since the initial baseline review, the CNE had reported that the Facility planned to have an Automated External Defibrillator (AED) for every home. However, from the documentation the Facility provided, LBSSLC continued to have only eight AEDs and had not ordered the remaining seven at the time of the review. The Facility should obtain the remaining AEDs to ensure that emergency equipment is readily available for all individuals that reside at LBSSLC. The Monitoring Team's observations of emergency equipment use by staff in 504 West, Sparrow found a number of problematic issues. They included: ▪ The RN observed did not know where to obtain batteries for the AED, in the event the battery needed replacement; ▪ The RN observed reported that when the suction machine was wrapped in plastic, it was not turned on to check to see if it was operational; ▪ The RN observed reported she did not know how to use the portable suction machine; ▪ There was no check sheet being kept for the portable suction machine to ensure it was operational; ▪ There were a number of blanks found on the emergency check sheets indicating that the emergency equipment was not being checked daily to ensure it was operational; ▪ The RN observed stated that she was told not to use the Facility's backboards if needing to do CPR; and ▪ Back-up oxygen tanks were not being checked to ensure they had oxygen, and were operational. Although the Facility had documentation indicating that the nurse observed on site during the review had attended and passed the competency-based training regarding Emergency Medical Equipment/AED in July 2010, she was unfamiliar with the use of	

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		some of the emergency equipment in a residence where a number of medically compromised individuals lived. As recommended in previous reports, the Facility should implement a system in which nurses are observed checking the emergency equipment at least quarterly to ensure they are familiar with the use of the equipment. In addition, all emergency equipment, including back-up equipment should have documentation that it is being checked regularly, and it is in good working condition.	
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.	LBSSLC 's POI for this requirement indicated that since the last review, the Facility had provided nursing staff with a number of in-service training sessions in the following areas: ▪ Processing PCP orders; ▪ Use of the Lippincott Fundamentals of Nursing resource book; ▪ Policy for Positive Behavior Supports and Psychological Evaluations; ▪ Nursing Practice Act Updates; ▪ Medications in the Elderly; and ▪ Policies for Restraints and Revised Restraint Checklist. Of significant importance, in response to the Monitoring Team's consistent past findings indicating problems regarding nursing competency related to assessments, in March 2011, the State developed and implemented a competency-based pilot training program at LBSSLC, addressing physical assessment skills, and utilizing Nurse Practitioners with Development Disabilities experience as trainers. At the time of the review, the training program recently had been conducted, and had focused on training the RN Case Managers and Nurse Educators. The program consisted of a day of classroom instruction, followed by a day of competency-based demonstrations of assessment skills, which the RN participants performed on each other. Additional competency-based demonstrations of assessment skills were to be conducted for a quarterly assessment, a chronic condition follow-up, and an acute illness review or/or clinic follow-up. These demonstrations would be completed with an individual assigned to the RN Case Manger's caseload, and would be supervised by the Nurse Practitioner trainers. Based on review of the Physical Assessment Competency Guidelines for Evaluation Criteria (draft), the training being provided was thorough and reflective of appropriate competency-based training for nursing assessment skills. From discussions with the APRN consulting with State Office on this project, once all RNs at the SSLCs had completed the training, LVNs also would be provided competency-based training regarding assessments in alignment with their licensure. This competency-based training is essential to the forward movement towards compliance with the Settlement Agreement provisions related to nursing clinical issues. The competency-based training program that the State Office had initiated was a very promising step forward for nursing.	Noncompliance

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		Since the competency-based training described had only been initiated recently at LBSSLC in March 2011, there was no appreciable difference in the quality of the documentation in the Nursing Assessments since the last review. The Quarterly Nursing Assessments of 25 individuals were reviewed, including: Individual #258, Individual #261, Individual #175, Individual #210, Individual #109, Individual #225, Individual #171, Individual #114, Individual #269, Individual #7, Individual #135, Individual #253, Individual #323, Individual #154, Individual #276, Individual #122, Individual #146, Individual #313, Individual #264, Individual #37, Individual #204, Individual #213, Individual #6, Individual #15, and Individual #43. ▪ Of the 25 individuals' nursing quarterlies reviewed, 19 (76%) were timely completed. Assessments that were not timely completed included: Individual #146, Individual #258, Individual #225, Individual #7, Individual #135, and Individual #122. ▪ Consistent with the findings from the previous reviews, the quality of all was poor, and none of the 25 (0%) assessments were adequate, specifically regarding the nursing summary section. ▪ Overall, none (0%) of the Nursing Summaries contained in the assessments included an adequate analysis of the health/mental health data between the previous and current quarters. There were some improvements noted in the information provided in the body of the quarterly assessments. However, no notable differences were seen in the quality of the nursing summary sections in all assessments reviewed. From the variable formats that were used to write the nursing summaries, it was evident that the nursing staff completing the assessments were struggling when trying to write an analysis of the health/mental health issues for the individuals reviewed. Some of the nursing assessment summaries were noted to be lengthier, but did not include any type of an analysis regarding the information contained in the summaries. In other nursing assessment summaries, the nurse used the problems found in the nursing care plans as a format for the summary sections. However, the information that was included in the summaries was not an analysis of the problem, but rather statements about the problematic issues with a few interventions cited from the Nursing Care Plans. For example: ▪ The Nursing Assessment Summary for Individual #264, dated 2/4/11, stated: *D: Risk for break in skin integrity related to history of self inflicted scratches secondary to self injurious behavior (SIB).* *(Individual #264) had had an increase in SIB behaviors but has not caused infection from scratches to self.*	

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		P: Continue HMP (Health Management Plan) with quarterly charting by RN with prn charting for SIB and increased assessments and charting for exacerbation. This summary included no analysis of the Individual's skin breaks as compared to the previous quarter and was more about the nursing care plan rather than the individual's status. ▪ The Quarterly Nursing Assessment Summary, dated 11/29/10, for Individual #213 stated the following: *Vibramycin for Sinusitis. Treated for Tinea Cruris. Went to [hospital] to the ER for a fall which resulted in a fracture for his tibia/fibula. He had a rod placed. Upon returning to the facility, he was admitted to Quail for a few days since he was taking Lortab for pain. [Individual #213] also had a couple of episodes of choking and throwing up.* Clearly, the individual had experienced a major health issue regarding the fracture. However, there were no details provided as to how the fracture occurred, or which leg was fractured. In addition, there was no analysis addressing the episodes of choking and throwing up, cited in the summary. Basically, this nursing assessments contained superficial information without an adequate assessment of the individual's health status as compared to the previous quarter, and/or an analysis indicating if the individual was making progress related to their health/behavior issues. ▪ In another example, the Quarterly Nursing Summary, dated 10/21/10, indicated that Individual #15 had significant health issues that included on 10/19/10, a right breast mastectomy for Metastatic Breast Cancer, and on 10/21/10, placement of a pacemaker due to a complete heart blockage. The summary also indicated that he was started on Tamoxifen, a medication used to treat cancer, and had a CT Scan of the head to determine if the caner had metastasized to the brain. However, a review of the Quarterly Nursing Summary, dated 1/5/11, for this individual found that it was blank. A request was made for the Discharge Nursing Assessments for five individuals including: Individual #206, Individual #54, Individual #11, Individual #268, and Individual #44. The documentation from the Facility indicated that the summary documentation had not been completed for three individuals (Individual #206, Individual #54, and Individual #11) even though two individuals had been transitioned into the community in December 2010, and the third was transitioned in February 2011. The documentation provided by the Facility for Individual #44 and Individual #268 did not reflect nursing discharge summaries. The lack of documentation regarding nursing discharge summaries indicated that the Facility did not have an adequate and consistent procedure regarding the requirements for nursing and nursing documentation. The	

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		Comprehensive Nursing Assessments that were provided for Individual #11, Individual #54, and Individual #206 were actually the most recent quarterly Nursing Assessments and not an adequate discharge assessment. Consistent with the finding above, none of the five individuals (0%) that were transitioned to the community had adequate Comprehensive Nursing Assessments addressing discharges. The Facility should review its nursing discharge procedures and documentation requirements to ensure that documentation addressing discharges is adequate. Consistent with the past reviews, there continued to be a significant lack of clinical assessments for critical clinical health indicators, a lack of timely and appropriate follow-up on unresolved issues, a lack of an analysis of health/mental issues, and a lack of critical thinking found in all the nursing assessments reviewed. It is hoped that the State's efforts in implementing the competency-based training program for nursing assessment skills will result in improvements in the documentation of nursing assessments and summaries.	
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 last review, the Facility continued to use nursing protocols templates as nursing care plans. Based on discussions with the CNE and review of the Facility's POI, since the last review, there had been no competency-based training provided addressing Nursing Care Plans. In addition, at the time of the review, the Facility had no plan in place for when a competency-based training curriculum would be developed and implemented. Consequently, there has been no measurable difference in the quality of the Nursing Care Plans from the previous two reviews. The Facility should develop and implement a clinically sound competency-based training curriculum to ensure nurses are appropriately trained, and can demonstrate the ability to develop clinically adequate nursing care plans. The records of 18 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #56, Individual #210, and Individual #116, for Osteoporosis; Individual #199, Individual #193, Individual #66, and Individual #109, for Aspiration; Individual #15, Individual #127, and Individual #147, for cardiac; Individual #82, for weight issues; Individual #233, and Individual #306, for behavior; Individual #281, for skin integrity; Individual #280, and Individual #135, for constipation; Individual #139, for urinary tract infections; and Individual #174, for dental. Of the 18 individuals' Health Management Plans (HMPs) reviewed: ▪ Nine (50%) were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have a related HMP included: Individual	Noncompliance

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		#193, Individual #210, Individual #147, Individual #66, Individual #116, Individual # 174, Individual #233, Individual #306, and Individual #135. ▪ None (0%) of the nursing interventions contained in the HMPs indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. ▪ None (0%) of the HMPs were found to be clinically adequate. ▪ None (0%) of the HMPs included proactive interventions addressing the health indicator. ▪ None (0%) of the HMPs were adequately individualized. As noted during previous reviews, the HMPs reviewed lacked any individual-specific interventions based on the individuals' needs, and did not provide adequate direction for caring for individuals who were identified as being at high risk for a n umber of health indicators. Also, consistent with previous reviews' findings, the nursing interventions contained in the HMPs included no proactive interventions directed at preventing or minimizing the specific health risks. For example: ▪ Individual #139 was identified as being at high risk for urinary tract infections. His HMP for this issue included the following interventions: o *Assess for and report signs and symptoms of urinary tract infection (cloudy urine, reports of chills, elevated temperature, urinalysis showing a WBC [White Blood Count] greater than 5 or the presence of nitrites or bacteria, positive urine culture);* o *Encourage fluid intake as ordered;* o *Reposition every 2 hours between wheelchair and daybed* o *Wash and dry peri-area promptly after urination and do 30 minutes diaper checks change if necessary; and* o *Administer medications and treatments as ordered.* This HMP included no individualized information, such as the fact that he had a suprapubic catheter, which would render the intervention regarding washing and drying peri-area promptly after urination not appropriate for this individual. In addition, no indication was provided of how much fluid he should be receiving daily to assist in preventing a UTI. Also, no mention was made regarding the care of the suprapubic catheter to focus staff's efforts at the prevention of a UTI. The HMP provided no indication of how often staff were to assess for signs and symptoms of a UTI, or where these assessments were to be documented. Based on review of the HMPs, the Facility was using both the old templates for the nursing care plans, as well as some of the new protocol templates. Consistent with the	

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		previous reviews, the interventions contained in both the old and new HMPs were clinically inadequate, and did not address preventative interventions, or interventions that would minimize the individuals' identified health risks. In order to attain the goal of quality Health Management Plans, the Health Care Protocols/Nursing Care Plans should be modified to include appropriate goals, and should be significantly individualized. In addition, as required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should occur regardless of the format, so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all health management plans. Consideration should be given to the use of an integrated health management plan that would incorporate all clinical disciplines' goals and interventions into one plan. An additional sample of individuals' records was reviewed to determine if individuals with infectious diseases had appropriate care plans to address their needs. Specifically, a review was completed of 16 individuals diagnosed with a variety of infectious diseases, including: Individual #265, Individual #202, Individual #104, Individual #266, Individual #135, Individual #107, Individual #199, Individual #284, Individual #257, Individual #15, Individual #299, Individual #113, Individual #17, Individual #50, Individual #160, and Individual #300. ▪ Of the 16 individuals reviewed, 10 (63%) had Nursing Care Plans addressing the infectious issue. Those that did not have a related Nursing Care Plan included: Individual #202, Individual #107, Individual #199, Individual #284, Individual #15, Individual # 299. ▪ Of the 10 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. Some of the deficiencies noted included: o The significant lack of individualization of the Nursing Care Plan template; o The lack of criteria for 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; o The lack of interventions addressing teaching and education for staff, as well as the individual regarding prevention of the spread of the infection; o The lack of proactive interventions; and o The lack of documentation demonstrating that interventions were actually being implemented. For example, the Nursing Care Plans for Individual #50, Individual #160, and Individual #300 were the identical copies of the nursing protocol for positive Purified Protein Derivative (PPDs). Aside from the individuals' names, the care plans were the same. From discussions with the IC Nurse, no system had been implemented to review the	

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		nursing care plans addressing infectious issues to ensure that they were clinically appropriate, individualized, and being implemented. Although the Facility's POI indicated that in-service training sessions were provided for staff regarding multi-drug resistant organisms, isolation, and MRSA/ORSA, there was no indication that the training provided impacted the quality of the Nursing Care Plans for this area. As noted in previous reports, it is imperative that nursing staff develop and implement clinically sound individualized Nursing Care Plans due to the clinical ramifications of not having adequate nursing care plans addressing infectious and communicable diseases. Consistent with the findings of the previous reviews, there continued to be no system in place that ensured that individuals with infectious diseases were actually being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. Nursing Administration, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that the Nursing Care Plans addressing infectious and communicable diseases are clinically adequate, individualized, and are consistently being implemented.	
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.	LBSSLC 's POI indicated that since the last review, the Facility had provided a number of in-service training sessions on the following areas: ▪ Adult sliding scale/hypoglycemia; ▪ Lab/x-ray requisitions; ▪ Red emergency phone use during life threatening emergency drills; ▪ Emergency Drills; ▪ Specimen Collection; ▪ Dehydration; ▪ Post Anesthesia Recovery; ▪ Infection Control Policy; ▪ Prevention and Treatment of Pica; and ▪ "Quality of Life Issues in the Developmentally Delayed." Although these important in-service training sessions were provided, there had been no modifications made to the procedures and protocols contained in the resource books obtained by the Facility. Such modifications were needed to bring them into alignment with the Facility's structure and systems. These modifications should include the specific responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, the frequency of these assessments, and the parameters and time frames for the reporting of symptoms to the practitioner/physician. Consequently, without appropriate nursing protocols in place, the Facility had no system guiding the nursing documentation to ensure that appropriate nursing assessments were conducted and documented at the appropriate frequency, and that there was timely	Noncompliance

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		communication with practitioners/physicians regarding changes in status. The consistent significant negative findings described with regard to Section M.1 related to the nursing assessment and documentation of individuals with acute changes in status reflected the lack of protocols in the Nursing Department. From discussions with the CNE, there seemed to be a lack of understanding regarding the elements of this requirement, and that the procurement of the State-approved resource books did not meet the criteria for compliance with this requirement. In order for the Facility to be in compliance with this requirement, the Facility should develop and implement nursing protocols that include specifics such as the responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type and frequency of assessments that should be conducted, and the timely reporting of symptoms to the practitioner/physician. At the time of the review, the Facility did not have a plan for when the procedures and protocols would be developed/modified, and implemented. The findings discussed in detail above with regard to Sections M.1, M.2 and M.3 of the Settlement Agreement reflect the crucial need for nursing protocols. Consistent with the previous two reviews, LBSSLC was clearly failing to adequately and timely address the health care needs of the individuals residing at the Facility.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	Since the last review at LBSSLC, the State and the SSLCs had developed a policy for At-Risk Individuals. The policy included Risk Guidelines, which contained criteria to serve as a guide to assist the teams in determining appropriate risk levels for the designated risk factors. The review of risks and the assignment of the risk levels were to occur during PST meetings. The Facility reported that all individuals would have their risk assessments and risk level ratings completed at either their regularly scheduled quarterly or annual PSPs, if the meetings occurred before May 2011. For those individuals whose annual PSP or quarterly review dates fell after May 2011, the Facility scheduled an additional risk meeting (PSP addendum meeting) to ensure that by the end of May 2011, all individuals residing at the Facility would have their risks reviewed. The new At-Risk policy indicated that nursing, in conjunction with the PCP, was responsible for assessing risk factors in the following categories: ▪ Aspiration; ▪ Respiratory Compromise; ▪ Cardiac Disease; ▪ Constipation/Bowel Obstruction; ▪ Diabetes; ▪ Gastrointestinal Problems; ▪ Osteoporosis; ▪ Seizures; ▪ Skin Integrity;	Noncompliance

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		▪ Infections; ▪ Fractures; ▪ Fluid Imbalance; ▪ Hypothermia; ▪ Urinary Tract Infections; and ▪ Circulatory. Although the new policy did not indicate that the Risk Assessment Tool-Nursing was to be used by nursing, the CNE reported that the nurses were continuing to use this tool to assess risks in the above categories. The Facility's POI indicated that the Facility had begun the implementation of the process of the new At-Risk Individuals policy in October 2010, and that all RNs and Case Managers received training on the new policy and the use of the new risk assessment tool. The Facility's POI indicated that: "first quarter analysis of monitoring reflects a compliance score of 72% in the area of nursing integration in the new process." However, there was no indication as to how this score was determined and what data it reflected. To assess the Facility's risk screening process, members of the Monitoring Team observed six individuals' PSP meetings or PSP addendum meetings (Individual #259, Individual #198, Individual #92, Individual #89, Individual #7, and Individual #62) while on site. Overall, the Monitoring Team noted some improvements, although not consistent, in the clinical discussions, and the use of supporting clinical data and the new Risk Guidelines, when the PSTs were discussing and determining the individuals' risk levels. Some problematic areas included team members not being aware of significant medication changes, and rating risks at a lower standard than would be used in a community setting. Specific findings are provided with regard to Section I.1 of the Settlement Agreement. Although the Monitoring Team noted some positive improvements in the at-risk process from the previous reviews, the Facility should consider additional training for PSTs to ensure that the at-risk process adequately identifies critical issues, so that appropriate and clinically sound action plans can be developed. A review of the Health Risk Assessment Tools-Nursing for 10 individuals who the Facility reported were assessed for risk using the new policy, and had been designated as being at high risk for health indicators (Individual #146 for choking and weight; Individual #313 for constipation and osteoporosis; Individual #264 for dental; Individual #37 for dental and weight; Individual #204 for GI and osteoporosis; Individual #213 for falls, fractures, and behaviors; Individual #6 for aspiration and osteoporosis; Individual #43 for GI, osteoporosis, and skin; Individual #15 for cardiac; and Individual #56 for osteoporosis) found none (0%) of the documentation contained in the Nursing Risk	

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		Assessments adequate. No Risk Assessment Tools were found for Individual #313, and Individual #264. The Risk Assessments for Individual #146, Individual #204, Individual #15, Individual #37, Individual 56, Individual #213, Individual #6, and Individual #43 did not include adequate individual-specific clinical data supporting the risk level. For example, the Risk Assessment Tool for Individual #6 who was identified as being at high risk for aspiration and osteoporosis did not include any supporting documentation indicating how the individual was diagnosed with osteoporosis, such as noting the data and score of a Dexa Scan. In addition, there was no supporting clinical data included on the assessment tool addressing the individual's status regarding aspiration. It also was noted that there were different forms/versions used of the Risk Assessment Tool, and five individuals' tools (Individual #146, Individual #313, Individual #264, Individual #204, and Individual #43) did not include the date when the tool was actually completed. In addition, for three individuals' tools (Individual #37, Individual #213, Individual #6) the dates when they were completed had been months prior to the PST date. For example the Risk Assessment Tool for Individual #37 was dated 7/27/10, while the PST was held on 1/12/2011. There was no indication that the Risk Assessment was reviewed and/or updated in preparation for the PST meeting. Additional findings are provided with regard to Section I.1. Although some improvement was noted from observations of the PST meetings while onsite, nursing should continue to focus its energies on ensuring that the Risk Assessment Tools for Nursing are adequately and appropriately completed, using clinical data to support health issues. An adequate at-risk system is critical in ensuring that those individuals who warrant the most clinical intensity are appropriately identified and provided adequate care. A number of examples have been provided throughout the findings in Sections M.1, M.2, and M.3 of the continued consistent lack of clinical interventions for individuals who were at risk. At the time of the review, LBSSLC's POI indicated 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	Since the last review, the Facility's POI indicated that the Nurse Educator and the Assistant Nurse Educator were assigned responsibility for the oversight of the monitoring of the medication observations. Also, the State-wide policy addressing Medication Administration Guidelines had been revised appropriately to reflect that all	Noncompliance

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	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.	nurses were to be observed administering medications at least quarterly. In addition, the CNE and the Clinical Pharmacist reported that they had been collaborating to improve the training and the process of medication administration. The Facility reported that training was provided in August and September 2010 to nursing staff regarding physicians' standing orders, the use of Pro-Stat, medication refusals, and controlled medications. However, no curricula were provided addressing the content of the training. In addition, percentages of staff attending the trainings was noted at the top of each of the training rosters, without information addressing how many RNs and LVNs were required to attend the trainings, and how many of each groups actually attended. Consequently, the percentages of staff attendance could not be accurately verified. The Facility's POI indicated that: "monitoring results reflected an overall compliance score of 87% in managing medication. An overall compliance score of 84% is seen in managing medication errors and an overall compliance of 96% in medication administration." However, there was no indication as to how these compliance scores were determined, or what the data represented. In addition, from the documents reviewed addressing LBSSLC's medication system, the Facility clearly was not in compliance with the requirements of the Settlement Agreement in this area. At the time of this review, there had been no process implemented to establish inter-rater reliability for medication observations. This process needed to be conducted since the Facility was using at least 25 different nurses (Case Managers, QA Nurse, Nurse Educators, and CNE) to complete medication administration observations. Inter-rater reliability was necessary to ensure that each auditor for this area was competent, and accurately and appropriately scoring compliance for the medication observations, resulting in the production of reliable data to accurately identify areas of strength and weakness. Such data then needed to be analyzed, and targeted plans of correction implemented to address deficient areas. A review of 67 Medication Administration Observations from September 2010 through February 2011 revealed that few problematic issues were identified, which did not comport with the Monitoring Team's findings during a medication administration observation while on site. From review of the Medication Observation Tracking 2009 data sheets, Medication Administration Observation (MAO) Quarterly report, and the Case Manager Medication Observation Tracking sheets the Facility provided, there was no indication that nurses at the Facility were consistently being observed administering medications every quarter. Also, as noted in the Monitoring Team's previous reports, the Facility produced no formal report summarizing and analyzing the issues found from medication observations. Furthermore, the Medication Error Committee minutes or	

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		Pharmacy and Therapeutics Committee minutes did not address any findings from these audits. When observing medication administration while on site for individuals living in the Quail residence, the following significant issues were identified, which also were found during the previous two reviews, most of which placed the individuals involved at risk. Specifically, the nurse did not: ▪ Ensure the individual was in the proper positioning prior to medication administration; ▪ Utilize the PNMP when administering medications; ▪ Pour liquids at eye level to ensure the correct dosage; ▪ Wash her hands consistently between individuals receiving medication; ▪ Use privacy screens consistently; ▪ Listen to lung sounds for individuals coughing before, during, or after receiving medications; ▪ Use gloves consistently when manipulating tubes; ▪ Tell individuals what she was doing and what medications she was administering; and ▪ Receive training on the PNMPs for individuals she was responsible for administering medications. In addition, a review of the MARs for the individuals from the Quail residence found a significant number of blanks on the MARs for carts A, B, C, and D. The Monitoring Team's onsite finding resulted in the Facility generating 117 Medication Error Reports. This finding did not comport with the Facility's medication variance data as reported below. The CNE reported that the Case Managers were conducting spot check audits of the MARs. However, the documentation provided by the Facility indicated that these spot checks were conducted by observation and not documented. The number of MAR blanks found indicated a significant breech in medication administration practices, and a critical lack of nursing supervision. The Facility should develop and implement a system to ensure that nurses are appropriately administering and documenting medications. In addition, the Facility should formalize the system of MAR spot checks to ensure that they are actually being conducted, and to ensure that any MAR blanks are timely investigated to determine if these blanks represent documentation and/or actual omission errors. A review of the Facility's Medication Error Report noted the following medication variances per month: ▪ September 2010 – 4; ▪ October 2010 – 3; ▪ November 2010 – 2;	

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		▪ December 2010 – 4; ▪ January 2011 – 2; and ▪ February 2011 – 2. As noted from the Pharmacy and Therapeutics Committee Meeting minutes dated 12/14/10, it was estimated that 122,400 doses of medication were administered at LBSSLC in September 2010, 124,746 in October 2010, and 120,140 in November 2010. Since the baseline review, the Facility's medication variance data had indicated that the Facility had a significant problem with the under-reporting of medication variances. In addition, the minutes of the Brainstorming Work Session, dated 3/9/11, indicated that a significant number of medications were returned to the pharmacy at the end of the seven-day fill period. The minutes noted that "hundreds of doses a month are being returned and many cannot be explained." Although there continued to be serious problematic issues regarding the medication administration and medication variance systems at LBSSLC since the previous review, the minutes of the Brainstorming Work Session meeting reflected that a thorough and promising systematic process was initiated by the Clinical Pharmacist and the committee to generate some initial responses to the following inquires: A. "Identify how medications get to the home for administration to residents; B. Identify circumstances/reasons that require extra medications be sent to the homes by pharmacy; C. Identify any other ways in which additional medications could get to the home; D. Identify events that happen on the home that would cause extra medications to be left at the end of the fill period; E. Identify policies in place (followed and not followed) re: return of medications to pharmacy from the homes before the end of the fill period; and F. Other Findings." Implementing this process of critically reviewing the medication system should result in the identification of system breakdowns. This will provide the opportunity for the development and implementation of policies and procedures to ensure the reliability of the Facility's entire medication system and safe medication practices. As noted in the Monitoring Team's previous reports, no formal report was generated reflecting an analysis of Facility's medication variances. However, once reliable data is collected with regard to the Facility's medication system, the medication variance data 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. The next step would be for strategies and corrective actions to be	

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		developed and implemented to address the problems identified. In addition, although the Facility had modified the format of the Medication Error Committee Meeting minutes since the last review, the current format was very superficial, and did not include enough information to determine what actions were actually being initiated, when they were initiated, who was responsible for the implementation, and what the outcomes were. The Facility should develop an appropriate format for the minutes of the Medication Error Committee to include issues such as a detailed analyses of the variance data, problematic trends identified, correction actions taken and when initiated, and the resulting outcomes. As noted in the past two reports, the Facility should consider expanding their medication error system into a medication variance system that would extend the scope of the review of the medication system. As noted previously, the current medication error system the Facility had in place was limited to the reporting and the reviewing of errors addressing the wrong patient, wrong time, wrong dose, wrong route, wrong drug, wrong technique, and omitted medications. A medication variance system expands the review to include not only these issues, but also issues related to the entire medication system, as well as proactively reviewing areas of potential variances. Consistent with the findings of the past two reviews, the Facility was not in compliance with the elements of this requirement.	

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 reallocations of nursing positions to meet the requirements of the Settlement Agreement.
2. As the Facility continues to implement its monitoring systems, a procedure addressing the establishment of inter-rater reliability should be developed and implemented, and staff that are assigned monitoring duties should be trained regarding this process.
3. Data generated from the monitoring tools should be reviewed regularly, addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems.
4. The Facility should develop a unified system to present the data from the monitoring tools in a meaningful way, so that the data can be easily analyzed and trends identified. In addition, a unified system also would allow data to be easily reviewed and interpreted between disciplines and departments.
5. The QA Nurse, and the Nursing Department should have regular discussions regarding the data generated from the monitoring process to ensure that all areas are being critically audited, and auditing focuses on the quality of the nursing services.
6. In conjunction with the newly developed competency-based training, the Nursing Department should establish appropriate nursing protocols to drive nursing documentation in order to build an adequate system that will have a lasting effect on the clinical outcomes for the individuals at LBSSLC.
7. Due to the significant problematic issues consistently found regarding Urgent Care, ER Visits, and Hospitalizations, the Nursing Department should begin generating and implementing plans of correction addressing the problematic issues.

8. The Facility should ensure that the documentation from the Hospital Liaison Nurse is timely filed in the individuals' medical records.
9. The Facility should continue to develop and implement systems to ensure that medical records are accessible, and that documents are filed in a timely manner, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
10. Both the IC Nurse and IC Assistant should continue to attend regular IC training to continue to increase their expertise in this clinical area.
11. The Facility should develop and implement formal procedures regarding how different systems are used to ensure reliability of infection data. The procedures should address specific information, such as when data are collected from each system, how discrepancies between the systems are tracked and addressed, and where unit reporting falls into the data collection system.
12. 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.
13. The Infection Control Committee should review the data generated from the Standard Precautions Monitoring Tool, in conjunction with the data addressing actual infectious processes. As appropriate, corrective action plans should be developed and implemented.
14. For the areas that have not conducted or inconsistently conducted these audits, the Facility should address the lack of completed Standard Precautions Monitoring Tool audits.
15. The Facility should consider formalizing the spot check audits for hand washing to ensure regular spot checks are conducted in different areas to generate additional data regarding hand-washing practices of the staff.
16. The audits the IC nurse conducts should be focused audits done in real-time, which include all individuals who have a contagious, infectious medical issue. The expertise of the IC Nurse would be better utilized reviewing these cases at the time they are identified to ensure that the appropriate infection control practices are being implemented.
17. 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 nurses, in conjunction with the practices on the units.
18. Training should be implemented, particularly for supervisory staff, regarding when the IC Nurse needs to be notified regarding staff illnesses.
19. The Facility should review the processes that were implemented for the scabies outbreak, and include them in the Facility's policies and procedures.
20. As noted from previous reports, additional expertise in Infection Control is needed to assist in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement.
21. 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.
22. There should be interdisciplinary collaboration with the CTD Department regarding medical emergency drills and the Facility's emergency systems.
23. 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.
24. The Facility should obtain the remaining AEDs to ensure that emergency equipment is readily available for all individuals that reside at LBSSLC.
25. 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.
26. 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.
27. The Facility should implement a system in which nurses are observed checking the emergency equipment at least quarterly to ensure they are familiar with the use of the equipment.

28. The Facility should review its nursing discharge procedures and documentation requirements to ensure that documentation addressing discharges is adequate.
29. The Facility should continue to participate in the competency-based training curricula for nursing assessments skills.
30. The Facility should develop and implement a clinically sound competency-based training curriculum to ensure nurses are appropriately trained and can demonstrate the ability to develop clinically adequate nursing care plans.
31. 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.
32. Nursing Administration, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that the Nursing Care Plans addressing infectious and communicable diseases are clinically adequate, individualized, and are consistently being implemented.
33. The Facility should develop and/or modify nursing policies, procedures, and protocols that include specifics such as the responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type and frequency of assessments that should be conducted, and the timely reporting of symptoms to the practitioner/physician. Once policies are developed, nursing staff should be provided with competency-based training on their implementation.
34. 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.
35. 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.
36. Although the Monitoring Team noted some positive improvements in the at-risk process from the previous reviews, the Facility should consider additional training for PSTs to ensure that the at-risk process adequately identifies critical issues, so that appropriate and clinically sound action plans can be developed.
37. Nursing should continue to focus it energies on ensuring that clinical data related to health issues are consistently used to determine risk levels and to complete the Integrated Risk Tools.
38. The Facility should ensure that nurses who are auditing medication administration observations are competent in the process of medication administration to ensure the Facility is receiving accurate data on the medication practices of the nursing staff.
39. The Facility should develop and implement a system to ensure that nurses are appropriately administering and documenting medications.
40. The Facility should formalize the system of MAR spot checks to ensure that they are actually being conducted, and to ensure that any MAR blanks are timely investigated to determine if these blanks represent documentation and/or actual omission errors.
41. Once reliable data is collected with regard to the Facility's medication system, the medication variance data 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. The next step would be for strategies and corrective actions to be developed and implemented to address the problems identified.
42. The Facility should develop an appropriate format for the minutes of the Medication Error Committee to include issues such as a detailed analyses of the variance data, problematic trends identified, correction actions taken and when initiated, and the resulting outcomes.
43. 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; o Single Patient Intervention Reports with signed doctors' copies; o Orders entered in one month – February 2011; o All chemical restraints LSSLC, report date 9/1/10 to 3/23/11; o All chemical restraints LSSLC, report date 8/1/10 to 1/31/11; o LBSSLC Summary of Chemical Restraints FY 2011, September to March: Sources: WorX STAT order report and Psychology Restraint Database; o Chemical restraint trend analysis: LBSSLC Restraint Trends through January 2011; o Face-to-face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint for the following: Individual #175, dated 9/23/10, pharmacy review date 10/19/10; Individual #306, dated 9/26/10, pharmacy review date 9/28/10; Individual #288, dated 11/1/10, pharmacy review date 11/2/10; Individual #34, dated 11/3/10, pharmacy review date 11/4/10; Individual #34, dated 11/3/10, pharmacy review date 11/4/10; Individual #51, dated 11/14/10, pharmacy review date 11/16/10; Individual #240, dated 12/8/10, pharmacy review date 2/22/11; Individual #51, dated 12/28/10, pharmacy review date 12/29/10; Individual #288, dated 2/5/11, pharmacy review date 3/4/11; Individual #190, dated 2/15/11, pharmacy review date 3/8/11; Individual #51, dated 2/18/11, pharmacy review date 3/4/11; Individual #33, dated 3/2/11, pharmacy review date 3/14/11; Individual #4, dated 3/5/11, pharmacy review date 3/17/11; Individual #4, dated 3/5/11, pharmacy review date 3/17/11; Individual #33, dated 3/10/11, pharmacy review date 3/30/11; Individual #4, dated 3/11/11, pharmacy review date 3/11/11; Individual #4, dated 3/11/11, pharmacy review date, dated 3/22/11; and Individual #33, dated 3/14/11, pharmacy review date 3/22/11; o Quarterly Drug Regimen Reviews (QDRRs) for the following individuals with dates of review: Individual #52, dated 1/13/11; Individual #146, dated 2/16/11; Individual #318, dated 2/16/11; Individual #6, dated 1/13/11; Individual #250, dated 1/13/11; Individual #70, dated 2/22/11; Individual #183, dated 2/16/11; Individual #26, dated 2/16/11; Individual #203, dated 2/16/11; Individual #1, dated 2/14/11; Individual #222, dated 2/16/11; Individual #299, dated 2/16/11; Individual #100, dated 1/13/11; Individual #35, dated 2/14/11; Individual #210, dated 1/13/11; Individual #296, dated 1/13/11; Individual #306, dated 2/14/11; Individual #99, dated 2/16/11; Individual #291, dated 1/13/11; Individual #170, dated 2/14/11; Individual #238, dated 2/16/11; Individual #45, dated 2/14/11; Individual #245, dated 2/14/11; Individual #290, dated 1/13/11; Individual #178, dated 2/16/11; Individual #113, dated 1/13/11; Individual #190, dated 2/16/11; Individual #95, dated 2/14/11; Individual #68, dated 1/13/11; Individual #271, dated 2/14/11; Individual #266, dated 2/14/11; Individual #143, dated 2/14/11; Individual #174, dated 2/15/11; Individual #132, dated 2/22/11; Individual #135, dated

	2/14/11; Individual #202, dated 2/14/11; Individual #315, dated 2/14/11; Individual #223, dated 1/13/11; Individual #302, dated 1/13/11; Individual #201, dated 2/16/11; and Individual #156, dated 2/16/11; o DISCUS reviews for the following individuals (identified by rater review dates): Individual #276, dated 11/30/10, 2/7/11; Individual #159, dated 11/29/10, 2/7/11; Individual #107, dated 11/29/10, 2/9/11; Individual #233, dated 11/30/10, 2/9/11; Individual #235, dated 11/30/10, 2/8/11; Individual #82, dated 11/29/10, 2/7/11; Individual #166, dated 11/30/10, 2/9/11; Individual #34, dated 11/30/10, 2/8/11; Individual #147, dated 11/29/10, 2/7/11; Individual #65, dated 11/30/10, 2/7/11; Individual #322, dated 11/30/10, 2/9/11; Individual #61, dated 11/29/10, 2/7/11; Individual #284, dated 11/29/10, 2/9/11; Individual #237, dated 11/30/10, 2/7/11; Individual #94, dated 11/30/10, 2/9/11; Individual #50, dated 11/29/10, 2/9/11; Individual #111, dated 11/29/10, 2/7/11; Individual #279 , dated 11/29/10, 2/7/11; Individual #140, dated 11/30/10, 2/7/11; Individual #220, dated 2/8/11; Individual #300, dated 11/30/10, 2/7/11; Individual #131, dated 1/31/11; Individual #155, dated 11/29/10, 2/7/11; Individual #232, dated 11/29/10, 2/9/11; Individual #124, dated 2/9/11; Individual #8, dated 11/29/10, 2/9/11; Individual #60, dated 11/30/10, 2/7/11; Individual #239, dated 11/29/10, 2/7/11; Individual #97, dated 1/31/11; Individual #106, dated 11/29/10, 2/7/11; Individual #165, dated 11/30/10, 2/7/11; Individual #25, dated 11/29/10, 2/7/11; Individual #288, dated 11/30/10, 2/9/11; Individual #310, dated 11/29/10, 2/7/11; Individual #259, dated 11/29/10, 2/7/11; Individual #255, dated 11/29/10, 2/9/11; Individual #240, dated 11/29/10, 2/7/11; Individual #274, dated 11/29/10, 2/9/11; Individual #121, dated 11/30/10, 2/7/11; Individual #197, dated 11/29/10, 2/7/11; Individual #253, dated 5/25/10, 2/7/11; and Individual #241, dated 11/29/10, 2/7/11; o MOSES reviews for the following individuals (identified by rater review dates): Individual #154, dated 7/26/10, 1/28/11; Individual #38, dated 7/26/10, 1/28/11; Individual #36, dated 7/27/10, 1/28/11; Individual #213, dated 7/26/10, 1/28/11; Individual #1, dated 7/26/10, 1/31/11; Individual #203, dated 2/15/11; Individual #235, dated 7/5/10, 1/25/11; Individual #166, dated 1/25/11; Individual #35, dated 7/26/10, 1/31/11; Individual #306, dated 7/26/10, 1/31/11; Individual #10, dated 7/26/10, 1/28/11; Individual #108, dated 7/27/10, 1/28/11; Individual #61, dated 7/2/10, 1/24/11; Individual #237, dated 7/1/10, 1/24/11; Individual #50, dated 9/24/10; 1/26/11; Individual #279, dated 8/26/10, 1/24/11; Individual #170, dated 7/26/10, 1/31/11; Individual #45, dated 7/26/10, 1/31/11; Individual #140, dated 7/6/10, 1/25/11; Individual #245, dated 7/26/10, 1/31/11; Individual #220, dated 7/6/10; Individual #300, dated 7/6/10, 1/25/11; Individual #131, dated 1/24/11; Individual #155, dated 7/6/10, 1/25/11; Individual #95, dated 7/26/10, 1/31/11; Individual #232, dated 7/9/10, 1/25/11; Individual #124, dated 2/7/11; Individual #60, dated 7/6/10, 1/24/11; Individual #251, dated 7/26/10, 1/28/11; Individual #125, dated 7/26/10, 1/287/11; Individual #239, dated 7/6/10, 1/24/11; Individual #143, dated 7/26/10, 1/31/11; Individual #320, dated 7/26/10, 1/28/11; Individual #271, dated 7/26/10,

	1/31/11; Individual #266, dated 7/26/10, 1/31/11; Individual #135, dated 7/26/10, 1/31/11; Individual #288, dated 7/2/10, 1/24/11; Individual #134, dated 7/27/10, 1/28/11; Individual #315, dated 7/26/10, 1/31/11; Individual #202, dated 7/26/10, 1/31/11; Individual #240, dated 7/2/10, 1/25/11; Individual #75, dated 7/26/10, 1/28/11; and Individual #84, dated 7/26/10, 1/28/11; o Drug Utilization Evaluation (DUE) Calendar Fiscal Year 2010 to 2011; o Adjunct Study – Phenytoin Administration in Residents receiving Enteral Feedings; o Adjunct Study to Phenytoin DUE, Phenytoin Administration with enteral feedings, August 2010; o Adjunct Study to Phenytoin DUE, Phenytoin Administration with enteral feedings, December 2010 follow up; o Phenytoin/enteral feeding follow-up work session, October 13, 2010; o Drug Utilization Review form: Drug Audited: Clozapine; o Drug Utilization Evaluation form: Clozapine, Summary of Findings; o Drug Utilization Evaluation form: Drugs Audited: Proton Pump Inhibitors; o Drug Utilization Evaluation Report, dated 12/10/10, Drugs audited: Proton Pump Inhibitors; o Lacosamide DUE, dated 3/29/11, P&T review; o Pharmacy and Therapeutics Committee minutes, dated 9/14/10; o Pharmacy and Therapeutics Committee minutes, dated 12/14/10; o Pharmacy and Therapeutics Committee agenda, dated 3/29/11; o Monthly Facility Review Psychoactive Medication Polypharmacy, dated 9/28/10, 10/26/10, 11/18/10, 12/21/10, 1/25/11, and 2/25/11; o Polypharmacy and Psychoactive Medications graphs, from 9/10 to 3/11; o Psychotropic Medication Review Reports for the following: Individual #233, Individual #82, Individual #175, Individual #106, Individual #58, Individual #302, and Individual #51; o LBSSLC Policy: Health Services – Controlled Medications, revised 10/27/10; o Policies, procedures, and/or other documents addressing medication administration; o Medication Errors January 2010 to January 2011 per month, medication errors per resident; o LBSSLC Monthly Medication Error Report January 2010 to January 2011; o For the past six months, any Adverse Drug Reaction (ADR) reports completed; o LBSSLC Monthly Case Manager Medication Observation Tracking, January-February 2011; o Medication Error Committee Meeting Minutes, dated 2/9/10, 8/25/10, and 9/7/10; o Medication Error Committee Meeting Minutes, dated 3/9/11; o Last 10 medication error forms completed; o Individuals with antipsychotics identified, from 8/1/10 to 1/31/11, run date 2/10/11; o LBSSLC draft policy: Adverse drug reaction reporting, draft date 2/2011, with background literature "ASHP (American Society of Hospital Pharmacists) Guidelines on Adverse Drug Reaction Monitoring and Reporting," Naranjo ADR Probability Scale; o Table: Unexplained Returned Medication Doses, fiscal year 2010-11;

	○ Brainstorming work session: Returned medications, Agenda and Minutes, dated 3/9/11; ○ Medication Error Summary by Home for September 2010 to February 2011; ○ Medication Error Summary by Type for September 2010 to February 2011; ○ Medication Error Summary by Month (with error rate%), dated September 2010 to February 2011; ○ Medication Error Severity Scoring for January 2010 to January 2011; ○ Quarterly Drug Review Date Comparison (current and previous QDRR dates); ○ Quarterly Drug Review Schedule 2011; ○ Orders entered from 2/1/11 to 2/28/11; ○ Individuals prescribed intra-class polypharmacy; and ○ MOSES/DISCUS Monitoring form for nursing/psychiatry/pharmacy. ▪ **Interviews with**: ○ Billy Bob Beck, R.Ph. Director of Pharmacy; and ○ John Todd, R.Ph., Clinical Pharmacist. ▪ **Observations of**: ○ Pharmacy and Therapeutics Committee meeting, on 3/29/11.
	Facility Self-Assessment: According to the Facility's POI, the pharmacy had increased recently the breadth of review done at the time of every new order. They had been using the software program in the WORx system, and now had added the software program, Avatar, which allowed for retrieval of laboratory test results for each individual. This will assist with compliance in Section N1. According to the Facility's POI, quarterly drug regimen reviews had been expanded to include important lab values, as well tracking each psychotropic agent to ensure a psychiatric diagnosis was provided. There was an additional entry for anticholinergics and benzodiazepine use. The Facility indicated that the use of "stat" medication for emergency restraints was successfully reported and tracked (although discrepancies remained between databases), allowing prompt input by the pharmacy staff for each chemical restraint. The Facility also reported that polypharmacy was being addressed, as well as ensuring the PCP (and psychiatrist, if appropriate) reviewed the recommendations. Comments or lack of agreement was recorded on the QDRR, reviewed by the pharmacist, and filed in the record. The POI indicated that drug utilizations were completed quarterly, and there was a calendar for the next several quarters. The Facility also reported that analysis of medication errors had continued, as well as an ongoing effort to reduce the medication error rate. According to the POI, the Facility had determined that it was in compliance with Section N.2, which addresses laboratory entries in the Quarterly Drug Regimen Review. The Facility had also determined that it was compliant with Section N.5, which addresses the quarterly monitoring of tardive dyskinesia using a validated rating instrument. The Facility also had determined that it was compliant with Section N.7, requiring the timely completion of drug utilization evaluations. Based on the Facility's self-assessment process, it was determined that the Facility remained out of compliance with Sections N.1, N.3, N.4, N.6, and N.8, although progress had been made in each of these sections. It should be noted that although the narrative descriptions of many of the steps taken to comply with the

	Settlement Agreement were helpful, the Facility provided no objective data to substantiate its findings of substantial compliance or noncompliance. For example, no data was provided related to audits completed to show that the efforts that were described had had the desired impact on the supports and services being provided to the individuals LBSSLC supported. As the Facility's self-assessment process develops, it will be critical for this to be included as one component of the POI. The Facility's findings with regard to compliance were consistent in some cases with those of the Monitoring Team, but not in others. Both the Facility and Monitoring Team found compliance with Section N.7. The Monitoring Team did not find substantial compliance with Sections N.2 or N.5, but the Facility did.
	Summary of Monitor's Assessment: The Pharmacy Department had made progress in many areas. In some areas they had achieved compliance, and in other areas were approaching compliance. There was a thorough review of new orders, and the recent additional capability to review lab results should allow compliance to be achieved. The quarterly drug regimen review process was an area that had improved over time. However, the Facility was not consistently completing them on a quarterly basis, due to a misinterpretation of how to calculate quarterly reviews. The Facility had interpreted this to mean completion any time within the third month following the previous review, which had the potential to result in review up to 120 days following the previous review. Additionally, the recommendations on the QDRRs needed to be more definitive. Statements such as "continue to monitor" were not helpful to the PCP, nor were they helpful in ensuring recommendations were completed. The PCPs appear to be reviewing the QDRR recommendations. A remaining challenge related to the use of chemical restraints. The pharmacy comments on the chemical restraint form needed improvement. The adverse drug reporting system had just been created, and implementation and application will be occurring by the time of the next Monitoring Team visit. This is an area that will require considerable in-service training of appropriate Facility staff. The drug utilization evaluations were timely and effective in raising the standard of care. Follow-up was being completed to apply the lessons learned to improve the drug regimens of individuals the Facility supported. There continues to be need for improvement in the MOSES/DISCUS reviews. In addition, the cause and resolution of medication errors remained a challenge. Focused efforts needed to be applied to improving reporting of medication variances, as well as developing and implementing plans to reduce variances to the extent possible.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The Pharmacy Department utilized the WORx system for screening all new medication orders. It would not print a label for a prescription until the software program was completed. Included in the database was the current drug regimen of the individual. When the new medication order was entered, the software identified significant drug interactions, side effects, and allergies. A red flag appeared. The pharmacy also reviewed the prescribed dosage to ensure consistency with generally recognized dosage ranges. During the past six months, there had been a change in protocol in processing drug interactions. In the past, Level 1 drug interactions (the most serious drug interactions) were identified, and, prior to filling the order, the prescribing PCP was notified to consider changing the order. For Level 2 and 3 drug interactions, which were less serious, a protocol was set up in which the PCP was not notified immediately, but there was a follow-up during, or at the end of treatment to determine any clinical adverse sequelae. Effective 2/28/11, the protocol was changed to include notifying the PCP immediately of Level 2 and 3 drug interactions. For drug interactions prior to 2/28/11, the Facility submitted "Interventions from 9/1/10 thru 2/28/11." Under the adverse drug reaction category, in 9/10, there were 24 interactions. In 10/10, 16 interactions were listed. In 11/10, 12 interactions were listed. In 12/10, 15 were interactions listed. In 1/11, 20 interactions were listed. In 2/11, 30 interactions were listed. The majority included Level 2 drug interaction information. The PCP's response was provided related to any effect after medication administration. There were two potential Level 1 drug interactions identified, and a response from the PCP was recorded. In both instances, adequate justification for use was provided on the intervention form (in one case the individual had been taking the combination for years without problems (order date 2/3/11), and for the other, the use of medication was temporary, and the entry recorded that there were no clinical signs of concern (order date 11/4/10). There were two orders considered Level 3 (both on 2/25/11). There was communication with the PCPs for this lowest risk category, and documentation of discussion on the interventions form. There were orders that had no Level drug interaction noted (9/23/10, 12/8/10, 2/1/11, and 2/7/11) and a PCP response was recorded for each of these. Since 2/28/11, a new protocol was in place. All Level 1, 2, and 3 drug interactions were communicated to the PCP, prior to pharmacy filling the order. Data was submitted from 2/25/11 through 3/29/11. Eighty-four single patient intervention reports were submitted with physician proof of review. As an example of the intensity of the pharmacy's processing of orders, for the month of February 2011 (2/1/11 to 2/28/11), 1161 medication orders were entered. A form entitled "PCP Communication Form," which offered a checklist of options, was provided to the PCP for each of the drug interactions. Options included making no change or changing the medication. If the decision was to make no change, the checklist justification included the following	Noncompliance

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		choices: "no adequate substitution for medication available, potential interaction has a lower risk profile than alternative medications, alternatives have been tried and are either ineffective or have unacceptable side effects in this patient, patient is allergic to alternative medication, other." The PCP could check one or more of these options. In each case, the prescribing PCP signed this form before the order was filled. The date of the form, name of the individual, and medications with potential interaction were listed at the top of the form. According to the Pharmacy Department, this had been a highly successful program, and demonstrated close communication between the Pharmacy Department and the Medical Department. The increased number of drug interaction forms during the approximate four-week interval indicated all drug interactions (Level 1 through 3) were treated with the same intensity of concern. This is a thorough approach to medication safety concerning drug interactions. The pharmacy recently had installed the software for the Avatar system, on 2/24/11. The pharmacy had not had ready access to laboratory data to determine if there was need for laboratory testing, or if drug levels were in the therapeutic range (if applicable). With this software program now being available in the pharmacy, this will assist in improving quality of care provided to the individual, as well as to allow compliance to be achieved with this section of the Settlement Agreement. At the time of the onsite review, it was suggested that the Pharmacy Department meet with the Medical Director for guidance as to what tests should be considered and reviewed for each of the medications prescribed at the Facility. Given the long list of medications prescribed, prioritizing this list to include the most commonly prescribed, those for which drug levels typically are tested, or those with potential serious side effects should be part of the discussion. Although this is additional valuable information, the task is time intensive, due to the number of prescriptions ordered and entered into the system each month. The pharmacy submitted information for orders submitted in February 2011. As noted above, this totaled 1161 orders placed. Once the Pharmacy Department receives guidance from the Medical Department concerning which lab tests are applicable for the medication prescribed, the pharmacy review and recommendations for laboratory testing will provide an added safety mechanism to ensure lab tests are completed and reviewed, and to ensure recommended lab tests are ordered in a timely manner.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	There were 41 quarterly drug regimen reviews (QDRRs) submitted. For January 2011, QDRRs were submitted for the following: Individual #52, Individual #6, Individual #250, Individual #100, Individual #210, Individual #296, Individual #291, Individual #290, Individual #113, Individual #68, Individual #223, and Individual #302. For February 2011, QDRRs were submitted for the following: Individual #146, Individual #318, Individual #70, Individual #183, Individual #26, Individual #203, Individual #1, Individual #222, Individual #299, Individual #35, Individual #306, Individual #99,	Noncompliance

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		Individual #170, Individual #238, Individual #45, Individual #245, Individual #178, Individual #190, Individual #95, Individual #271, Individual #266, Individual #143, Individual #174, Individual #132, Individual #135, Individual #202, Individual #315, Individual #201, and Individual #156. For these, the pharmacist reviewed laboratory results, and identified lab values that were above or below the therapeutic range, if applicable, as well as other lab test results relevant to specific medications. The range of laboratory testing reviewed included the following, depending on the drug regimen prescribed: 25 Hydroxy Vitamin D level, complete blood count, basic metabolic profile/complete metabolic profile (potassium sodium, calcium, glucose), Hemoglobin A1C, lipid panel, hepatic function, ammonia level, and thyroid function. This occurred in 41 out of 41 (100%) of the QDRRs reviewed. There was additional guidance concerning which test to monitor for a specific medication. A document entitled "Quarterly Drug Review Date Comparison" listed the most current QDRR date and the prior date. The Facility had utilized the system where the QDRR was due anytime in the month in which the 90th day occurred from the prior QDRR date. However, this could technically expand the review to an every four-month review of 120 days, which would not constitute a quarterly review. The current list suggested many were completed after the 90-day interval had ended. The date of each QDRR should adhere to requirement of quarterly reviews, with completion every 90 days and not later. A schedule for the calendar year 2011 was submitted, documenting which residences were reviewed during which months of the calendar year. Each residence was reviewed every three months, according to this schedule.	
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	Pharmacy collaboration in monitoring the use of stat (emergency) medication and chemical restraints was documented through a form entitled "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint." There were 18 chemical restraints listed on a report entitled "All chemical restraints LSSLC reports date 9/1/10-3/23/11." Through different departments and mechanisms, the Facility had in the past developed two lists of chemical restraints, but they were not identical, according to the minutes of the Pharmacy and Therapeutics Committee, dated 9/14/10. Events generated from the WORx system included "stat" orders that the psychiatrist had verified as a restraint. These totaled only 12 restraints. A separate Facility database listed events from a chemical restraint database, which totaled 18. Some of the discrepancy was due to the difference in definition of the term, but the pharmacy continued to explore this area in an attempt to resolve the discrepancies. The pharmacy continued to determine the actual chemical restraint use, and considered the submitted list of 18 to be accurate.	Noncompliance

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	to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The pharmacy section of the "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint" was reviewed to determine if the section was completed appropriately. This included review in three areas: whether the medication was used in a clinically justified manner, describing the potential medication related risks that should be considered (in this area would be recorded such aspects as drug interactions, and potential side effects), and actions/recommendations (such as increase or reduction in dosage depending on recorded effect, need for monitoring and level/length of monitoring, etc.). All eighteen forms were submitted. These included the following individuals with the date/time of restraint: Individual #175, dated 9/23/10; Individual #306, dated 9/26/10; Individual #288, dated 11/1/10; Individual #34, dated 11/3/10, at 1:19 p.m.; Individual #34, dated 11/3/10, at 7:45 p.m.; Individual #51, dated 11/14/10; Individual #240, dated 12/8/10; Individual #51, dated 12/28/10; Individual #288, dated 2/5/11; Individual #190, dated 2/15/11; Individual #51, dated 2/18/11; Individual #33, dated 3/2/11; Individual #4, dated 3/5/11, at 3:25 a.m.; Individual #4, dated 3/5/10, at 8:55 a.m.; Individual #33, dated 3/10/11; Individual #4, dated 3/11/11, at 12:30 p.m.; Individual #4, dated 3/11/11, at 3:27 p.m.; and Individual #33, dated 3/14/11. The following represent the findings from this review: ▪ All had been signed and dated by the pharmacist. ▪ For six out of 18 (33%), there was information concerning clinical justification or lack of justification. This included the forms for the following: Individual #288, dated 11/1/10; Individual #34, dated 11/3/10 1:19 p.m.; Individual #34, dated 11/3/10 7:45 p.m.; Individual #51, dated 12/28/10; Individual #33, dated 3/2/11, and Individual #33, dated 3/10/11. ▪ For the area of medication related risks, such as potential drug interactions with the individual's drug regimen and potential significant side effects, two forms had this information, including those for Individual #34, dated 11/3/10 1:19 p.m., and Individual #34, dated 11/3/10 7:45 p.m. Compliance for this aspect of completion of the form was two out of 18 (11%). ▪ For documentation of suggested potential actions, or recommendations, none of the reports included this valuable aspect of pharmacy guidance (0%). The Pharmacy Department provided trend analysis concerning chemical restraint use. In bar graph format, the monthly use of chemical restraints was recorded since June 2005. The use has remained low since September 2009. Physical restraint use during the same period of time increased. The QDRR was the instrument used to monitor the use of benzodiazepines. From the 41 submitted QDRRs, benzodiazepines were prescribed to 11 individuals, including:	

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		Individual #318, Individual #250, Individual #70, Individual #100, Individual #99, Individual #290, Individual #68, Individual #132, Individual #315, Individual #302, and Individual #156. For seven of these 11 individuals (64%), there was a diagnosis/clinical justification to justify the clinical use, as well as clinical review of the individual's record for side effects and/or recommendation when needed for monitoring of specific side effects. These included Individual #318; Individual #250; Individual #99; Individual #290; Individual #68; Individual #302, and Individual #156. For Individual #70, Individual #100, Individual #132, and Individual #315, there was clinical justification of the use of the medication, but no mention of side effects or monitoring recommendations. Anticholinergics were also monitored through the use of the QDRR. There were only six individuals identified as taking an anticholinergic medication or medication with significant anticholinergic side effects. Compliance was five out of six (83%). More specifically: ▪ Individual #70 was prescribed Glycopyrrolate and amitriptyline. Clinical justification and side effects/monitoring were also documented. ▪ Individual #113 received ipratropium (nebulizer or inhaler treatment), but no clinical justification or risk assessment/monitoring recommendations were recorded. ▪ Individual #190 received Benztropine. Clinical justification and review of any side effects (there were no side effects) was noted. ▪ Individual #143 received Glycopyrrolate, and clinical justification was recorded, as well as review for side effects (there were none). ▪ Individual #174 received Benztropine. Clinical justification and review for side effects (there were none) were documented. ▪ Individual #156 received Glycopyrrolate. Clinical justification and review for side effects (there were none) were documented. Polypharmacy was also monitored through the use of the QDRR. There were a total of 12 identified with polypharmacy out of the 41 QDRRs. All had clinical justification for the polypharmacy (100%), but only two (17%) provided information about identified risks and alternative recommendations or concerns. For example: ▪ Individual #250 was on four seizure medications. Side effect monitoring was listed with the benzodiazepine. One medication was recently increased, but the only comment was "continue to monitor." It was not clear what steps should be taken. ▪ Individual #222 received three seizure medications. One medication was recently increased. There was the comment "continue to monitor," but it provided no guidance as to whether the monitoring that was to occur was related to a decrease or change in seizures, or monitoring the potential side	

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		effect of increasing the medication. ▪ Individual #299 was on three psychoactive medications, but there was no comment or monitoring recommendation concerning the polypharmacy. ▪ Individual #245 was on three medications for constipation, but there was no comment, recommendation, alternative options, or concerns mentioned. ▪ Individual #290 was on five medications for seizures, and three for allergies. One of the medications had a recent dosage increase. There was no comment about drug interactions, side effects, or alternative strategies/recommendations for either category of medication. ▪ Individual #315 was on three psychoactive medications. Monitoring for side effects was recommended for the new generation antipsychotic, but the only recommendation for lithium was to "continue to monitor." It was not clear if that meant monitoring drug levels, tremors, renal function, or other concerns. Additionally, from the medical peer reviews completed in February 2011, the reviewers made comments that the pharmacy recommendations were not concise. Responses from the providers were not clear. In one instance, for Individual #82, the pharmacy indicated there was no polypharmacy, but the individual was taking three medications for psychiatric reasons. The psychiatric diagnosis was not defined. Follow-through from the PCP was needed to correct this, not simply a statement that they agreed with the recommendation. As a separate process in reviewing polypharmacy for psychoactive medication, the Facility conducts a monthly review of psychoactive medication polypharmacy. Minutes were reviewed for the following meeting dates: 9/28/10, 10/26/10, 11/18/10, 12/21/10, 1/25/11, and 2/25/11. Each individual was reviewed, and information was listed concerning current psychoactive medications, the diagnosis/reason for the medication, and a clinical update of psychiatric and behavioral concerns. Various brief reviews by the psychiatrists were documented in the discussion section, and the committee review was also documented. At the end of the meeting, there was additional information regarding who had successful medication reduction, so that they were no longer classified as receiving polypharmacy, as well as those individuals who might have had a failed reduction plan and who resumed a regimen of polypharmacy. It also listed those admitted to a state psychiatric hospital. The psychiatrist followed closely all individuals prescribed polypharmacy. For instance: ▪ Individual #233 was prescribed four psychotropic agents. Psychiatry tracked this individual through a number of meetings and updates, including: a 30-day psychoactive medication review on 9/13/10, Integrated Progress Note/Review on 9/14/10, Integrated Progress Note/Review on 9/22/10, Integrated Progress Note/Review on 9/27/10, 30-day Psychoactive Medication Review on 10/6/10,	

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		Progress Note on 10/21/10, Progress Note on 10/29/10, Progress Note on 11/1/10, Progress Note on 11/9/10, Quarterly Psychoactive Medication Review on 11/9/10, 30-day Psychoactive Medication Review on 12/6/10, 30-day Psychoactive Medication Review on 1/3/11, and Quarterly Psychoactive Medication Review 2/9/11. ▪ Another example was Individual #82, who was prescribed three psychotropic medications. Psychiatry tracked this individual through a number of meetings and updates, including 30-day Psychoactive Medication Review on 9/13/10, 30-day Psychoactive Medication Review on 10/6/10, Quarterly Psychoactive Medication Review on 11/9/10, 30-day Psychoactive Medication Review on 12/6/10, Progress Note on 12/16/10, 30-day Psychoactive Medication Review on 1/3/11, and Quarterly Psychoactive Medication Review on 2/9/11. Other individuals that psychiatry similarly had tracked who were on polypharmacy psychotropic medication, or had been during the prior six months included: Individual #175, Individual #106, Individual #58, Individual #302, and Individual #51. New generation antipsychotic monitoring also occurred through the use of the QDRR. Out of the 41, 17 individuals were prescribed this class of medication. These individuals were Individual #146, Individual #6, Individual #70, Individual #26, Individual #1, Individual #35, Individual #306, Individual #99, Individual #245, Individual #178, Individual #113, Individual #271, Individual #266, Individual #315, Individual #223, Individual #201, and Individual #156. All related QDRRs provided evidence of monitoring for metabolic and endocrine risk factors. However, one QDRR from this group was confusing and provided conflicting information. For Individual #266, the recommendation for Olanzapine was to "continue to monitor blood glucose, Hemoglobin A1C, diet and weight." But under the record of lab results, it labeled the Hemoglobin A1C as N/A (either not applicable or not available), which was not consistent with the recommendation to continue to monitor the Hemoglobin A1C. It is imperative that the documentation and recommendations clarity, and not confuse, the ongoing treatment and monitoring of the individual. Compliance was 16 out of 17 (94%).	
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	The 41 QDRRs were reviewed to determine if the PCPs considered the pharmacist's recommendations. All 41 QDRRs had a physician signature to indicate review. There were only three in which the PCP did not check whether there was agreement or not. These were for Individual #183, Individual #178, and Individual #201. There was one QDRR, Individual #290, in which the physician disagreed with the assessment. The PCP wrote on the QDRR the rationale for the disagreement. The QDRRs are placed in the record. Compliance was 39 out of 41 (95%). Additionally, the Facility required the psychiatrist to also review and address the QDRR	Substantial Compliance

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	justification why the recommendation is not followed.	recommendations, when there were psychotropic medications. Of the 41 individuals, 29 were prescribed psychotropic medication. In 28 QDRRs, the psychiatrist signed the document and agreed with the recommendations. On only one, for Individual #302, was no psychiatry signature found to indicate review, or an indication of agreement or disagreement. Psychiatrist compliance with considering the QDRR recommendations, and making a determination of agreement or not, was 28 out of 29 (97%).	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The following documents were submitted for the most current and prior completed Dyskinesia Identification System: Condensed User Scale tools. Emphasis of review was on timeliness from one DISCUS to the next quarterly DISCUS, identified through the date entered for the rater completion of the instrument. The quarterly documents were considered in compliance if the rater date of completion was within 90 days of the prior rater date. The psychiatry date of review and signature were considered in compliance if completed within 10 days of the rater review date. There were 42 individuals for which DISCUS forms were submitted. The following summarizes the findings of the review completed: ▪ Four only had one set of quarterly information. Three of these were baseline reviews (Individual #131; Individual #124, and Individual #97). For one individual, Individual #220, the reason for the lack of submission of the previous quarter review was not determined. ▪ For the previous quarter, the time between rater review date and the psychiatry review date was timely in 38 out of 38 (100%). ▪ There was no PCP date of review for 26 reviews, and there was no signature or date of review for seven reviews. Combined, there was information lacking for the PCP review on 33 out of 39 reviews. Compliance was six out of 39 (15%). ▪ The most recent quarterly review was within 90 days in 37 out of 38 reports (97%). Individual #253 was the only overdue quarterly DISCUS review (5/25/10 and 2/7/11). A notation on the 2/7/11 review indicated he was restarted on Reglan on 11/30/10, after it was discontinued on 4/23/10, and suggested the need for a new baseline according to the HealthCare Guidelines ("tardive dyskinesia screening to include DISCUS immediately prior to initiating therapy as a baseline"). ▪ For the most current DISCUS review, all psychiatry reviews were completed within 10 days of the rater review date. ▪ For the most current DISCUS review, there was a PCP signature and review date for all reviews, which was a marked improvement from the earlier quarter reviews. Documents were submitted for the most recent and previous Monitoring of Side Effects Scale evaluation tool. Emphasis of review was on timeliness of completion of the MOSES.	Noncompliance

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		Compliance was based on the current rater review date completion within six months of the prior MOSES evaluation tool. Compliance was also based on completion of the psychiatry review with signature and date within 10 days of the rater review date. There were evaluations of MOSES submitted for 43 individuals. Of these, two had baseline evaluations recently (Individual #131 and Individual #124), and there was no preceding review for comparison. For two individuals, Individual #203, and Individual #166, no information was available regarding the reason for lack of submission of a copy of the prior completed MOSES. Based on this, for 39 MOSES evaluations, the most recent review could be compared to the prior review. The following show the results of this review: ▪ Compliance was defined as the most recent evaluation completed within six months of the prior evaluation (by rater review date). There were 26 MOSES reviews not completed in a timely manner. Individual #235, Individual #61, Individual #237, Individual #140, Individual #300, Individual #155, Individual #232, Individual #60, Individual #239, Individual #288, and Individual #240 had ratings completed significantly overdue (over 19 days), and an additional 15 individuals were over due between one and nine days from the prior rating date. Compliance for timely completion was 13 out of 39 (33%). ▪ The time from the rater review date to the psychiatry review date was considered in compliance if there was no more than 10 days between the two dates. There were four reviews from the prior MOSES evaluations that went beyond the ten days (Individual #61, Individual #237, Individual #288, and Individual #240). Compliance was 35 out of 39 (90%). ▪ For the most recent MOSES, there was only one review that exceeded 10 days between the rater review date and the psychiatry review date (Individual #235). Compliance was 41 out of 42 reviews (98%). The denominator of 42 was determined based on the original 43 individuals reviewed. However, with the most recent MOSES reviews, one individual's review was not submitted (Individual #220). The reason was not determined.	
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 and Therapeutics Committee minutes of 12/14/10 documented there was one adverse drug reaction since the last P&T meeting in 9/10. The Facility was awaiting a State Office decision on a standard definition of the term "adverse drug reaction." In the meantime, the Pharmacy Department had a draft policy entitled: LBSSLC Policy: Adverse Drug Reaction Reporting date of the draft 2/2011. It included definitions of an ADR, responsibilities of various licensed and non-licensed staff at LBSSLC, reporting procedure, and guidance regarding documentation. Additional information included a probability-scoring tool to determine if an event was an ADR, documentation of the	Noncompliance

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		outcome of the event (including management of the individual and any medication change), a review and recommendation section for the Pharmacy and Therapeutics Committee, and whether the event was reportable to the Food and Drug Administration. Several articles from the literature were included, which were used as reference material in creating this draft policy. An important aspect of compliance with this Section is the need for in-service training for staff to assist them in identifying an adverse drug reaction and reporting this observation. Once the definition is finalized, training should include a variety of staff (direct support professionals, nurses, physicians, etc.). The Pharmacy Department had begun to develop a competency based educational program for identification, reporting and follow up monitoring of adverse drug reactions.	
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.	A DUE calendar was provided for the fiscal year 2010 to 2011. For September 2010, the drug reviewed was Clozapine (immediate and long acting dosage forms). For December 2010, the drug class reviewed was proton pump inhibitors. For March 2011, the drug reviewed was Lacosamide. For June 2011, the drug class to be reviewed is HMB-CoA Inhibitors. The results of the Clozapine study indicated six individuals were prescribed this medication, and the result was that Clozapine was managed appropriately in 100% of the cases. For the DUE involving proton pump inhibitors, 114 individuals were noted to be prescribed this class of medication. Included in the study were topics such as indications, contraindications, and patient monitoring. The study uncovered no problems with the monitoring for drug interactions or side effects, There was an additional follow up study in August 2010, concerning the prescribing of Dilantin, and the interaction and timing of administration with enteral feedings. The pharmacy met with the PCPs to discuss and review orders. Ten individuals had orders changed to separate phenytoin dosing and tube feedings when possible. For one individual, no change was possible, and for one individual, no changes were required. One of the ten individuals for which a timing change was made for feeding did not tolerate the change and reverted to the prior time of administration. A number of recommendations were made when ordering Dilantin in an individual enterally fed. At the time of the review, the Facility had an effectively working DUE process. As the process identified issues, follow-up was being completed to modify individuals' medication regimens, as appropriate. The Facility was found in compliance with this provision.	Substantial Compliance

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N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	Nine completed medication error forms were submitted. Seven of these were considered Category C (an error occurred that reached the consumer, but did not cause consumer harm). There were two Category D errors (an error occurred that reached the consumer, and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm). There were ongoing medication administration observations of nurses, which appeared to include most shifts and times of administration. A Medication Error Report was submitted which documented per month, the number of errors, category of error, individual, medication, possible factors, type of error, and plan of correction. From January 2010 to August 2010, there was a range of one to 20 errors per month. For the more recent months, the overall number appeared to have decreased, according to the following information: September 2010 - four errors, October 2010 - three errors, November 2010 - two errors, December 2010 - four errors, and January 2011 – two errors. As is discussed with regard to Section M.6, based on the Monitoring Team's review of Medication Administration Records, these numbers likely were inaccurate, and represented a significant underreporting of variances. There were four Category D errors, and one Category E error (An error occurred that might have contributed to or resulted in temporary harm to the consumer and required intervention). The January 2011 data included a plan of correction for each of the errors, but the prior months generally did not. In October, only one error was followed by a comment in the plan of correction section. In the other months, no plan of correction was listed for any of the errors. Medication errors were broken down according to the residence for 9/2010 to 2/2011. There were a total of 97 error reports received. Sparrow residence had the most errors at 16, followed by Quail at six errors. These residences supported the most medically complex individuals with high rates of medication administration. Medication errors also were broken down into type of error for the period 9/2010 to 2/2011. All errors were considered administration errors. Medication not given was the error type with the highest number of medication errors at 16, followed by incorrect dose/rate/or frequency at 12. The error rates were calculated, and were small. However, there were several Category D and one Category E error. The quantity of errors and the error rate should not be the only parameters considered. The severity of the medication error is equally important, such as the case in which the wrong type insulin was administered. A table of information concerning severity scores from January 2010 to January 2011 was submitted. There were 52 Category C errors, 11 Category D errors, and one Category E error. The preventability of the errors also is a factor that needs to be considered. When proper procedures for medication administration are followed, most errors are preventable.	Noncompliance

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		Medication Error Committee meeting minutes were reviewed for 8/25/10, 9/7/10, and 3/9/11. At the 8/25/10 meeting, the pharmacy stated that they had begun to process returned medications. Reasons for the return were documented. At the 9/7/10, meeting, there was further discussion concerning the tracking of returned medications. There was also the realization that some nurses did not return the old medications, creating unexplained overages. At the 3/9/11 meeting, it was stated that the nurse educator would be covering the medication pass program, rather than the case manager RNs. Several concerns were voiced at this meeting, but there was no plan of action developed to address these significant concerns. Moreover, a system should have been put in place to prevent giving the wrong type of insulin to the wrong person. Nurses reportedly were distracted during medication passes, which increased the error rate. Nurses were to wear a vest when the medication pass occurred, and they were not to be interrupted unless there was an emergency. Discussion occurred about the need for a system to assist nurses in identifying individuals for a medication pass, and a decision and guidance about where medications could be passed. These appeared to be valuable recommendations, but there was no documented follow-up of these suggestions. The Nursing Department needed to provide information concerning medication errors to the Pharmacy Department for inclusion in the database and trend analysis. As noted above, similar to the Monitoring Team's concerns, the Medication Error Committee was concerned the numbers recorded on paper were not accurate as illustrated by the low numbers of medication errors reported per month for the last five months. Another concern related to the lack of guidance for determining when a medication error was to be reported. The concern that medication error forms were not standardized throughout the campus did have an associated action step, which had been assigned to the CNE. Other identified concerns did not have an assigned member of the committee responsible for follow-up. The Monitoring Team noted the gap between the September 2010 and the March 2011 meetings of the Committee. It was not clear if minutes were not submitted, if there was a meeting with no minutes taken, or there was no meeting. The recent valid concerns raised at the March 2011 meeting provided an opportunity to improve many of the systems issues contributing to medication errors. However, the lack of structure concerning follow up was problematic. There should be closure and documentation of closure for these many concerns. A document was submitted entitled "Unexplained returned medication doses, fiscal year 2010-2011." This listed a large number of returned medications, which might indicate medication errors, but would require further investigation. In October 2010, 1194 doses	

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		of medications were returned. In November 2010, 856 returned doses were returned. In December 2010, 285 doses were returned. In January 2011, 301 doses were returned. In February 2011, 343 doses returned were. Doses of medication per month varied from 114,000 to 126,000 doses dispensed per month. However, the number per month of medications returned might represent errors until proven otherwise, which is a significantly different number than reported in medication error data. To respond to the need to reduce the high numbers of returned medications, on 3/9/11, a "Brainstorming Work Session" was held specifically to address the large numbers of returned medications. The meeting minutes outlined important areas of consideration, along with several bullets under each area. Topics reviewed included "identify how medications get to the home for administration to residents," "identify circumstances/reasons that require extra medications be sent to the homes by pharmacy," "identify any other areas in which additional medications could get to the home," "identify events that happen on the home that would cause extra medications to be left at the end of the fill period," and "identify policies in place about return of medications to pharmacy from the homes before the end of the fill period." The date of the next meeting was pending. This was an important first step in addressing the many returned doses of medication. The momentum should continue until returned doses of medications are minimized in numbers, and a monitoring system is in place that identifies the reason for each returned dose of medication. There was a revision of the policy LBSSLC Health Services: Controlled Medications, specifically revising the section entitled "Counting of Controlled Medications." There were no other new or revised policies, procedures or other documents addressing medication administration during the prior six months.	

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

1. The Pharmacy Department should meet with the Medical Director for guidance concerning tests that should be considered and reviewed for each of the medications prescribed at the Facility when new orders are being processed. Given the long list of medications prescribed, prioritizing this list to include the most commonly prescribed, those for which drug levels typically are tested, or those with potential serious side effects should be part of the discussion.
2. Each QDRR should be completed quarterly (i.e., completed every 90 days and not later).
3. The pharmacy review and recommendation section in the "Face to Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint " form includes three components, each of which should be completed: clinical justification, medication related risks, and potential actions or recommendations.
4. When completing the QDRRs, the pharmacy should provide precise recommendations, rather than vague statements such as "continue to monitor," which often cannot be measured, and/or leave room for interpretation.
5. Documentation and recommendations in the QDRR should be reviewed for inconsistencies.
6. A valuable next step in the medical QI process should 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.

7. 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.
8. It is imperative the Nursing Department provide information concerning medication errors to the Pharmacy Department for database input and trend analysis.
9. The Medication Error Committee 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.
10. Determination of the reason(s) for overages that are returned to the Pharmacy should continue to be actively pursued. A database system should be created that tracks the reason for returned doses of medications, along with the residence from which they are returned.

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 Presentation Book for Section O; o Section O Presentation LBSSLC (Lubbock State Supported Living Center) Monitor's Compliance Visit, dated March 2011; o The following documents: Occupational Therapy/Physical Therapy/Speech Language Pathology Evaluation, Aspiration Pneumonia/Enteral Nutrition Evaluation, Nutrition Evaluation; OT/PT/SLP consultations for the last year, Personal Support Plan and PSP Addendums for the last year, including PSPA for PSP Risk Assessment and Physical Nutritional Management Team Evaluation/Action Plan, Physical and Nutritional Management Plan with pictures, Integrated Risk Rating Form, Action Plan for Risk Assessment, person-specific monitoring for the past year, PNMP Clinic Notes for the past year, competency-based training for staff, dining plan with pictures, supporting documentation for PST Risk Assessment and Action Plan and PNMT Action Plan implementation, PNMT (Physical Nutritional Management Team) Evaluation and PNMT Action Plan Update(s) documentation for the following 16 individuals: Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, Individual #258, Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139; o The following documents: OT/PT/SLP Assessment and Updates, APEN Evaluation, Nutrition Assessment, PSP and PSPAs for the last year, PNMP with pictures, Integrated Risk Rating Form, Action Plan for Risk Assessment, PNMP Clinic notes for past year, person-specific monitoring, competency-based training for staff, dining plan with pictures, and supporting documentation for PST Risk Assessment Action Plan for the past year for the following eight individuals: Individual #17, Individual #7, Individual #324, Individual #78, Individual #89, Individual #37, Individual #181, and Individual #281; o The dining plan/diet card for the following nine individuals: Individual#190, Individual #203, Individual #195, Individual #215, Individual #258, Individual #185, Individual #167, Individual #78, and Individual #138; o List of PNM team members, and Curriculum Vitae, dated 7/10 through 2/11; o List of continuing education sessions for PNMT members, from 7/31/10 through 2/11/11; o PNMT Assessment follow-ups, from 9/10 through 2/11; o PNMT Evaluations, for 1/11 and 2/11; o Integrated Risk Rating Form (blank) and Guidelines, undated; o List of Individuals with PNM needs, dated 3/9/11; o List of Individuals without PNM needs, dated 3/9/11; o PNM Screening Documents, Habilitation Therapies (HT) Assessments, PNMT

	Spreadsheets, Communication Spreadsheets, and At Risk Spreadsheets (by home and category), dated 3/16/11; o Tools used to assess PNM Status and Needs, dated 10/10; o List of Individuals receiving PNM Assessments, undated; o PSP Addendum, dated 1/27/11; o PNMPs for Multiple Individuals, dated 3/10 through 3/11; o Tools used to monitor implementation of PNM Procedures (blank), revised 1/26/11; o List of individuals for whom PNM monitoring tools were completed, undated; o Tools utilized for validation of PNM Monitoring (blank), revised 1/26/11; o Meal Monitoring Observations, from 12/10 through 2/11; o Dining Plan (template), undated; o Competency-based Training sheets for Dining Plans for Multiple Individuals, from 2/11 through 3/11; o PNM Spreadsheets for Multiple Individuals, from 3/10 through 12/10; o Wheelchair/PNMP Clinic (by home), from 10/09 through 2/11; o List of Individuals on Modified Diets, revised 2/24/11; o List of Individuals Requiring Mealtime Assistance, undated; o List of Individuals on Enteral Feeding, from 2/1/11 through 2/28/11; o List of Individuals with Diet Texture Downgrades, from 2/10 through 2/11; o List of Individuals with Body Mass Index (BMI) greater than 30, undated; o List of Individuals with BMI less than 20, undated; o List of individuals who had unplanned weight loss equal to or greater than 10%, during a six months period, from 2/10 through 8/10; o List of individuals who had a choking incident, during the past 12 months, dated 2/25/11; o List of individuals who have had an aspiration and/or pneumonia incident, during the past 12 months, dated 2/11/11; o List of individuals who have had chronic respiratory infections, chronic dehydration, skin breakdown, and/or active pressure ulcer, during the past six months, dated 2/18/11; o List of individuals who have had a fall, during the past 12 months, undated; o List of individuals who have experienced a fracture during the past 12 months, dated 2/22/11; o List of individuals who have had a fecal impaction, during the past 12 months, dated 2/18/11; o List of individuals who are considered to be at risk of: choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and/or pneumonia, along with corresponding risk severity, dated 2/18/11; o List of individuals who are non-ambulatory or require assisted ambulation, undated; o List of individuals with poor oral hygiene, dated 2/25/11; o List of individuals who have received a video fluoroscopy or modified barium swallow study, during past year, undated; o Schedule of meals (by home), undated; o List of all PNM-related meetings scheduled during the week of 3/28/11, dated 3/16/11;

	○ Curricula on PNM used to train staff, undated; ○ Agenda and Curriculum for foundational in-services completed during the last six months, dated 11/10; ○ PNM Competency-based training sessions, during the past 6 months, dated 2/11; ○ PNMPs and Dining Plan tools and checklists, from 11/10 through 2/11; ○ HT Meal Monitoring/Home Observations, from 9/10 through 1/11; ○ Meal Time Coordinator Duties, undated; ○ Number of budgeted positions, staff contractors, unfilled positions, full-time equivalent (FTE), and staff-to-individual ratios, dated 3/3/11; ○ List of Admissions, Deaths, and Transitions to community, undated; ○ Mealtime Committee Notebook, various dates; ○ Mealtime Coordinator Notebook, various dates; ○ Choking Policy, dated 12/31/10; ○ Agenda and Schedule for NEO training, active treatment curricula, Ombudsman materials, Positive Behavior Support (PBS)/ABA and Core Intervention training, Skin Integrity, Hydration, Seizure Safety/Management, Vehicle Mileage Log, various dates; ○ CTD Employee training calendar, dated 3/11; ○ List of Individuals sent to ER (and reason) during past year, dated 2/9/11; ○ List of Individuals Admitted to Hospital (and reason for admission), during past year, dated 2/9/11; ○ Pneumonia Profile Report, dated 2/11/11; ○ List of individuals involved in a swallowing incident, undated; ○ Laminated SSLC Risk Guidelines, undated; ○ PSP dates for 2010 and 2011, undated; ○ 14-Day Implementation of At-Risk, High-Risk Individuals, dated 10/10 through 2/11; ○ Head of Bed Elevation (HOBE) Assessment Protocol (draft), undated; ○ List of Individuals At Risk for Enteral Feeding, Pneumonia, and PICA, revised 3/2/11; ○ ICF/MR Mock Survey Plan of Correction, from 1/24/11 through 1/28/11; ○ PNM Core Team Training presented by Karen Hardwick, State Coordinator for Specialized Services, dated 3/10; ○ PNM Policy, dated 3/11/11; ○ Facility Policy on Choking, dated 12/31/10; ○ Program Implementation Monitor, dated 10/1/07; ○ PSP Policy Personnel Support Plan, dated 3/8/11; and ○ Dining Plans, 3/10 through 3/11. ▪ **Interviews with**: ○ Linda Thomas, Habilitation Therapies Director; ○ Karen Hardwick, State Coordinator for Specialized Services; ○ Debbie Ellison Jones, SLP, PNMT Member; ○ Frances Shaw, PT, PNMT Member; ○ Corey Verett, Registered Dietician (RD), PNMT Member; ○ Sarah McDonald, OT, PNMT Member;

	○ Robin Seale, Assistant Director of Programs; ○ Caleb Westin, Unit I Director; and ○ Norma Guiterrez, Safety Officer. ▪ **Observations of**: ○ PNMT Meeting, on 3/29/11; ○ PNMT meeting, on 3/31/11; and ○ Residences 504 Mesquite Drive (Quail/Sparrow); 518 South Cedar Avenue (Oak); 526 North Cedar Avenue (Tulip); 527 North Cedar Avenue (Iris); and 528 North Cedar Avenue (Zinnia).
	Facility Self-Assessment: LBSSLC Plan of Improvement, updated 1/31/11, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was in noncompliance with each of the provisions. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the eight sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: The Facility PNMT membership included a Physical Therapist, Registered Dietician, two Occupational Therapists, Speech Language Pathologist, and Registered Nurse. The PNMT's membership was consistent with the Settlement Agreement requirements. In addition, the Medical Director and Chief Nurse Executive attended the PNMT meetings. Although it was extremely positive that these medical and nursing resources had been assigned to the PNMT, consideration should be given to assigning a physician that did not have the administrative responsibilities of the Medical Director to allow fuller participation from the Medical Department. The attendance of PNMT members at PNMT-related continuing education state webinars should be non-negotiable and mandatory. However, documentation did not substantiate PNMT members' consistent attendance at seminars the State Office had developed to improve the physical and nutritional supports provided to individuals. Team members should be held accountable to attend continuing education courses. The PNMT had evaluated and completed an action plan for seven individuals since the last compliance review. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs, the PNMT needs to take a number of actions, including, but not limited to, reviewing risk guideline levels to determine if they remain accurate based on any changes in health status; incorporating the PSTs' Action Plans into the PNMT Action Plans, as appropriate; completing a comprehensive positioning evaluation to determine the status of safe

	positioning; identifying individual triggers for direct support professionals and professional staff; providing support and monitoring to individuals at highest risk on a more frequent basis; incorporating the PNMT Action Plan into individuals' PSPs, including criteria in the recommendations, as well as measurable outcomes to measure the efficacy of interventions; ensuring staff complete performance check-offs to document competency for identified skills for individuals at highest risk; and implementing an individualized monitoring plan correlated to PNMT recommendations and measurable outcomes. A review was conducted of an additional sample of individuals identified at risk due enteral feeding, pneumonia, and pica, all of whom met the priority criteria for review by the PNMT. None of these individuals had been referred and/or evaluated by the PNMT. Moreover, their teams had not followed the At-Risk policy, and had not met regularly to review the implementation of the Risk Action Plan, or develop measurable outcomes to determine if the action plan successfully minimized, and/or reduced high risk indicators. Professional staff had not provided competency-based training for direct support professionals responsible for implementation of the plans. The Facility is to be commended for developing an interdisciplinary problem-solving approach to address mealtime concerns. LBSSLC Administration had established a Meal Time (MT) Improvement Committee, whose members covered a broad array of disciplines and programs. The Committee's purpose was to identify issues/concerns occurring during meal times that could negatively impact the safety, and proactively work toward systemic solutions. The Committee was charged with implementing and monitoring action plans to address identified issues/concerns. The most significant solution to ameliorate mealtime concerns was to identify a dining room supervisor and provide training. A policy has been developed to define the role of Mealtime Coordinators, responsible for oversight at each meal. This was a positive initiative, but for it to fulfill its intent, the Mealtime Coordinators required additional training. LBSSLC had developed a number of competency-based checklists for staff related to physical and nutritional management. In addition to the need for the Facility to develop additional checklists to cover the full array of staff competencies, the documentation reviewed did not substantiate that the available checklists were being implemented with any consistency. This was having a negative impact on individuals' supports. During the onsite review, the Monitoring Team observed many errors as staff were implementing PNMPs. Monitoring is another area that requires focused attention to assist in remedying these issues. As discussed in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two	Due to the multiple requirements included in this provision of the Settlement Agreement, 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan (“PNMP”) of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual’s annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual’s ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals’ physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, Physical Therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician’s assistant. All members of the team should have specialized training or experience</td><td>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, Occupational Therapist, Physical Therapist, Registered Dietician, and, as needed, ancillary members [e.g., MD, Physician’s Assistant (PA), Registered Nurse.
The Facility PNMT membership included a Physical Therapist, Registered Dietician, two Occupational Therapists, Speech Language Pathologist, and Registered Nurse. The PNMT’s membership was consistent with the Settlement Agreement requirements. In addition, the Medical Director and Chief Nurse Executive attended the PNMT meetings. Although it was extremely positive that these medical and nursing resources had been assigned to the PNMT, consideration should be given to assigning a physician that did not have the administrative responsibilities of the Medical Director to allow fuller participation from the Medical Department.

The Facility Administration had approved two full-time positions for the PNMT. The Director of Habilitation Therapies was in the process of recruiting a dedicated registered nurse and clerk position for the PNMT. The Facility is to be commended for making this commitment to support the PNMT’s work. In addition, a third dietician had been approved, which should have a positive impact on the caseload of the PNMT dietician.

In the section of this report that addresses Section O.2 of the Settlement Agreement, the Monitoring Team’s review of the seven individuals the PNMT assessed since the last onsite compliance review (Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, and Individual #258) is discussed.

At the time of the review, the current LBSSLC census was 227 individuals. Based on interview and document review, the following chart identifies the current caseloads and/or responsibilities of the PNMT members. It should be noted that these caseloads generally consisted of individuals with the most medical complexities, many of whom the PNMT would support:

<table>
<tr><th>PNMT Members</th><th>Current Caseloads and Responsibilities</th></tr>
<tr><td>Registered Nurse (RN)</td><td>Supporting 33 individuals in Quail and Sparrow homes</td></tr>
<tr><td>Physical Therapist (PT)</td><td>Supporting 33 individuals in Quail and Sparrow</td></tr>
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</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
	demonstrating competence in working with individuals with complex physical and nutritional management needs.		

	homes
Occupational Therapist (OT)	Supporting 33 individuals in Quail and Sparrow homes, and an additional 17 individuals in 518 South Cedar Avenue (Oak)
Dietician (RD)	Supporting 33 individuals in Quail and Sparrow homes
Speech Pathologist (SLP)	Supporting 33 individuals in Quail and Sparrow homes

Physical Nutritional Management Core Team Training, dated March 2010, presented by Karen Hardwick, Ph.D., OTR, State Coordinator for Specialized Services, consisted of ten clinical instructional domains with multiple components:

- Physical Nutritional Management Teams;
- Nutritional Management /GI Issues;
- Clinical Assessment Technologies;
- Seating and Positioning for Dysphagia;
- Evaluation of Seating and Positioning;
- Wound Investigation Protocol;
- Communication Issues/Strategies;
- Nursing Issues in PNMP;
- Dietary Issues with PNMP; and
- Respiratory Therapy.

Given the significant need to improve the physical and nutritional supports provided to individuals, the expectation for PNMT members should be mandatory attendance at these state-sponsored clinical instruction courses. There should be written documentation that individual PNMT members attended these sessions, including the title of the clinical instruction, the staff member's signature, and date. As documented below, PNMT members' attendance documentation was not consistent.

PNMT members (OT, PT, SLP, RD, and RN) submitted continuing education documentation. However, there were webinars and/or outside clinical continuing education courses PNMT members attended that were not documented on a completed training roster for state-supported clinical instruction, and/or a certificate of completion for outside continuing education units (CEUs). The following chart illustrates continuing education courses, webinars and conferences PNMT members submitted. If the training roster and/or certificate of completion columns are blank, this indicated that no documentation was submitted to verify attendance.

#	Provision	Assessment of Status			Compliance
		Continuing Education Webinars	**Training Roster**	**Certificate of Completion**	
		PNMP and Wheelchair Clinic Teleconference (1/13/10)	PT, two OTRs, SLP		
		Diet Texture Training (1/13/10)			
		PNM and Wheelchair Clinic (2/10)			
		Dysphagia and Nutritional Management (3/10)	OT		
		PNM and Wheelchair Webinar Clinics (3/10)			
		Dysphagia and Nutritional Management (3/10)			
		TBOTE [Texas Board Of Occupational Therapy Examiners] 2010 Updates, Licensure and Ethics (3/10)			
		Texas Speech Language Hearing Association (TSHA) Annual Conference (3/10)			
		Overcoming the Challenges of Applying the Nutritional Care Process/Standardized Language Today (4/10)			
		PNM and Wheelchair Clinic (4/10)			
		Shoulder Disorders and other related shoulder injuries (4/10)			
		PNM and Wheelchair Clinic (5/10)			
		Region 17 Autism Conference (6/10)			
		Texas Assistive Technology Network Latitude Conference (6/10)			
		PNM and Wheelchair Clinic (6/10)			
		Mealtime Success for Kids on the Spectrum (6/10)			
		Texas Assistive Technology Network-Statewide Conference (6/10)			
		Technical Advances in Management of Dysphagia (7/10)			
		Issues in Nutritional Management Part I Webinar (7/10)			
		PNMT Risk/Development of Interventions II (7/10)			
		PNMT Risk/Development of Interventions III (7/10)			
		Essential Lean Body Mass (7/10)			

#	Provision	Assessment of Status			Compliance
		PNMT Identification of Risk and Development of Interventions (7/9/10)	OT		
		PNM for Nursing (7/16/10)	PT, OT		
		PNM Teleconference (7/19/10)	PT, two OTs,		
		PNMT Identification of Risk and Development of Interventions Teleconference (7/23/10)	PT, two OTs, SLP, RD		
		PNMT Teleconference (7/30/10)	PT, OT, SLP		
		Pediatric Dysphagia (8/10)			
		Fall Prevention (8/10)			
		Issues in Nutritional Management (8/13/10)	SLP		
		PNMT Wound care Teleconference (8/13/10)	Two OTs, SLP, RD		
		PNM Seating and Positioning for Eating and Dysphagia (9/1/10)	PT, two OTs, SLP, RD		
		Habilitation Therapies Conference (9/10)			
		A Day and a Half with Van Dijk-Deaf/Blindness (10/10)			
		Moving Toward Standardizing Dysphagia Practice: Introducing the Modified Barium Swallow Impairment Profile (10/10)			
		Keeping Your Center of Gravity Over Your Base of Support (10/10)			
		Core PNMT Training Definition, Expectation and Assessment Technologies (10/6/10)	PT, two OTs, SLP, RD		
		Sensory Integration and Sensory Processing Disorder (12/10)			
		Breath of Hope - Living with Amyotrophic lateral sclerosis (ALS) (12/10)			
		TSHA Intervention Boot Camp Webinar Series (12/10)			
		Dehydration and Weight Loss (12/9/10)		RD	
		Speech CEU and PNMT Training Risk (12/15/10)	PT, OT, SLP, RD		
		Nutritional Management Part III (12/15/10)			
		Dysphagia and Enteral Feeding (1/11)			
		Risk Question and Answer (1/11)			
		Diet Textures Training (1/11)			
		Monitoring Forms (1/25/11)	PT, two OTs		

#	Provision	Assessment of Status	Compliance

Evaluation and Intervention for Musculoskeletal Injuries: A Biomechanical Approach (2/11)		
Aging Body Aging Mind (3/10/11)		
Nutrition and Autism (3/21/11)		RD
PNMT Core Training GI Issues (3/24/11)	PT, two OTs, SLP, RD, RN	

A certificate of completion for continuing education was submitted for the PNMT nurse. However, the nurse did not attend state-sponsored webinars, with the exception of the PNMT Core Training for GI Issues, conducted on 3/24/11.

Review of training rosters for the following clinical instruction webinars revealed the following:

- One of six (17%) PNMT members attended the PNMT Identification of Risk and Development of Interventions webinar, on 7/9/10;
- Two of six (33%) PNMT members attended the PNM Nursing webinar, on 7/16/10;
- Three of six (50%) PNMT members attended the PNM Teleconference, on 7/19/10;
- Five of six (83%) PNMT members attended the PNMT Identification of Risk and Development of Interventions, on 7/23/10;
- Three of six (50%) PNMT members attended the PNM Teleconference, on 7/30/10;
- One of six (17%) PNMT members attended Issues in Nutritional Management, on 8/13/10;
- Four out of six (66%) PNMT members attended the PNMT Wound care teleconference, on 8/13/10;
- Five of six (83%) PNMT members attended Seating and Positioning for Dysphagia, on 9/1/10;
- Five of six (83%) PNMT members attended Core PNMT Training Definition, Expectation and Assessment Technologies on 10/6/10;
- Four out of six (66%) PNMT members attended Speech CEU and PNMT Training Risk on 12/15/10; and
- Three of six (50%) PNMT members attended the Monitoring Forms webinar on 1/25/11.

It should be noted that PNMT members documented attending additional state-sponsored webinars, but no training rosters were submitted to verify the PNMT member's attendance.

#	Provision	Assessment of Status	Compliance
		The attendance of PNMT members for PNMT-related continuing education state webinars should be non-negotiable and mandatory. PNMT team members have a responsibility to participate in on-going continuing education opportunities to expand their knowledge and skills, and ensure they are knowledgeable about current trends within their respective fields, as well as other team members' fields of expertise. Team members should be held accountable to attend continuing education courses. A continuing education tracking system for PNMT members should be implemented to consistently document attendance through training rosters and/or certificate of completion for state-sponsored webinars, off-site clinical instruction, and conferences. The Habilitation Director should review the information regularly to ensure that staff are attending continuing education sessions as appropriate. <u>PNMT meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> The LBSSLC PNMT Protocol, dated 3/1/11, indicated that the PNMT would meet every week on Tuesday and Thursday. The Tuesday meeting would be attended by PNMT members only to complete the following: ▪ Conduct evaluations; ▪ Follow-up on individuals being followed by the PNMT; ▪ Review/update action plans; ▪ Prepare for presentation to PST for PNMT recommendations and action plans; and ▪ Prepare for individuals' discharge from PNMT. Thursday meetings were focused on meeting with the individuals' PSTs to present the PNMT recommendations, and action plan, and/or discharge an individual from the PNMT. A document entitled Protocol to Identify Individuals from Priority List, dated 3/1/11, identified prioritization of individuals to be evaluated by the PNMT, including: ▪ All individuals identified on the Priority List who were enterally nourished, had been diagnosed with aspiration pneumonia, and/or pneumonia; ▪ Individuals referred through the PST, as a result of the risk assessment per the At-Risk policy; ▪ Individuals who had been identified on the Initial Priority List would be prioritized per diagnosis and/or hospitalization with consideration of enteral nourishment based on the following criteria: o Priority 1 included individuals who had any aspiration pneumonia, and were enterally nourished; o Priority 2 included individuals who had had aspiration pneumonia, and	

#	Provision	Assessment of Status	Compliance
		ate orally; o Priority 3 included individuals who had had pneumonia, and were enterally nourished; and o Priority 4 included individuals who were enterally nourished, and had not been diagnosed with aspiration pneumonia. The PNMT had completed a PNMT Evaluation and Action Plan for the following seven individuals: Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, and Individual #258. Additional information on these individuals is provided below in relation to Section O.2. An additional individual record sample was drawn from the Combined List for Risk Discussion Meetings (Enteral Feeding, Pneumonia, and Pica), undated, which identified 76 individuals at high risk. The sample included the following nine individuals: Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139. None of these nine individual records reviewed (0%), documented the PST members had followed the At-Risk Process outlined in the LBSSLC At-Risk Individuals policy, dated 2/4/11. In addition, all of these nine individuals met the priority criteria for review by the PNMT, but none of these individuals had been referred and/or evaluated by the PNMT. The PSTs had not met regularly to review the implementation of the Risk Action Plan, or develop measurable outcomes to determine if the action plan successfully minimized, and/or reduced high risk indicators. Professional staff had not provided competency-based training for direct support professionals responsible for implementation of the plan. The following individual examples provide examples of concerns identified: ▪ Individual #6's Integrated Risk Rating Form, dated 12/21/10, documented high-risk ratings for aspiration pneumonia, respiratory compromise, gastrointestinal problems, osteoporosis, infections, and fluid imbalance. His Risk Assessment Action Plan, dated 12/12/10, stated: "[Individual #6] will follow his PNMP and Dining Plan for appropriate positioning (in or out of bed) to prevent aspiration." His PNMP, revised 2/25/11, did not address strategies for bathing or personal care, which had the potential to place him at risk for aspiration pneumonia. The Action Plan stated: "receive weekly weights to ensure he continues to gain weight," but there was no goal for weight gain. There were no PSPAs to provide updates to his Action Plan. On 6/15/10, Individual #6 received a PEG tube. The Protocol to Identify Individuals from Priority List, dated 3/1/11, indicated that all individuals who were enterally nourished, and had been diagnosed with aspiration pneumonia and/or pneumonia would be reviewed by the PNMT. However, Individual #6 had not been reviewed by the PNMT.	

#	Provision	Assessment of Status	Compliance
		▪ On 7/8/10, Individual #228 was hospitalized with a diagnosis of dehydration, and, on 11/19/10, with a diagnosis of aspiration pneumonia. Individual #228 died on 12/8/10. Individual #228's PST had not completed a Risk Assessment, nor had the PNMT reviewed her. ▪ Individual #193's Integrated Risk Rating Form, dated 3/3/11, placed her at high risk for aspiration. Individual #193's objective for aspiration stated: "[Individual #193] will have reduced risk for choking/aspiration." Her Action Steps were: "1) dining room is monitored throughout all meals; 2) will have a recliner in her bedroom so she can recline or nap without lying down after meals; and 3) in-service for workshop staff concerning [Individual #193] drinking from water fountains." The action steps did not provide measurable outcomes. For example, no guidance was provided with regard to the individual-specific directions/triggers that were to be monitored completed during mealtime time monitoring to minimize her risk for aspiration; or who would review mealtime monitoring that was completed. Her PNMP, revised 3/22/11, did not address the presence and/or use of a recliner after mealtimes. Sporadic monitoring checks were to be completed in the workshop "concerning [Individual #193] drinking from water fountains." These actions steps were not aggressive, and/or sufficiently comprehensive to minimize her risk of aspiration. ▪ Individual #109's Integrated Risk Rating Form, dated 12/14/10, identified his high-risk areas as choking, aspiration, constipation/bowel obstruction, and seizures. His Integrated Risk Rating Form was updated on 1/21/11. The following risk categories were also rated as high: osteoporosis, falls, and fractures. His Action Plan, dated 12/14/10, was not updated to reflect these changes. His APEN evaluation, undated, included an objective to: "prevent [Individual #109] from episodes of aspiration pneumonia," and action steps, frequency, and persons responsible were "listed on Risk Action Plan." The timeline was "for the remainder of the year and upon reevaluation if needed with episodes of aspiration pneumonia if one occurs." The Risk Action Plan did not present specific, measurable action steps to minimize his risk of aspiration pneumonia, or outcomes to determine if the action steps were effective. ▪ Individual #225's Integrated Risk Rating Form, dated 2/2/11, identified his high-risk categories as aspiration, weight, gastrointestinal (GI) problems, osteoporosis, infections, polypharmacy/side effects, and fluid imbalance. There was no Risk Action Plan developed to address his high-risk areas. His Action Plan objective in his APEN Evaluation, undated, was: "[Individual #225] will have no hospitalizations for aspiration this year." The action steps were: "continue to follow current PNMP, continue suction toothbrush and he needs to be stabilized with his J-tube." Individual #225 did not have an adequate Risk Action Plan to address his high-risk concerns. ▪ Individual #196's Integrated Risk Rating Form, dated 3/8/11, placed her at high	

#	Provision	Assessment of Status	Compliance
		risk for aspiration and respiratory compromise. There was no Risk Action Plan developed to address these high-risk concerns. ▪ Individual #139's Integrated Risk Rating Form, dated 1/25/11, placed him at high risk for aspiration and urinary tract infections. His Risk Action Plan, dated 1/25/11, stated: "[Individual #139] will receive intervention to prevent incidents of aspiration." His action plan did not identify measurable action steps to minimize his risk of aspiration, or criteria to measure whether or not the action steps were effective.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	A process is in place that identifies individuals with PNM concerns. Protocols had been developed, dated 3/1/11, to identify individuals from the LBSSLC Priority List for referral to the PNMT. However, the PNMT had not reviewed individuals who met these criteria, as evidenced by the discussion with regard to Section O.1 related to the sample of nine individuals. The PNM Team provides individuals identified as being at an increased risk level with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day, and during nutritional intake. During the onsite review, the State Coordinator for Specialized Services presented a draft Head of Bed Elevation Assessment Protocol, undated. It stated: "All individuals who require elevation for GERD, enteral eating, respiratory/breathing concerns, medication administration, oral care, hygiene, etc. must be evaluated for a range of appropriate elevation levels. A maximum and minimum elevation is determined to accommodate various activities." The HOBE assessment information would be integrated into the PNMT Evaluation, as well as OT/PT Evaluation updates for individuals meeting the criteria stated in the HOBE Assessment Protocol. This was a positive and needed addition to the assessment process. At LBSSLC, this assessment process had just begun to be implemented. Since the last compliance review, the PNMT reviewed the following seven individuals: Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, and Individual #258. A review of the PNMT evaluations and action plans for these seven individuals revealed the following: ▪ In none of the seven records reviewed (0%) was there documentation of risk identification levels completed by the PNMT based upon physical and nutritional history, current status, and specific criteria for guiding placement of individuals in specific risk levels. ▪ In seven of the seven records reviewed (100%), there was documentation of a comprehensive assessment. ▪ In none of the seven records (0%) did the PNMT evaluation include an analysis	Noncompliance

#	Provision	Assessment of Status	Compliance
		to consistently provide a rationale for the development of recommendations and measurable, functional outcomes for individuals at highest risk to minimize and/or reduce the identified health risk. ▪ In one of the seven records (14%), a PSP Addendum for the PNMT meeting was present, which included the integration of the PNMT Action Plan (Individual #29). ▪ In none of the seven records (0%) was there documentation of development of implementation strategies. ▪ In none of the seven records (0%) was there documentation of competency-based training for individual strategies. ▪ In none of the seven records (0%) was there documentation of a monitoring schedule for individuals at highest risk. ▪ In none of the seven records (0%) was there documentation in Integrated Progress notes of progress, and/or lack of progress with the Action Plan; ▪ In none of the seven records (0%) was there documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes. In the Monitoring Team's review of the seven individuals evaluated by the PNMT, the following issues were identified: ▪ The PNMT should have reviewed an individual's Integrated Risk Tracking Form during the PNMT evaluation to determine if the current risk levels were an accurate reflection of the individual's current status. ▪ The PNMT should have reviewed the PST Risk Action Plan, and determined how the PST Action Plan would be incorporated into the PNMT Action Plan. ▪ Aspiration Triggers Data Sheet(s) were not submitted for any of the individuals evaluated by the PNMT. ▪ Individual #226's PNMT Evaluation, dated 10/26/10, was reviewed, and the following observations were made: o One measurable objective in the PNMT Action Plan, dated 10/26/10, stated: "appropriate positioning per PNMP six out of six monitoring visits," but this objective did not state how this objective would minimize and/or reduce an identified health risk. o The measurable objectives in the PNMT Action Plan did not provide an aggressive approach to address his risk of aspiration. o Monitoring for bathing, sitting in the wheelchair, sitting in the recliner, lying in bed, oral care, and feeding was scheduled for once per week. The PNMT Monitoring results were to be documented in an Integrated Progress Note, but no Integrated Progress Notes were submitted. o The PNMT Action Plan was not integrated into the individual's PSP. o The PNMT Assessment Follow-up, dated 10/26/10, stated that	

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		Individual #226 was on Do Not Resituate status in the hospital. His physician was "to check to see if he has a qualifying condition to be classified DNR but he doesn't feel that he does." There were no further updates provided in subsequent follow-ups. o PNMT Follow-up, dated 11/16/10, reported that nursing had not completed bowel baseline, which was recommended on 10/26/10, to include "full abdominal check (i.e. pain, bowel sounds, bowel movements, distension, etc.) and document." o PNMT Follow-up, dated 11/16/10, referred Individual #226 to the Respiratory Therapist (RT) for assessment. The PNMT Follow-up, dated 12/14/10, did not discuss an assessment by the RT. The PNMT Follow-up did not provide a comprehensive update to the PNMT Action Plan. o PNMT Follow-up, dated 1/25/10, stated: "PNMT agrees [?] is doing well. All pictures for positioning are complete. Nursing not in attendance and no information regarding RT and/or whether currently receiving CPT [chest physical therapy]. RC [?] not present-information regarding medical triggers are not provided. Will contact PNMT nurse and attempt to gain missing follow up information. Follow up pending reorganization of team." There were no additional PNMT follow-ups completed. ▪ On 10/16/10, the PNMT evaluated Individual #312. He was "considered to be at high risk due to diagnosis of left to middle lobe pneumonia requiring treatment in the hospital and multiple incidences of respiratory illness requiring hospitalization in the last year." The following concerns were noted: o Risk Assessment results were not integrated into his PNMT Action Plan. o A new recommendation was made for: "HT to look at HOB [head of bed] elevation," but this was not incorporated into the PNMT Action Plan, nor was there a rationale/analysis provided to support this recommendation. This recommendation was not discussed in subsequent PNMT Follow-ups. o PNMT Follow-ups documented that progress with PNMT Action Plan recommendations had not been made and/or were not implemented. For example, a PNMT Action Plan action step under monitoring stated: "residuals-baseline, document exact measurement of residuals prior to feedings and bathing, if greater than 100 this should be noted as high." This recommendation was restated on the PNMT Follow-up, dated 11/16/10, with no further information provided. The PNMT Follow-up, dated 12/7/10, indicated: "reported residuals for two weeks. CLARIFICATION NEEDED-are these prior to feeding and bathing?" PNMT Follow-up, dated 12/14/10, did not provide any updates related to residuals. There were no additional follow-ups submitted.	

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		o No Integrated Progress Notes were submitted to document PNMT interventions. ▪ On 10/21/10, the PNMT evaluated Individual #29. "[Individual #29] was referred to PNMT prior to State Supported Living Centers Risk Guidelines implementation. At the time of his referral, he was considered to be at high risk due to a diagnosis of pneumonia requiring treatment in the hospital in the last 30 days, and multiple incidences of respiratory illness requiring hospitalization in the last year." A review of his records revealed the following concerns: o The PNMT had not integrated his PST Risk Action Plan into the PNMT Action Plan. o The PNMT's evaluation, measurable outcomes, and recommendations did not support an aggressive approach to minimize Individual #29's high risk for aspiration pneumonia and respiratory compromise. o The PNMT Assessment Follow-up, dated 10/21/10, included information in the discussion/recommendation section that should have been captured in the PNMT Evaluation sections. For example, his history of aspiration pneumonia, pneumonia, pneumonitis, bronchitis, and airway obstruction, a Braden score of 14, etc., would have fit more appropriately in the evaluation section. o The PNMT Evaluation did not address his history of choking, GERD, or aspiration; history of frequent vomiting, respiratory infections, pneumonias, or rumination; respiratory insufficiency and hypoxia; medical conditions that alter intake or nutrient supplements; documented or suspected GI bleeding or ulcers; presence of neurological and musculoskeletal conditions; improper body alignment due to orthopedic deformities; enteral nutrition; oral motor dysfunction resulting in dysphagia; and/or presence of severe oral dental abnormalities. o PNMT monitoring for positioning and feeding was to occur one time a week, at the minimum. The PNMT Follow-up, dated 11/4/10, stated: "monitoring completed by RNCM" [Registered Nurse Case Manger]," but no monitoring documentation was submitted. o The PNMT Follow-up, dated 1/11/11, updated the PNMT Action Plan, but the action steps did not identify specific criteria for completion, or measurable objectives to reduce risk or measure progress, or lack thereof, with regard to identified health risk indicators. For example, the action steps included: "2) weight; 3) research HEPA filter-how to obtain and required maintenance… ; 5) wheelchair system; and PNMT to present all information to PST as soon as can be scheduled." o The next scheduled PNMT meeting date for Individual #29 was 2/1/11, but no documentation was submitted for this meeting. The PNMT	

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		should have been mindful that they were providing supports to individuals at the highest risk, and waiting a month to meet and provide updates was not sufficient. o The PNMT Action Plan was not integrated into his PSP. ▪ Individual #176's PNMT Evaluation, dated 8/16 and 8/24/10, indicated he was referred due to multiple incidences of pneumonia and aspiration pneumonia. The analysis section of the report affirmed: "The team agrees that positioning continues to be of great importance as a safeguard for preventing aspiration and or reflux. PST reports the home has been in-serviced on positioning. The team recommends that reflux precautions and appropriate oral care are monitored." Prior to completion of the PNMT evaluation, the PNMT should have conducted random monitoring across shifts to determine if staff were competent to implement PNMP positioning. The PNMT Action Plan confirmed that positioning monitoring should be documented in the Integrated Progress Notes, but no Integrated Progress Notes were submitted to support implementation of the Action Plan. ▪ Individual #138's PNMT Action Plan, dated 3/17/11, used a revised format, including objectives, action steps, frequency, person responsible, completion/timeline, and type and frequency of data. This format was an improvement from the previous action plan formats. The PNMT Action Plan should be updated in a timely manner to document completion of action steps. Individual #138's PNMP should have been updated to reflect triggers for lethargy. ▪ The PNMT Evaluation, dated 3/3/10, 3/5/10, and 3/15/11, indicated that Individual #258's PST met on 1/31/11, and placed him at high risk for respiratory compromise, aspiration, fluid imbalance, osteoporosis, urinary tract infections, dental, choking, weight, constipation/bowel obstruction, and gastrointestinal problems. The PNMT Action Plan, dated 3/17/11, did not consistently address recommendations/strategies to address these high-risk areas of concern. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs, PNMT members should: ▪ Review the individual-specific risk levels assigned by PSTs for individuals referred to the PNMT to determine if a change in status has changed the risk levels, and review any changes with the individual's PST; ▪ The PST Risk Action Plan should be incorporated into the PNMT Action Plan, and/or revised, if appropriate, due to PNMT evaluation results; ▪ If sections of the PNMT Evaluation are not applicable, document that the section was not applicable to the individual being evaluated;	

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		▪ Complete a comprehensive positioning evaluation to determine the status of safe positioning for an individual within natural environments (nighttime positioning, personal care, seating system, bathing, tooth brushing, classroom, work, leisure, medication administration, etc.) to determine the efficacy of current PNMP strategies, including staff instructions, prior to the PNMT and subsequent PST meeting; ▪ Identify individual triggers for direct support professionals and professional staff to monitor for identified risk indicators, such as aspiration pneumonia, and integrate these triggers into relevant working plans, such as the PNMP, Dining Plan, BSP, Nursing Care Plan, etc.; ▪ Ensure the assessment provides recommendations for clinically justified techniques for mealtime (including individuals who are enterally nourished), oral care, bathing, dental appointments, bedtime positioning, medication administration, etc.; ▪ Provide support to individuals at highest risk on a much more frequent basis. Timeframes for review should not be extended across months, but rather days for individuals at highest risk. The PNMT should develop procedures for timely and proactive assessment, intervention, review, documentation, monitoring, and analysis to determine efficacy of supports provided at both individual-specific and systemic levels; ▪ Incorporate the Action Plan into the individual's PSP through the addendum process; ▪ Include in the analysis section of the PNM Evaluation assessment data, which provides justification and rationale for the recommendations. The analysis should provide a correlation between the identified high-risk indicators that resulted in referral to the PNMT, and should summarize the assessment data, which provides justification for the recommendations and measurable outcomes; ▪ Include criteria in the recommendations and measurable outcomes to measure the efficacy of the interventions; ▪ Develop implementation strategies to ensure recommendations and measureable outcomes are implemented; ▪ Ensure staff complete performance check-offs to document competency for identified skills for those individuals at highest risk; ▪ Develop a simple method to document, monitor, and track objective clinical data to support the effective implementation of recommendations; ▪ Implement a mechanism to report a change in an individual's status to the PNMT to enable the PNMT to evaluate the plan, and/or make modifications to the plan; and ▪ Develop an individual-specific monitoring plan for the PNMT to complete that is correlated to PNM recommendations and measurable outcomes enabling the	

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		Team to quickly determine the efficacy of identified implementation strategies. A review of the records of nine individuals who were enterally nourished and at risk for aspiration pneumonia (Individual #6, Individual #228, Individual #199, Individual #193, Individual #55, Individual #109, Individual #225, Individual #196, and Individual #139) revealed the following: ▪ In none of the nine records (0%) was documentation found of PNMT review/analysis of the findings of relevant discipline-specific assessment(s), including but not limited to PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. Such a summary should have 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 during nutritional intake. ▪ In none of the nine records (0%) were measurable, functional outcomes identified. ▪ In none of the nine records (0%) was documentation found of PNMPs developed with input from the PNMT for those individuals at highest risk. ▪ In none of the nine records (0%) was congruency found between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. ▪ In none of the nine records (0%) were comprehensive summary results integrated into the design of the appropriate PNM support plans as outlined in HCG VI and VIII and SA O.3 through O.8. ▪ In none of the nine records (0%) were PNMT updates provided as needed until the individual was discharged from the PNMT. Individual examples are provided in the section that addresses Section O.1 of the Settlement Agreement.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> A review was conducted of 14 individuals identified at high risk, including: Individual #226, Individual #312, Individual #29, Individual #176, Individual #138, Individual #258, Individual #6, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139. The record review included	Noncompliance

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	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.	review of the individuals' PNMPs. Although many of the components of an adequate PNMP were present for these individuals, there were components missing. More specifically: ▪ In 14 of 14 records (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In 14 of 14 records (100%), transfer instructions were included. ▪ In 14 of 14 records (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks and/or addressed receiving nutrition through a feeding tube. ▪ In 14 of 14 records (100%), the mealtime/dining plan included food/fluid textures and/or addressed receiving nutrition through a feeding tube. ▪ In 14 of 14 records (100%), the time was identified that an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ In 14 of 14 records (100%), the mealtime/dining plan included behavioral concerns related to intake and/or addressed receiving nutrition through a feeding tube. ▪ In 14 of 14 records (100%), strategies for medication administration were included. ▪ In 14 of 14 records (100%), strategies for oral hygiene were included. ▪ In 14 of 14 records (100%), individual adaptive equipment was included. ▪ In one of 14 records (7%), bathing/showering positioning and related instructions were included. ▪ In none of 14 records (0%), personal care instructions were included. ▪ In 14 of 14 records (100%), communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included: ▪ According to the Settlement Agreement, PNMPs must incorporate strategies for bathing/showering, and personal care for those individuals identified at risk. The PNMPs of individuals who received enteral nutrition, had been diagnosed with aspiration pneumonia, and/or were at risk of aspiration pneumonia needed to include staff instructions for bathing/showering and personal care (i.e., checking and changing) to ensure individuals were not in a flat, supine position during bathing/showering and personal care. ▪ PNMP strategies needed to be integrated within an individual's nursing care/healthcare plan, and competency-based training provided to nursing staff to support nurses during medication administration, as well as other procedures requiring attention to individual triggers, adaptive equipment, positioning and presentation techniques. Furthermore, for individuals who must be elevated and not be placed in a flat supine position, current strategies in PNMPs should be reassessed to identify appropriate	

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		elevation levels. PNMPs should reflect elevation strategies in every environment for those individuals who are at risk of aspiration pneumonia, have a diagnosis of GERD, or have other related health risk indicators (i.e., respiratory concerns). <u>PNM plans were incorporated into individual's Personal Support Plans.</u> In 16 records reviewed (Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, Individual #258, Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139), none of the PNMPs (0%) were incorporated into individuals' Personal Support Plans. Information from the PNMP should be integrated within the PSP, not simply referenced and/or listed. Examples of where individual PNMPs were not incorporated in PSPs included: ▪ On 2/3/11, Individual #176's PNMP was revised to incorporate his Communication Dictionary, but there was no PSPA to integrate the use of his Communication Dictionary into his PSP. ▪ On 2/25/11, Individual #6's PNMP was revised to incorporate the use of a wedge in his day bed. There was no PSPA to discuss the implementation of using a wedge in his day bed. ▪ On 2/17/11, Individual #199's PNMP was revised under mobility to include "walks at home at least once on 6-2 and 2-10 shifts; use padded gaitbelt with hands on assist of 2; use wheelchair for mobility-encourage to self propel." There was no PSPA to incorporating these revisions into his PSP. <u>PNMPs are developed with input from the PST, home staff, medical and nursing staff.</u> In 16 records reviewed (Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, Individual #258, Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139), none (0%) of the PNMPs were developed with input from 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: ▪ On 3/22/11, Individual #193's PNMP was revised, but there was no indication of what had been revised. ▪ On 1/14/11, Individual #66's PNMP was revised to incorporate the use of a voice output communication aid and communication dictionary. Her PSP, dated 1/12/11, incorporated the use of her communication device, but did not discuss the purpose and use of her communication dictionary. ▪ On 1/21/11, Individual #109's PNMP was revised to add in the following: "promote healing of right hip fracture, use wheelchair for all	

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		transportation/mobility, stand pivot transfer weight bearing through left leg only with hands on assistance of 2 people and gait belt and caution brittle bones." There was no PSPA to incorporate these revisions to his PNMP into his PSP. <u>PNMPs are reviewed annually at the PSP meetings, and updated as needed.</u> In none of 16 records reviewed (0%) were PNMPs reviewed annually at the PSP meeting, updated as needed, and integrated within the PSP. As discussed above, there was no evidence that the PNMPs were actually reviewed, discussed, and integrated into skill acquisition programs, BSPs, nursing care plans, and/or daily routines at the PSP meetings. 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, transition (change in setting), or as dictated by monitoring results.</u> In none of nine records reviewed (Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139) (0%) 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: ▪ On 11/26/10, Individual #6 was hospitalized with a discharge diagnosis of septicemia (blood poisoning). There was no PSPA meeting to address his change in status, and to determine if changes needed to be made to his PNMP. ▪ On 7/24/10, Individual #199 was hospitalized with a discharge diagnosis of pneumonia organism unspecified. A Habilitation Therapies Consultation, dated 8/5/10, acknowledged: "[Individual #199] was admitted to the hospital with a diagnosis of pneumonia-aspiration/healthcare acquired vs. pneumonitis. He returned on 8/2/10 and a PSPA was held during which it was determined a re-evaluation should be performed to determine his current status for HT." However, no PSPA documentation was submitted to address his hospitalization. ▪ On 9/7/10, Individual #193 was hospitalized with a discharge diagnosis of aspiration pneumonia. On 9/13/10, there was a PSPA meeting "to discuss nutritional options for [Individual #193] when she returns to LBSSLC." Although it was documented that Individual #193 would need reflux precautions, there was no discussion of revisions to her PNMP. ▪ On 2/19/10 and 9/10/10, Individual #66 was hospitalized with a discharge diagnosis of aspiration pneumonia. There were no PSPA meetings to address her hospitalizations for aspiration pneumonia, and/or to recommend a re-assessment of her PNMP to ensure strategies were effective to minimize her ongoing risk for aspiration pneumonia.	

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O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> The Facility was to be commended for developing an interdisciplinary problem-solving approach to address mealtime concerns. LBSSLC administration had established a Meal Time Improvement Committee. The members were the Assistant Director of Programs, the Unit Directors, Nursing Operations Officer, Director of Behavioral Services, Safety Officer, Director of Active Treatment, Chief Nursing Executive, Director of Food Service, Program Compliance Coordinator, Director of Habilitation Therapies, Risk Manger, and QMRP Coordinator. The purpose of the Committee was to identify issues/concerns occurring during meal times, which could negatively impact the safety of the individuals served, and to proactively work toward systemic solutions. The MT Committee was tasked with developing and implementing an action plan to address identified issues/concerns, to monitor the implementation of the action plan, and revise the plan, as necessary. Multiple workgroups were formed to address the MT Committee goals, including the Workshop Meal Time Work Group, Supervisor Work Group, Active/Programming Work Group, Environment Work Group, Policy Work Group, and Positioning/Enteral Fed Work Group. The MT Committee identified the following areas needing improvement: cleanliness, environment, correct diet textures and fluid consistency, interaction of staff to individuals during mealtimes, availability of communication devices, providing adequate staffing ratios, program implementation, mealtime schedule, oversight, implementation of correct dining techniques, providing consistency assigning food service workers, and meals at the workshop. The most significant solution to ameliorate these mealtime concerns was to identify a dining room supervisor and provide training. A policy for MT Coordinators, dated 5/20/10, defined an MT Coordinator as a "person designated by residential services to coordinate the services provided to the individuals served during meal time." The policy further defined the steps and/or responsibilities of a MT Coordinator. LBSSLC utilized three mealtime monitoring forms. The LBSSLC Mealtime Monitoring form was submitted with 16 indicators used to monitor dining rooms. A second mealtime monitoring form for MT Coordinators had indicators to be completed prior to the meal, during mealtime, and additional items to take into account if mealtime was not running effectively, and a section for additional comments. The HT Meal Observation was individual-specific with 15 indicators. Consideration should be given to merging these three forms into a simple format for general environment indicators and individual-specific indicators to produce consistent monitoring mealtime results. Meal Time Coordinator Training was provided, but it was not competency-based. A	Noncompliance

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		written test was administered at the conclusion of the MT Coordinator training. LBSSLC was to be commended for developing and implementing an integrated approach across all disciplines/departments committed to resolving identified mealtime concerns. However, issues of concern continued to be noted during mealtime observations. The Monitoring Team observed meals where several MT Coordinators were not performing their responsibilities to provide coaching and mentoring to enhance staff competency during mealtimes. Specifically, during observations, MT Coordinators did not intervene to correct position and alignment, and/or model for staff the correct techniques when dining plan instructions were not being followed. These observations led the Monitoring Team to the conclusion that MT Coordinators might not be competent to perform their roles and responsibilities. To support this important ongoing mealtime safety initiative, the Facility should: ▪ Provide competency-based training to MT Coordinators, including a mealtime training curriculum with specific learner objectives and competencies to provide foundational knowledge and skills related to ensuring safety at mealtimes in the following areas: o Mealtime position and alignment; o Diet texture and fluid consistency; o Presentation techniques to enhance nutritional intake and hydration; o Care and use of adaptive equipment; o Aspiration and choking precautions and rationale; o Understanding a swallow study; o Risk indicators and problem solving; and o Techniques to promote optimal levels of independence and skill acquisition during mealtimes. ▪ Develop and implement competency-based performance check-offs for MT Coordinators to ensure MT Coordinators are competent with mealtime learner objectives. ▪ Revise the LBSSLC Mealtime Monitoring Form to address generic mealtime indicators, such as environment, staff ratio, cleanliness, sufficient adaptive equipment, etc. Reformat the form for individual-specific monitoring indicators to address, at a minimum, position and alignment, correct diet texture and fluid consistency, adaptive equipment, presentation techniques, and recognition of individual triggers. ▪ Develop competency-based training and performance skills check-off for mealtime monitors. ▪ Establish a validation and re-revalidation process for MT monitors, which involves auditing MT Coordinators to ensure competency with mealtime indicators;	

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		▪ Establish protocols for implementation of a mealtime monitoring schedule, and auditing of completed mealtime monitoring forms to formulate corrective strategies to address individual-specific and/or systemic areas of deficiencies for specific indicators. This process should be integrated into the Facility's QA/QI and Risk Management systems. ▪ Establish compliance benchmarks for mealtime monitoring results to celebrate success. If monitoring results fall below established benchmarks, determine what action will be necessary, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic. ▪ Ensure a heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk due to aspiration pneumonia, respiratory concerns, choking, weight, fluid imbalance, etc. Twelve individual observations were completed of staff's implementation of dining plans and/or PNMPs in residences on campus. During a dinner observation at 526 North Cedar Avenue (Tulip), the Monitoring Team observed appropriate mealtime intervention, when the QMRP halted the meal for Individual #190 who was observed to be in poor alignment and support, as well as presenting with lethargy. To support mealtime safety, this level of direct support professional and/or supervisory intervention should be evident from all disciplines. However, overall, staff did not consistently implement interventions and recommendations outlined in the PNMPs and/or dining plans. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration, or other risks, such as skin breakdown, etc. The following provides additional details regarding the observations: ▪ In one of seven observations (14%), staff were following dining plans. ▪ In zero of one observation (0%), staff were following positioning instructions, while individuals were receiving enteral nutrition. ▪ In zero of six observations (0%), staff were following wheelchair positioning instructions. ▪ In one of two observations (50%), staff were following alternate positioning instructions. ▪ In zero of one observation (0%), nursing staff were following the PNMP, including 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 in the PNMPs and/or mealtime plans were as follows:	

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		▪ Individual #195's dining plan provided staff instructions for head support during meals and snacks, but the staff person presenting food did not follow these instructions. ▪ Individual #258 and Individual #185 did not have dining plans present during a dinner observation. The Mealtime Coordinator was present in the dining room, but did not retrieve their dining plans. Staff were not following the presentation techniques in the dining plan. ▪ Individual #167 was receiving enteral nutrition in a recliner in poor alignment and support. ▪ Individual #78 was observed during medication administration in poor alignment and support in her seating system. The nurse referred the Monitoring Team to her PNMP, which was attached to the MAR, but stated she had not received training to re-position Individual #78. ▪ Individual #138 was in poor alignment and support in her recliner. ▪ Individual #196 was in poor alignment and support in her seating system. The majority of individuals within this sample resided in Quail and/or Sparrow (currently in Zinnia while the residence was being renovated), where individuals were at high risk for aspiration pneumonia. These observations reinforced the importance of heightened monitoring for those individuals identified at high risk. LBSSLC draft Policy for Positioning During Dental Treatment, dated 3/1/11, affirmed the Dental Department would follow positioning instructions for individuals with a PNMP. Language from the HOBE Assessment Protocol should be incorporated to address the maximum and minimum elevations to be maintained during oral care. The goals of the LBSSLC Special Events On-Campus and Off Campus Activities with Foods and/or Fluids, dated 10/27/10, were to: ▪ Ensure the safety for individuals during Special Events involving food and/or fluids, during on and off campus events; and ▪ Minimize and/or eliminate incidents of choking, aspiration and aspiration pneumonia. The policy addressed activities away from the center for boxed meals and dining out. Activities at the Center discussed special events, home events, and visits by family and friends. The Facility should incorporate a modified version of mealtime monitoring for off-campus events to ensure compliance with this policy. Activities at the Center (special events, home events, and visits by family and friends) should receive routine mealtime monitoring. Family and friends, who would like to assist individuals during mealtimes while on campus, should be offered competency-based training on the dining plan. Consideration should be given to incorporating language that family/friends will only provide the food and/or fluid within the prescribed food texture and fluid consistency	

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		while on the grounds of LBSSLC to ensure mealtime safety. LBSSLC Choking Policy, dated 12/31/10, presented steps to recognize signs and symptoms of choking, treatment, and notification. The Facility policy should be modified to include the following: ▪ Staff should initiate a call to 3733 and/or a call to 911 much earlier than identified in the Treatment section; ▪ Under Notification, the policy should define who will assess the individual after any treatment is performed; ▪ The policy should define the timeframe for Habilitation Therapy to be notified; ▪ The policy should define Habilitation Therapy's responsibilities, such as completion of a mealtime assessment; ▪ The policy should define who will notify the investigators; ▪ Action response timeframes should be defined for all disciplines, documentation requirements, follow-up, and review guidelines; and ▪ The policy should define operational guidelines for QA/QI and Risk Management Departments in relation to choking incidents. The Mealtime Committee might want to consider developing a method to identify staffing ratios for mealtimes/snacks. For example, in another State, a Facility had used the following eight weighted descriptors, which were assigned to each individual, to determine staffing ratios: ▪ Dysphagia with a weight of 0.1; ▪ PNM - no weight; ▪ Enteral - no weight; ▪ Independent with a weight of 0; ▪ Minimal assist with a weight of .25; ▪ Moderate assist with a weight of .50; ▪ Maximum assist with a weight of .75; and ▪ Dependent with a weight of 1.0. Each individual was scored in each of the eight indicators. An individual score was calculated for each individual. The individual score for each individual was totaled for all individuals within the residence to produce the number of staff needed for each meal and/or snack. This information would be helpful to managers in the development of staffing schedules for mealtimes to ensure staffing ratios were sufficient to support mealtime safety.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> New Employee Orientation dedicated a day for instruction by Habilitation Therapies staff. The following agenda was presented:	Noncompliance

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	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.	▪ Alternative/Augmentative Communication (8:00 to 9:30 a.m.); ▪ Orientation and Mobility (9:30 to 11:15 a.m.); ▪ Feeding/Mealtime Management (11:15 to 12:15 p.m.); ▪ PNMP (1:15 to 2:15 p.m.); ▪ Positioning (2:15 to 3:30 p.m.); and ▪ Mealtime Assistance (3:30 to 4:30 p.m.). Competency-based training should identify learning objectives/outcomes that define what a staff person must do, and provide the opportunity for staff to demonstrate the mastery of the learned skill. Habilitation Therapies had revised their curricula to include a written test and/or competency-based performance check-offs as evidenced by the following: ▪ Alternative/Augmentative Communication o List types of communication signals; o Understand what Alternative and Augmentative Communication (AAC) is; Why AAC is used; How often AAC is used; Where AAC is used, Flexibility of AAC; Use of Picture Dictionary; and use of PNMP for communication needs; o NEO AAC Competency Test with ten written questions, and no performance check-off; ▪ Orientation and Mobility o Vision impairments, hearing impairments, impairments that affect perception and correct techniques; o Audio, Hearing and Orientation Mobility test with 12 written questions, and no performance check-off; ▪ Feeding/Mealtime Management o Understand different stages of oral motor development, identify different types of food textures, identify different consistencies of thickened fluids offered at LBSSLC, understand what a dining plan is and how to use it with adaptive feeding equipment, positioning and dining strategies; o Dining Chair Feeding Competency; Wheelchair Feeding Competency, and Enteral Feeding Competency; o Follow-up NEO Mealtime Competencies identified seven demonstration competencies with an additional indicator which stated "verbalized what they would do to assist person to eat as instructed (small bites, slow pace, liquid between bites); o Feeding and Meal Time Management written test with ten true/false questions; ▪ PNMP o PNMP's Purpose, where to find them, type of information on them, how	

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		a change is made, who to ask for help and what are monitors; o Assistive Equipment - where it is listed, who is responsible for assuring it is clean and in good working order, how to use it, what to do when it is removed; and who to contact when it is missing, needs repair, no longer fits, etc. o Wheelchairs - who has a wheelchair and how to identify it, parts of the wheelchair and how they work, when to clean the wheelchair; o PNMP, Handling and Positioning Quiz with ten written questions; o Positioning Competencies with ten demonstration competencies; ▪ Positioning o Recognize/recall responsible related lifting and transferring people, recall information about consumer/patient transfers and lifts and recognize staff actins that comply with lifting guidelines, and perform stand-pivot transfer, two-person lift and mechanical lift; o Stand-pivot transfer assessment checklist; two-person manual lift assessment checklist; mechanical lift assessment checklist; ▪ Nutrition Services o Understand the diet cards, identify different food textures, identify common food allergies, and identify snack items; o Mealtime assistance written test with 11 written questions. The HT Department should re-evaluate the NEO PNM sections that only had a written test as documented above, and develop a staff performance check-off and/or an individual-specific performance check-off during on the job training for new employees. For the example, the Alternative/Augmentative Communication section should incorporate a performance check-off for the use of generic and individual-specific communication devices. The Facility will need to incorporate performance-based check-offs for individual-specific training for PNMPs and/or other therapy programs. Staff verbalization of a learned skill does not meet the standard of competency-based training and performance-based check offs for physical and nutritional supports. For example, the Monitoring Team observed multiple individuals who were not in optimal alignment and support in their seating systems. This led the Monitoring Team to the conclusion that staff were not competent in positioning individuals, or that they did not understand the importance of it, which should be a component of the training. To ensure staff competency in positioning and alignment, staff must demonstrate this skill. Competency-based training should identify learning objectives/outcomes that define what a staff person must do, and provide the opportunity for staff to demonstrate the mastery of the learned skill. Review of the Facility's training curricula revealed that it did not include adequate PNM training in the following areas:	

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		▪ Generic and individual-specific mealtime risk triggers that alert staff to problems, and what staff were to do if these triggers were observed; ▪ Techniques to promote independence and skill acquisition during mealtimes; ▪ Presentation and position/alignment strategies to support safety during oral hygiene, bathing, personal care, and medication administration; The PNM competency-based training curriculum should identify the following: ▪ Required competencies for foundational skills in PNM; ▪ For each competency, there should be a list of tasks and/or activities that must be demonstrated; ▪ A description of how staff will demonstrate mastery of the skill; ▪ A description of how the training will reinforce why it is important in my job to know this information; and ▪ A training schedule that is spaced out to allow participants the opportunity to practice new skills, ask questions, and obtain a lot of feedback. <u>All foundational trainings are updated annually</u>. LBSSLC CTD Employee Training Calendar for March 2011, dated 2/28/11, did not document refresher training for physical and nutritional supports. The document identified HT Videos (8:00 to 11:00 a.m.) and HT Day (8:00 a.m. to 5:00 p.m.) on multiple days, but it was not clear if this was related to foundational training for physical and nutritional supports. <u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u> Based on a review of staff PNMP training records, competency-based individual-specific training was not documented as being provided by appropriately trained personnel. This was illustrated as follows: ▪ In zero of 16 records reviewed (0%), licensed therapists, assistants, and/or PNMP Coordinators had completed competency-based training for supervisors, and/or other designated staff, who would be responsible for implementation of PNMPs. ▪ In zero of 16 records reviewed (0%), licensed therapists, assistants, PNMP coordinators, and/or competently trained designated supervisors/residential managers, etc. had provided instruction to direct support professionals. <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 two of 16 staff training records reviewed (13%) (Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, Individual #258,	

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		Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139), staff who had successfully completed competency-based training provided assistance to individuals determined to be at an increased level of risk. However, the following concerns were noted with regard to the individuals for whom some training documentation was submitted: ▪ Individual #301 was referred to the PNMT for his stage III decubitus ulcer, frequent hospitalizations, and recurrent episodes of aspiration pneumonia/pneumonia. The PNMT Physical Therapist completed a Mechanical Lift Transfer Competency checklist for one staff, dated 2/15/11, and a Transfer Competency checklist for one staff, dated 11/9/10. There were no additional staff training competency checklists completed, even though he had positioning instructions for a three person manual transfer from the left side only, right and left sidelying in wheelchair cart, wheelchair positioning, and right and left sidelying in bed. Individual #301 was to be monitored for positioning during feedings, bathing, and oral care, but no staff competency checklists were completed to support staff competency for these daily activities. ▪ A Physical Therapist Assistant (PTA) completed a Bed Positioning (supine, left and modified right side lying) Competency checklist, dated 3/11/11, for Individual #225. However, only one checklist was completed, and it was unclear what the individual staff member had demonstrated. The competency checklist submitted did not follow the positioning instructions for supine and/or left sidelying. <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 16 individual records, zero out of 16 (0%) showed that staff were re-trained using competency-based methods, when changes occurred to the PNMP. As stated above, staff verbalization of a change in a PNMP did not meet the standard of competency-based training.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> <u>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).</u> The monitoring section in DADS Policy #012.1 for Physical and Nutritional Management, effective date 3/11/11, stated: "PNMPs should be monitored as determined by need and risk level. Individuals at highest risk shall be monitored at greater frequency to reduce the impact of high risk conditions and to prevent recurrences if possible." The policy provided six steps to further define monitoring, but did not provide specific directions to implement PNMP and PNMT monitoring. It will be the responsibility of the Facility to	Noncompliance

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		develop a step-down policy to ensure the PNMT conducts comprehensive monitoring. LBSSLC did not have a policy/protocol that addressed the monitoring process for the following monitoring forms that the Facility submitted: ▪ HT PNMP Observation; ▪ HT Meal Observation; and ▪ PNMT Monitoring Tool. The absence of established guidelines/protocols for monitoring forms will result in the inconsistent scoring, as well as lack of follow-up for identified issues/concerns. This was reinforced upon the review of multiple completed PNMP Monitoring Form-Routine forms that were submitted. The following were examples of monitoring not being completed, or forms submitted for which identified concerns/issues were not resolved: ▪ Individual #6's Integrated Risk Rating Form, dated 12/21/10, affirmed his high-risk status for aspiration, respiratory concerns, gastrointestinal problems, osteoporosis, infections, and fluid imbalance. Per the State policy for Physical and Nutritional Management: "individuals at highest risk shall be monitored at greater frequency to reduce the impact of high risk conditions and to prevent recurrences of possible." Only one HT PNMP Observation, dated 2/24/11, was submitted, although Individual #6 was an individual at high risk. The monitoring form noted the PNMP was not in use, the enteral feeding position was not correct, the appropriate elevation was not correct, and his communication device was not in use. However, there was no documentation that resolution had occurred and/or action had been taken. In addition, Individual #6's "mattress on daybed slid down resulting in him being flat." A work order was submitted to fabricate an inset to be placed between the footboard and bottom mattress. His PNMP, revised 2/25/11, did not document this insert under assistive equipment. ▪ Individual #199's Aspiration Pneumonia/Enteral Nutrition Evaluation history, dated 2/9/11, acknowledged: "[Individual #199] is being evaluated due to aspiration pneumonia on 4/29/10 and 7/24/10. On 9/11/09, he had a PEG tube placement due to anorexia and weight loss." Individual #199 was at high risk, but no PNMP monitoring had been completed. ▪ Individual #193's was on the Combined List for Risk Discussion Meetings (enteral feeding, pneumonia and PICA), which identified individuals at high risk for aspiration pneumonia, but no PNMP monitoring had been completed. ▪ Individual #66's Integrated Risk Rating Form, dated 1/12/11, affirmed her high-risk status for aspiration, respiratory compromise, and osteoporosis, but no PNMP monitoring had occurred. ▪ Individual #196's HT PNMP Observation form, dated 1/30/11, documented her PNMP was not in use; positioning was not correct, but did not identify the	

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		position observed; positioning supports were not utilized; communication device not in use; wheelchair not clean and in good repair; communication device not in good repair; and adaptive equipment not in good repair. A second HT PNMP Observation, dated 2/9/11, identified staff non-compliance with PNMP availability and use, wheelchair position not correct, poor alignment, positioning equipment not utilized, no repositioning occurring, communication device not in use, and adaptive equipment not clean/in good repair. Indicators were marked "N/A" that should have been marked "yes" or "no." For example, her communication device was marked "no" for in use, but communication device clean/in good repair was marked "N/A." Monitoring forms should be audited to ensure these forms were completed correctly. Concerns noted on the form were "no repositioning occurring and All About Me Books falling apart." Actions taken were listed as: "[Individual #196] was repositioned by the PT and PTA and staff were trying to locate [Individual #196's] adaptive equipment." Individual #196 was at high risk with recurring themes of staff non-compliance with PNMP implementation, but based on documentation provided, it was not clear that adequate follow-up had occurred to correct the deficiencies noted. ▪ The PNMT evaluated Individual #258, but no PNMT monitoring had occurred. ▪ On 3/3/11, the PNMT evaluated Individual #138, but no PNMT monitoring had occurred post PNMT evaluation. As discussed in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans. At a minimum, such a policy should include: ▪ Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, tooth brushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.); ▪ A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability; ▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability; ▪ Formal schedule for monitoring to occur; ▪ Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors; ▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; ▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and ▪ Establishment of thresholds for staff re-training.	

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		<u>All members of the PNM team conduct monitoring.</u> At the time of the Monitoring Team's review, PNMT members were not conducting consistent monitoring. This is discussed with regard to Section O.2 in the examples of individuals reviewed and assessed by the PNMT. <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 the Quality Assurance Department, did not illustrate that a mechanism was in place to ensure 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 should 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 QA/QI, Incident Management and Risk Management systems. <u>Immediate intervention is provided if the person is determined to be at risk of harm.</u> Examples are provided above with regard to Section I.2 and Section O.1 of individuals who were at risk, but had not been reviewed by the PNMT, and/or had timely intervention completed by the PNMT.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.</u> For none of the nine individual records reviewed (Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139) (0%), had the PNMTs completed a comprehensive assessment leading to the development of strategies for these individuals. These individuals received enteral nutrition, and had had aspiration pneumonia and/or pneumonia, and according to the Protocol to Identify Individuals from Priority List, dated 3/1/11, would be evaluated by the PNMT. As a result, the PNMT did not document progress of individual strategies on a monthly basis to ensure the efficacy of those strategies in minimizing and/or reducing PNM risk indicators. In none of the nine records was documentation found to support if strategies were not effective, that these strategies and the PNMP were revised. The PNMT had completed a comprehensive assessment for seven individuals (Individual #226, Individual #312, Individual #29, Individual #301, Individual #176, Individual #138, and Individual #258), but the PNMT did not consistently implement necessary	Noncompliance

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		components of the PNM process. These seven individuals had PNMT Assessments and Action Plans completed, but these assessments and action plans did not consistently show that the PNMT had completed a review of the individuals' assigned risk levels to determine if they remained accurate based on changes in health status; incorporate PST Action Plans, as appropriate; include a comprehensive positioning evaluation to determine the status of safe positioning; identify individual triggers for direct support professionals and professional staff; include provisions for support and monitoring to individuals at highest risk on a more frequent basis; include criteria in the recommendations and measurable outcomes to measure the efficacy of interventions; require staff to complete performance check-offs to document competency for identified skills for individuals at highest risk; and/or set forth a monitoring plan correlated to PNMT recommendations and measurable outcomes. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> Based on review, in none of the nine individual records (Individual #6, Individual #228, Individual #199, Individual #193, Individual #66, Individual #109, Individual #225, Individual #196, and Individual #139) (0%) did the PNMT evaluate these individuals at high risk for aspiration pneumonia, and as a result did not develop an individualized action plan, document the efficacy of the individual plans, conduct person-specific monitoring to ensure the implementation of the plan, and/or revise the plan if identified strategies to minimize and/or reduce PNM risk indicators were not effective.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.</u> Per State policy, all individuals who received enteral nutrition would receive an annual Aspiration Pneumonia/Enteral Nutrition Evaluation. Assessment information was to be obtained from the PCP, RN, Habilitation Therapies, Dietary, and PST members. The Nurse Case Manager would compile the APEN evaluation document. The major elements of the APEN Nutrition Evaluation were: ▪ History to be completed by Primary PCP and RN, including diagnosis, comorbidities, history of aspiration pneumonia, other respiratory infections/conditions, hospitalizations for aspiration pneumonia/respiratory conditions, tracheostomy, reflux, emesis, and dental/oral heath issues (to be completed by dentist); ▪ Risk Level-Health Status to be completed by Team (risk level and rationale); ▪ Method of eating to be completed by PCP and Dietician (nasogastric tube, gastrostomy tube, jejunostomy tube, type of enteral feeding and oral eating); ▪ Reason/rationale for enteral eating to be completed by PCP, RN and Habilitation Therapies;	Noncompliance

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		▪ Diagnostic tests performed to be completed by PCP, RN, and Habilitation Therapies; ▪ Attempts to return to oral or least restrictive method of eating to be completed by Habilitation Therapies; ▪ Current treatment; ▪ Analysis of findings to be completed by team; ▪ Recommendations; ▪ Measurable outcomes; and ▪ Action plan. The evaluation format stated: "not all sections will be applicable to every individual." Based on the review of eight individual records (Individual #17, Individual #7, Individual #324, Individual #78, Individual #89, Individual #37, Individual #181, and Individual #281), who were enterally nourished and/or received supplemental tube feedings, eight (100%) of these individuals had received an annual APEN evaluation. The individuals within this sample were selected from the Combined List for Risk Discussion Meetings (Enteral Nutrition, Pneumonia and Pica), undated, which identified individuals the Facility had identified as being at highest risk. The following concerns were noted: ▪ Individual #37's APEN Evaluation was undated. There was no PSPA completed to incorporate his APEN Action Plan recommendations. Individual #37's PSPA, dated 3/16/11, indicated his discharge diagnosis from the hospital on 3/12/11 was aspiration pneumonia. The PST did not reassess his Risk Guidelines after his hospitalization for aspiration pneumonia. His hospitalization for aspiration pneumonia would have changed his risk status to "high" for aspiration pneumonia. ▪ Individual #17's APEN Evaluation, dated 3/23/11, acknowledged that Individual #17 received his nutrition via a G-tube at a continuous rate. The attempts to return to oral or least restrictive method of eating were described as: "06/26/09: Guardian declines MBS at this time. Team does not believe he is a good candidate for oral feeding due to aspiration pneumonia." There was no further discussion and/or evaluation to move Individual #17 to a less restrictive method of receiving enteral nutrition. Individual #17 had not been diagnosed with aspiration pneumonia since 2000. The APEN evaluation did not provide justification to maintain the current feeding method, and/or strategies to transition Individual #17 to a less restrictive form of enteral nutrition. ▪ Individual #7's APEN Evaluation, dated 3/28/11, affirmed he received enteral nutrition continuously. The analysis of findings stated: "[Individual #7] has been evaluated and it has been determined by the PST that [Individual #7] remains a high risk level for aspiration. [Individual #7] has had one incident of aspiration	

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		pneumonia this year and receives his tube feeding at a continuous rate. The team agrees that it is appropriate for him to continue to receive his nutrition via his J-tube." The APEN evaluation did not provide justification to maintain the current feeding method, and/or strategies to transition Individual #7 to a less restrictive form of enteral nutrition. ▪ The recommendations in Individual #78's APEN Evaluation, undated, were: "Continue current treatments listed above. Research and see if may return to intermittent feeding per dietician." It was unclear why the team did not complete this research during the evaluation phase. The purpose of an APEN Evaluation was to determine if feeding the individual by tube was medically necessary, and, where appropriate, to implement a plan to return the individual to oral feeding. This also would include the team evaluating the potential to move an individual to a less restrictive form of receiving enteral nutrition. <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 eight records, individuals were provided with a PNMP that: ▪ In eight of eight records (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In eight of eight records (100%), transfer instructions were included. ▪ In eight of eight records (100%), staff instructions were provided to identify the prescribed time an individual was to remain upright after receiving enteral nutrition. ▪ In eight of eight records (100%), strategies for medication administration were included. ▪ In eight of eight records (100%), strategies for oral hygiene were included. ▪ In eight of eight records (100%), individual adaptive equipment was included. ▪ In none of eight records reviewed (0%), bathing/showering positioning and instructions were included. ▪ In none of eight records (0%), personal care instructions were included. ▪ In eight of eight records reviewed (100%), communication strategies were included. The following provide examples of concerns identified as a result of this review: ▪ Individual #78's PNMP pictures, dated 9/20/10, stated: "These positions are also appropriate for enteral feeding, administrating medication and dental/oral care." However, there was a "most reclined" position, which would be contraindicated per the PNMP that prescribed: "ensure upright position for all meals and one hour after meal." ▪ These eight individuals' PNMPs did not provide positioning elevation	

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		instructions for staff for bathing/showering, and personal care for checking/changing. The absence of these strategies had the potential to place these individuals at risk for aspiration. The draft Head of Bed Elevation Assessment Protocol, undated, stated: "All individuals who require elevation for GERD, enteral eating, respiratory/breathing concerns, medication administration, oral care, hygiene, etc. must be evaluated for a range of appropriate elevation levels. A maximum and minimum elevation is determined to accommodate various activities." This protocol was in the initial stages of implementation. The results of the HOBE assessment might necessitate changes to individuals' PNMPs to identify the appropriate elevation range to support safety during activities throughout the 24-hour day. <u>The need for continued enteral nutrition is integrated into the PSP.</u> Based on a review of eight individuals' PSPs who received enteral nutrition, none (0%) of the individuals' PSPs documented the rationale for the continued need for enteral nutrition, attempts to return the individual to oral intake, or the least restrictive method of receiving nutrition. <u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).</u> The DADS At-Risk Individuals policy (Policy Number 006, dated 11/02/10) stated: "a regular risk assessment and management system will be used to identify persons at risk of illness and injury." A component of the At-Risk Individuals policy required "a comprehensive integrated assessment performed at least annually and as indicated for individuals who have a long history of/or recent hospitalization for aspiration pneumonia and for individuals who receive enteral nutrition. The assessment is designed to reduce the incidence of aspiration pneumonia and its complications and to assess continued need for enteral eating." All individuals who were enterally nourished were to be evaluated using the APEN evaluation format. According to the documentation provided, eight of the eight individuals within this sample had received an annual APEN evaluation. <u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.</u> Individual #323, Individual #128, and Individual #6 received therapeutic feedings. None of these three individuals (0%) had a formal therapeutic feeding program with documentation to support the efficacy of the program. The following concerns were noted: ▪ Individual #323's Consultation Report, dated 2/16/11, documented his case	

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		history, findings/clinical impressions of a therapeutic/pleasure feeding assessments, and recommendations. His PSPA, dated 2/16/11, was convened to discuss the implementation of therapeutic pleasure feeding. Dining instructions were developed, but there were no measurable, functional outcomes developed to support the efficacy of the therapeutic feeding program. ▪ Individual #128's Consultation Report, dated 2/5/11, provided a comprehensive chronology and feeding assessment leading to the initiation of pleasure feedings. There were no measurable, functional outcomes developed to support the efficacy of the therapeutic feeding program.	

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

1. PNMT members' attendance at state-sponsored PNMT-related continuing education courses should be non-negotiable and mandatory.
2. A continuing education tracking system for PNMT members should be implemented to consistently document attendance through training rosters and/or certificate of completion for state-sponsored webinars, off-site clinical instruction, and conferences. The Habilitation Director should review the information regularly to ensure that staff are attending continuing education sessions as appropriate.
3. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs, PNMT members should:
    a. Review the individual-specific risk levels assigned by PSTs for individuals referred to the PNMT to determine if a change in status has changed the risk levels, and review any changes with the individual's PST;
    b. The PST Risk Action Plan should be incorporated into the PNMT Action Plan, and/or revised, if appropriate, due to PNMT evaluation results;
    c. If sections of the PNMT Evaluation are not applicable, document that the section was not applicable to the individual being evaluated;
    d. Complete a comprehensive positioning evaluation to determine the status of safe positioning for an individual within natural environments (nighttime positioning, personal care, seating system, bathing, tooth brushing, classroom, work, leisure, medication administration, etc.) to determine the efficacy of current PNMP strategies, including staff instructions, prior to the PNMT and subsequent PST meeting;
    e. Identify individual triggers for direct support professionals and professional staff to monitor for identified risk indicators, such as aspiration pneumonia, and integrate these triggers into relevant working plans, such as the PNMP, Dining Plan, BSP, Nursing Care Plan, etc.;
    f. Ensure the assessment provides recommendations for clinically justified techniques for mealtime (including individuals who are enterally nourished), oral care, bathing, dental appointments, bedtime positioning, medication administration, etc.;
    g. Provide support to individuals at highest risk on a much more frequent basis. Timeframes for review should not be extended across months, but rather days for individuals at highest risk. The PNMT should develop procedures for timely and proactive assessment, intervention, review, documentation, monitoring, and analysis to determine efficacy of supports provided at both individual-specific and systemic levels;
    h. Incorporate the Action Plan into the individual's PSP through the addendum process;
    i. Include in the analysis section of the PNM Evaluation assessment data, which provides justification and rationale for the recommendations. The analysis should provide a correlation between the identified high-risk indicators that resulted in referral to the PNMT, and should summarize the assessment data, which provides justification for the recommendations and measurable outcomes;

j. Include criteria in the recommendations and measurable outcomes to measure the efficacy of the interventions;
k. Develop implementation strategies to ensure recommendations and measureable outcomes are implemented;
l. Ensure staff complete performance check-offs to document competency for identified skills for those individuals at highest risk;
m. Develop a simple method to document, monitor, and track objective clinical data to support the effective implementation of recommendations;
n. Implement a mechanism to report a change in an individual's status to the PNMT to enable the PNMT to evaluate the plan, and/or make modifications to the plan; and Develop an individual-specific monitoring plan for the PNMT to complete that is correlated to PNM recommendations and measurable outcomes enabling the Team to quickly determine the efficacy of identified implementation strategies.

4. For individuals who must be elevated and not be placed in a flat supine position, current strategies in PNMPs should be reassessed to identify appropriate elevation levels. PNMPs should reflect elevation strategies in every environment for those individuals who are at risk of aspiration pneumonia, have a diagnosis of GERD, or have other related health risk indicators (i.e., respiratory concerns).
5. PNMP strategies should be integrated within an individual's nursing care/healthcare plan, and competency-based training provided to nursing staff to support nurses during medication administration, as well as other procedures requiring attention to individual triggers, adaptive equipment, positioning, and presentation techniques.
6. To support the Facility's important ongoing mealtime safety initiative, the Facility should:
    a. Provide competency-based training to MT Coordinators, including a mealtime training curriculum with specific learner objectives and competencies to provide foundational knowledge and skills related to ensuring safety at mealtimes in the following areas:
        - 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 and rationale;
        - Understanding a swallow study;
        - Risk indicators and problem solving; and
        - Techniques to promote optimal levels of independence and skill acquisition during mealtimes.
    b. Develop and implement competency-based performance check-offs for MT Coordinators to ensure MT Coordinators are competent with mealtime learner objectives.
    c. Revise the LBSSLC Mealtime Monitoring Form to address generic mealtime indicators, such as environment, staff ratio, cleanliness, sufficient adaptive equipment, etc. Reformat the form for individual-specific monitoring indicators to address, at a minimum, position and alignment, correct diet texture and fluid consistency, adaptive equipment, presentation techniques, and recognition of individual triggers.
    d. Develop competency-based training and performance skills check-off for mealtime monitors.
    e. Establish a validation and re-revalidation process for MT monitors, which involves auditing MT Coordinators to ensure competency with mealtime indicators;
    f. Establish protocols for implementation of a mealtime monitoring schedule, and auditing of completed mealtime monitoring forms to formulate corrective strategies to address individual-specific and/or systemic areas of deficiencies for specific indicators. This process should be integrated into the Facility's QA/QI and Risk Management systems.
    g. Establish compliance benchmarks for mealtime monitoring results to celebrate success. If monitoring results fall below established benchmarks, determine what action will be necessary, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic.
    h. Ensure a heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk due to aspiration

pneumonia, respiratory concerns, choking, weight, fluid imbalance, etc.

7. Language from the Head of Bed Elevation Assessment Protocol should be incorporated into the LBSSLC draft Policy for Positioning During Dental Treatment to address the maximum and minimum elevations to be maintained during oral care.
8. The Facility should incorporate a modified version of mealtime monitoring for off-campus events to ensure compliance with the related policy. Activities at the Center (special events, home events, and visits by family and friends) should receive routine mealtime monitoring. Family and friends, who would like to assist individuals during mealtimes while on campus, should be offered competency-based training on the dining plan. Consideration should be given to incorporating language that family/friends will only provide the food and/or fluid within the prescribed food texture and fluid consistency while on the grounds of LBSSLC to ensure mealtime safety.
9. The Facility's PNM NEO training curriculum should be revised to include:
    a. Generic and individual-specific mealtime risk triggers that alert staff to problems, and what staff are to do if these triggers are observed;
    b. Techniques to promote independence and skill acquisition during mealtimes; and
    c. Presentation and position/alignment strategies to support safety during oral hygiene, bathing, personal care, and medication administration
10. The PNS competency-based training curriculum should identify the following:
    a. Required competencies for foundational skills in PNM;
    b. For each competency, there should be a list of tasks and/or activities that must be demonstrated;
    c. A description of how staff will demonstrate mastery of the skill;
    d. A description of how the training will reinforce why it is important in my job to know this information; and
    e. A training schedule that is spaced out to allow participants the opportunity to practice new skills, ask questions, and obtain a lot of feedback.
11. As was recommended in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans. At a minimum, such a policy should include:
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, tooth brushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.);
    b. A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability;
    c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    d. Formal schedule for monitoring to occur;
    e. Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors;
    f. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    g. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
    h. Establishment of thresholds for staff re-training.
12. Aspiration Pneumonia/Enteral Nutrition Evaluations should evaluate the potential for moving an individual to a less restrictive form of receiving enteral nutrition.
13. Information gained from the APEN evaluations should be integrated, as appropriate, into individuals PSPs, Risk Action Plans, nursing care plans and PNMPs. Any plans developed to modify the individual's feeding should be accompanied by measurable, functional outcomes, which should be used to measure the efficacy of the plan.

The following are offered as additional suggestions to the State and Facility:

1. As recommended with regard to Section G.1, consideration should be given to assigning to the PNMT the PCP with the caseload that includes the highest number of individuals who have feeding tubes and severe dysphagia/gastroesophageal reflux disease conditions. This PCP already would know the individuals most often discussed at the PNMT, and this arrangement would facilitate changes being made to the medical treatment plans for these individuals. This would provide an efficient and effective resource to the PNMT.
2. The Mealtime Committee might want to consider developing a method to identify staffing ratios for mealtimes/snacks.

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 Presentation Book for Section P; o Section P Presentation LBSSLC Monitor's Compliance Visit, dated March 2011; o The following documents: OT/PT Evaluations, PT Treatment Plan, PSP and PSPAs for the past year, PNMP with pictures, PNMP Clinic Notes, person-specific monitoring, competency-based training for staff, OT/PT consultations for the past year, Nutrition Evaluation, Modified Barium Swallow Study, Integrated Risk Rating Form, Action Plan for Risk Assessment, and PT progress notes related to PT treatment plan for the following 18 individuals: Individual #206, Individual #11, Individual #54, Individual #283, Individual #161, Individual #213, Individual #167, Individual #118, Individual #34, Individual #235, Individual #185, Individual #192, Individual #267, Individual #175, Individual #242, Individual #261, Individual #125, and Individual #37; o List of OT, Certified Occupational Therapy Assistant (COTA), PT, and PTA staff and current caseload, undated; o List of continuing education courses completed by OT/PT staff, since last onsite visit, from 8/10 through 2/11; o List of Individuals Using Wheelchair as Primary Mobility, dated 2/15/11; o List of Individuals Using Wheelchair for Transport, dated 2/14/11; o List of Individuals with Ambulation Assistive Devices, undated; o List of Individuals with Orthotics and/or Braces, undated; o List of Individuals with Decubitus/Pressure Ulcer during past year, undated; o List of individuals who have experienced a falling incident during past three months, undated; o PNM maintenance log utilized to track modifications made to adaptive/assistive equipment, from 2/10 through 2/11; o OT/PT Updates (template), undated; o Five most current OT/PT Assessments and corresponding PSPs, from 10/10 through 2/11; o Log of PSPs and date completed, from 9/10 through 3/11; o For the past month, completed OT/PT monitoring forms; o PNMP/Wheelchair Clinic Notes (template), PNMP (template), OT/PT-Update (template), undated; o OT/PT - Updates and Wheelchair Clinic Notes, dated 2/11; o OT/PT related spreadsheets, dated 2/15/11 and 2/16/11; o HT Meal Monitoring, from 9/10 through 1/11; o List of Individuals Receiving Direct OT/PT services, undated; o Number of budgeted positions, staff contractors, unfilled positions, FTE, and staff to individual ratios, dated 3/3/11; and

	○ List of Admissions, Deaths, and Transitions to community, undated. ▪ **Interviews with**: ○ Linda Thomas, Director of Habilitation Therapies. ▪ **Observations of**: ○ Residence - 504 Mesquite Drive (Quail/Sparrow); 518 South Cedar Avenue (Oak); 526 North Cedar Avenue (Tulip); 527 North Cedar Avenue (Iris); and 528 North Cedar Avenue (Zinnia).
	Facility Self-Assessment: The LBSSLC Plan of Improvement/Self Assessment, updated 3/14/11, provided comments/status for Section P. Compliance for each of these sections was documented as noncompliance. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: According to the current census provided to the Monitoring Team, there were 227 individuals living at LBSSLC. The Facility had four full-time Occupational Therapists, including the Director of Habilitation Therapies. There were two unfilled Occupational Therapist positions. At the time of the review, there were three full-time Physical Therapists. There was one unfilled position for Physical Therapy. The current staff-to-individual ratio list, undated, indicated the LBSSLC ratio for OTs was 1:56, and PTs was 1:75. Technically, the staff-to-individual ratio for OT was 1:75, because the Director of Habilitation Therapies did not carry an active caseload. As has been encouraged in the past, the Facility should conduct a review to determine the staffing necessary to complete the tasks necessary to comply with the Settlement Agreement. In addition, efforts should continue to recruit Occupational and Physical Therapists. Therapists were not active members of the PSTs, as evidenced by insufficient provision of direct therapy, lack of completion of comprehensive OT/PT Evaluation updates when a change in status occurred, lack of development and integration of therapy recommendations into formal skill acquisition programs, and the lack of development of informal strategies to reinforce assessment recommendations and measurable outcomes. Systems were not in place to ensure the timely delivery of, or the ongoing fit, availability, function, condition, and effectiveness of individuals' adaptive and assistive equipment.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>P1</td><td>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.</td><td><u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u>
According to the current census provided to the Monitoring Team, there were 227 individuals living at LBSSLC. A list of therapy staff with titles, current caseloads, and license numbers was requested. There were six budgeted positions for Occupational Therapy. The Facility had four full-time Occupational Therapists, including the Director of Habilitation Therapies. There were two unfilled Occupational Therapist positions.

LBSSLC had four budgeted positions for physical therapy. At the time of the review, there were three full-time Physical Therapists. There was one unfilled position for Physical Therapy. The following chart represented the current therapists' caseloads, as reported for 225 individuals:

<table>
<tr><th>Occupational Therapist(s)</th><th>Current Caseloads and Responsibility</th></tr>
<tr><td>OT #1</td><td>Director of Habilitation Therapies</td></tr>
<tr><td>OT #2</td><td>PNMT Member, and supported 50 individuals</td></tr>
<tr><td>OT #3</td><td>Supported 88 individuals</td></tr>
<tr><td>OT #4</td><td>Supported 87 individuals</td></tr>
<tr><td>OT #5</td><td>Vacant</td></tr>
<tr><td>OT#6</td><td>Vacant</td></tr>
<tr><th>Physical Therapist(s)</th><th>Current Caseload</th></tr>
<tr><td>PT #1</td><td>PNMT Member, and supported 33 individuals</td></tr>
<tr><td>PT #2</td><td>Supported 99 individuals</td></tr>
<tr><td>PT #3</td><td>Supported 93 individuals</td></tr>
<tr><td>PT #4</td><td>Vacant</td></tr>
</table>

The current staff-to-individual ratio list, undated, indicated the LBSSLC ratio for OTs was 1:56, and PTs was 1:75. Technically, the staff to individual ratio for OTs was 1:75, because the Director of Habilitation Therapies did not carry an active caseload. The psychology staff-to-individual ratio required by the Settlement Agreement was 1:30. OTs and PTs had similar duties with regard to assessment, planning, monitoring, and provision of direct supports and/or oversight. Efforts should continue to recruit Occupational and Physical Therapists.

The Plan of Improvement/Self Assessment, dated 3/14/11, for Section P, Physical and Occupational Therapy identified the following outcome, which was a recommendation from the Monitoring Team: "The Facility should complete an analysis to determine the adequacy of OT/PT therapy positions to support these professional being active members of individual's PSTs, and providing the supports and services required by the SA. Efforts should continue to fill currently vacant OT positions." The action steps were</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		to identify areas of responsibility by therapist per discipline, gather and review input from disciplines, and complete an analysis for each discipline. This was documented as having been completed on 12/15/10. Documentation in the Presentation Book for Section P presented multiple analyses of OT and PT staffing needs with different numbers identified of OTs and PTs needed at LBSSLC. There was no additional documentation included in the Presentation Book and/or in the document request that summarized the final analysis of the therapy staffing, and/or the action(s) to be taken. Staffing was potentially one factor that resulted in the inadequate provision of occupational and physical therapy supports to individuals. In sum, therapists were not active members of the PSTs, as evidenced by their collective absence from annual PSP meetings, insufficient provision of direct therapy, lack of completion of comprehensive OT/PT Evaluation updates, when a change in status occurred, insufficient development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the lack of development of informal strategies to reinforce assessment recommendations and measurable outcomes. The OT and PTs attended a wide variety of continuing education courses and conferences, but did not consistently attend state-sponsored continuing education courses. As stated above with regard to Section O.1 of the Settlement Agreement, therapists should attend these courses. The Facility should continue to support therapists' attendance at a variety of off-site continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at LBSSLC. Per report, none of the 227 individuals residing at LBSSLC (0%) were receiving direct OT services. Seven of the 227 individuals living at LBSSLC (3%) (Individual #283, Individual #161, Individual #197, Individual #213, Individual #293, Individual #167, and Individual #109) were receiving direct PT services. Eighteen (18) records were reviewed, including those for: Individual #206, Individual #11, Individual #54, Individual #283, Individual #161, Individual #213, Individual #167, Individual #118, Individual #34, Individual #235, Individual #185, Individual #192, Individual #267, Individual #175, Individual #242, Individual #261, Individual #125, and Individual #37. These 18 individuals had identified needs related to, but not limited to movement, mobility, range of motion, independence, regression of functional skills, a change in status, and/or community transition. <u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u>	

#	Provision	Assessment of Status	Compliance
		Since the last review, there were six individuals admitted to LBSSLC. A sample of four individuals who were newly admitted was selected for review. Four of four individuals (100%) (Individual #173, Individual #92, Individual #131, and Individual #124) received an OT/PT evaluation within 30 days of admission. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> The LBSSLC OT/PT Update template included the following sections: ▪ Active problems; ▪ Medications; ▪ Communication; ▪ HT Assessments; ▪ PT/OT Consults; ▪ Physical Nutritional Management Plan; ▪ Assistive Equipment; ▪ Strengths; and ▪ Recommendations. During the onsite review, the State Coordinator for Specialized Services provided a template for OT/PT/ST Habilitation Therapies Update, undated, which included the following sections and within each section there were subsections: ▪ Risk levels; ▪ Consultations/evaluations in past year; ▪ Assistive equipment; ▪ Other services/supports; ▪ Physical Nutritional Management Plan; ▪ Eating/dining/swallowing; ▪ Recommendations; and ▪ Measurable objectives. The majority of the sections included the incorporation of rationale/assessment findings, efficacy, recommendations, and measurable objectives. However, the template did not include the guidance necessary to ensure a complete evaluation was conducted. The following guidance should be incorporated into the LBSSLC OT/PT update template: ▪ Assessment process should be sufficiently discreet to identity an individual's functional skills, interests, and preferences via observation and clinical assessment; ▪ Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition; ▪ There should be an analysis of findings to provide a rationale for functional	

#	Provision	Assessment of Status	Compliance
		recommendations and intervention strategies; ▪ Recommendations should be integrated into an individual's PSP; ▪ Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and ▪ A process should be delineated for implementing change in an individual's supports when progress is made or a lack of progress is noted. The lack of progress would identify a re-evaluation timeframe. <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 a subset of the sample previously identified, none of the 10 individuals who experienced a change in status (Individual #206, Individual #11, Individual #118, Individual #34, Individual #235, Individual #185, Individual #242, Individual #267, Individual #261, and Individual 125) (0%) had received an evaluation within the past three years and/or a timely interim update. Changes in status included events, including but not limited to diet downgrade, BMI which placed an individual at risk, skin breakdown, being identified as at high risk for respiratory concerns, and/or community transition. The following individual concerns were identified: ▪ Individual #206 transitioned from LBSSLC to the community on 2/7/11. Her most current OT Evaluation was completed on 5/11/07, and PT Evaluation was on 6/22/04. A HT consultation, dated 5/19/10, was requested for an adaptive feeding equipment and diet texture update. A current OT/PT evaluation and/or update had not been completed prior to her transition to the community to provide information to her community provider about the supports she required for a successful transition. ▪ Individual #11 transitioned to the community on 12/13/10. Her OT/PT Evaluation Update, dated 7/21/10 to 7/22/10, did not address her upcoming change in status for community transition. ▪ Individual #118 experienced a diet downgrade with his fluid consistency from thin to nectar. A Dysphagia Medical Workup Form-Physician's Order Medicare Guidelines, dated 2/8/11, stated: "appears to be doing well; however, due to history of silent aspiration want to look at functional as well as esophageal motility due to pneumonia in 2010." He received a Modified Barium Swallow study on 2/8/11. There was no therapy consultation to discuss the MBS recommendations. The MBS stated: "may benefit from dietary consult with calorie count," but this was not completed. Individual #118's Integrated Risk Rating Form, updated 2/9/10, changed his risk for aspiration and fluid imbalance to high. His Risk Action Plan, dated 1/28/11, was not revised to reflect these changes. ▪ Individual #34's Nutrition Service Annual Assessment, dated 3/9/11, identified	

#	Provision	Assessment of Status	Compliance
		a Body Mass Index (BMI) of 53.2 (morbid obesity, Class III). The BMI ranges are based on the relationship between body weight, disease and death. Overweight and obese individuals are at increased risk for many diseases and health conditions, including the following: hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems and some cancers (endometrial, breast, and colon) (http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html). The OT/PT Evaluation Update PNMP Review Update, dated 1/10/11, did not include specific recommendations to address her high-risk status for weight. The recommendations were "continue PNMP to prevent respiratory problems from aspiration/reflux, to improve alignment/circulation of legs with equipment and to promote healthy weight." No direct and/or indirect therapy was recommended to address her significant health concerns related to her status of morbid obesity. ▪ Individual #235's Nutrition Service 30-Day Evaluation, dated 5/24/10, identified a BMI of 51.5 (extreme obesity, Class III). The recommendations in the OT Evaluation, dated 5/17 and 6/1/10, were: "encourage him to speak in complete sentences, redirect any inappropriate communication attempts and re-assess in one year (2011) prior to next PSP." The PT Evaluation, dated 5/12/10, did not recommend skilled physical therapy, and recommended reassessment in one year prior to PSP. There were no recommendations to address his high-risk status for weight, as well as other health concerns. ▪ Individual #185's Nutrition Service Annual Assessment, dated 3/3/11, identified his BMI as 16.1, underweight (normal 18.5 to 24.9). HT Meal Observations, dated 1/11/11 and 2/28/11, confirmed that dining plans were not in use, and mealtime strategies were not being followed. The Monitoring Team observed Individual #185 at dinner, and his dining plan was not present on the dining table and staff were not following his mealtime presentation techniques. Staff's failure to follow his dining plan presentation techniques might be contributing to his underweight status. The Facility's monitoring results should have initiated a mealtime assessment to review the effectiveness of his mealtime strategies, and to develop strategies to support staff compliance with these strategies. ▪ Individual # 242 was identified as being at risk for pneumonia according to the Combined List for Risk Discussion Meetings. Her Risk Meeting occurred on 12/20/10, but no Integrated Risk Rating form or Risk Action Plan was submitted to address her high-risk status. ▪ Individual #267 was identified as being at high risk for pneumonia. Her Risk Meeting occurred on 3/7/11, but her Integrated Risk Rating Form and Risk Action Plan were not submitted.	

#	Provision	Assessment of Status	Compliance
		▪ Individual #261 had skin breakdown, which was described as follows: "necrotic appearing area to right heel. Unstageable when noted. Eventually, it progressed up to a stage 3 after final debridement by MD. Wound was never resolved prior to the client expiring 1/28/11." Individual #261 was hospitalized with the following discharge diagnoses: 3/21/10 for dehydration; 5/1/10 for infection device unspecified; 5/9/10 for colostomy status; 8/4/10 for urinary tract infection, unspecified; 8/24/10 for dehydration; and 1/8/11 for pneumonia organism, unspecified. Individual #261 died on 1/27/11. It was unclear why Individual #261 was not referred to the PNMT. ▪ Individual #125 had experienced seven slip/trip/falls from August 2010 to January 2011. No current PT updates and/or consultations addressed his fall status. <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.</u> None of the 10 OT/PT evaluations reviewed (0%) (Individual #206, Individual #11, Individual #118, Individual #34, Individual #235, Individual #185, Individual #242, Individual #267, Individual #261, and Individual 125) addressed medical issues and health risk indicators that would have an impact on the analysis utilized to establish rationale for recommendations/therapeutic interventions. <u>Evidence of communication and or collaboration is present in the OT/PT assessments.</u> Based on record review, 18 of the 18 OT/PT Evaluations (Individual #206, Individual #11, Individual #54, Individual #283, Individual #161, Individual #213, Individual #167, Individual #118, Individual #34, Individual #235, Individual #185, Individual #192, Individual #267, Individual #175, Individual #242, Individual #261, Individual #125, and Individual #37) (100%) included signatures and date 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	<u>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.</u> Based on a review of four individuals (Individual #283, Individual #161, Individual #213, and Individual #167), who were selected from the submitted list of individuals receiving direct/indirect OT/PT services, none of the four (0%) therapy programs were integrated in the individuals' PSPs. The following individual examples illustrate the absence of a plan and/or documentation of integration into the PSP: ▪ The purpose of Individual #283's HT PT Activity Plan, dated 3/7/11, was: "for the next 6 months (October 2010-March 2011) [Individual #283] will participate in activities designed to improve her abilities with bed mobility, coming to sitting, (supported and unsupported) sitting balance, increased cervical/bilateral lower extremity passive range of motion, increased functional	Noncompliance

#	Provision	Assessment of Status	Compliance
	include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	active movement of left lower extremity, encourage recognition and active movement of right lower extremity and increased independent mobility." The PT program was initiated in June 2008. The Monitoring Team requested her PSP and PSPAs for the past year. The most current PSP submitted was dated 7/9/08. Individual #283 did not have a current PSP. ▪ The purpose of Individual #161's HT PT Activity Plan, dated 12/31/10, was: "for the next two months (December 2010 through January 2011, [Individual #161] will participate in activities designed to improve ability with upright sitting posture and sit [to] stand pivot transfers." The plan was "to continue with current activity plan and increase treatment frequency as she appears to feel better. Treatments will emphasize on increasing hip range of motion, relaxation of right neck and back musculature to allow improved sitting posture and comfort, and increased participation/weight bearing in sit [to] stand, static standing and transfers." No current PSP was submitted for review to determine if the plan was integrated into the PSP. ▪ The purpose of Individual #213's HT PT Activity Plan's, dated 1/18/11, was: "for the next month (January 2011), [Individual #231] will participate in activities designed to improve abilities with conditioning and strengthening at left lower extremity." There was no PSP and/or PSPA addendum submitted that integrated his HT PT Activity Plan. ▪ The purpose of Individual #167's HT PT Activity Plan's, dated 1/24/11, was: "For the next 2 months (remainder of January, February and March), [Individual #167] will participate in activities with emphasis on improving his standing posture (measured by therapist observation), ambulation independence (measured by assistance required for weight shifting from one lower extremity to the other and overall amount of assistance required), and functional ambulation distance (measure by distance ambulated)." There was no PSP and/or PSPA addendum submitted that integrated his HT PT Activity Plan. Active and inactive therapy interventions should be analyzed, during the assessment and/or update process, as well as in clinical progress notes to determine if progress is being made and/or if changes need to be instituted. Justification for therapy interventions should be outlined in the analysis of findings section to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies. Therapy plans should be integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. These supports should be defined in an individual's PSP. Monthly documentation should justify the initiation, continuation or discontinuation of assessment recommendations and measurable outcomes. Quarterly documentation should be provided for the provision of indirect supports. There should be a formal process for	

#	Provision	Assessment of Status	Compliance
		implementing changes in an individual's supports, when progress is made and/or a lack of progress is noted, including a timeframe for re-evaluation. Within 30 days of development of the plan, it is implemented. As stated above, there were plans developed and implemented for four individuals (Individual #283, Individual #161, Individual #213, and Individual #167), but none of these four (0%) individuals' formal PT Programs were integrated into formal and/or informal current PSP Action Plan objectives and/or skill acquisition programs. Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes. Based on documentation provided, none of the four individuals (Individual #283, Individual #161, Individual #213, and Individual #167) (0%) with direct and/or indirect PT services had their plans integrated into the PSP. 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. When individuals' status changed, there was not consistent review and/or modifications to plans. This is discussed in further detail above.	
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.4 of the Settlement Agreement with regard to staff not following PNMPs, which OTs and PTs had recommended. Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. Based on review of individual records, direct support professionals were identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs and other activity plans for none of 18 individuals reviewed (0%). Discussion with regard to Section O.5 provides further information related to the lack of competency-based training.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and	System exists to routinely evaluate: fit; availability; function; condition and effectiveness of all adaptive equipment/assistive technology. None of the 18 individual records reviewed (Individual #206, Individual #11, Individual #54, Individual #283, Individual #161, Individual #213, Individual #167, Individual #118, Individual #34, Individual #235, Individual #185, Individual #192, Individual #267, Individual #175, Individual #242, Individual #261, Individual #125, and Individual #37) (0%) had an annual comprehensive evaluation/review by the PNMP	Noncompliance

#	Provision	Assessment of Status	Compliance
	physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	Clinic to evaluate the fit, availability, function, condition, and effectiveness of all prescribed PNMP adaptive/assistive equipment. The following issues were noted: ▪ Individual #206's adaptive equipment was not reviewed in a PNMP Clinic. ▪ Individual #11's bed elevation wedge was not reviewed in a PNMP Clinic. ▪ Individual #54 had no documentation submitted for a PNMP Clinic to review his adaptive equipment for fit availability, function, condition and effectiveness. ▪ Individual #118's PNMP, revised 1/27/10, identified the assistive equipment as wheelchair with elevating leg rests, walker, glasses, hospital bed, Jobst socks, and shower chair with seatbelt. Documentation from the PNMP Clinic, dated 8/27/10, stated: "seen on home by OT for annual update WC [wheelchair], PNMP & pictures reviewed; assessment initiated." There was no discussion of the fit, availability, function, condition, and effectiveness of all prescribed PNMP adaptive/assistive equipment. ▪ Individual #235's PNMP, dated 10/01/10, identified the assistive equipment as a wedge under mattress, but no PNMP Clinic documentation was submitted to review this assistive equipment. ▪ Documentation from Individual #185's PNMP Clinic, dated 3/29/11, stated: "[Individual #185's] PNMP was reviewed with staff. No concerns noted. His 2 person side-by-side manual lift was performed (sic) and continues to be working well. Dining Plan reviewed with staff. Mat assessment, foot assessment and postural assessment followed." Neither the PNMP Clinic nor his OT/PT evaluation, dated 4/14/10, 4/16/10, and 4/26/10, documented the fit, availability, function, condition, and effectiveness of all prescribed PNMP adaptive/assistive equipment. The Facility should develop procedures to ensure individuals' adaptive/assistive equipment will be reviewed annually for the fit, availability, function, condition, and effectiveness. Wheelchair/PNMP Clinic: List by Home tracking system had the following fields: ▪ 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.	

#	Provision	Assessment of Status	Compliance
		Although this database included relevant fields, consideration should be given to contacting CCSSLC Habilitation Therapies to review their more comprehensive database. A review of the Wheelchair/PNMP Clinic for 504 E. Mesquite identified the following concerns: ▪ No date of delivery for a wheelchair; ▪ No definition for criteria for Priority 1, 2 and 3; ▪ Individual #181 was a Priority 1 for a new system, but her mat assessment had occurred in June 2008. It was identified she had a Medicare Solara, but it was unclear if she had received a new seating system; ▪ Individual #263 was a Priority 1 for a new system and positioner, and had received a mat assessment in November 2006. It was unclear why she had not received a current mat assessment for a new seating system. The tracking form did not document the delivery date of a new seating system. ▪ The Facility should consider completion of an audit to determine compliance with established timelines, and provide resolution and/or adequate justification for timelines that have been exceeded. The Master HT PNMP tracking system identified the following information by individual: ▪ Complex PNMPs; ▪ PNMPs to include medical adaptive equipment, walker, gait belt, upper extremity orthotics, lower extremity orthotics, positioning equipment, seat inserts, wheelchair, helmets, seatbelts for wheelchair and/or recliner, lift/transfer, mobility/walking, mechanical lift; ▪ At risk for osteoporosis/brittle bones; ▪ Earplugs, hearing, aides, pocket talker, and communication book/device; ▪ Dining plan, dysphagia, food and fluid texture, Thick-It, diet texture, adaptive eating equipment, J-tube, G/PEG tube, G-tube for supplement; ▪ Reflux precautions, history of choking, history of aspiration pneumonia, and history of pneumonia; and ▪ Hospital bed with chains, bed elevated with blocks, bed elevated with wedge, and degree of elevation. There were no policies/procedures developed for the Wheelchair/PNMP Clinic: List by Home tracking system and/or the Master HT PNMP tracking system adaptive equipment tracking system. <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>	

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		Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. <u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u> Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. <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>. Systemic and individual-specific issues related to training staff are discussed above with regard to Section O.5 of the Settlement Agreement. <u>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).</u> Systemic and individual-specific issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. <u>Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.</u> As discussed above, adequate safeguards were not in place to ensure each individual had appropriate adaptive and assistive technology supports. <u>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).</u> As is discussed above with regard to Section O.5 of the Settlement Agreement, adequate training and monitoring of staff on individual-specific plans was not being completed. <u>Data collection method is validated by the program's author(s).</u> For none of the four of the individuals (0%) receiving a PT Activity Plan was the data collection method validated by the program's author (Physical Therapist).	

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

1. The Habilitation Therapies Department should finalize the analysis of OT and PT staffing needs, and collaborate with Facility Administration to develop strategies to achieve reasonable OT/PT staff-to-individual(s) caseloads.

2. As recommended with regard to Section O.1, therapists should attend state-sponsored continuing education courses.
3. The following guidance should be integrated into the OT/PT Evaluation template:
    a. Assessment process should be sufficiently discreet to identity an individual's functional skills, interests, and preferences via observation and clinical assessment;
    b. Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition;
    c. There should be an analysis of findings to provide a rationale for functional recommendations and intervention strategies;
    d. Recommendations should be integrated into an individual's PSP;
    e. Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and
    f. A process should be delineated for implementing change in an individual's supports when progress is made or a lack of progress is noted. The lack of progress would identify a re-evaluation timeframe.
4. The Facility should develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines as outlined in the OT/PT evaluation template.
5. The Facility should develop procedures to ensure individual's adaptive/assistive equipment will be reviewed annually for the fit, availability, function, condition, and effectiveness. Guidelines should ensure at least the following:
    a. Therapist's signatures document their PNMP Clinic attendance;
    b. All PNMP prescribed assistive equipment is assessed on an annual basis for fit, availability, function, condition and effectiveness; and
    c. A documentation process is established for resolution of problems with fit, availability, function, and condition of prescribed equipment.

The following are offered as additional suggestions to the State and Facility:

1. Although LBSSLC's wheelchair database included relevant fields, consideration should be given to contacting CCSSLC Habilitation Therapies to review their more comprehensive database.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Dental progress notes for the following: Individual #264; Individual #296, and Individual #257; o Medical/Dental Restraint report, from 8/1/10 through 1/31/11; o Per month, percentage of individuals utilizing mechanical restraints for dental exams/treatment, from September 2010 through February 2011; o Per month, percentage of individuals utilizing oral sedation for dental exam/treatment, from September 2010 through February 2011; o Per month, percentage of individuals utilizing intravenous (IV) sedation for dental exams/treatment, from September 2010 through February 2011; o Annual exams/prior exams and Oral Health (OH) rating for following buildings: 515S (dated October 2010), 517S (dated January 2011), 518S (dated February 2011), 521S (dated November 2010), 523N (dated December 2010), 525N (dated September 2010), and 526N (dated November 2010); o List of annual assessments completed in last six months, and the date of previous exam; o Most recent Facility oral hygiene data, from September 2010 through February 2011; o Annual dental summaries provided to the PST for the following individuals: Individual #63, dated 1/10/11; Individual #264, dated 12/30/10; Individual #38, dated 12/30/10; Individual #37, dated 12/30/10; Individual #226, dated 12/30/10; Individual #77, dated 1/10/11; Individual #6, dated 12/30/10; Individual #222, dated 1/10/11; Individual #16, dated 1/4/10; Individual #56, dated 12/30/10; Individual #41, dated 1/10/11; Individual #35, dated 1/10/11; Individual #100, dated 1/10/11; Individual #74, dated 1/10/11; Individual #314, dated 1/11/11; Individual #306, dated 12/30/10; Individual #147, dated 1/10/11; Individual #99, dated 12/30/10; Individual #66, dated 12/30/10; Individual #296, dated 1/10/11; Individual #116, dated 12/30/10; Individual #270, dated 12/30/10; Individual #237, dated 12/30/10; Individual #161, dated 1/10/11; Individual #50, dated 1/10/11; Individual #176, dated 1/10/11; Individual #131, dated 1/10/11; Individual #178, dated 12/30/10; Individual #113, dated 12/31/10; Individual #275, dated 1/10/11; Individual #86 , dated 1/10/11; Individual #60, dated 1/10/11; Individual #167, dated 1/10/11; Individual #14, dated 12/30/10; Individual #174, dated 12/30/10; Individual #324, dated 1/10/11; Individual #230, dated 1/11/11; Individual #310, dated 12/30/10; Individual #80, dated 12/30/10; Individual #263, dated 12/30/10; Individual #272, dated 12/30/10; Individual #162, dated 12/30/10; Individual #121, dated 1/10/11; Individual #115, dated 1/11/11; Individual #29, dated 12/30/10; Individual #84, dated 1/10/11; Individual #253, dated 1/10/11, and Individual #215 1/10/11; o Desensitization Committee meeting minutes, dated 1/13/11, and 3/18/11; o LBSSLC Health Services, Dental Desensitization Policy, dated 3/1/11; o Dental/medical Desensitization programs;

	o Medical/dental desensitization plans; o List of medical/dental desensitization plans; o Dental desensitization plan for Individual #119, dated 12/7/10; o LBSSLC Health Services, Comprehensive Annual Dental Examination, revised 3/1/11; o LBSSLC Health Services, Dental Clinic Operations Policy, revised 3/1/11; o LBSSLC Health Services, Dental Examinations Policy, revised 3/1/11; o LBSSLC Health Services, Dental Services Overview, revised 3/1/11; o LBSSLC Health Services, Dental Emergencies, revised 3/1/11; o LBSSLC Health Services, Dental/Medical Sedation and Restraint, revised 1/14/10; o Complete copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes, consents, second opinions, consult reports, pre-operative checklist or evaluation, and postoperative checklist or monitoring forms for individuals undergoing general anesthesia/conscious sedation, including: Individual #26, dated 12/20/10; Individual #103, dated 12/20/10; Individual #135, dated 12/10/10; and Individual #259, dated 1/27/11; o Appointment schedule for those undergoing general anesthesia, from 9/20/10 through 1/27/11; o Dental progress notes/treatment record for emergency dental visits for the following: Individual #250, from 9/24/10 to 2/25/11; Individual #34, from 8/6/10 to 2/25/11; Individual #61, from 8/16/10 to 3/9/11; Individual #300, from 9/22/10 to 3/3/11; Individual #103, dated 2/25/11; Individual #182, from 8/30/10 to 1/12/11; Individual #310, from 5/5/10 to 12/13/10; Individual #55, from 8/19/10 to 1/12/11; and Individual #51, from 3/1/10 to 2/25/11; o List of those who have outstanding need for dental x-rays, from September 2010 through February 2011; o Correspondence concerning restraint and sedation use for office visit (to QMRP, team, psychologist, etc.) for the past six months; o List of interventions per individual for missed appointments (follow up appointment schedule, whether follow up completed, any correspondence to QMRP, home manager, team, etc.); o List of refusals for past six months per date of refusal (list reason for appointment); o List of those who have not seen dentist in one year and reason; o Attendance tracking sheet for dental appointments for last six months; o QMRP, PST minutes that review, assess, develop, and implement strategies for dental visit refusals and no shows last six months; o List of refusals per building per month for last six months; o List of no shows/missed appointments per building per month for last six months; o List of other reasons for missed appointments per date for past six months; o List of individuals admitted to Facility for past six months and dental services rendered; o List of individuals that were seen for dental services during the past six months other than for annual exam, date of visit, and reason or type of visit; o List of individuals that have refused dental services;

	○ List of individuals that have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the make-up appointment; ○ List of individuals having had tooth extraction; ○ List of individuals seen for dental emergencies; ○ List of individuals that have had preventive care; ○ List of individuals that have had restorative care; ○ List of individuals that were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete these exams; ○ Most recent comprehensive dental exams (copy of dental record of visit and copy of active record documentation for same visit) for the following: Individual #52; Individual #250; Individual #6; Individual #160; Individual #59; Individual #291; Individual #290; Individual #296; Individual #51; and Individual #223; ○ Annual dental assessments completed in the last 30 days and for the prior year for the following individuals: Individual #52; Individual #70; Individual #250; Individual #6; Individual #160; Individual #100; Individual #59; Individual #210; Individual #296; Individual #291; Individual #290; Individual #113; Individual #68; Individual #97; Individual #223; Individual #302; and Individual #51; ○ For the following individuals given dental pre-treatment sedation, copies of progress notes from the record and dental office from the start of sedation to release from monitoring, including pre-treatment sedation sheets: Individual #51; Individual #293; Individual #253; Individual #111; Individual #130; Individual #127; Individual #184; Individual #301; Individual #195; and Individual #136; ○ Dental pre-treatment sedation assessments for following: Individual #276; Individual #136; Individual #252; Individual #195; Individual #293; Individual #127; Individual #184; Individual #270; Individual #111; Individual #300; Individual #178; Individual #95; Individual #301; Individual #167; Individual #315; Individual #130; Individual #115; Individual #51; and Individual #253; ○ Data per year (2006 to present) for numbers of extractions, restorations, chemical restraints used, physical restraints used, mechanical restraints used, and IV sedation/general anesthesia used; ○ Oral hygiene index score per level per quarter for two years; and ○ List of individuals with suction tooth brushing. ▪ **Interviews with**: ○ Russell Reddell, DDS, MBA, Director of Dental Services.
	Facility Self-Assessment: The Facility's POI identified that it remained out of compliance with both sub-provisions of Section Q. This was consistent with the Monitoring Team's findings. The Facility's POI provided a narrative description of steps it had taken to achieve compliance. According to this summary, the Dental Department tracked the "no show" appointments, determined the reason for the "no show," and entering this information into the database. To make the dental annual summary

	information more user-friendly, an Annual Dental Summary was placed in the record. This same information reportedly was available to members of the PST through the shared "M" drive. An interdisciplinary committee was created to address the complexities of desensitization, and the to develop desensitization programs. Additionally, a number of policies were approved and implemented. The Facility did not include any data in its POI to substantiate findings related to compliance. As the Facility develops its self-assessment process, it will be important to include data from monitoring/auditing activities. These efforts should include evaluation to substantiate the provision of adequate dental care (e.g., emergency care, restorative care, etc.), as well as to review the quality of the dental services being provided and the outcomes being achieved for individuals (e.g., improved oral hygiene index scores). Although the Facility recognizes it is not compliant with Section Q of the Settlement Agreement, LBSSLC continued to advance towards compliance.
	Summary of Monitor's Assessment: The Dental Department had made great strides in improving oral hygiene across the campus, which is an essential aspect of preventive dental care. There was a user-friendly dental summary created for the PST, and available in individuals' records. Although the Dental Department did not have significant issues with refusals for appointments, the number of missed appointments remained high, and the Department needed to begin to review and expand the categories of missed appointments. Desensitization programs continued to be a challenge, and the Dental Department has taken the lead in creating an interdisciplinary process for developing revised desensitization programs. This process was in the initial stages, and its success was still to be determined. For acute care dental problems, there was a need to review pain management, documentation of follow-up, as well as the length of time from beginning of the acute care need to closure of the problem. Database management and a review of documentation content would assist in this process. Monitoring of sedation before and after the dental visit remained inconsistent across the campus.

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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	The Dental Department had a dental assistant position upgraded from part-time to full-time. This in turn allowed the Hygienist and Assistant to teach and train tooth brushing in the residences, as well provide assistance in the desensitization process. At the time of the Monitoring Team's visit, there was one dentist, two dental assistants, and one dental hygienist in the Dental Department. Given the size of the population at LBSSLC, and the need for preventive dentistry with emphasis on oral hygiene, it is recommended that the Facility administration consider providing another dental hygienist position in the department. This would allow the department to expand teaching and training of	Noncompliance

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	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.	individuals on tooth brushing, as well as training direct support professionals on assisting the individuals. It also would allow a Dental Department staff person to assist with desensitization programs during the implementation phase. According to the POI, by 9/27/10, the Dental Director changed the oral hygiene rating system into a numerical system of three categories. These included good (3), fair (2), and poor (1). The Dental Department submitted oral hygiene ratings completed during the annual dental exams from September 2010 through February 2011. There were four individuals who could not be rated. Of the 106 individuals receiving oral hygiene index ratings, 44 out of 106 (42%) had a rating of "good;" 49 (46%) had a rating of "fair;" and eight (7%) had a rating of "poor." For five individuals (5%), a rating was not recorded. From a separate document, the Dental Department calculated similar, but not identical, values for oral hygiene from September 2010 through February 2011 (good oral hygiene 48%, fair oral hygiene 45.7%, and poor oral hygiene 6.2%, and there was not a category of "not recorded"). For trending information, the Dental Department submitted oral hygiene index scores per quarter for 2009 and 2010. Comparing the first quarter of 2009 to the last quarter of 2010 revealed some early evidence of significant change, although one must be cautious using data from only two years. In the first quarter of 2009, only 25% of the individuals were considered to have good oral hygiene, 40% had fair hygiene, and 34% had poor hygiene. For the last quarter of 2010, the percentage of individuals with good oral hygiene had increased from 25% to 48% (an approximate doubling), 44% had fair oral hygiene, and the percentage of individuals with poor oral hygiene dropped from 34% to 9%. This suggested significant progress with preventive dental care. With improved oral hygiene ratings, preventive and maintenance dental care could theoretically reduce the number of extractions over time (except for new admissions). Data per year indicated that in 2006, there were 31 extractions, in 2007 there were 73 extractions, in 2008 there were 120 extractions, in 2009 there were 140 extractions (a potential peak in the trend), and in 2010 there were 84 extractions. Restorative work continued to increase, perhaps related to the increased use of IV sedation and general anesthesia. In 2006, there were 24 restorations; in 2007, there were 123 restorations; in 2008, there were 140 restorations; in 2009, there were 172 restorations; and in 2010, there were 183 restorations. In the first three months of 2011, there were 64 restorations, suggesting a continued increase. Intravenous sedation/ general anesthesia increased from only one case in 2006, and one case in 2007, to 19 cases in 2008, 64 cases in 2009, and 98 cases in 2010, paralleling the increase in	

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		restorative care. In the first three months of 2011, there were 22 cases of IV sedation/general anesthesia. A reverse trend was seen with mechanical restraint use. In 2006, 149 mechanical restraints were used; in 2007, 152 mechanical restraints were used; in 2008, 47 mechanical restraints were used; in 2009, 13 mechanical restraints were used; and in 2010, two mechanical restraints were used. There also was a change in the number of physical restraints used over time. In 2006, 162 physical restraints were used; in 2007, 151 physical restraints were used; in 2008, 42 physical restraints were used; in 2009, seven physical restraints were used; and in 2010, three physical restraints were used. Chemical restraints also changed over time. In 2006, 74 chemical restraints were used; in 2007, 119 chemical restraints were used (peak year); in 2008, 56 chemical restraints were used; in 2009, 61 chemical restraints were used; and in 2010, 52 chemical restraints were used. For the last three years, chemical restraint use appeared to have plateaued. The Dental Department was asked to submit a list of those individuals who had an outstanding need for dental x-rays. According to the Dental Department, all individuals at LBSSLC were current in this area, and there were no individuals who were overdue for a dental x-ray. Timeliness of annual exams also was assessed based on information submitted. Of the 106 annual exams submitted, there were four currently past 365 days since the most recent annual review. These remained outstanding at the time of this review. They included: Individual #238, last exam dated 12/9/09; Individual #171, last exam dated 1/8/10; Individual #1, last exam dated 12/9/09; and the fourth was actually a new admission, Individual #321, with no annual recorded, (although if it was labeled an initial assessment, it might not have been captured in this data). Additionally, from the most recent annual submitted to the prior one, there were 21 individuals for whom more than 365 days passed between annuals (i.e., Individual #70, dated 12/9/09, and 2/25/11; Individual #222, dated 12/9/09, and 12/20/10; Individual #43, dated 8/10/09, and 1/12/11; Individual #16, dated 1/8/10, and 1/12/11; Individual #317, dated 9/14/09, and 12/13/10; Individual #147, dated 3/12/09, and 1/12/11; Individual #99, dated 12/9/09, and 1/12/11; Individual #270, dated 1/8/10, and 1/12/11; Individual #111, dated 1/8/10, and 1/12/11; Individual #103, dated 10/5/09, and 12/20/10; Individual #47, dated 10/6/09, and 10/25/10; Individual #8, dated 5/16/09, and 11/9/10; Individual #106, dated 11/4/09, and 11/9/10; Individual #182, dated 1/8/10, and 1/12/10; Individual #174, dated 10/21/09, and 12/10/10; Individual #80, dated 1/8/10, and 1/12/11; Individual #55, dated 1/8/10, and 1/12/11; Individual #3, dated 1/8/10, and 1/12/11; Individual #253, dated 1/8/10, and 1/12/11; Individual #2, dated 10/15/09, and 10/22/10; Individual #156, dated 12/7/09, and 12/26/10). The four	

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		currently overdue and the twenty-one that were past due when completed totaled 25 overdue annual exams. Compliance was 81 out of 106 (76%). Not included in the calculation were four for which sufficient information was not recorded to determine if an annual exam was timely or not. Individual #190 and Individual #306 did not have a date of completion for the previous annual exam. Individual #58 and Individual #266 had no last or previous exam dates submitted to determine timeliness. New admissions had initial dental evaluations within 30 days. Individual #131 had an initial exam within two days of her admission. Individual #124 had an exam within two weeks of admission. Individual #173 had an exam within 29 days of admission. Individual #92 was newly-admitted to the Facility, and information regarding a dental examination was not available at the time of the review. Separately, dental progress notes/treatment records were reviewed to determine timeliness of annual exams. Individuals with dates of annuals included the following: Individual #52, with exams on 8/2/10, and 2/25/11; Individual #70, with exams on 12/9/09, and 2/25/11; Individual #250, with exams on 8/2/10, and 2/25/11; Individual #6, with exams on 8/2/10, and 2/25/11; Individual #160, with exams on 8/2/10, and 2/25/11; Individual #100, with exams on 8/2/10, and 2/25/11; Individual #59, undated in 2010 (but between 7/2/10 and 8/13/10), and 2/25/11; Individual #210, with exams on 8/2/10, and 2/25/11; Individual #296, with exams on 8/2/10, and 2/25/11; Individual #291, with exams on 12/13/10, and 2/25/11; Individual #290, with exams on 8/2/10, and 2/25/11; Individual #113, with exams on 8/2/10, and 2/25/11; Individual #68, with exams on 12/28/10, and 2/25/11; Individual #97, with exams on 8/2/10, and 2/25/11; Individual #223, with exams on 8/2/10, and 2/25/11; Individual #302, with exams on 8/2/10, and 2/25/11; and Individual #51, with exams on 8/2/10, and 2/25/11. Most of the annuals, except for Individual #70, appeared to occur at intervals of six months or less. This was based on reviewing documentation containing the stamped entry entitled "annual exam." This stamp might have been used for interval evaluations, but it was not clear the reason for the increased frequency of the annual assessments. When there is a brief time between annual assessments, it is recommended that a reason be listed. The Dental Department provided information concerning the appointments for teeth cleaning for the following months: September 2010 - 16 cleanings completed, October 2010 - 20 cleanings, November 2010 - 16 cleanings, December 2010 - 15 cleanings, January 2011 - 23 cleanings, and February 2010 - five cleanings. The Dental Department provided data on restorations for the following months: September 2010 - two restorations, October 2010 - seven restorations, November 2010 - nine restorations, December 2010 - four restorations, January 2011 - six restorations,	

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		and February 2011 - two restorations, for a total of 28 restorations over this six-month time period. The Dental Department provided data related to extractions during the past six months. In September 2010, there was one extraction. In October 2010, there were three extractions. In November 2010, there were two extractions, and in December 2010, there were three extractions. The submitted information covered the prior six months, and based on this assumption, there were no extractions in January 2011 or February 2011. The Dental Department provided integrated oral health care treatment for those individuals with dysphagia. A total of 55 individuals residing in nine different residences required suction tooth brushing. The most recent dental pre-treatment sedation assessments were submitted for review. Attention was directed to monitoring of the individual before, during, and after the dental visit. The following provides examples of individuals who received pre-treatment sedation: ▪ Individual #184 received Ativan on 9/2/10. The pre-treatment sedation assessment form was utilized. Vital signs were taken at 0715, and the Ativan was administered 0730. The next vital sign was at 0900 in the dental office. She remained unable to cooperate and the procedure ended at 0905. She returned to the residence, with vital signs at 0930. ▪ On 9/7/10, Individual #167 had vital signs recorded at 0625, and Ativan was given at 0630. Vital signs were recorded every 15 minutes until seen in the dental clinic at 0845. Vital signs were taken at the start of the procedure, 0845, and at the end of the procedure at 0900. On return to the residence, vital signs began at 0905 and continued every 15 minutes until 10:35 a.m. ▪ On 9/9/10, Individual #252 had vital signs recorded at 0630, and Ativan was administered at 0630. Vital signs were recorded every 15 minutes until 0800. The dental procedure began at 0835 with a set of vital signs. It ended at 0840, as she remained unable to cooperate. Vital signs were taken at 0840. In the residence, one set of vital signs was taken at 0900. ▪ On 9/24/10, Individual #136 had vital signs recorded at 0630, followed by Ativan at 0630. Vital signs were then recorded every 15 minutes until 0815 (except the 0730 reading was not completed or not recorded). The dental clinic recorded vital signs at 0840. The procedure then began and ended at 0845. Vital signs were recorded at 0845. Back at the residence, vital signs were recorded at 0900, and then at increasing intervals of time. The last vital sign was recorded at 1215. ▪ On 9/22/10, Individual #300 had vital signs at 0645, with administration of Ativan at the same time. Vital signs were recorded every 15 minutes until 0815.	

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		In the dental clinic, vital signs were recorded at 0830, followed by a procedure from 0835 to 0910. Vital signs were recorded at 0845 and 0905. In the residence, vital signs were recorded at 1000 to 1115 at 15 to 30 minute intervals. ▪ On 10/4/10, Individual #95 had vital signs recorded at 0720, and Zyprexa was given at 0720. Vital signs were recorded at 0735, 0812, and 0830. He was seen in the dental office, with vital signs recorded at 0930. The procedure began at 0930, and ended at 0935. Vital signs were recorded at 0935. There was a note from the residence recorded at 0940, which indicated that he had returned to the workshop without difficulties. There were no vital signs recorded after the dental clinic visit. ▪ On 12/3/10, Individual #111 had vital signs recorded at 0730, with administration of Zydis at 0730. He had vital signs recorded at 0800 and 0830, but he refused pulse oximetry. Vital signs were recorded in the dental office at 0850. The procedure started at 0850, and ended at 0900. Vital signs were recorded at 0900. He did tolerate oxygen saturation readings in the dental clinic. At the residence, he had vital signs recorded at 0915 and 1015. ▪ On 1/18/11, Individual #293 had Ativan administered at 0630 with a narrative LVN note. He was on three liters of oxygen by nasal cannula. At 0800, his oxygen saturation was recorded, but no other vital signs. There were no other vital signs recorded until the dental visit at 0840, when vital signs were recorded. The procedure started at 0840 and ended at 0900. Vitals signs were taken at 0845, but were not recorded at the end of the procedure. Vital signs in the residence were recorded at 0930, and serially at increasing intervals until 1400. ▪ On 1/20/11, Individual #195 had Ativan administered at 0635. Vital signs were recorded in two different places, at 0630, in a narrative note, and at 0700, in the pre-procedural monitoring log, and were taken again at 0730 and 0800. In the office, vital signs were taken at 0840, and the procedure started at 0840 and ended at 0850. Vital signs were taken at 0850. Back at her residence, vital signs were recorded at 0915, and every 15 minutes until 1000 hour, then every half hour until the final recording at 1100. Additionally, the integrated progress notes had a nurse entry with vital signs recorded at 1430. ▪ On 1/24/11, Individual #178 was given Ativan at 0700. Vital signs were recorded at that time. There was an additional vital sign recorded in the pre-procedural monitoring log, but it had no time identified. The dental clinic noted that he did not arrive at 0830 for the appointment. The residence was waiting to be called to send him. The effects of the medication wore off before the telephone communication at 1000. There was no further set of vital signs after 0700. These ten cases indicated the variation in monitoring individuals once sedation was administered. There were variations in timing and frequency of vital signs after administration and after returning to the residence, and in one instance, there was	

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		variation concerning where to document the vital signs on the form. It is recommended that the Dental Department meet with the Nursing Department to clarify the irregularities in monitoring, and nursing staff be provided an in-service training on the dental monitoring policy. The Dental Department submitted copies of dental progress notes for those undergoing tooth extractions during the prior six months. The following provide some examples: ▪ On 11/15/10, Individual #296 underwent an extraction of tooth #7 under general anesthesia. He was given Motrin post-operatively. There was no second opinion note, but the dental anesthesiologist was considered the second opinion. He also underwent an exam and prophylactic treatment, indicating that the need for an extraction likely was not discovered until the exam under general anesthesia, hence, no prior second opinion note. However, no prior notes were copied for this review. There was no follow-up office appointment made except to recheck in six months. ▪ Individual #251 had several attempts at treatment under IV sedation/general anesthesia. On 8/13/10, he became agitated, and was unable to cooperate. On 10/18/10, he arrived for dental anesthesia, but had eaten a hot dog. On 2/16/11, he underwent extraction of tooth # 3under general anesthesia. He received Motrin for pain, and there was no follow up appointment made. ▪ On 12/10/10, Individual #55 underwent extraction of tooth #23 under general anesthesia. He was given antibiotic, and was to be recalled in six months. ▪ On 9/20/10, Individual #13 underwent extraction of tooth #32. The note was handwritten, and difficult to read, but did not mention general anesthesia during this visit. She did receive local anesthesia. Post-operatively, she received Motrin, and no follow-up visit was offered. ▪ On 10/22/10, Individual #265 had tooth extraction of tooth #20 under general anesthesia. There might have been two other teeth extracted, but the legibility made it difficult to confirm this. She was prescribed Motrin for pain. ▪ On 12/10/10, Individual #135 underwent extraction of one or two teeth (legibility limited interpretation) under general anesthesia. He was given Motrin for pain, and a six-month recall. ▪ On 11/15/10, Individual #223 underwent extraction of several teeth under general anesthesia. He was given Motrin for pain and a six-month recall. ▪ On 10/18/10, Individual #264 underwent extraction of two teeth under general anesthesia. He was given Lortab and Motrin for pain. There was no information concerning follow up. ▪ On 10/22/10, Individual #257 underwent tooth extraction under general anesthesia. Post-operatively, she was given Keflex, Lortab, and Allegra. There were follow-up dental notes recording telephone communication with her residence on 10/22/10, 10/23/10, and 10/25/10.	

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		▪ Individual #103 underwent tooth extraction on 12/20/10 (date not legible). From the hand written note, it appeared this occurred under local anesthesia. He was to follow up in six months. With regard to these ten individuals who had extractions, the hand-written notes often were difficult to interpret, especially in some cases regarding the number of teeth extracted. Reasons given were usually the teeth were non-restorable. In nine cases, it appeared general anesthesia or IV sedation was used, and the visiting dentist provided the second opinion. Attention appeared to be paid to pain control post-operatively. There were no follow-up visits to verify healing, although these individuals historically were resistant to oral examination and care. It is recommended that these notes be dictated and transcribed. In instances where only local anesthesia was given, a second opinion should be obtained, and in the record prior to the extraction. When the dental anesthesiologist provides the second opinion, a brief note should be included in the record. There were several visits in the prior six months recorded as emergencies. In September 2010, there were five emergency visits. There were no emergency visits recorded in October 2010, or November 2010. In December 2010, there was one emergency visit. In January 2011, there was one emergency visit. In February 2011, there were three emergency visits. Several records of dental emergencies were submitted, including the following: ▪ On 2/11/11, Individual #51 was referred for purulent exudate from his mouth. In the dental office, he was too agitated for an examination. It was noted that he was due for an annual exam on 2/25/11, and he was scheduled for IV sedation for evaluation and x-rays. ▪ On 2/3/11, Individual #300 presented as a walk-in for a toothache. He was examined, as a filling had been placed in that tooth on 1/26/11. The plan was to monitor for pain. On 2/25/11, he again presented as a walk-in. Tooth #31 was noted to be non-restorable. Attempts at local anesthesia were resisted. He was scheduled for extraction with Ativan, and given Keflex and Motrin. On 3/2/11, an extraction occurred. On 3/3/11, a follow up visit occurred, and he had no complications. ▪ On 9/24/10, Individual #250 was referred for a loose tooth and bleeding. He was examined, and no loose tooth was found. The bleeding was due to gingivitis and improper brushing. Two staff to assist with brushing was recommended. He was to be seen in recall with IV sedation. ▪ On 11/17/10, Individual #34 was seen. A filling was missing from tooth #29. Debris was removed, and the filling was replaced. On 2/7/11, a filling was missing from tooth #18, and was replaced. ▪ On 8/16/10, Individual #61 had a filling placed in tooth #4. He then presented	

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		with dental pain on 1/4/11. The dental hygienist saw him, and the filling was lost. He was being given Tylenol for pain. On 1/6/11, he had an appointment, but did not show for the appointment. He was then seen on 1/26/11, and the filling was restored under local anesthesia. ▪ On 2/25/11, Individual #103 had an emergency exam for what he believed were teeth growing from the gums. These were exostoses, and no treatment was indicated. ▪ On 12/30/10, Individual #182 was referred for suspected dental pain. There was no swelling or fistula noted on exam. The severe bruxism, and teeth worn to the pulp suggested pain from apical root trauma. It was decided he needed sedation for x-rays. The next note was dated 1/12/11, in which he was given an annual exam, but there was no follow up note concerning the potential dental pain. ▪ On 9/20/10, Individual #55 was referred for possible toothache. An exam did not provide any source of pain. He was scheduled for IV sedation on 12/10/10. These examples suggested the individuals had ready access to dental care through the dental clinic. Notes related to dental emergencies should have documentation of whether or not pain medication is needed, and that, if appropriate, pain medication has been prescribed. If the individual does not need pain medication, especially if referred for dental pain, then this should be clearly documented. Further, the length of time to definitive treatment varied, but was up to approximately three months. For those individuals with dental pain, they should be tracked through to resolution of the problem, and steps taken to minimize time between presentation with pain and definitive treatment leading to closure. It also would be helpful after a few days to have a telephone follow-up with the residence to ensure resolution of the discomfort. General anesthesia was available on the campus of LBSSLC for dental procedures. A copy of the appointment schedule was submitted. Dates on which general anesthesia was scheduled included 9/20/10, 10/18/10, 10/22/10, 10/25/10, 11/19/10, 11/22/10, 12/10/10, 12/13/10, 12/17/10, 12/20/10, 12/27/10, 12/28/10, 1/7/11, 1/14/11, and 1/27/11. It appeared that there were three to six individuals scheduled per session. Dental records for several individuals who had undergone general anesthesia/conscious sedation were submitted. The following provides some examples: ▪ For Individual #103, who underwent IV sedation on 12/20/10, there were notes describing the head motion and tongue thrusting of the individual, as well as attempts at giving Ativan without success. The period of time of these evaluations and medication trials was from 11/5/09 to 5/6/10. He was then scheduled for IV sedation/general anesthesia. The 12/20/10 annual exam was noted with a brief entry about an extraction, and other evaluation and treatment.	

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		There was a copy of the anesthesia record, completion of the preoperative evaluation on 12/20/10, and a brief recovery note with the discharge scoring system completed. HRC approval was completed on 10/13/10, and consent was signed on 11/3/10. There was no postoperative monitoring of vital signs submitted. He recovered in the dental chair, and was discharged to his home. ▪ For Individual #259, he had an annual dental exam on 1/12/11, with the notation to recall for general anesthesia, which occurred on 1/27/11. Included in the submitted documents were the anesthesia record, a brief recovery note, a discharge scoring system completed, a preoperative anesthesia record, HRC approval on 1/12/11, and consent obtained on 1/14/11. There was no postoperative monitoring of vital signs submitted. He recovered in the chair (records did not identify if that meant his wheelchair or the dental chair). ▪ Individual #135 had a no-show appointment on 3/19/10, and a prophylactic treatment on 6/17/10. He had unsafe head and hand movements. He underwent IV sedation and general anesthesia on 12/10/10. He recovered in the dental chair, and then was assisted to a wheelchair. A discharge scoring system was completed. An anesthesia record was completed. HRC approval was obtained on 9/29/10, and consent was obtained on 10/9/10. ▪ For Individual #26, there were no notes prior to the date of anesthesia. There was a dental note, dated 12/20/10 [could be interpreted as 12/26/10], describing the procedure under general anesthesia and IV sedation. There was an anesthesia record, a brief recovery note, and completion of the discharge scoring system. He recovered in the dental chair. HRC approval was obtained on 2/16/11, and consent was obtained on 11/14/10. No further postoperative vital signs were submitted. These four cases indicated the complexity of obtaining required documents for the procedure, such as consent and HRC approval. They were all available, but some of them had taken time to obtain. It was noted that there was no submission of documentation of vital signs following the procedure and discharge by the anesthesiologist. This might have been completed and located elsewhere in the record. However, if there was not a formal document, there should be verification of stability of vital signs, and ability to swallow food and liquids safely before assuming closure. On 12/16/10, the Nursing Department was in-serviced on the topic of pre-treatment sedation assessment. This might need to be repeated, until record reviews indicate the appropriate frequency of monitoring of vital signs.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two	The Dental Department developed an "annual dental summary" for each individual, which was provided to the PST for the completion of the PSP. It also was placed in the Facility's "M," or shared drive. Forty-eight annual dental summaries recently completed	Noncompliance

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	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.	were submitted for review. It appeared this form was evolving, because additional information and a change in format occurred from the 2010 to the 2011 form. They were written clearly without dental abbreviations. The forms completed in 2011 appeared to include a comment about the behavior of the individual, an important aspect of dental care that the PST needed to understand. Additionally, a rating of oral hygiene was included. However, a few observations and recommendations might assist with increasing the value of this important document to the PST, including: ▪ In many of the cases, a number of areas were left unanswered, such as whether or not there were missing teeth. Only two individuals stated there were no missing teeth, including Individual #275, and Individual #121. The current form also provided no indication of which teeth, or the number of teeth that were missing. Individual #264, Individual #37, Individual #66, Individual #270, Individual #237, Individual #161, Individual #14, and Individual #174 were documented to have missing teeth, but there was no further information. It would be helpful to have a simple generic diagram of the teeth (none of the submitted "annual dental summaries" reviewed included a diagram) on which to indicate the teeth missing. ▪ Caries were documented for the following individuals: Individual #37, Individual #35, Individual #147, Individual #296, and Individual #310. For many of these individuals, there was no comment as to how this issue should be addressed. Individual #147 was an exception, in which there were comments addressing his need for further treatment. ▪ Several forms did not indicate whether or not caries were present, leaving this important aspect of care unanswered, including for: Individual #56, Individual #270, Individual #237, Individual #161, Individual #167, Individual #272, and Individual #84. A generic diagram also would assist in providing information as to the location and number of caries. ▪ Under the section of work completed, it would be helpful to list details, such as how many fillings, or this could be part of the diagram. Additionally, the comment section could be used to guide the team in determining the need for a desensitization program. Given the importance of oral hygiene in preventing dental disease, further information concerning the level of participation in a tooth-brushing program would be helpful to the team, and the current goal for eventual independence in this aspect of personal hygiene. A brief entry using a stamp with blank sections to be completed was located in both the dental progress note/treatment record, and integrated progress note. This provided basic information to any member of the team who might read the IPN entries. The annual dental assessments were similar, and used this stamp. Completed notes were reviewed for the following individuals: Individual #52, Individual #250, Individual #6,	

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		Individual #160, Individual #59, Individual #291, Individual #290, Individual #296, Individual #51, and Individual #223. Information was submitted concerning the missed appointments per month. The following summarizes this data: ▪ In September 2010, there were 21 missed appointments, 12 of which were "no shows" (57%). There were a total of 64 appointments scheduled. The missed appointment rate was 21 out of 64 (33%). ▪ In October 2010, the total number of missed appointments was 25, with 18 being "no shows" (72%). There were a total of 69 scheduled appointments. The missed appointment rate was 25 out of 69 (36%). ▪ In November 2010, there were 22 missed appointments, of which nine were "no shows" (41%). There were a total of 74 scheduled appointments. The missed appointment rate was 22 out of 74 (30%). ▪ In December 2010, there were 16 missed appointments, of which six were "no show" (38%). There were a total of 73 scheduled appointments. The missed appointment rate was 16 out of 74 (22%). ▪ In January 2011, there were 29 missed appointments, of which 14 were "no show" (48%). There were 85 scheduled appointments. The missed appointment rate was 29 out of 85 (34%). ▪ In February 2011, there were 18 missed appointments, of which four were " no show" (22%). There were 52 scheduled appointments. The missed appointment rate was 18 out of 52 (35%). These are significant percentages of missed appointments and "no shows." It will be important to determine the reason for the many "no shows," in order to make dental care more effective and timely for the individual, and more efficient for the dental office. Creating a database with the many categories of potential reasons would assist in this endeavor. There were few refusals (only four from September 2010 through February 2011), and the reason for the significant numbers of "no shows" remained unknown or undocumented. Additionally, when removing the "no show" numbers from the missed appointments, there remained other areas that should be reviewed. In September 2010, out of nine missed appointments (removing "no shows"), five were due to cancellations by the dental office (56%). In October 2010, there were five due to cancellations by the dental office (5/10=50%). In November 2010, there were two due to cancellations by the dental office (2/12 = 17%). In December 2010, there were six due to cancellations by the dental office (6/10= 60%). In January 2011, there were nine due to cancellations by the dental office (9/15 = 60%). In February 2011, there were three due to cancellations by	

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		the dental office (3/13 = 23%). Because it represents a significant portion of the missed appointments other than "no shows," the number of cancellations by the dental office also should be reviewed and actions developed and implemented to minimize this occurrence. Increased communication with the residential staff and Nursing Department, to address such concerns as not ensuring that individuals have "nothing by mouth" prior to appointments, and pre-treatment sedation not being given, would assist in improving the missed appointment rate. For those that had a missed appointment, data was submitted concerning rescheduling and follow-up visits. The following information was calculated from a list of rescheduling dates. It was not determined whether these rescheduled appointments were always kept. In some instances there was notation of "made up" date suggesting completion of an appointment, but the information was not complete. Concerning rescheduling of missed appointments, the following were percentages of missed appointments which were rescheduled: September 2010 - 13 out of 20 (65%), October 2010 – six out of 25 (24%), November 2010 – 15 out of 21 (71%), December 2010 – 12 out of 16 (75%), January 2011 – 28 out of 29 (97%), and February 2011 – 10 out of 18 (56%). This represented a wide variation in rescheduling. That one of the months had a 97% rescheduling rate suggested improvement in the overall rate was possible. The Dental Department should create a system in which follow-up appointments are routinely entered and tracked. Again, because of the many categories and data trends which should be reviewed to reduce "no show" rates, it is important that the Dental Department develop and maintain a database in which all these categories can be entered. The data should be tracked, trended, and analyzed monthly, and the results used to initiate improvements, including changes in protocols and policies, and, most important, practices. Although there were significant "no show" rates, the Dental Department indicated that all individuals at LBSSLC had seen the dentist in the past year. The dental desensitization program had been revamped. The Dental Director was the new chairperson of the Desensitization Committee, and new members were recruited for participation. This was an interdisciplinary committee, with members from Nursing, Psychology, and Habilitation services, as well as Dental. From the 3/18/11 Desensitization Committee minutes, two individuals were near completion of the development of desensitization plans. The Desensitization Committee minutes of 1/13/11 noted in the past, 163 desensitization programs were created, but none had been implemented. Two residences were identified as pilot homes for this program (521 North Cedar, and 523 North Cedar). A Dental Desensitization Policy was implemented as of 3/1/11. The Dental Department provided information concerning restraint use. In the prior six	

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		months, the dental clinic did not use any mechanical restraints. The dental clinic did use oral sedation in a number of cases. In September 2010, out of 25 office visits for exams and treatments, seven individuals utilized oral sedation (28%). In October 2010, 25 individuals were seen for exams and treatment, and four utilized oral sedation (16%). In November 2010, there were 22 office visits, and four individuals used oral sedation (18%). In December 2010, there were 26 office visits, and three individuals used oral sedation (11.5%). In January 2011, there were 27 office visits, and two individuals used oral sedation (7%). In February 2011, there were 13 office visits, and two individuals utilized sedation, which was 15% of the office visits that month. There was also data generated indicating pre-treatment sedation used for dental appointments from 8/1/10 through 1/31/11. During this time, there were 27 pre-treatment sedations given, for dental procedures for 20 individuals. The number of individuals utilizing IV sedation for dental exams and treatment generally exceeded the use of oral sedation. In September 2010, out of 25 office visits, three involved the use of IV sedation, a 12% rate. In October 2010, out of 25 office visits, 11 involved the use of IV sedation, a rate of 44%. In November 2010, out of 22 office visits, nine involved the use of IV sedation, a 41% rate. In December 2010, out of 26 office visits, 12 involved the use of IV sedation, a 46% rate of use. In January 2011, there were 27 office visits, of which 11 utilized IV sedation, a 41% rate of use. In February 2011, there were 11 office visits, of which two involved the use of IV sedation, a rate of 15%. According to the Dental Director, referencing the monograph "Oral Health for People with Special Needs: Guidelines for Comprehensive Care," there is a national trend to increase use of IV sedation, and general anesthesia. However, the teams should continue to search ways to minimize medications, and provide desensitization plans with positive outcomes, whenever possible. As part of the evidence gathering for the Monitoring Team's visit, the Dental Department was requested to submit copies of any correspondence concerning restraint and sedation use that had been sent to the QMRP, PST, psychologist, etc., and there was no written documentation submitted. Although there might have been telephone communication, it is important to document dates, times, and the name and title of the person with whom information was shared. Given the current rate of oral and IV sedation, definitive steps need to be taken to decrease its use. Additionally, the Dental Department provided a number of newly created, or revised dental policies. Most of these policies reflected updates and changes to clarify protocols or provide definitions. These included: ▪ Comprehensive Annual Dental Examination, revised 3/1/11;	

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		▪ Dental Clinic Operations Policy, revised 3/1/11; ▪ Dental Desensitization, dated 3/1/11; ▪ Dental Examinations Policy, revised 3/1/11; ▪ Dental Services Overview, revised 3/1/11; ▪ Dental Emergencies, revised 3/1/11; and ▪ Dental/Medical Sedation and Restraint, revised 1/14/10.	

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

1. Facility Administration should consider providing another dental hygienist position to the Dental Department.
2. When there is a brief time between annual assessments, a reason should be listed, because it would seem an unnecessary visit from the perspective of the individual.
3. The Dental Department should meet with the Nursing Department to clarify the irregularities in monitoring for pre-treatment sedation.
4. Nursing staff be provided an in-service training on the dental monitoring policy in relation to pre-treatment sedation.
5. The dentist's entries for restorations and extractions should be dictated and transcribed to ensure others can easily review the information.
6. In instances where only local anesthesia was given, a second opinion should be obtained, and in the record prior to the extraction. When the dental anesthesiologist provides the second opinion, a brief note should be included in the record.
7. Notes related to dental emergencies should have documentation of whether or not pain medication is needed, and that, if appropriate, pain medication has been prescribed. If the individual does not need pain medication, especially if referred for dental pain, then this should be clearly documented.
8. For those individuals with dental pain, they should be tracked through to resolution of the problem, and steps taken to minimize time between presentation with pain and definitive treatment leading to closure. The length of time to definitive treatment/closure should be tracked as an internal quality assurance measurement, especially with those presenting with pain.
9. For individual having extractions, after a few days, telephone follow-up should occur with the residence to ensure resolution of the discomfort, and provide added closure and evidence of no complications.
10. For those individuals undergoing general anesthesia or IV sedation, documentation should include post anesthesia vital signs until the individual is alert, as well as documentation that the individual is able to safely swallow liquids and solids before closure of postoperative care.
11. With regard to the annual dental summary:
    a. All sections of the annual dental summary should be answered/completed, rather than leaving areas blank.
    b. Use of a simple generic diagram should be considered, allowing an indication of which teeth or the number of teeth which are missing.
    c. A comment section should indicate follow-up plans for caries, etc., and caries could also be marked on the diagram. The comment section should be used an opportunity to guide the PST in the need for a desensitization program, and outline the areas of focus in desensitizing that individual to the dental office.
    d. An additional entry describing the level of the individual's participation in tooth brushing would provide valuable information to the team.
12. The Dental Department should create a database including 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.

13. The Dental Department should define a baseline rate for each category of missed appointment for measurement of future progress and improvement.
14. The number of cancellations by the dental office should be tracked and steps taken to minimize this occurrence.
15. The Dental Department should create a system in which follow-up appointments scheduled as a result of missed appointments are routinely entered and tracked.
16. The Dental Director should review the database for any trends at periodic intervals, and identify areas needing improvement. This should be a written document provided on a quarterly basis and forwarded to the Facility administration, including the QA/QI Committee, for review. As appropriate, action plans should be developed and implemented to address issues identified.
17. The Dental Department should work with other departments to develop and implement strategies for reduce the use of IV sedation or oral sedation, and these efforts should be documented.

The following are offered as additional suggestions to the State and Facility:

1. A dental peer review process, with focus on reviewing oral hygiene index scores, and on acute care needs would add a needed dimension of dental review.

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 Presentation Book for Section R; o Section R Presentation LBSSLC Monitor's Compliance Visit, dated March 2011; o The following documents were requested: SLP Evaluation and Updates, SLP Progress notes, SLP communication program, instructional program for AAC device, PSP and PSPAs for past year, Behavior Support Plan, SLP consultations for the last year, competency-based training, person-specific monitoring, and AAC equipment monitoring for the following 11 individuals: Individual #306, Individual #140, Individual #288, Individual #4, Individual #264, Individual #132, Individual #25, Individual #276, Individual #53, Individual #119, and Individual #168; o Protocol for Communications, undated; o AAC Tracking System, undated; o Integrated Meeting Notes, from 8/10 through 3/11; o OT/PT/SLP Caseloads, undated; o Continuing Education Courses completed by SLP, since last onsite visit, from 7/31 through 3/28/11; o List of SLP and Audiology Staff with corresponding caseloads, undated; o List of individuals with AAC devices and corresponding type of devices, undated; o Communication Master List, undated; o AAC Screening forms (blank) and Speech-Language Evaluation forms (blank), undated; o AAC Evaluation (template) and Speech-Language Update form (template), undated; o Five (5) Most Current AAC and SLP Assessments conducted by each therapist and corresponding PSPs, from 10/10 through 1/11; o Tracking Log of completed assessments, from 8/10 through 2/11; o Monitoring Tools (template) for AAC and SLP, revised 10/21/10; o HT Meal Observation and HT PNMP Observation forms, revised 1/26/11; o AAC Individual Equipment Monitoring forms, revised 12/3/10; o Summary Reports and Resulting Action Plans, during past 12 months, from 5/10 through 3/11; o AAC-related spreadsheets, undated; o List of Individuals Receiving Direct Speech Services and Focus of Intervention, undated; o List of individuals with behavioral issues and coexisting severe language deficits, undated; and o List of individuals with PBSPs and replacement behaviors related to communication, updated 2/17/11. ▪ **Interviews with**: o Linda Thomas, Habilitation Therapies Director; and o Members of Willow PST conducting Integrated Meetings to address functional communication initiative.

	▪ **Observations of**: o Residences: 504 Mesquite Drive (Quail/Sparrow); 518 South Cedar Avenue (Oak); 526 North Cedar Avenue (Tulip); 527 North Cedar Avenue (Iris); and 528 North Cedar Avenue (Zinnia).
	Facility Self-Assessment: LBSSLC Plan of Improvement, updated 3/14/2011, provided comments/status for Section R. Compliance for each of these sections was documented as noncompliance. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: There were four budgeted SLP positions. Three SLPs were employed. One SLP had been hired, and was scheduled to begin New Employee Orientation on 3/15/11. The current staff-to-individual ratio with four SLPs on staff would 1:57. SLPs were completing evaluations that did not recommend direct and/or indirect therapy supports for individuals who presented with severe communication deficits, but had documented strengths, potentials, and abilities for functional communication. Insufficient direct and/or indirect speech therapy supports were provided for individuals with an identified need. 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 successfully utilize the device in a variety of natural environments. Habilitation Therapies should complete an analysis of all current documents (e.g., PNMP) and monitoring forms related to communication devices to ensure consistency across all documents. For example, communication dictionaries were not incorporated into the communication equipment monitoring forms. The Facility Speech Language monitoring policy should incorporate the following: ▪ Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual; ▪ Monitoring forms that include instructions for individual monitoring indicators to support monitor consistency and support inter-rater reliability; ▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability; ▪ Formal schedule for monitoring to occur; ▪ Auditing process of completed monitoring forms to identify forms completed accurately, and

	analysis of individual-specific concerns and systemic issues; ▪ Feedback loop identified in which deficiencies are noted, and shared with appropriate supervisory staff to ameliorate deficiencies; and ▪ Establishment of thresholds for staff re-training. Facility Administration, in collaboration with the SLPs, should continue to problem-solve and identify solutions to significantly increase staff compliance with utilization of individual communication systems. Furthermore, SLPs should continue to monitor individuals' current communication devices to ensure they are effective to support functional communication.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>R1</td><td>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.</td><td><u>The Facility provides an adequate number of speech language pathologists or other professionals [i.e., Assistive Technology (AT) specialists] with specialized training or experience. Training should include augmentative and assistive communication.</u>
There were four budgeted SLP positions. The staff-to-individual ratio document revealed that three SLPs were employed. One SLP had been hired, and was scheduled to begin New Employee Orientation on 3/15/11. The following chart shows the status and caseloads of the SLPs:

<table>
<tr><th>Current SLPs</th><th>Current Caseloads and Other Responsibilities</th></tr>
<tr><td>SLP #1</td><td>PNMT member, and supported 33 individuals</td></tr>
<tr><td>SLP #2</td><td>Supported 76 individuals</td></tr>
<tr><td>SLP #3</td><td>Supported 116 individuals</td></tr>
<tr><td>SLP #4</td><td>Recently employed, and had not been assigned a caseload</td></tr>
</table>

The current staff-to-individual ratio list, dated 3/3/2011, indicated the LBSSLC ratio for SLPs was 1:75, which did not appear to be accurate. The current staff-to-individual ratio with four SLPs on staff would 1:57. The psychology staff-to-individual ratio required by the Settlement Agreement was 1:30. SLPs had similar duties with regard to assessment, planning, monitoring, and provision of direct supports and/or oversight, but their caseloads were significantly higher, which was impacting their ability to comply with Section R.

The Plan of Improvement/Self Assessment, dated 3/14/11, for Section R, Communication identified the following outcome, which was a recommendation from the Monitoring Team: "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</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		training, monitoring, etc. This analysis should identify the number of SLP positions needed to achieve compliance with Section R of the SA." The action steps were to identify areas of responsibility by therapist, gather and review input from disciplines, and complete analysis for each discipline. This was documented as having been completed on 1/10/11. Documentation in the Presentation Book for Section R included multiple analyses of SLP staffing needs with different numbers identified of SLPs needed at LBSSLC. No additional documentation was included in the Presentation Book and/or in the document request that provided a final analysis of the therapy staffing needs, and/or action(s) to be taken. Staffing was potentially one factor that resulted in the inadequate provision of speech and communication supports to individuals at LBSSLC. In sum, therapists were not active members of the PSTs, as evidenced by their absence from annual PSP meetings, insufficient time to provide direct therapy (only one individual was receiving direct speech services), lack of development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the insufficient development of informal strategies to reinforce assessment recommendations and measurable outcomes. The SLPs attended a wide variety of continuing education courses and conferences, but did not consistently attend state-sponsored continuing education courses, and/or attend continuing education related to AAC. As stated above with regard to Section O.1, therapists should attend the state-sponsored courses. The Facility should continue to support therapists' attendance at a variety of off-site continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at LBSSLC. The Monitoring Team continues to encourage SLPs having additional opportunities to attend continuing education courses related to augmentative/alternative communication. <u>Communicative Aiders and Speech Generating Devices (SGDs) (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 is relevant.</u> Eleven individual records were reviewed, including: Individual #306, Individual #140, Individual #288, Individual #4, Individual #264, Individual #132, Individual #25, Individual #276, Individual #53, Individual #119, and Individual #168. One individual in the sample (Individual #276) was currently receiving direct speech services. Four other individuals in the sample were reported to be receiving direct speech therapy, but they were not currently receiving direct speech services. These individuals had received direct speech services within the past two years (Individual #25, Individual #53, Individual #119, and Individual #168). The remaining six individuals were not reported	

#	Provision	Assessment of Status	Compliance
		to be receiving direct speech therapy services. Of the six individuals reported not to be receiving direct speech therapy (Individual #306, Individual #140, Individual #288, Individual #4, Individual #264, and Individual #132), all were in need of formal and/or informal functional communication supports as documented below: ▪ Individual #306's Speech-Language Update, dated 11/10/10, 11/23/10, and 11/24/10, and 12/3/10, 12/8/10, 12/9/10, and 12/14/10, stated: "His communicative intent requires interpretation by Direct Support Staff for his specific wants and needs." Individual #306 was reported to have "adequate hearing for his communication needs as indicated with periodic localization to a sound source and responding appropriately when greeted by clinician," but there was no report of a current audiological evaluation. The SLP recommended: "object picture cards to initiate his communication project and included 19 cards which could be carried in a backpack. On December 15, 2010, SLP generated six Talking-My-Way object/symbol communication boards to provide another means to access objects and use objects during his structured routine and strengthen [Individual #306's] ability for increased association recognizing that objects are an expressive language tool to increase his communication skills in his home environment." His SLP evaluation recommendations did not include direct speech services to support integration of his low-tech communication devices, formally and informally, into his PSP. His Personal Support Plan, dated 1/25/11, stated: "[Individual #306] will be encouraged to use his augmentative alternative communication (AAC)," but did not specifically identify his low-tech devices. It was unclear if the SLP attended the PSP, because the signature Sheet was blank. AAC materials and single message VOCA [voice output communication aide], dated 3/10/11, provided pictures of his low tech devices and staff instructions, but these staff strategies were not integrated into competency-based training. There were multiple AAC Object/Picture Competencies completed for staff, but these competencies were not individualized for Individual #306's low-tech devices. There was no PSPA meeting to integrate these devices into formal skill acquisition programs, and/or informal activities throughout the 24-hour day. ▪ Individual #140 had a BSP, could not communicate verbally, and was diagnosed with autism. He was identified as Priority 1 for collaboration with psychologists, and for the provision of communication. Individual #140's SLP Evaluation Update, dated 7/16/10 and 8/17/10, stated: "[Individual #140] was seen on the above dates for a communication functioning update secondary to AAC/AT consults for update in his personalized AAC equipment [that] were written after his August 2009 speech language update." Individual #140's evaluation identified his personalized AAC equipment, which was a communication card,	

#	Provision	Assessment of Status	Compliance
		communication book, U-shape communication placemat, and home programming materials. The update stated: "SLP will be available to provide in-service and assist in planning appropriate communicative programming," but did not recommend direct speech services to support the integration of his communication devices formally and/or informally into his PSP. His PSP, dated 9/28/10, incorporated the following training objectives: "E) by 2/11, [Individual #140] will sign 'sick' to staff with/without prompt for 1 out of 1 trial for 16 data taking sessions; and G) by 3/11, [Individual #140] will use his communication book once a day without prompts for 1 out of 1 trial for 18 data sessions." The SLP did not attend his PSP meeting. The communication equipment identified in his SLP evaluation update was not consistently represented in his PSP objectives. There was no competency-based staff training for the utilization of his communication devices. ▪ Individual #288's Speech-Language Update, dated 7/14/10, 8/4/10 and 8/6/10, stated: "due to his success in task completion using his [visual] schedule, his psychologist requested the speech-language pathologist to generate update pictures for a daily schedule for [Individual #288] to incorporate his activities and home chores which became part of his daily routine due to his new home placement. He was provided an updated visual schedule in addition to his home programming grooming schedule." His PSP, dated 9/14/10, did not integrate the use of these communication devices, and his SLP did not attend. ▪ Individual #4's Speech-Language Update, dated 3/18/11, stated: "He currently has a PBSP, dated 3/16/11, addressing aggression, self–injurious behavior, and outbursts. Replacement behaviors for these include communication, participation, and appropriate use of materials." It was recommended in his previous Speech-Language Update "to provide AAC for the purpose of decreasing maladaptive behaviors and increasing ability to request items not in his immediate environment. AAC provided consisted of a picture-sign book. Staff instructions for the book include encouraging [Individual #4] to use his communication book to supplement communicative intent and to strengthen his use of sign language and/or picture recognition of his wants and needs. Review of his AAC monitoring documentation, dated January to 3/16/11, indicated that his AAC is not regularly provided to him and often found in the chart room. Staff noted that when [Individual #4] is agitated he throws items at staff or on top of the roof." One of his recommendations stated: "In view of the above clinical impressions, Speech-Language therapy is not indicated at this time as needs can best be addressed in the content of daily living activities." Individual #4 had severe communication deficits, and required direct and indirect speech supports. ▪ Individual #264 was identified as Priority 1 to receive communication supports, because he had a PBSP, autism and did not communicate verbally. Individual	

#	Provision	Assessment of Status	Compliance
		#264's Speech Language Update, dated 12/13/10, documented his communication equipment as two choice communication boards, one in the bedroom and the other in the day room, choice communication cards, and general communication devices, as provided for all person within the residence. No recommendations were made for formal speech supports, even though he had severe communication deficits. ▪ Individual #132 was identified as Priority 4 for communication supports. Individual #132's Speech-Language Update, dated 12/14/10 and 1/12/11, presented the following communication equipment: "daily visual schedule/calendar, communication dictionary page and general communication devices as provided for all serviced within the home." The action plan in his PSP, dated 3/15/10, stated: "within the next year (3/10 to 3/11) at the end of the day [Individual #132] will remove the pictures from his daily schedule in his communication book and will discuss the events of his day with staff." There were home programming recommendations, but these were not integrated into skill acquisition programs in his PSP, dated 3/15/10, nor was a PSPA meeting held to integrate communication strategies. There was no competency-based staff training documentation for his communication equipment. Per report, one of the 227 individuals residing at LBSSLC (.4%) was receiving direct SLP services, but no documentation was submitted to support the receipt of direct speech services. The following issues were noted: ▪ Individual #276's was reported to be receiving direct speech services. An HT Consultation, dated 11/18/10, was requested for: "start of treatment. The team agreed that if he was in need of assistance outside of the structured environment of the LSSLC, he would experience communication breakdown when communicating with strangers. The team discussed that, even if he had a book for this, infrequent use of it would lead to decreased use in actual emergency situations. It was discussed that direct speech therapy would be initiated with [Individual #276] for the purpose of enhancing his expressive communication skills to increasing independence. Treatment notes will be kept throughout therapy sessions and progress notes will be submitted to the team monthly. AAC will be re-considered as appropriate and a consult will be initiated at the close of therapy." No therapy communication program, progress notes for therapy sessions, and/or PSP monthly progress notes were submitted. The SLP evaluation should include an analysis of findings to provide a rationale for individuals receiving direct speech therapy and justification for individual recommendation(s). The progress note should justify the initiation, continuation or discontinuation of speech therapy supports, including an analysis to determine the efficacy of the direct therapy supports provided. If progress was not made,	

#	Provision	Assessment of Status	Compliance
		recommendations and/or objectives should be revised.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>All individuals in need of AAC are identified as being in need of AAC.</u> None of the six records reviewed (Individual #306, Individual #140, Individual #288, Individual #4, Individual #264, and Individual #132) (0%), for individuals identified with severe expressive/receptive language deficits and in need of AAC systems, were provided ongoing support by an SLP to facilitate functional communication. Examples of concerns are provided with regard to Section R.1 of the Settlement Agreement. LBSSLC Protocol for Communication, undated, identified the following: ▪ Priority criteria for provision of communication supports (Phase 2); ▪ Collaboration with behavioral services; and ▪ Communication dictionaries. In collaboration with Behavioral Services, criteria were established, and used to prioritize individuals to be assessed by the SLP. The following criteria were used: ▪ Priority 1 included individuals with Behavior Support Plan and/or Autism who did not speak. Individuals who are classified as Priority 1 were to be addressed in conjunction with their next annual PSP meeting unless otherwise indicated by BSC/individual need/ status change. Based on staff report, 64 individuals had been identified as Priority 1, and 46 individuals had assessments completed (72%). ▪ Priority 2 referred to individuals with BSP and/or Autism who spoke. Individuals classified as Priority 2 were to be assessed within the next 18 months unless otherwise indicated by BSC/individuals needs/status change. Based on staff report, 69 individuals had been identified in this category, and 35 individuals had assessments completed (51%). ▪ Priority 3 referred to individuals with/without a BSP and/or autism who did not speak. Individuals classified as Priority 3 were to be assessed within the next 24 months unless otherwise indicated by BSC/individual needs/status change. Per staff report 86 individuals had been identified in this category, and 45 individuals had assessments completed (52%). ▪ Priority 4 referred to individuals without a BSP and/or autism who spoke. Individuals classified as Priority 4 were to be assessed within the next 24 months unless otherwise indicated by BSC/individual needs/status change. Per staff report, eight individuals had been identified in this category, and four individuals had assessments completed (50%). Within each priority, the following was to be considered: ▪ If there was already a communication device; whether or not there were identified strategies; whether or not there was a communication dictionary; and collaboration with BSS [behavior support staff]/integration into the BSP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The LBSSLC Communication Master List database identified the following fields: first name, last name, case number, home, current evaluation, next updated/evaluation, AAC consultant, PBSP, Autism, Priority, communication dictionary, status, individual's AAC/AT system, recommended shared devices augmentative or alternative, other shared, device: high-tech, low-tech or no-tech, device type, active treatment, focus of treatment and communication modes. A review of the communication tracking system, undated, and the prioritization system identified the following concerns: ▪ Sixty-four individuals were identified as Priority 1 to have a SLP evaluation completed at their next PSP meeting unless otherwise indicated by BSC/ individual need and/or status change. The scheduled evaluation timelines for Multiple Priority 1 individuals did not reflect the established timeframes for completion of the assessments. For example: o Individual #70's current evaluation was dated 4/2/09, but he was not scheduled for a re-evaluation until 4/2014. o Individual #318's current evaluation was dated 11/9/09, but he was not scheduled for a re-evaluation until 11/2014. o Individual #314's current evaluation was dated 12/17/08, but he was not scheduled for re-evaluation until 12/2012. o Individual #322's current evaluation was dated 7/7/09, but she was not scheduled for re-evaluation until 7/2014. o Individual #257's current evaluation was dated 3/11/08, but she was not scheduled for re-evaluation until 3/2013. ▪ The timelines assigned to individuals within the priority levels should be re-evaluated. For example, individuals assigned a Priority 2 were assigned evaluation completion dates prior to individuals who had been assigned Priority 1 status. <u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u> Since the previous review, there were six individuals admitted to LBSSLC. Records for four of these individuals were requested, including Individual #173, Individual #92, Individual #131, and Individual #124. Four of four individuals (100%) received a Speech Language (SL) evaluation within 30 days of admission. The admission evaluations were signed and dated by respective Speech Language Pathologist(s). The Facility's Speech Language Evaluation format, dated 9/77, included the following: ▪ Reason for referral; ▪ Significant information; ▪ Behavioral considerations; ▪ Hearing and vision;	

#	Provision	Assessment of Status	Compliance
		▪ Communication history; ▪ Previous assessment; ▪ Reports from significant others; ▪ Observation; ▪ Current findings: o Receptive/expressive language; o Pragmatics; o Articulation, voice, and fluency; o Oral mechanism; ▪ Consults; ▪ Augmentative/alternative communication; ▪ Assistive technology; ▪ Clinical Impressions; ▪ Recommendations: o Communication equipment; o Language/modality preference; o PST consideration of suggested home programming; o SLP will be available to provide in-service to assist in planning appropriate communicative programming as requested; and o Communication status will be reassessed in one year prior to staffing. The Facility Speech-Language Update, dated 9/77, included the following: ▪ Current findings: o Receptive/expressive language; ▪ Speech consults; ▪ Augmentative/alternative communication; ▪ Assistive technology; ▪ Clinical impressions; ▪ Recommendations: o Communication equipment; o Language/modality preference; and o Communication/programming instructions. The following domains and/or guidance should be incorporated into the SL Evaluation and SL Evaluation Update template: ▪ Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, and current and/or future therapeutic intervention; ▪ Functional reading skills and literacy; ▪ Assessment process should be sufficiently discreet to identity an individual's functional skills, interests and preferences via observation and clinical	

#	Provision	Assessment of Status	Compliance
		assessment; ▪ Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition; ▪ Discussion of efficacy of formal and informal functional communication strategies; ▪ Analysis of findings to provide a rationale for functional recommendations and intervention strategies; and Additional guidelines to ensure: ▪ Integration of recommendations into an individual's PSP; ▪ Documentation to justify initiation, continuation or discontinuation of direct and/or indirect therapy supports; and ▪ Process for implementing change in an individual's supports when progress is made or there is a lack of progress. The lack of progress should identify a re-evaluation timeframe. To ensure SLPs use a consistent approach during the evaluation process, additional guidelines should be developed to supplement the format. Also, to ensure SL Evaluations follow established guidelines, the Facility should develop and implement an audit protocol. In addition, the development of procedures defining the SL update process when an individual experienced a change in status would be beneficial. <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> In none of one record reviewed (Individual #276) (0%), for an individual reported to be receiving direct speech therapy services, were measurable, functional outcomes developed and documented on a monthly basis. Individual examples are provided with regard to Section R.1. 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 also were provided above with regard to Section R.1 of the Settlement Agreement. As noted above with regard to Section R.1, SLPs were completing evaluations that did not recommend direct and/or indirect therapy supports for individuals who presented with severe communication deficits, but had documented strengths, potentials, and abilities for functional communication. 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 successfully utilize	

#	Provision	Assessment of Status	Compliance
		the device in a variety of natural environments. The integration of functional communication recommendations on a formal (skill acquisition programs) and/or informal basis (integrated into daily activities) within an individual's PSP and multiple environments is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis. <u>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.</u> None of the eight records reviewed for individuals with BSPs (Individual #276, Individual #25, Individual #306, Individual #140, Individual #288, Individual #4, Individual #264, and Individual #119) documented collaboration between the psychologist and SLP in the development of the Behavior Support Plans within the PBSP, SL Evaluation, and/or a SLP consultation. For example: ▪ The Behavior Analyst for Individual #140 sent an email to his SLP, dated 3/16/11, acknowledging the development of a PBSP, and asking to use his communication book and add in a daily schedule board. The Behavior Analyst requested input from the SLP in the development of the daily schedule. A review of his PBSP, pending consent, incorporated the use of his communication book and a daily schedule, but the PBSP did not document collaboration with the SLP. A HT Consultation, dated 4/6/10, stated: "During [Residence's] Health Status Meeting, 3/25/10, [Individual #140's] home psychologist requested more recognizable symbols for 'I want' and 'I don't want' in his communication book to support his Positive Behavior Support Plan (PBSP)," but there were no consultations to address integration of communication devices into his pending PBSP. ▪ One of the targeted replacement behaviors in Individual #25's PBSP, dated 1/12/11, was defined as communicating his needs through use of signs and/or his communication book/device without displaying aggression, agitation, or SIB. His Speech-Language Update, dated 3/7/11, did not address behavioral considerations for integration of his functional communication devices into his PBSP, nor were there SL Consultations to document collaboration with the psychologist in the development of his PBSP. ▪ A targeted replacement behavior identified in Individual #264's PBSP, dated 6/28/10, was functional communication training, defined as "[Individual #264] will use his sensory key chain with pictures of sensory activities, as well as two mand cards, one indicating readiness to eat at meals and one to seek staff assistance to solve problems and meet needs, to learn to communicate what he wants, what he wants to stop and what he needs (i.e., sensory, escape from activity, desired items) previously obtained by the target behaviors." His Speech Language Update, dated 12/13/10, did not present behavioral considerations	

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		related to integration of communication devices into his PBSP, nor were there SL Consultation(s) to address collaboration with his psychologist in the development of his PBSP. <u>Policy exits that outlines assessment schedule and staff responsibilities.</u> The Facility did not have a policy that outlined an assessment schedule and staff responsibilities.	
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.	For individuals with intellectual disabilities, the use of AAC devices has the ability to change the way an individual is able to communicate their needs in the classroom, home, work, and leisure environments, through increasing participation, making choices, and enhancing functional 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. Speech language pathologists should provide sufficient competency-based training and instructional support to staff to provide them with foundational skills and stated competencies to support individuals in the utilization and implementation of individual-specific and generic functional communication devices in multiple natural environments. <u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.</u> None of the 11 records reviewed (Individual #306, Individual #140, Individual #288, Individual #4, Individual #264, Individual #132, Individual #25, Individual #276, Individual #53, Individual #119, and Individual #168) (0%) had a clear rationale and description of communication interventions integrated into the PSP. <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> Communication interventions were not integrated into individuals' daily schedules. <u>AAC devices are portable and functional in a variety of settings.</u> None of the seven PNMPs reviewed (Individual #140, Individual #4, Individual #132, Individual #25, Individual #276, Individual #53, and Individual #168) (0%) reinforced the use of AAC devices that were portable and functional in a variety of settings (i.e., mealtime, work, leisure, residence, and community outings). <u>AAC devices are individualized and meaningful to the individual.</u> For the one individual receiving direct speech services (Individual #276), the record did	Noncompliance

#	Provision	Assessment of Status	Compliance
		not indicate how the direct speech language services would be individualized, and did not encourage the use of speech generating devices beyond the direct speech services sessions to ensure these devices were meaningful and functional for the individual. In addition, the one individual record did not document the use of individual communication equipment in the individual's residence. The one record reviewed (Individual #276) did not have formal communication programs developed with individualized strategies to be implemented by staff to reinforce what was being learned in direct speech therapy related to the individual's AAC device. 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/or provide multiple opportunities to practice the use of their AAC device. <u>Staff are trained in the use of the AAC device.</u> The one individual record reviewed (Individual #276) (0%) did not include competency-based staff training documentation. 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. Competency-based training should require staff to demonstrate both of these sets of skills. Habilitation Therapies attended Integrated Meetings at 520 South Cedar Avenue (Willow) to support an integrated approach for functional communication. Six Integrated Meetings had occurred (8/24/10, 9/2/10, 10/12/10, 1/11, and 3/22/11), but no formal plan had been developed. There were discussions related to the development of an action plan during the 10/12/10 Integrated Meeting. The Monitoring Team recommended the development of an action plan to be implemented within the residence. The plan should be developed using an interdisciplinary problem-solving approach leading to the development and implementation of measurable, observable outcomes. The plan should support the implementation of functional communication for individuals with staff support within an individual residence leading to an expansion to multiple environments, such as work, leisure activities, and experiences within the community. The Monitoring Team will continue to review this project during the next onsite review.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and	<u>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.</u> The Facility did not have policies/procedures to define the current speech equipment (AAC) monitoring process.	Noncompliance

#	Provision	Assessment of Status	Compliance
	implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	The AAC Individual Equipment Monitoring Form was completed to determine if the communication device was "present, clean, in-use, staff demonstrated and a section for comments." The second page of the form had sections for staff signature, training provided, competency (verbal and/or demonstration), date, concerns, actions taken and notification. There were no instructions provided on the form. None of the 11 individual records reviewed (Individual #306, Individual #140, Individual #288, Individual #4, Individual #264, Individual #132, Individual #25, Individual #276, Individual #53, Individual #119, and Individual #168) documented a consistent approach to monitoring communication devices. The following individual concerns were noted: ▪ Individual #276's AAC Individual Equipment Monitoring Form, dated 12/13/10, documented his pocket communication book was not present. There were no other monitoring forms completed. The assistive equipment and/or communication sections of his PNMP, dated 1/31/11, did not list a pocket communication book. ▪ Individual #119's Speech-Language Update, dated 2/23/11, documented a communication dictionary located in her "All About Me Book." There was no monitoring form completed to determine the presence or use of her communication dictionary, nor did she have a PNMP that included this communication device. ▪ Individual #25's AAC Individual Equipment Monitoring Form, dated 12/13/10, listed a communication book, but documented his book was not present. The monitoring form did not list his Palmtop 3 speech-generating device or communication dictionary. His PNMP, dated 1/13/11, did not list his communication book or communication dictionary. ▪ Individual #140's AAC Individual Equipment Monitoring Form, dated 2/14/11, documented his communication book and U-shape communication placemat were present, and in use, but not clean. His communication card for "sick" was present, and clean, but not in use, and staff could not demonstrate its use. On the form for Individual #140, no comments and/or resolution for staff non-compliance were noted. ▪ Individual #168's AAC Individual Equipment Monitoring Form, dated 1/25/11, documented his adapted radio, jellybean switch, and switch latch timer were present, clean and in use, but the monitoring form did not identify the function, condition, and effectiveness of his AAC equipment. ▪ Individual #132's AAC Individual Equipment Monitoring Forms, dated 12/8/10, 12/9/10, 12/14/10, and 2/15/11, documented that his visual schedule was not present. There was no resolution for his visual schedule not being present.	

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		▪ Individual #53's AAC Individual Equipment Monitoring Form, dated 1/23/11, documented her DynaVox SGD was present, clean, and in use. The monitoring form did not track the presence of her communication dictionary. ▪ Individual #264's Speech-Language Update, dated 12/13/10, identified his communication equipment as two choice communication boards, and choice communication cards. No AAC monitoring had been completed for his communication devices. Individual #264 did not have a PNMP to address his communication devices and/or strategies for staff. ▪ Individual #288's AAC Individual Equipment Monitoring Form, dated 2/14/11, documented his grooming visual schedule was present and in use. His daily visual/choice schedule was not present or in use. The comments section acknowledged: "[Individual #288] choose not to use his daily visual schedule," but there were no further comments to address this issue and/or make a referral to a SLP. ▪ Individual #306's AAC Individual Equipment Monitoring Form, dated 2/15/11, affirmed his Talking My Way Object/Symbol Communication Board was not present or in use, but was clean. The comments were illegible. ▪ Individual #4 had a communication dictionary and a picture/sign communication book. His AAC Individual Equipment Monitoring Form, dated 12/13/10, indicated his picture sign communication book and communication card for "thank you" were not present. There were no additional monitoring forms, and no resolution of the issue related to the communication equipment not being present. None of the 11 individuals' (Individual #306, Individual #140, Individual #288, Individual #4, Individual #264, Individual #132, Individual #25, Individual #276, Individual #53, Individual #119, and Individual #168) AAC Individual Equipment Monitoring Forms equipment completed documented the presence of all of their communication equipment and monitored the equipment for function, condition, and effectiveness of the AAC equipment. Habilitation Therapies should complete an analysis of all current documents (i.e., PNMP) and monitoring forms related to communication devices to ensure consistency across all documents. For example, communication dictionaries were not incorporated into the communication equipment monitoring forms. The Facility Speech Language monitoring policy should incorporate the following: ▪ Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual; ▪ Monitoring forms that include instructions for individual monitoring indicators	

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		to support consistency and inter-rater reliability; ▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability; ▪ Formal schedule for monitoring to occur; ▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; ▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and ▪ Establishment of thresholds for staff re-training. Facility Administration, in collaboration with the SLPs, should continue to problem-solve and identify solutions to significantly increase staff compliance with utilization of individual communication systems. Furthermore, SLPs should continue to monitor individual's current communication devices to ensure they are effective to support functional communication. <u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.</u> The individual record sample documented that equipment monitoring occurred in the individual's residence only. <u>Validation checks are built into the monitoring process and conducted by the plan's author.</u> There was no evidence that validation checks were built into the monitoring process and conducted by the plan's author.	

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

1. The Habilitation Therapies Department should finalize the analysis of SLP staffing needs, and collaborate with Facility Administration to develop strategies to achieve reasonable SLP staff-to-individual(s) caseloads.
2. As recommended with regard in Section O.1, therapists should attend state-sponsored continuing education courses. In addition, SLPs should increase attendance at continuing education related to augmentative/alternative communication.
3. Progress notes should be completed, and should justify the initiation, continuation or discontinuation of speech therapy supports, including an analysis to determine the efficacy of the direct therapy supports provided. If progress was not made, recommendations and/or objectives should be revised.
4. The individual evaluation timelines included in the LBSSLC Protocol for Communication should be re-evaluated. For example, individuals assigned a Priority 2 status were assigned evaluation completion dates prior to an individual's evaluation date who had been assigned Priority 1 status was incongruent. Individuals assigned Priority 1 status should have evaluations completed prior to individuals within Priority 2 status.
5. The following domains and/or guidance should be incorporated into the SL Evaluation and SL Evaluation Update template:

a. Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, and current and/or future therapeutic intervention;
b. Functional reading skills and literacy;
c. Assessment process should be sufficiently discreet to identity an individual's functional skills, interests, and preferences via observation and clinical assessment;
d. Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition;
e. Discussion of efficacy of formal and informal functional communication strategies;
f. Analysis of findings to provide a rationale for functional recommendations and intervention strategies; and

Additional guidelines to ensure:

a. Integration of recommendations into an individual's PSP;
b. Documentation to justify initiation, continuation or discontinuation of direct and/or indirect therapy supports; and
c. Process for implementing change in an individual's supports when progress is made or there is a lack of progress. The lack of progress should identify a re-evaluation timeframe.

6. To ensure SL Evaluations follow established guidelines, the Facility should develop and implement an audit protocol.
7. Procedures should be developed defining the SL update process when an individual experiences a change in status.
8. Individual communication programs should be integrated into PSPs through skill acquisition programs, as well as their BSPs to ensure the AAC device is meaningful to the individual and they have a voice in multiple environments.
9. Habilitation Therapies should reevaluate the Engagement/Integration pilot initiative. The project should be used to promote interdisciplinary planning in the development and implementation of an environment that supports and encourages functional communication throughout the 24-hour day, including the implementation of individual communication strategies, such as AAC devices, as appropriate, in addition to generic devices.
10. Habilitation Therapies should complete an analysis of all current documents (i.e., PNMP) and monitoring forms related to communication devices to ensure consistency across all documents. For example, communication dictionaries were not incorporated into the communication equipment monitoring forms.
11. The Facility Speech Language monitoring policy should be modified to incorporate the following:
    a. Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual;
    b. Monitoring forms that include instructions for individual monitoring indicators to support consistency and inter-rater reliability;
    c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    d. Formal schedule for monitoring to occur;
    e. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    f. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
    g. Establishment of thresholds for staff re-training.
12. Facility Administration, in collaboration with the SLPs, should continue to problem-solve and identify solutions to significantly increase staff compliance with utilization of individual communication systems.

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 Active Treatment Organizational Chart; o LBSSLC – IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring, dated 2/11/11; o Community Outing Summary, monthly data from September 2010 through February 2011; o Community Integration Reports for each residence, as available, from September 2010 through February 2011; o Summary engagement data of Active Treatment Monitoring/Coaching Tool across residential programs from September 2010 – January 2011; o New monitoring tools used by active treatment staff to document competency training and direct observation related to engagement and active treatment, including skill acquisition programming; o Sample of completed Active Treatment Probing Tools completed at 523, 526, 527, 520, 515, and 516 in February 2011; o LSSLC Active Treatment Monitoring/Coaching Tool; o Sample of completed Active Treatment Monitoring/Coaching Tools completed October 2010 – January 2011; o Program Observation Drill summary data grid across all residential programs for December 2010 and January 2011; o List of individuals who attend each day/vocational program; o Description of Vocational and Day Programs; o LBSSLC Person Served Employed Off-Campus – Number of Hours Worked Per Week and How They Are Supported; o Personal Focus Assessment (PFA) rubric; o Skill Acquisition Program Strategy Sheet, revised 12/7/10; Performance Documentation, revised 9/10; Performance Probe, Skill Acquisition Plan Data Graph, and Maintenance Sheet; o Skill Acquisition Plans Responsibility; o Preference Assessment – Dual Presentation Data Form, and related process notes; o Skill Acquisition Program Training Power Point Slides, including example Strategy Sheet; o In-service Training form, evidence of Skill Acquisition Program Training for pilot homes, dated 3/9/11; o Sample skill acquisition programs for Individual #513, and Individual #527, dated 12/7/10; o Specific Program Objectives (SPOs), as well as associated SPO data for the last three months, as available, for: Individual #51, Individual #75, Individual #94, Individual #100,

	Individual #103, Individual #118, Individual #127, Individual #140, Individual #161, Individual #242, Individual #254, and Individual #304; o Personal Support Plans, Personal Focus Assessments, Positive Assessment of Living Skills (PALS), Vocational Assessments, and Monthly/Quarterly Reviews, as available, for: Individual #38, Individual #318, Individual #173, Individual #127, Individual #100, Individual #306, Individual #108, Individual #66, Individual #94, Individual #161, Individual #103, Individual #271, Individual #174, Individual #118, Individual #242, and Individual #315; o Data on competitive and supported work, including off and on-campus settings, and related individual schedules, revised 3/22/10, 9/15/10, 2/11/11, and 3/27/11; and o Breakdown of Current Contracts, revised 9/1/10 and 11/5/10. ▪ **Interviews with**: o Tracy Murphy, Residential Services Coordinator, and two Unit Directors, exploring potential on-campus placements to reduce Pica, on 3/28/11; o Jim Forbes, Director of Behavioral Services, on 3/28/11, 3/29/11, and 3/30/11; o Lola Walker, QMRP Coordinator; Marisol Gonzales, ISP Coordinator; Rodshadi Moore, Active Treatment Supervisor; and Melissa Moore, Psychologist, on 3/29/11; o Tracey Murphy, Residential Service Coordinator; Rodshadi Moore, Active Treatment Supervisor; and Active Treatment Coordinators, including Erika Flores, Adrian Richardson, Stephanie Garcia, and Kimberly Scott-McGruder, on 3/30/11; o Psychologists including: Carolyn Milton, Philip Kite, Melissa Moore, Lamecca Abduljaami, Teresa Balawejder, Christina Sosa, Ronald Flint, Michelle Hutton, Krista Leubner, and Beckie Crawford, on 3/30/11; o Psychology Assistants including: Nicole Johnson, Anna Shackelford, Amber Flores, Blake Perez, and Jamie Trevino, on 3/30/11; o Interdisciplinary meeting with psychology, speech and OT staff, on 3/30/11; o Teresa Balawejder, BCBA and Melissa Moore BCBA, on 3/30/11; o Laura Anciso, Director of Vocational and Day Programs; and Rosie Driver, Supportive Employment Coordinator, on 3/31/11; o Mary Ortiz, Direct Competency Training and Development, on 3/31/11; and o Laura Anciso, Director of Vocational and Day Programs, on 4/1/11; ▪ **Observations of**: o Pica Reduction Committee Meeting, on 3/28/11; o Restraint Reduction Committee Meeting, on 3/29/11; o Behavior Support Committee Peer Review Meeting, on 3/31/11; o Onsite direct observation and/or interaction with direct support professionals, and other professionals including, for example, Residence Coordinators, Psychologists, Psychology Assistants, Home Team Leaders and Assistant Home Team Leaders, Active Treatment Staff, and/or QMRPs were conducted throughout the day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Estacado Industries Residential Services, on 3/28/11; ▪ Aspen (513), on 3/28/11 and 3/29/11;

	▪ Birch (514), on 3/28/11 and 4/1/11; ▪ Elm (515), on 3/29/11; ▪ Fir (516), on 3/29/11; ▪ Maple (517), on 3/29/11; ▪ Oak (518), on 3/29/11; ▪ Violet (523), on 3/30/11; ▪ Willow (520), on 3/31/11; ▪ Zinnia (528), on 3/31/11; ▪ Iris (527), on 4/1/11; ▪ Estacado Industries Workshop, on 4/1/11, and; ▪ Tulip (526), on 4/1/11.
	Facility Self-Assessment: The Facility had developed a Plan of Improvement with regard to Section S of the Settlement Agreement. The POI contained outcomes, action steps, required evidence, Facility target dates, completion status, a determination of non-compliance (N) or substantial compliance (S), and additional comments. The POI included two action plans and the associated action steps, evidence, start/target dates, and completion status. According to the POI, the Facility reported that the two action plans were still in progress, although, some specific action steps had either been completed or not started yet. These activities are discussed as appropriate throughout the remainder of this section. The Facility developed a self-assessment tool based on the Monitoring Teams' Section S rubric. Currently, no data was provided to reflect active use of this monitoring tool. According to the POI, LBSSLC indicated that it was in noncompliance with Sections S.1, S.2, and S.3. These findings were consistent with the Monitoring Team's review.
	Summary of Monitor's Assessment: Limited progress had been made in providing habilitation training, and specifically with regard to skill acquisition programs being developed and implemented to promote growth, development, and independence for all individuals. An initial pilot examining the development, implementation, and monitoring of new skill acquisition programs (SAPs) was discontinued and a second pilot was started recently. This second pilot appeared to be supported by professionals from behavioral services and revisions to the SAP format and process, including the responsibilities of several PST members, had been made. At the time of the current review, only a limited number of sample SAPs were available for review. Policy and procedures related to the competency-based training of direct support staff in implementing SAPs, as well as related on-going monitoring appeared to require additional specification and support. Progress had been made in developing a system for completing preference assessments in association with SAPs. The new assessment appeared to have been integrated within the PFA process. The new PFA format appeared to be well integrated within the PSP process. Estimates of engagement reflected moderately high levels during on site observations. However, this included many instances where individuals were passively engaged. Observations also evidenced low staff-

	to-individual ratios across some sites. Limited increases in on-campus and off-campus vocational opportunities were observed. The number of individuals employed in competitive positions did not change. Recent data evidenced a decrease in community integration for some residential programs. Sampled documentation suggested fewer skill acquisition programs targeting implementation in community settings. However, these plans appeared to more integrated within on-campus vocational settings.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Limited progress had been made in regard to providing adequate habilitation training with regard to skill acquisition programs developed and implemented to promote growth, development, and independence for all individuals. As previously reported following both of the Monitoring Team's previous reviews, skill programs (i.e., Specific Program Objectives, or SPOs) were found to be inadequate. That is, plans were found to vary in detail and comprehensiveness and, consequently, appeared vague and lacking sufficient specificity for their adequate implementation by direct support professionals. Many of the sampled SPOs did not typically include: 1) an operational definition of the target behavior (i.e., what is 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. In response to these concerns, revisions within the PSP processes, including changes to how skill acquisition plans were developed, implemented, and monitored, were reported during the previous compliance visit. At that time, the Director of Active Treatment reported the development of a new local policy (i.e., 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, which were now referred to as Skill Acquisition Plans or SAPs (e.g., Skill Acquisition Plan Guidelines, LBS Strategy Sheet, and Performance Probe). The PST, through the PSP process, determined the SAPs. More specifically, the PST utilized information from the completed Personal Focus Assessment (as described in the State Supported Living Centers Procedures – Personal Focus Assessment Policy and Personal Support Plan Instructions, dated 07/23/10), as well as other assessments to develop the Personal Support Plan (PSP), which served as the basis of active treatment programming for each individual. Through this process and document, the PST identified the goals/objectives that the SAPs targeted.	Noncompliance

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		At the time of the Monitoring Team's previous visit, the newly developed SAP format appeared to be an improvement over the previous SPO format. The new format appeared thoughtfully developed through the 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, these included the: 1) integration of the objective with the overall goal; 2) inclusion of a behavioral objective; 3) identification of a method of training, including forward, backward or total task chaining; 4) determination of a schedule of training; 5) provision of relevant discriminative stimuli; 6) specification of consequences for correct and incorrect responding; 7) identification of a criterion for mastery; and 8) programming for generalization and maintenance. In general, development of the new SAP format appeared to be very positive, and had the potential to improve significantly the quality of the skill acquisition programs at LBSSLC. Unfortunately, at the time of the previous compliance visit, there were no new SAPs completed and, consequently, none were available for review. At that time, the new SAP format and related procedures were being "piloted" in three residential programs (i.e., Aspen, Violet, and Iris), and no new SAPs had been completed. Surprisingly, according to verbal reports at the time of the most current monitoring visit, the initial pilot had been discontinued. According to current verbal reports, the initial pilot was not implemented as planned due to "confusion" between leadership and the professional staff responsible for developing and implementing the new SAPs. That is, verbal descriptions suggested that there was likely inconsistent coordination, inadequate training, and inadequate data collection. This situation might have been influenced by a change in the administrative structure within Active Treatment department. That is, the previous Director recently took a position at another facility, and the position of Director of Active Treatment was phased out. Subsequently, the decision was made to initiate a second pilot of the new SAP format and process. At the time of the current review, four residential programs (i.e., 518, 523, 521, and 520) had been identified for inclusion within the second pilot. According to staff report, the collaborative efforts of professionals from several departments (i.e., active treatment staff, QMRPs, and behavioral services) led to the further refinement of the SAP format, as well as monitoring documentation. At the time of the review, this process involved the utilization of a Strategy Sheet, Performance Documentation sheet, and the Skill Acquisition Plan Data Graph. Staff responsibilities within programs selected for this pilot included: Psychologist/BCBA, who was responsible for writing the SAP, and for revising the plan once the goal had been met or the plan required revision; Home Team Leader, who had responsibility for ensuring staff they supervised were implementing and	

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		documenting performance on the SAPs; Active Treatment Coordinators and Residence Coordinators, who were responsible for monitoring the integrity of implementation and documentation of SAPs; and QMRPs, who in addition to monitoring the implementation and documentation of SAPs, would develop the monthly progress note. Documentation provided evidenced the development of a training curriculum (PowerPoint slides, handouts, activity) targeting habilitation, training, education, and skill acquisition programs. It appeared that on 3/9/11, 21 staff from the identified pilot homes attended initial training on the new skill acquisition process. Documentation also indicated that a few sample skill acquisition programs had been developed (e.g., for Individual #116 and Individual #77). However, these appeared to be associated with the initial pilot (i.e., these individuals did not live in residences identified as part of the second pilot). These examples, although an obvious improvement over previous SPOs, continued to evidence inadequacy in a number of areas, including: 1) identifying a measurable objective; 2) identifying mastery criteria; 3) identifying initial prompt level and change criteria; 4) specifying reinforcer delivery following correct responding; and, 5) specifying change in prompt level following an incorrect response. Only taking data once or twice a week also was problematic. More specification should be added to the Strategy sheet, including, for example: 1) provide a box that staff could choose if training was conducted in the community; 2) specify that the reinforcer was provided following correct responding (also need to identify which prompt level was included in the mastery criterion); 3) provide specification regarding "reinforcer schedule" (it was unclear what to this referred); and 4) specify "incorrect response", not "inappropriate response," as listed. Given the fact that limited progress had been made in developing and implementing SAPs utilizing the new standardized format, specific program objectives, and related SPO data were reviewed for a small sample of individuals (N=12). This sample was 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 previous review. In general, the current review evidenced similar findings previously observed during the baseline review and compliance visit. These included the lack of: 1) an objective, measureable, operational definition of the skill being targeted for acquisition or maintenance; 2) specific detailed teaching steps based on a task analysis; 3) detailed instructions on the use differential reinforcement, including the use of specific reinforcers (i.e., other than verbal praise); 4) detailed instructions on how to introduce and fade necessary prompts; 5) instructions for error correction; 6) use of discriminative stimuli, such as an initial instruction or other relevant stimuli; 7) programming for maintenance and/or generalization; and/or 8) sufficient trials per day	

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<tr><td></td><td></td><td>or week to promote acquisition and maintenance.

It should be noted that the Facility had been responsive in addressing issues related to the use of individualized reinforcers, and the need to conduct regular preference assessments. Documentation evidenced multiple meetings, active examination (trials) of a dual presentation (choice) preference assessment format with multiple individuals (four individuals from 515), and the development of a standardized process and data format. It appeared that on 2/9/11, approval was obtained to integrate this assessment within the PFA process.

Consistent with findings of the Monitoring Team's previous reviews, the method in which skill acquisition plan data was collected and summarized continued to be inadequate. At the time of both these reviews, skill programming data was not displayed in tables or graphs, thereby making efficient interpretation of progress over time challenging. Currently, data was still not displayed in a format (i.e., table or graph) that would facilitate efficient analysis of individual performance on skill acquisition programs.

Given the above findings, it continued to be unlikely that the majority of skill acquisition programs were currently promoting growth, development, and independence across most individuals served at LBSSLC. Proposed changes, if they occur, appeared likely to facilitate the development of more rigorous and fundamentally sound skill acquisition programs and monitoring.

As similar to the two previous monitoring reviews, observations were conducted during brief onsite visits to estimate the level of engagement, as well as staffing ratios across random residential and day/vocational programs. Engagement was measured 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 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 observed level of engagement (number of individuals engaged to total number of individuals) in relation to staff-to-individual ratios across program sites.

Engagement and Staffing Ratio Observations

<table>
<tr><th>Location</th><th>Engaged</th><th>Staff-to-individual ratio</th></tr>
<tr><td>EIRS</td><td>7:7</td><td>4:7</td></tr>
<tr><td>Aspen</td><td>6:7</td><td>2:7</td></tr>
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Aspen	3:4	2:4
Birch	3:3	0:3
Birch	3:3	1:3
Elm	5:6	1:6
Elm	6:7	1:7
Fir	2:2	1:2
Fir	1:1	1:1
Fir	1:2	0:2
Maple	----	1:9
Maple	----	1:5
Maple	----	2:8
Oak	1:11	1:11
Aspen	7:7	2:7
Aspen	4:4	2:4
Willow	3:3	2:3
Tulip	2:2	0:2
Birch	2:2	1:2

According to collected data, during brief residential visits, overall engagement was 79%. An engagement level of at least 75% would be a typical target for a facility like LBSSLC. However, it should be noted that this percentage is likely an overestimate of the level of engagement occurring across the Facility. More specifically, at least one television was on in every setting where observations occurred. This was true even in a setting (Oak) where the television appeared to be malfunctioning. In many cases, individuals were orientated toward the television and were scored as "engaged." Although in many of these situations, it was difficult to assess whether or not individuals were really attending to the current program. Observations across settings did evidence available materials and resources for individuals to utilize (e.g., electronic keyboards, monopoly, etc.). However, direct support professionals did not offer these materials as options to individuals in multiple settings.

Overall, observations provided mixed findings with regard to the nature of engagement and staff-to-individual interactions. In some settings, direct support professionals appeared to energetically encourage individuals to actively participate in activities. This included multiple observations, for example, where direct support professionals encouraged individuals to participate in household "chores," choosing television shows, taking a turn at a game, and/or utilizing augmentative devices to assist with effective communication. Once again, a high level of engagement was observed in the EIRS setting. In other settings, however, direct support professionals appeared more interested in the activity at hand, rather than encouraging individuals to participate in the activity, or staff

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		were more interested in reading case notes than interacting with individuals. In one setting, direct support professionals did not appear to interact with two individuals seated in a living room area during the Monitoring Team's entire observation. The staff-to-individual ratios observed in some settings were concerning. The ratios evidenced at Elm, Maple, and Oak were clearly inadequate to support active engagement, or participation in more structured opportunities for skill acquisition. Although engagement might have been estimated as high, it was only due to individuals' passive engagement (watching television), and did not reflect meaningful interaction with staff or available materials. Often during these observations, the staff-to-individual ratios would improve the longer the member of the Monitoring Team was in a particular setting. As previously reported, an LBSSLC policy, dated 6/30/10, outlined 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. At the previous compliance visit, it was reported that these tools had been implemented. However, at that time, summary data was not available. Currently provided documentation indicated that the Active Treatment Monitoring/Coaching Tool was utilized between September and January 2011, across all residential programs. Average (and range) monthly engagement scores for September, October, November, December, and January were 84% (67 to 97%), 84% (64 to 100%), 92% (67 to 100%), 94% (76% to 100%), and 90% (58 to 100%), respectively. Review of these scores indicated that several residences (i.e., 518, 523, 526, and 527) consistently reflected the lowest engagement estimated scores. These findings were consistent with direct observation during recent site visits at Oak (low engagement), as well as Tulip (low staff-to-individual staffing ratio). Data from Program Observation Drills collected in December 2010 and January 2011 across all residential programs was also provided. Review of the summary data evidenced lower scores across some residences with regard to: 1) the trainers' knowledge of individual's skill acquisition programs; 2) collecting skill acquisition data accurately; and 3) collecting skill acquisition data as scheduled. Five of the six lowest performing residences according to the December (i.e., 515, 516, 520), and January (i.e., 520, 523, 526) observation drills were identified for further examination using Active Treatment Probing Tool. This is discussed in further detail below. Surprisingly, verbal reports from the Active Treatment Supervisor indicated that the use of the Active Treatment Monitoring/Coaching Tool to measure engagement had been "suspended" in February in order to devote more time to training, and the implementation of competency-based training of SPO/SAPs. Although directing	

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		resources toward improving the integrity of skill acquisition programming was certainly important, consistent monitoring of engagement should not be overlooked. Engagement monitoring should continue, especially in sites previously identified as problematic. Efforts to improve training regarding skill acquisition programming resulted in the development of the Level of Engagement rubric, SPO Training rubric, and the Active Treatment Probing Tool. According to the Active Treatment Supervisor, the Active Treatment Probing Tool was developed and implemented initially at six sites that appeared most problematic, these included 515, 516, 520, 523, 526, and 527. The probes included examining engagement, as well as issues related to showering, dressing, grooming, and mealtimes. Observations were conducted across approximately eight to nine days, during two-hour sessions across all identified sites. Review of raw data appeared to suggest that many of the issues identified were consistent with recent observations of the Monitoring Team. That is, that recreational and/or leisure materials were present, but not utilized, televisions were typically on, and, at times, staff were not actively engaging the individuals. These probes appeared limited by the lack of additional items related to engagement (e.g., staffing ratios), and many of the data sheets were not fully completed (i.e., "NA" was answered for many of the items related to self-care). However, notes on many of the probes indicated that the observations were helpful in identifying barriers to engagement. A summary of the results and related implications, as well as a description of how these findings were integrated, if at all, into policy, training, or other area of current practice was unclear. If the use of these probes are continued, the tools should be expanded to, for example, include additional items related to engagement, including staff-to-individual ratios, number of targeted SAPs implemented, nature of engagement (active or passive), and/or identification of reinforcers used to reward participation. As presented above, the use of any new monitoring tools and/or procedures should be outlined in current Active Treatment policy (i.e., IDT Program Development: Active Treatment Program Development, Implementation, and Monitoring, dated 2/11/11R). Additional specificity within the policy describing the nature of competency-based training and monitoring will likely assist staff to more fully understand how to effectively implement new procedures. Based on recent discussions with Active Treatment staff, for example, it appeared that there was considerable confusion regarding how often direct support professionals needed to be assessed, on how many SAPs should the assessments be completed, and what criterion to use when determining competency on SAPs. In regard to the vocational/employment settings both on and off the LBSSLC campus, current observations were consistent with those from the previous compliance and baseline reviews. 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	

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		television materials, etc.) that were completed both onsite (i.e., EIWS, EIRS, and Pine workshop), and off-site (i.e., supported enclaves in the community and competitive employment). The enterprise program continued to provide individuals the opportunity to pursue their own creative and business interests, and the "client worker" program allowed individuals to trial new jobs in supported on-campus settings, although some positions were listed as "off-campus." It appeared that the availability of off-campus employment had not improved between the baseline and initial compliance visit. At the time of the previous review, the number of individuals in supported employment, enclave work, or competitive employment had not changed significantly since baseline. As of August 2010, there were five and one individual(s) in supported employment/enclave work and competitive employment, respectively. Currently, according to documentation, there appeared to be approximately seven to nine individuals in supported employment/enclave work, and one individual still in competitive employment. In addition, at the previous compliance visit, it was reported that approximately 17 individuals were involved in the enterprise program. Current estimates suggested that approximately 18 individuals were employed in this program. Lastly, at the time of the previous review, approximately seven to 10 individuals were employed as "client workers." Currently, based on provided documentation, there appeared to be approximately 10 to 18 individuals employed as "client workers." Overall, there appeared to be a slight increase in the number of individuals supported in off-campus enclave settings. This was likely due to an addition of three new enclave sites since February 2011. In addition, there appeared to be a slight increase in the number of individuals supported in on-campus "client worker program," which was likely due to the addition of a new setting (i.e., the diner) on campus. Documentation related to off-campus employment indicated that most individuals worked, on average, less than 2.6 hours per week. More specifically, 20 individuals (i.e., 69% of those identified as working off-campus) appeared to work less than 2.6 hours per week. Of the nine individuals that worked more than 2.6 hours per week, five worked less than 5 hours per week. The remaining individuals appeared to be outliers who worked 10, 13, 25, and 30 hours per week. It should be noted that the Monitoring Team received data that was somewhat inconsistent with regard to individuals attending vocational and day programs (TX-LB-1103-VIII.22), data on individuals who were served/employed off-campus (TX-LB-1103-VIII.23), and data on "client worker" and supported work (TX-LB-1103-PH.20 and 21). It is likely that the first two documents were outdated. However, because they were not dated, it was difficult to determine if the information was current. In addition, it was unclear why individuals identified as "client workers," and who appeared to be only employed within on-campus settings were listed on the "persons served employees off-	

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		campus" summary (i.e., TX-LB-1103-VIII.23). One of the barriers to off campus employment, previously identified during the baseline and last compliance visit, included the lack of sufficient transportation. This was addressed this past December when new vans were delivered. Verbal reports from vocational and active treatment staff indicated that transportation was no longer a barrier to community integration and employment opportunities. However, reports continued to reflect challenges with off-campus employment related to the economy. The Facility should thoroughly examine available community-based opportunities, including vendors and others within the systems the Facility utilizes to identify and place individuals in supported or competitive employment positions. Overall, additional community-based enclave positions, as well as expanded on-campus work opportunities (e.g., increasing trend in available or additional settings and contracts) were evident over the past six months. Successful community-based employment will need to continue to expand as PSTs attempt to place individuals in the most integrated work setting.	
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 after the last compliance visit, 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 implemented in July 2010 (i.e., 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, 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 prior Personal Focus Worksheet: Individualized Assessment Screening Tool. In addition, the use of the PALS continued to be central to the PSP assessment process. In an attempt to estimate how well the new PSP process had been implemented, specific to the completion of PFAs, a review was completed of a sample of documentation for individuals who recently had a PSP meeting (i.e., since the previous compliance visit). In the current sample (N=16), 12 (75%) individuals had completed PFAs. PFAs were unavailable for Individual #306, Individual #108, Individual #271, and Individual #315. However, although the PFAs were available for 75% of the sample, the Monitoring Team found the assessment incomplete for four of these twelve individuals (i.e., Individual #318, Individual #103, Individual #127, and Individual #242). More information is provided below. As reported after the last compliance review, the Positive Assessment Of Living Skills	Noncompliance

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		also was completed annually for each individual to assist with the development of the 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=16), 12 individuals (75%) had current PALS completed. For the remainder of individuals, one of the PALS was not dated (i.e., Individual #318), and one was not provided for another individual (i.e., Individual #173). In addition, two PALS were provided, but appeared outdated (completed in excess of 12 months ago) for Individual #127, and Individual #271. Based on the sampled documentation, examples of concerns regarding completed PFAs, as well as PALS are described below: ▪ Often the PFA document did not appear to be completed adequately. For example, the PFA summary related to important preferences for Individual #318 and Individual #103 was not completed. ▪ The PFA Preferences Summary was not completed, and, in addition, the subsequent assessments (i.e., assessments needed based on identified preferences) were not identified for Individual #127 and Individual #242. Multiple pages were simply missing from the PFA for Individual #174. ▪ A good example of where identified sections of the PALS were completed as recommended within the PFA was found in recent documentation for Individual #100. ▪ As documented within the PFA for Individual #38, it appeared that the PST recommended the completion of three sections of the PALS. However, the entire assessment was completed. This finding was consistent across other individuals as well (e.g., Individual #94). Similarly, for Individual #318, six sections of the PALS were identified for completion, and, of those, only one was completed. Interestingly, other sections not identified for completion were completed. The PFA identified four sections of the PALs to be completed for Individual #66, but only two out of the four sections were completed as recommended. A good example of where this process appeared to work well was found in documentation for Individual #103. ▪ Often it was difficult to determine if the PALS was completed in a timely manner, because the PALS document was not dated. This occurred, for example, for Individual #318. In addition, inconsistency in how the PALS was completed was evident. That is, the table of contents indicated that the money management section was completed, when it had not been completed for Individual #318. In addition, the summary section of the PALS was often not completed (e.g., Individual #318, Individual #242, and Individual #108). As reported during the last visit, a new vocational assessment was under development to replace the previous assessment. According to the Director of Vocational and Day	

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		Programming, the new assessment was more comprehensive, and included a format (i.e., open-ended questions) designed to elicit responses central to vocational/employment issues and vision. At that time, it was reported that, once approved, this new assessment would be adopted statewide. However, there were no completed examples available for review. At the time of this most recent review, it appeared that this new assessment format was still not being utilized. According to recent verbal reports from the Director of Vocational and Day Programming, the previous form was currently still being utilized, and the revised form was still under consideration by State Office. In an attempt to more closely examine the current vocational assessment process, documentation from the same sample was examined with regard to the completion of vocational assessments, as recommended within the PFA and/or PSP. Of the individuals sampled (N=16), six (38%) individuals appeared to have vocational assessments completed in the last 12 months (i.e., Individual #173, Individual #127, Individual #94, Individual #271, Individual #118, and Individual #242). Of these, however, one vocational assessment appeared to be a brief update (i.e., Individual #242), which appeared inadequate. Of the remaining individuals without current vocational assessments, the completion of a more recent vocational assessment appeared to be recommended within the PFA and/or described in the PSP for seven individuals (i.e., Individual #38, Individual #66, Individual #318, Individual #306, Individual #108, Individual #315, and Individual #103). It should be noted that no vocational assessment was provided with sampled documentation for Individual # 315. Lastly, it appeared that the vocational assessments for three individuals were outdated (Individual #100, Individual #174, and Individual #161). However, a vocational assessment was not recommended in the PFA or PSP for these three individuals. Based on the sampled documentation, examples of concerns regarding completed vocational assessments are described below: ▪ Vocational assessments appeared to estimate work attendance. However, it appeared that this estimate was based on a very brief amount of time. For example, attendance was evaluated for Individual #173 only during the vocational assessment period (i.e., approximately five days). An entire year of data should be utilized to evaluate trends in attendance and other important variables. ▪ Vocational assessments (or Vocational Updates) completed for some individuals appeared inadequate. For example, the update for Individual #100, dated 3/1/10, did not provide any descriptive information regarding vocational skills, employment history, and/or rational why the PST recommended that he "stay in the programs." If the vocational assessment was referring to his continued participation in day programming (as opposed to vocational), a brief rationale appeared appropriate.	

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		▪ The vocational assessment provided for Individual #306, dated 1/28/08, as well as vocational updates, dated 1/23/09 and 1/15/10, were not current. In addition, each update recommended completing a reassessment prior to the 2010 PSP. This did not appear to have occurred. ▪ At times, the PSP indicated that the "… Assessment of Vocational Development … was used during the PSP discussion." However, a recently updated vocational assessment was not found for several individuals (e.g., the most recent assessment completed for Individual #66 was in 12/09). ▪ Overall, recommendations listed in the Vocational Assessments appeared to be "boiler plate" and not helpful. That is, they did not appear to be individualized or provide direction to the PST regarding specific issues or concerns related to success within an employment or vocational setting. Many of the recommended items pertained to required employment documentation (e.g., proper identification, tax forms) or the potential for re-assessment (e.g., Vocational Assessments for Individual #108 or Individual #94).	
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 discussed (with regard to Section S.1 and K.11 of the Settlement Agreement), and as consistent with findings at the previous compliance visit, it was unlikely that the majority of skill acquisition programs were currently promoting significant growth, development, and independence across most individuals served at LBSSLC. In addition, the current method in which skill acquisition plan data was collected and summarized continued to be inadequate. However, proposed changes as well as those that recently had been initiated (in the current pilot) 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. The Monitoring Team looks forward to reviewing these changes and the Facility's progress during the next compliance visit.	Noncompliance
	(b) Include to the degree practicable training opportunities in community	Findings from the previous reviews indicated that the majority of individuals did not have SPOs designed for implementation within a community setting. Of the twelve individuals sampled during the last compliance visit, it was found that 50% had at least	Noncompliance

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	settings.	one SPO identifying the community as the setting (or potential setting) for training. This previous finding seemed to suggest greater emphasis on skill acquisition opportunities within the community. Currently, requested documentation regarding a listing of instances of skill training provided in community settings indicated "NONE" (i.e., document request TX-LB-1103-VIII.25). It was initially unclear to the Monitoring Team if this reflected the absence of a summary listing of formal skill training in the community, or the absence of skill training in the community (since the last compliance visit). However, it appears that this data, in some degree, was generally collected, by direct support professionals and summarized within the monthly Community Integration Reports. Unfortunately, upon reviewing these reports, it was difficult to discern which individuals were practicing skills related to formal SPO/SPAs programs. As a result, efforts to offer opportunities for skill programming in community settings appeared to have occurred, but formal data collection and summary of the nature of their implementation was missing. The Facility should collect and summarize this data (number of opportunities, number of programs reflecting success/improvement, etc.). As described with regard to Section S.1 of the Settlement Agreement, skill acquisition programs were reviewed for a limited sample of individuals (N=12). This sample was examined to determine the integration of skill programming within community and vocational/day settings. Of the sample, four (33%) had SPOs that targeted implementation within a community setting. These included, for example, money management programs (e.g., Individual #51 and Individual #100), or healthy food choice/eating programs (e.g., Individual #94 and Individual #103) targeted for completion in the community. This was a lower estimate than determined during the previous compliance review when, at that time, 50% had at least one SPO targeting the community as a potential setting for implementation. While reviewing SPO data sheets associated with these programs, it was challenging to determine if they had been implemented in a community setting. Data collection should include a method for staff to conspicuously record when skill acquisition training was conducted in the community. In the current sample (N=12), six (50%) had SPOs targeted for completion within a vocational setting at either EIRS (i.e., Individual #94, Individual #103, and Individual #254) or EIWS (i.e., Individual #75, Individual #127, and Individual #140). This was an improvement over the previous compliance review, when it was estimated that only 16% of those sampled had SPOs that targeted completion within a work setting. Of those sampled, only one SPO appeared to be targeted for completion with a day programming setting (i.e., Communication SPO for Individual #242). As observed during the previous compliance visit, Active Treatment Coordinators and Supervisors monitored community integration through completion of monthly	

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		community integration reports. Verbal reports indicated that this process continued to be currently in effect. Summary data, based on these reports, reflected an increase in total community outings across residential programs between September and November 2010. However, a decreasing trend in the total number of community outings was evident since that time, from December through February. Upon closer examination, the sharpest declines occurred within several programs within Unit 1 (i.e., Quail, Sparrow, Iris, and Oak). It was unclear if the weather, the recent relocation of certain programs, and/or other variables were the basis for the reduction in opportunities for community inclusion. Indeed, this was a surprising finding as reports indicated that additional vans were finally available in December. Review of Community Integration Reports, as available, during this time period reflected the absence of any community outing data in the months of January and February for Quail, Sparrow, Iris, and Oak. In addition, data within the Community Integration Reports was not consistent with summary data listed during October 2010 (for Quail and Oak), and November (for Quail, Iris, and Oak). That is, according to information recorded within the monthly community integration reports, the summary data listed on the Community Outing Summary appeared inaccurate (i.e., included inflated values). Lastly, as evidenced across the baseline and previous compliance visit, only a very small number of individuals worked in supported employment, enclave, or competitive work settings within the community. At the last review, approximately five individuals (including one in a competitive employment position) were reported to work in these settings, and, as reported at that time, this number had not changed significantly. Verbal reports from the Director of Vocational and Day Programs indicated a slight increase in the number of individuals currently working in enclave settings in the community. More specifically, verbal reports at the time of the current review indicated that six individuals were employed in enclave settings. Although, this total was not consistent with provided documentation (as discussed with regard to Section S.1 of the Settlement Agreement). Verbal reports also indicated recent success in attracting three new enclave employment settings as well. However, these new sites were not listed within summary documentation (i.e., TX-LB-1103-VIII.23). Overall, it appeared that the number of individuals in community based employment positions increased only very slightly since the last review. This is discussed in greater detail with regard to Section S.1 of the Settlement Agreement.	

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

1. The Facility is strongly encouraged to continue with the skill acquisition pilot program at 518, 523, 521, and 520. This process should include active monitoring and collaboration, including opportunities for staff at all levels to participate in critical review and feedback of the new

process and SAPs.

2. More specification should be added to the Strategy sheet, including, for example: 1) provide a box that staff could choose if training was conducted in the community; 2) specify that the reinforcer was provided following correct responding (also need to identify which prompt level was included in the mastery criterion); 3) provide specification regarding "reinforcer schedule" (it was unclear what to this referred); and 4) specify "incorrect response", not "inappropriate response," as listed.
3. Monitoring of engagement should continue. The Facility is encouraged to attempt to examine both active and passive engagement in an effort to ensure that individuals are actively engaged.
4. If the Active Treatment Probing Tools continues to be used, the tools should be expanded to, for example, include additional items related to engagement, including staff-to-individual ratios, number of targeted SAPs implemented, nature of engagement (active or passive), and/or identification of reinforcers used to reward participation.
5. The Facility should thoroughly examine available community-based opportunities, including vendors and others within the systems the Facility utilizes to identify and place individuals in supported or competitive employment positions.
6. The Facility should track and regularly analyze other indicators that reflect efforts at supporting individuals in on-site and, especially, off-site employment opportunities. That is, the number of hours worked in a site, for example, might not accurately reflect the amount of time and resources necessary to offer that opportunity. In addition, tracking the number of opportunities individuals have been provided with new employment options, whether successful or not, might help to more accurately reflect the ongoing support to individuals at the Facility.
7. As LBSSLC continues to implement revisions within the PSP process, including how skill acquisition programs are developed, implemented and monitored, the Facility should provide ongoing guidance to teams on this process, as well as continued feedback on how SAPs should be prioritized, how individual preferences should be incorporated, and how to ensure that this process is conspicuous.
8. As LBSSLC proceeds with implementation of the new SAPs, the Facility should ensure that Active Treatment Coordinators and Supervisors, Psychologists, QMRPs and Residential Coordinators, 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 was being piloted in four residences, and once the pilot is completed and any necessary changes are made to the training, the training should continue across all residential, day and vocational programs.
9. Policies and procedures related to competency-based training for skill acquisition programming and how competency should be assessed should be developed/revised. Collaborative efforts across disciplines (including behavioral services) should continue in an effort to closely examine the nature of competency-based training for SAPs, as well as ongoing monitoring and provide more specification in regard to these processes.
10. 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 both internal review of the PSP process.
11. 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 SPA process, contributions from psychology will likely facilitate a better outcome.
12. Efforts to expand meaningful day and vocational programs in an effort to provide adequate habilitation in the most integrated setting should continue.
13. Efforts to finalize the Vocational Assessment, as well as guidelines for its use should be continued.
14. Efforts should be made to integrate or completion skill acquisition programs in day program, vocational settings, or community based settings. It appeared that the majority of current skill acquisition programs were completed in residential programs. Expectations regarding implementation of skill acquisition programs in these other programs/settings should be added to the current policy.
15. Regular preference assessments, now integrated within the PFA, should be conducted in an attempt to identify more individualized reinforcers.
16. 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, including the specific location off campus, this program was implemented.

17. Additional summary data should be generated regarding community outings to facilitate better examination of the nature of skill acquisition in the community. That is, the data collection procedure should be refined to reflect outings that offered opportunities for SPO/SAP implementation (including data collection). It would be helpful to note this on SPO data sheets as well.

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 For the last 12 months, list of individuals assessed for placement with the following statement: "There is no assessment for placement. The PST refers an individual for transition to the community based upon the results of the living options discussion"; o Since the last onsite review, list of individuals referred for placement; o Since the last onsite review, a list of individuals who have requested community placement, but have not been referred; o Community Placement Obstacles Report – Legally Authorized Representative (LAR) Only, Report Date 9/17/10 through 1/31/11, dated 3/4/11; o Since the last onsite review, a list of individuals who have had a community living discharge plan developed; o Community Placements since 9/17/10; o Since the last review, a list of individuals who have returned from a community placement: "None;" o Since the last review, a list of all deaths, if any, that occurred following transition to the community: "None;" o Since the last onsite review, a list of individuals discharged pursuant to an alternate discharge; o A current list of alleged offenders committed to the Facility following court-ordered evaluations, undated; o Community Placement Obstacles Report (Duplicated Count), dated 3/4/11; o In response to request for analysis of obstacles, the statement that: "The State Office database is near completion. Upon its completion, the Q Coordinator will be in-serviced. The Q Coordinator will then in-service the QMRPs for implementation of the database;" o Community Placement Report, from 9/17/10 through 1/31/11; o Description of how the Facility assesses individuals for placement, undated; o For the last 12 month, a list of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices, undated; o Since the last compliance visit, a list of all training and educational opportunities for staff that address community living, including sign-in sheets; o Lubbock State School Family Association Quarterly Meeting agenda, dated 3/13/11; o LBSSLC Most Integrated Setting Update with sign-in sheets, dated 3/13/11; o Provider Fair flier, for 3/25/11 fair; o LBSSLC Provider Fair, dated 3/25/11, with sign-in sheets; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; o Mental Retardation Authority (MRA) Service Coordinator Community Living Options

	Information Process (CLOIP) Worksheet, undated; o Client Assignment Registration System (CARE) Mental Retardation (MR) Needs blank form; o Avatar Living Options Discussion, dated April 2009; o Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options, revised February 2011; o Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options Guidelines, revised February 2011; o Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 1 and 4 – Planning for Movement, Transition, and Discharge and Alternative Discharges – Review of Community Living Discharge Plan (CLDP), revised February 2011; o Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 1 and 4 – Planning for Movement, Transition, and Discharge and Alternative Discharges – Review of CLDP Guidelines, revised February 2011; o Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post Move Monitoring, revised February 2011; o Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post Move Monitoring Guidelines, revised February 2011; o PSPs and related assessments for the following individuals: Individual #37, Individual #38, Individual #116, Individual #184, and Individual #215; o Special Review Team Documentation Community Placement Return for Individual # o Community Living Discharge Plans, PSPs, and related assessments for: Individual #11, Individual # 54, and Individual #206; o Since the last onsite review, a list of all post-move monitoring visits completed, undated; o Pre-Move and Post-Move Monitoring Checklists for: Individual #11, Individual #54, and Individual #206; o Draft LBSSLC Most Integrated Setting Policy, dated 2/28/11; o Psychiatrist's notes from 3/24/11 meeting regarding Individual #159; o CLOIP for Individual #159, undated; o Plan of Improvement/Self Assessment for Section T, dated 3/14/11; o Plan to Increase Community Referrals, dated 3/18/11; o QMRP Department Meeting Agenda, dated 3/18/11; 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 Marisol Gonazales, ISP Coordinator; and

	○ Lola Walker, QMRP Coordinator. ▪ **Observations of**: ○ PSP Meeting for Individual #92.
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section T of the Settlement Agreement, the Facility found that it remained out of compliance with the majority of the indicators. However, it was not clear that the conclusions drawn were based on objective data. Generally, the Facility's findings were consistent with that of the Monitoring Team. Both LBSSLC and the Monitoring Team found compliance with Section T.1.c.2, related to identifying the staff responsible and timeframes for completing action steps in the CLDPs, and T.1.h, related to the submission of a Community Placement Report. The Monitoring Team found the Facility in compliance with one provision with which the Facility had not found itself in compliance. Specifically, the Monitoring Team found compliance with Section T.1.c.3, which requires teams to review CLDPs with individuals and their guardians. Although Facility staff explained that, in addition to data from monitoring efforts, staff's judgment about whether compliance had been achieved also was used in making decisions about compliance in the self-assessment, the POI did not provide a rationale for these decisions. For example, with regard to Section T.1.c.3, it appeared that Facility staff had reviewed the same data as the Monitoring Team, but there was a discrepancy in the conclusions drawn. The Facility noted in the POI that two of the three individuals who recently transitioned had guardians, and the two guardians participated in the CLDP process. All three individuals participated. However, the Facility found itself out of compliance with this provision that requires that the CLDP be "reviewed with the individual and, as appropriate, the LAR…" In other instances, it appeared that the Facility's reviews were addressing the presence of an item, as opposed to the quality of the support or service. For example, the Facility cited data for Section T.2, which addresses post-move monitoring, indicated 100% compliance with the completion of monitoring. However, no comments were provided in the Facility's POI related to the quality of the monitoring. As noted below, the Monitoring Team had concerns about the quality of the monitoring.
	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 obstacles often listed areas of need 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. Obstacles had not yet been analyzed, which will be an essential support in developing plans to overcome them on a more systemic level.

	The Facility had begun to use the new Community Living Discharge Plan (CLDP) process. It was resulting in better documentation of many of the planning efforts. The CLDPs reviewed included essential and non-essential supports. However, the Facility continued to be continued to be refining this process. Teams did not consistently identify all the protections, services, and supports that the individual needed to transition safely to the community, nor did teams adequately define the essential and non-essential supports in measurable ways. The Facility had been conducting pre-move monitoring, and this was resulting in better confirmation that essential supports were in place prior to the individual's transition to the community. 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 post-move monitoring checklists, 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	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. The State provided the Monitoring Panel with a copy of a revised draft policy on Most Integrated Setting Practices. This policy was very similar to the draft policy LBSSLC provided the Monitoring Team. The Monitoring Panel will be submitting joint comments to the State Office on the draft policy. As a result, this report does not contain specific comments on either the draft State policy, or the draft LBSSLC policy.	Noncompliance

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	the State, the resources available to the State, and the needs of others with developmental disabilities.	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 once an individual's team referred him/her for community placement, 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. 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, independent recommendations. For example: ▪ According to Individual #38's 1/5/11 PSP, he stated different preferences for his living options at different times. At times, he said he wanted to live with his parents or with a friend in an apartment, but, at other times, he said he wanted to remain at LBSSLC. His parents, who did not appear to be his guardian(s), wanted him to remain at LBSSLC "as they feel this is the safest environment for him due to the history of aggressive outburst." The PSP included no statement of the recommendations of the professionals on the team. The PSP stated that: "supports that would be needed for [Individual #38] to be successful in a group home would have to be provided by the Provider and that it is just a matter of identifying what each Provider offered." The team agreed to provide Individual #38 with opportunities to learn more about community option. The team concluded that LBSSLC "is the most integrated setting at this time and he will receive supports such as programming in various areas, medical supports, and other supports as discussed above." ▪ Although it did not appear that professionals on the team had made independent recommendations regarding community transition, Individual #37's team concluded that he should remain at LBSSLC because he required 24-hour nursing and staffing supports. The team indicated that these supports "could only be duplicated in a nursing home environment." This appeared to be a misunderstanding on the part of the professionals on the team with regard to the configurations of services and supports that are or should be available in integrated community settings. ▪ Individual #184's guardian clearly did not want to discuss community transition. However, the professionals on the team offered no independent opinion, and concluded that her "guardian would like for her to remain at her current home… the PST is in agreement with his wish." The professional teams supporting individuals at LBSSLC should make independent	

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		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. LBSSLC recognized the need to increase referrals to the community. A plan had been developed, and was in the process of being implemented. The plan included a number of steps, including increasing community exposure tours from once to twice a month; holding meetings with a number of groups to discuss the community referral process, as well as the need to increase referrals, including the QMRPs, the Mental Retardation Authority staff, Unit Meetings, and community providers; and continuing efforts such as the provider fair. In addition, the list of individuals LBSSLC served had been reviewed. The plan stated that: "PSTs will concentrate on those individuals who have no LAR and who are not medically fragile or behaviorally challenged to see if they are living in their most integrated setting." It was positive that the Facility had identified a need to increase referrals, and many of the steps outlined in the plan should assist in further educating teams and community providers about the need to prioritize this issue. Although efforts to identify individuals who were not being served in the most integrated setting was necessary, and consistent with the Settlement Agreement, as is discussed below, it was concerning that this group was limited to those without significant medical or behavioral challenges. The lack of supports to serve individuals with these characteristics in the community is an obstacle, perceived or real, that the State should assess, and take actions to address. In addition, as is discussed with regard to Section T.1.b.2, efforts to address guardian reluctance to consider community transition should be individualized. In addition, the State should analyze the overarching reasons for guardians' reluctance, and address these reasons to the extent possible.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The Facility policy was in draft format at the time of the review. It had been modified to reflect the most recent draft of the State policy, had been reviewed by the Operating Procedures Manual (OPM) Committee, and returned to the Admissions Placement Coordinator for additional changes. As noted above, the Monitoring Panel will be submitting joint comments to the State Office on its draft policy. As a result, this report does not contain specific comments on either the draft State policy, or the draft LBSSLC policy. Once the Facility policy is finalized, the Monitoring Team will review it to ensure compliance with the Settlement Agreement.	Noncompliance
	1. The IDT will identify in each individual's ISP the	The two major requirements of this section of the Settlement Agreement are discussed separately below:	Noncompliance

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	protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	Identification in PSP of needed protections, services and supports: 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 habilitation, physical and nutritional supports, and communication). 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. Identification of obstacles and strategies to overcome them: Teams continued to be struggling with the identification of obstacles and strategies to overcome them. The new format for the PSP included a section on obstacles identified by the PST. In reviewing the sample of five PSPs that utilized the new format, often some obstacles were identified. It often was unclear if: 1) the lists of obstacles were based on the team's knowledge of what was or was not available in the community, because often they were written in terms of the needs of the individual as opposed to lack of availability of such supports in the community, or the lists included items that were not actually obstacles; and 2) if the lists were complete. Of the five PSPs reviewed, four had some obstacles defined (80%) (i.e., Individual #38, Individual #184, Individual #215, and Individual #116). Individual #37 did not.	

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		Moreover, action plans to overcome the obstacles identified generally were not present. Of the five PSPs, one (20%) included an action plan to address educational opportunities for the individual and/or family/guardian. None (0%) included plans to address other identified barriers. The following provide examples of teams who had identified obstacles, and plans to over come them: ▪ Individual #38 stated different opinions at different times about whether or not he should move to a community setting. His team appropriately included an action plan to expose him to more community options. The plan was not measurable. However, it was positive that the team had included it. Specifically, the objective stated: "[Individual #38] will participate in a community exposure tour," with the "How often or due date" column listed as "as available." This did not provide a due date, and it was not clear how the team would assess Individual #38's experience with the community tour. The following provide examples of PSPs that did not adequately define obstacles, and/or the plans to overcome them were inadequate: ▪ As noted above, Individual #38's team identified his possible reluctance to move as an obstacle, and developed a plan to address it. However, another obstacle appeared to be his parents' reluctance to have him move, but this was not formally addressed. His parents seemed to be concerned about his behavioral issues, and maintaining his safety. No action plan was included in the PSP to further educate the family about specific options that might be able to meet Individual #38's needs. In addition, the narrative of his PSP indicated that he had a schedule on campus that allowed him to go to work in the morning, finish his work quickly, and walk back to his residence so that "he can watch his favorite television shows and this is very important to him at this time." When asked, the MRA representative indicated that there were community providers who offered this type of transportation back and forth to work. However, this would not be a typical schedule for someone living in the community, and likely could present a barrier to community transition. The team did not recognize this, or develop a plan to either identify providers who would offer this flexibility, and/or, more appropriately, to assist Individual #38 to expand his tolerance for maintaining a typical work schedule. ▪ In the obstacles section Individual #37's team identified the guardian's preference that he remain at LBSSLC. It appeared that the guardian believed LBSSLC was supporting Individual #37 well, and did not want to make a change. In addition, the team stated that Individual #37 "receives 24 hour nursing care (g-tube feedings, medications, treatments) and 24 hour care provided by staff	

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		could only be duplicated in a nursing home environment. It is believed that he would not receive as much interaction, be provided with the opportunities to participate in activities, or be have (sic) the opportunity to participate in community outings should he move to that type of setting. There is also a Physician that works on campus and this could not be duplicated in an alternative setting." The Monitoring Team does not dispute that team's conclusion that a nursing home would not be an appropriate setting. However, 24-hour nursing care and staffing should be able to be provided in other integrated community settings. It was not clear whether or not the team understood that similar supports could be provided in a community setting, and/or if the team believed that such supports were currently lacking in a specific area(s) of the State. In addition, the team did not define specifically what physician services Individual #37 receives on a daily basis. ▪ Individual #184's plan did not identify her guardian's reluctance as an obstacle, and inadequately defined other obstacles. The following three obstacles were listed: "Medical," "Behavioral," and Level of Supervision "hands on assist of 1." These obstacles lacked specificity, and did not identify supports that the team believed were not available in the community. LBSSLC remained at the beginning stages of identifying obstacles to community transition, and developing plans to overcome such obstacles. This deficiency, in addition to PSPs that did not adequately identify individuals' needs for protections, supports, and services, resulted in a finding of noncompliance with this provision of the Settlement Agreement.	
	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 3/25/11, a provider fair was held. According to the Admissions/Placement Coordinator (APC), all individuals LBSSLC supports were invited, and approximately 65 attended. All families, guardians, and correspondents were sent an invitation. Two attended the Provider Fair. All 888 staff were invited, and approximately 94 attended. Based on documentation provided, invitations were sent to 29 provider agencies, and 12 set up booths at the Provider Fair. Members of the Self-Advocacy Group were present, and handed out evaluation forms. During the week of the onsite review, the QA/QI Committee discussed some of the suggestions, including having the Provider Fair twice a year, having staff better prepared to that they understood the purpose, educating individuals and staff so that they could ask better questions about community services, and increasing the number of community providers present. As the QA/QI	Noncompliance

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		Committee recognized, these were all valuable suggestions. ▪ Visits to community group homes and day/vocational programs continued to occur. As noted above, a plan had been developed to increase these from once to twice a month. The Facility worked in conjunction with the local MRA to schedule these visits. 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. For the six months prior to the review, 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 the majority of staff participating in these visits were QMRPs, as well as some Residential Coordinators and direct support professionals. LBSSLC is encouraged to continue offering regular visits to community homes and day programs, and to expand the options for other PST members to participate in these activities. ▪ Individuals and their guardians also were provided information through the Mental Retardation Authority Community Living Options Information Plan process. This was occurring regularly as part of the individual planning process. ▪ As reported in the previous report, 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 Home and Community-based Services (HCS) Individual Plan of Care; and the Community Referral Process. ▪ On November 1, 2010, the MRAs for the Lubbock catchment area met with PST members in meetings designed specifically to provide information about services and supports that were available in the community. Families and guardians, as well as individuals, and the staff from LBSSLC were invited to attend as well. According to the training materials submitted, an overview was provided on the following topics: MRAs or IDD Local Authority, the CLOIP process, the referral process, living options, ICFs/MR, and HCS options. The most challenging area with regard to education of individuals and families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. Of the five PSPs reviewed for individuals who were not referred for transition to the community, one (20%) identified a need for further	

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		education (Individual #38), and this one included a written action plan, albeit not measurable. 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 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 Settlement Agreement. Although the Facility was continuing to complete some of the basic activities related to education, little progress had been made since the last review in individualizing the process.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The Monitoring Team requested for the last 12 months, a list of individuals who had been assessed for placement. In response to this request, LBSSLC submitted the following statement: "There is no assessment for placement. The PST refers an individual for transition to the community based upon the results of the living options discussion." As is discussed above with regard to Section T.1.a of the Settlement Agreement, 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. Professionals on individuals teams should formulate such recommendations, and they 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.	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	LBSSLC was in the initial stages of implementing the new Community Living Discharge Plan process. Many of the changes to the CLDP format were in response to discussions that Monitoring Teams had with Facility and State staff during onsite monitoring visits, as well as in response to findings noted in baseline monitoring reports. The Monitoring Teams appreciate and acknowledge the Facility and State's responsiveness.	Noncompliance

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	coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Additional comments regarding the specific CLDPs reviewed are offered later in this section. The following comments are based upon a review of the blank template: ▪ Overall, the form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. ▪ The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. This will provide an opportunity for PST members to be involved in all aspects of transition, including visiting potential community providers, ensuring that all relevant assessments are completed and reviewed, and following up after the individual has moved by reviewing the results of each post-move monitoring visit. ▪ The form included a section for documentation of key events, such as dates referral packages were sent to the MRA, dates potential provider lists were sent to the PST, dates the PST met to decide upon providers for pre-selection visits, information related to pre-selection visits, and results/deliberations of such visits. Because the CLDP is a document that would need to be updated at many stages of the process, it is recommended that dates be included each time the document is revised. For example, such dates could be added to the first page, or placed in the footer. ▪ A list of standard items to be completed and in place prior to every individual's move now appeared on page six (e.g., 30-day supply of medications, signed physician orders, required adaptive equipment). In the previous format, these items filled (i.e., unnecessarily cluttered) the list of essential supports and, thereby, detracted from the PST's ability to focus on identifying those essential and non-essential supports that were truly based upon individual needs and preferences. ▪ The list of summaries and recommendations on page nine was also an improvement. It was designed to help the PST remain focused on its primary task related to reviewing assessment, that is, ensuring that all recommendations are reviewed and, moreover, that recommendations are then included in the list of essential or non-essential supports. ▪ Psychiatry should be added to the list of summaries and assessments. ▪ Likewise, if the PNMT has conducted specific assessments, and/or made recommendations, these should be included. ▪ The review of every action plan (i.e., training objective and service objective) was another good addition to the process. The final statement on page 12, however, indicated that the PST could only make recommendations about action plans. It is the opinion of the Monitoring Team that the PST can, and should, make certain action plans (training objectives and/or service objectives) essential or non-essential supports, if the PST believes that implementation of	

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		any of these plans is important. The CLDP is the PST's chance to specify the supports and services that the provider must agree to provide. PSTs should be assertive in this area and not squander this opportunity. DADS should remove the statement on page 12 because it appeared to be at odds with the State's desire for transition to grow out of the PSP process. ▪ Many of the person directed planning questions included on pages 13 and 14 should assist teams in planning for individuals' transition to the community. It will be essential, as the process is implemented, to ensure that the information gathered from this component of the new process is incorporated into the essential and non-essential supports. ▪ It was also good to see that the CLDP required a description of the evidence to indicate whether or not an essential or non-essential support was in place. This was a new component to the CLDP. PSTs will need to be thoughtful and ensure that the requirements look for observable, objective evidence with specific criteria. ▪ The pre-move site review should also be sure to include the list of standard items on page six. This could be added to the list on page 23. ▪ Neither the pre-move nor post-move monitoring forms included a column in which to state definitively the findings (i.e., Yes, No, N/A). In reviewing completed forms, the narrative in the comments section had to be analyzed to determine if the monitor had found the items/activity to be present and/or completed. These forms should be revised to clearly indicate the presence of absence of an essential or non-essential protection, support, or service. CLDPs were reviewed for three individuals, as well as a draft CLDP. This represented all individuals who had transitioned from the Facility to the community since the last onsite review. In addition, the draft CLDP for Individual #159 was reviewed, because it represented an example of the new CLDP process and format. At the time of the review, only one other individual was in the process of having a CLDP developed. As noted during the previous reviews, 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. As is described below, though, the CLDPs continued to need to be further enhanced. They are the documents that define what is provided to the individual by the new provider agency, and should be used by Post-move Monitor 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, for the three individuals who already had transitioned to the community, it appeared that all three	

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		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. However, the CLDP for Individual #159 utilized the new format. The CLDP documented the many efforts of the team from the time of the referral, until the time of transition. This spanned approximately six months. According to the documentation, the team began discussing essential and non-essential supports during the meeting at which the decision was made to make a referral to the community.	
	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 and non-essential supports the individuals required. 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 four 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. ▪ 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.	Noncompliance

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	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 four of the four plans reviewed (100%) sign-in sheets were provided that confirmed the presence of the individual and his/her guardian.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	It appeared that a process had been put in place to improve compliance with this requirement. Brief updates often were included to supplement full assessments or evaluations that had been completed as part of an earlier PSP process. These updates indicated that reviews had been completed of the previous documents, and provided new information, as applicable. This was helpful in determining what had changed with the individual since the formal assessments had been completed. For none (0%) of the four CLDPs was a comprehensive set of assessments provided. Assessments that were consistently missing were nursing, day/vocational, and psychiatric assessments. In addition, the quality of the assessments was often not adequate. For example, a request was made for the Discharge Nursing Assessments for five individuals including: Individual #206, Individual #54, Individual #11, Individual #268, and Individual #44. The documentation from the Facility indicated that the summary documentation had not been completed for three individuals (Individual #206, Individual #54, and Individual #11) even though two individuals had been transitioned into the community in December 2010, and the third was transitioned in February 2011. The documentation provided by the Facility for Individual #44 and Individual # 269 did not reflect nursing discharge summaries. The Comprehensive Nursing Assessments that were provided for Individual #11, Individual #54, and Individual #206 were actually the most recent quarterly Nursing Assessments and not an adequate discharge assessment.	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	The three CLDPs and one draft CLDP reviewed included essential and non-essential supports. Improvements continued to be made with regard to the definition of essential and non-essential supports, but LBSSLC was still at the stage of refining this process. Teams did not consistently identify all the essential and non-essential supports that the individual needed to transition safely to the community, nor did teams adequately define	Noncompliance

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	judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	the essential non-essential supports in measurable ways. Although some of the plans included individuals' preferences, not all of the plans consistently identified 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. The following provides only a few examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ For Individual #11, whose CLDP was developed using the older format, the following protections, supports, and/or services were identified in either the narrative sections of the CLDP or in the assessments submitted in preparation for the CLDP, but were not translated into adequate measurable essential or non-essential supports: o The CLDP identified as an essential support: "30-day supply of medication." According to the narrative in the CLDP, the team identified that she would "require medication delegation, as she did not have the ability to self-medicate." This was not identified as an essential or non-essential support. Moreover, her PCP specifically identified the importance of her receiving her seizure medication, and the need to monitor for side effects of these medications. No measureable outcome was included in the CLDP to ensure these supports were provided. Although a neurology follow-up examination was listed, it was not due until six months after her move. The team did not identify the procedures that would be used to ensure she had her seizure medications after the 30-day supply ran out. For example, it was unclear if the team anticipated that the PCP in the community would refill prescriptions that the neurologist at LBSSLC had been ordering, and, if so, what information would be provided to the PCP to ensure this occurred. o According to the narrative section of Individual #11's CLDP, her PCP indicated that some testing had been completed to identify potential causes for vomiting, and recommended that a gastric emptying study could "further define the vomiting issue," and if it was negative, one of her medications could potentially be reduced. This appeared to be an example of medical testing that had begun at LBSSLC that required follow-through in the community. However, no non-essential support was included to ensure that the community provider clearly passed this recommendation on to the new PCP to ensure that this important	

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		information was not lost in the transition. o During the CLDP meeting, Individual #11's team discussed that she needed general anesthesia for "all dental procedures." There was no evidence that the team had developed a plan to ensure these supports were available to her in the community. The only reference to dental supports in the Essential or Non-Essential Support sections of the CLDP stated: "Dental follow-up examination, with a due date a year from the time of her transition to the community. o Both assessments, as well as the narrative sections of her CLDP indicated that Individual #11 had specific dietary requirements, including a "bland, chopped dieted, with no grapefruit products and limited caffeine, 8 oz [ounces] milk with meals and at bedtime, 8 oz of prune juice twice a daily, and ½ c. chopped fruit with meals." According to her nutrition update, this diet was helping to control her constipation. Reference also was made to providing Ensure, if Individual #11 refused meals. In the narrative, a number of Individual #11's food preferences were listed, including hot cereal with breakfast, and spaghetti with lunch. In addition, her Medical Discharge Summary included a recommendation that was not referenced anywhere in the CLDP, which stated: "Make sure that she gets plenty of fluids daily to prevent constipation, dehydration, UTI, etc." Her OT/PT assessment indicated that she had "reflux precautions in place due to a diagnosis of GERD/reflux. She should be encouraged to remain upright one hour after meals. The only related references to diet in the CLDP were listed under Essential Supports, and read: "Chopped diet to ½" size cubes," and "Copy of Dining Plan." Although the evidence listed for the diet texture was a "Demonstration of the ability to chop the diet to ½" size cubes," the evidence listed for the diet plan was "Copy of Dining Plan." This did not provide any assurance that the dining plan, including the very specific dietary requirements would be carried out by the community provider, or that the Post-Move Monitor would conduct adequate monitoring to ensure that the appropriate diet, and diet texture was provided consistently, and that appropriate precautions were in place. o Although an essential support was listed as "PBSP in-service training for group home and Day Hab staff," and the evidence was listed as "Completed in-service training," no essential or non-essential supports addressed the need for the ongoing implementation of the PBSP, or the qualifications of staff necessary to oversee the plan, train staff, or make modifications, as necessary. o No day or vocational assessment was included, and the CLDP	

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		documented limited discussion team discussion related to day/vocational activities. The only reference to day/vocational supports in the essential and non-essential supports was: "Enrollment in [Provider Name] Day Hab for support services." There was no specificity, such as staffing requirements, a schedule that addressed the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. o Based on a Speech Language assessment, Individual #11 used some signs, and due to her deafness, and vision problems, some specific communication techniques were recommended. This was not included anywhere in the essential or non-essential supports. o Her OT/PT Assessment identified the need for a wheelchair when she was pre-medicated for appointments. This was not included in the essential and non-essential supports. It also identified the need for shoes with "very good arch supports." This was not included in the plan. o The only reference to staffing in the essential and non-essential supports was "24-hour awake staff." There was no indication of what level of supervision the staff needed to provide Individual #11. In addition, her assessments identified many supports that were necessary to keep her safe and healthy, but these were not adequately defined. Some of these required staff to implement plans (e.g., PBSP, dining plan, etc.), and others related to daily care. For example, supports identified in the residential summary included checking and changing her briefs every two hours, ensuring the use of the wedge under the head of her bed, monitoring for seizures, monitoring for the presence of medication side-effects, and providing hand-over-hand assistance with "all tasks." None of these supports were outlined in the essential and/or non-essential supports. ▪ For Individual #159, whose draft CLDP was developed using the new format, it was clear that the team had met several times since the referral was made, and that the individual and guardian had been significantly involved in the process. Individual #159 had a complex history, and significant psychiatric and behavioral needs. On a positive note, the psychiatrist who had worked with her at LBSSLC provided training to the Foster Care provider on her diagnoses. At the recommendation of the psychiatrist, the team also developed sets of rules that would assist in providing structure. Based on documentation, the team had spent significant time identifying supports that would allow Individual #159 to be successful. However, the CLDP generally did not thoroughly define the	

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		ongoing expectations for the community providers with regard to the delivery to protections, supports, and services. As is illustrated in the examples below, other than establishing a relationship with a vocational provider, the team defined no expectations with regard to day/vocational supports. From a residential perspective, very few expectations were identified, except for the provider participating in initial training, and setting up appointments. Likewise, expectations were not established for the ongoing provision of clinical services. Ongoing implementation of protections, supports, and services is essential to the success of an individual in a community setting. This was not reflected in the plan. The following details a few of the concerns that were noted with regard to the supports defined in the CLDP: o She had a history of numerous failed placements in the past. Based on the documentation provided, it was not clear that the team analyzed factors that might have contributed to her failed community placements in the past, and ensured that supports were put in place to prevent such failures in her new community home and vocational program. o No psychiatric assessment was included as part of the CLDP package, so it was unclear specifically what the LBSSLC's recommendations were. However, in an addendum to the original CLDP, the psychiatrist mentioned that: "it had been two years since [Individual #159's] last restraint, noting maturity and medication changes have been a tremendous help." This indicated the need for collaboration between the LBSSLC psychiatrist and the new community psychiatrist. The CLDP also should have, but did not identify the frequency with which a psychiatrist should review Individual #159's medications, and behavioral data. The only support identified in the plan related to psychiatry was: "Establish services with a Psychiatrist." This was to be completed within approximately six weeks of her transition to the community. o With regard to behavioral data, the essential and non-essential support section of the CLDP did not require implementation of her PBSP. It merely stated that the Foster Care Provider would be trained on the plan. In the narrative section, the Foster Care Provider had agreed to implement the plan "with support from LBSSLC staff." The agency supporting the Foster Care Provided indicated that: "a psychologist would be obtained should [Individual #159] require revisions to the Positive Behavior Support Plan that went beyond the support of Lubbock SSLC staff." This discussion was documented in the narrative section of the CLDP, but was not formalized in the essential or non-essential support sections. Therefore, it was unclear if this was a formal relationship between LBSSLC and the Foster Care Provider, and, if so, no	

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		definition was provided of what supports LBSSLC psychology staff would provide Individual #159 in her new setting. For example, given her behavioral and psychological profile, as well as the support configuration being provided at LBSSLC, at least initially, a psychologist should have conducted regular reviews of behavioral data at both day/vocational settings, and supported staff, as necessary. In an addendum to the CLDP, the psychologist answered questions about the implementation of the PBSP, and was quoted as saying that: "calling 911 might be the only recourse," if Individual #159 became a danger to her self or others. It was unclear if the team had thought about the need for psychological consultation services to be available 24 hours a day, so that calling 911 would not be the only recourse, and less restrictive methods could be employed to assist the Foster Care Provider in addressing escalating or crisis situations. Individual #159 was an example of an individual for whom a Crisis Intervention or Safety Plan should have been developed. Such a plan should have identified, amongst other supports, community psychiatric crisis services that would be available to her should she need them. o The counseling component of the non-essential section of the plan did not specify the need to address her specific diagnoses, as the psychologist recommended, nor did it specify the need for a female counselor, as identified by the team in one of the first meetings related to transition. It also did not identify the frequency or duration of the counseling sessions. The action step read: "Establish Counseling." o In September 2010, Individual #159 had issues related to her blood pressure, requiring blood pressure readings to be taken prior to the administration of blood pressure medication. The Medical Discharge Summary was not clear regarding the resolution of this issue, or any necessary follow-up for high blood pressure. o Individual #159 was 149 pounds above her Ideal Weight Range, with a BMI of 45.7, placing her in the morbidly obese range. At LBSSLC, a dietician was following her. The only reference to her dietary needs in the essential and non-essential sections of the CLDP was "1500 calorie heart healthy diet with no concentrated sweets," and the evidence that would show compliance was that the Foster Care Provider would demonstrate "Verbal knowledge of diet portions and heart healthy choices." The team had not identified the need for continued intervention by a nutritionist/dietician, or the need for the prescribed diet to be followed. A non-essential support was listed as "Walks with supervision of Foster Care Provider," but no frequency or duration was listed to make this a measurable support.	

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		o Individual #159's vocational supports were weakly defined. The essential supports section of the plan stated: "Employment at [Name of Provider Agency]," and the evidence required was "verbal verification" by the provider agency staff. No definition was provided of the vocational supports to be provided, such as staffing requirements, a schedule that addressed the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. Despite the fact that at an addendum meeting, the team discussed contingencies should Individual #159 exhibit behaviors, and not be allowed to return to work, the team had not identified that behavioral supports were necessary at the day/vocational program, nor were the contingencies discussed written into the CLDP as non-essential supports. A future action item was for a referral to be made to the Department of Assistive and Rehabilitative Services (DARS). One area in which improvements had been seen was with regard to ensuring the essential supports that had been identified were in place prior to an individual's transition. The Facility had begun to use the pre-move site review form, which was part of the new CLDP process. For each of the three individuals who had transitioned to the community from LBSSLC since the last review (100%), including Individual #11, Individual #54, and Individual #206, pre-move site reviews had been conducted. As is discussed above, at times, the essential supports were not well defined and/or were not sufficient. This hindered efforts to ensure the individuals' health and safety needs could be met. However, based on the protections, supports, and services that were identified, and the information that would have been available prior to the individuals' transitions, it appeared that reasonable efforts had been made to confirm their existence.	
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.	In February 2011, the Facility began using the revised monitoring tools developed by the State Office. Both a Program Compliance Monitor (PCM) from the Quality Assurance Department and the Admission Placement Coordinator (APC) were conducting reviews. Based on staff interview and document review, issues related to inter-rater reliability still existed. One of the causes for the lack of congruency in the findings was the availability of the documents needed for the review in individuals' records. The APC explained to the Monitoring Team that she obtained documents she needed to conduct the reviews from sources other than the individuals' records, while the PCM relied on what was filed in the records. If a document was missing from the records, the PCM marked the related indicators as being out of compliance. Facility staff were working on rectifying this issue.	Noncompliance

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		The revised monitoring tools that the State Office provided included guidelines. They also were divided into three different review tools. The three tools addressed: 1) Planning for Movement, Transition, and Discharge/Review of Living Options; 2) Planning for Movement, Transition, and Discharge/Review of CLDP; and 3) Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs/Review of Post-Move Monitoring. This allowed the reviewer(s) to draw samples of individuals who remained at the Facility, as well as individuals who already had transitioned to the community. Having these various samples was necessary to review the various provisions of the Settlement Agreement that address planning activities, transition activities, pre- and post-move monitoring, and alternate discharges. The Facility had developed a grid that identified the samples that would be drawn for each review tool, and each auditor responsible for their completion (i.e., QA staff and departmental staff). The development of guidelines to supplement the review tools was a positive step. The Monitoring Team will not comment here on the full set of guidelines. However, it is important to note that some of the interpretations included in the guidelines were inconsistent with those of the Monitoring Teams. This likely will result in differences in the Monitoring Team's compliance determinations and the Facility's self-assessment of its compliance with the Settlement Agreement. The following provide a couple of examples of this: ▪ With regard to Section T.1.a of the Settlement Agreement, one of the State's guidelines read: "Is there documentation that the PST members were individually in consensus with the placement decision? Refer to the living options discussion." As is discussed above with regard to this section, the Monitoring Teams expect to see an independent recommendation(s) from the professionals on the team. ▪ Question #4 on the Review of Post Move Monitoring tool addressed: "If any of the noted deficiencies appear to be in areas essential to health and safety, these were addressed in (however are not limited to) the manner below: immediate manner, effective manner, recommendations were made, and actions taken to remedy all deficiencies noted." The guidelines read: "This is referring to deficiencies that the facility is accountable for. For example, if it is discovered through a PMM visit that we did not provide a piece of assistive equipment, actions were taken to correct the issue as soon as possible." This is not an accurate interpretation. The Monitoring Teams would expect to see that the Facility took appropriate action to address any deficiencies related to health and safety regardless of whether or not the Facility was identified in the CLDP as responsible. ▪ Some of the guidelines provided incomplete direction. For example, for Section T.2.a, it is important for the reviewers to ensure that post-move monitoring	

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		visits included visits to each site at which protections, services, and supports are provided (e.g., home and day/vocational sites). However, clear instructions to this effect were not found in the guidelines. The guidelines read: "Check PMM documentation to ensure that all of the required timeframes were met, that they were thoroughly completed, and that the documentation is reflective of the specifics of the visit." Without additional guidance regarding specifically what is expected, there likely will be discrepancies between reviewers. At the time of the review, this monitoring process was fairly new. A relatively small sample had been reviewed. Based on the documentation provided, the data had not yet been aggregated and/or analyzed. In addition to establishing inter-rate reliability, the analysis of data will be an important next step, which should be facilitated by a database State Office was finalizing for use by all of the SSLCs.	
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	Based on interview and document review, the State was finalizing a database into which the Facilities would be expected to enter information regarding obstacles. Upon the database's completion, the QMRP Coordinator would complete in-service training, and in turn train the QMRPs on the implementation of the database. As noted above, the obstacles that teams were identifying were not yet adequately defined. However, the draft revised State policy on Most Integrated Setting included a revised set of obstacles, including definitions. As stated previously, the Monitoring Panel will be providing comments to the State on the revised policy. In the meantime, it appeared that LBSSLC was entering information into a database of community placement obstacles that included older categories. The total number of individual was listed as 293. However at the time of the review, the census was reported to be 227. It appeared that for a number of individuals, information from two PSP cycles had been included in the data. Appropriately, more than one obstacle also was frequently identified for individuals. The totals for this duplicated count of obstacles was as follows: ▪ LAR Choice – 162; ▪ Behavior/Psychiatric – 91; ▪ Medical – 100; ▪ Citizenship/Funding – 0; ▪ Prefers Family/Not Available – 2; ▪ MRA Not Present – 1; ▪ Exploring Community Options – 7; ▪ Legal Issues – 1; ▪ Pending Community Risk Assessment – 0; ▪ Intra-State Transfer – 0; and	Noncompliance

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	legislature.	▪ Other – 97. Although this data provided some valuable information, no analysis had yet been completed. The Monitoring Team looks forward to reviewing reports on obstacles, including analyses of the data during future reviews. As indicated in the previous report, based on interviews with staff, anecdotally, a number of potential obstacles to individuals receiving the supports they needed in the community were identified. In addition, the Monitoring Team discussed with Facility staff patterns regarding recent admissions, which were also indicative of concerns in the community system that result in individuals requiring placement in more restrictive settings. Obstacles and concerns included: ▪ Since the last review, four individuals had been admitted to LBSSLC. The primary reason for these individuals being admitted was behavioral concerns that did not allow them to be supported safely in the community. When asked what supports could be provided at the SSLC that were lacking in the community, staff identified structured environments, adequate staffing (e.g., in the community, two staff usually would be the maximum available in a group home versus multiple staff being available in a residence on campus), and availability of psychology staff (i.e., psychology staff were not available on a 24 hour basis, seven days a week in the community). Based on the Monitoring Team's visits to community settings, another major issue appeared to be the lack of qualified staff developing and monitoring Behavior Support Plans, training staff, and overseeing the implementation of BSPs. ▪ 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,	

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		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 Settlement Agreement, 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.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this	In response to a document request, the Facility submitted to the Monitoring Team a Community Living Placement Report, for the period between 9/17/10 and 1/31/11. The report listed: ▪ Current Referrals: This included individuals who had been referred by their teams for community placement and had an open referral, including the individual's name, the date of referral, and the status of the referral. Two individuals were included on this list. However, since the list had been generated one of these individuals recently had transitioned to the community, and another individual had been referred to the community. ▪ Community Placements: This included individuals who had transitioned to the community, including their name, date of referral, and date on which their transition to the community occurred. This included two individuals. As noted above, a third individual recently had transitioned to the community. During December 2010, the Monitoring Panel requested some information regarding transition be added to the reports in order to capture categories of individuals who had either requested community transition, or whose teams had determined they could be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template each of the Facilities uses. For meetings occurring between 9/17/10 and 1/31/11, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the name of one individual with the date of the meeting at which the decision not to refer was made. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included two individuals, including the date of the meeting and a brief description of the reason for the referral not being made. For both individuals, the reason was noted as "behavior/ psychiatric." ▪ LAR Prefers Community, Not Referred: No individuals were listed in this category.	Substantial Compliance

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	paragraph by means of a Facility Report submitted pursuant to Section III.I.	The Monitoring Panel asked that a final category be added that includes a list of names of individuals who would be referred by the team except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The State indicated that at this time, its data system did not include this information, but it was working toward being able to produce the data the Monitoring Panel requested. The Monitoring Team looks forward to reviewing this information in the future. According to State Office staff, this report also had been provided to the United States 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 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	Timeliness of Checklists: Post-move monitoring documentation was provided for three individuals who had transitioned from LBSSLC to the community, including for Individual #11, Individual #54, and Individual #206. Based on a list of monitoring completed, it appeared that additional monitoring had been completed for individuals who had moved from other Facilities into the LBSSLC area, including for Individual #5, Individual #18, Individual #24, and Individual #32. The post-move monitoring documentation was not provided for these individuals. For the three individuals for whom monitoring documentation was provided, eight reviews should have been completed. Of the eight required visits, six (75%) had been documented as having been completed on time, and the remaining two (25%) were late or not provided. Specifically, although a list was provided indicating that monitoring visits had occurred for Individual #11 on 3/13/11, and for Individual #206 on 3/22/11, no monitoring reports were submitted for these two visits. It should be noted that for Individual #54, the pre-move and seven-day monitoring were completed on the same day. Both were completed on the day of the individual's transition to the community. This did not seem appropriate, and defeated the purpose of having one check completed before the individual's move, and others after the move. Progress had been made in ensuring that if visits had been made to both the residential and day sites of the individuals, this was clearly documented in the reports. For all three individuals reviewed, there was documentation to show that visits had been made to	Noncompliance

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	appropriate MRA or regulatory agency.	both the residential and day sites of the individuals. In order to adequately ensure that all essential and non-essential supports are in place, visits should continue to be conducted in whatever settings protections, supports and services are being provided. Content of Checklists: LBSSLC had begun to use the revised Post-Move Monitoring checklist, which was consistent with Appendix C of the Settlement Agreement, with some improvements. It had a column for evidence reviewed, which was helpful. 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. In order for this to occur, thorough reviews need to be conducted. For none of the three of the individuals reviewed (0%) had thorough reviews been consistently conducted. For example: ▪ For Individual #54, essential supports were poorly worded (e.g.," blood pressure cuff," and "Training programs on Money Management and Self Administration of Medications and will participate in activities at Day Hab."). As a result, it was unclear whether or not adequate monitoring had occurred. For example, one would expect that the blood pressure cuff would be used to take Individual #54's blood pressure, but the notes for each of the three visits from the Post-Move Monitor indicated: "PMM present when RN trained provider on use of blood pressure cuff and gave it to provider." There was no indication if monitoring had occurred to ensure the individual's blood pressure had been taken, and appropriate actions taken if the readings were above or below certain parameters. Similarly, the notes indicated the Post-Move Monitor had interviewed the provider and was told about training he was working on. It did not appear that record reviews were conducted to ensure appropriate active treatment was being provided regularly. He was supposed to be provided spending money every Monday and Friday. The only notes regarding this support related to witnessing the in-service training, but not confirming it was happening on a weekly basis. ▪ The evidence being reviewed was not consistently adequate to confirm the existence of protections, supports, and services. For example, Individual #206 required "Routine level of supervision with staff knowing whereabouts at all times." The evidence was listed as "Record of staff training," and for the seven-day monitoring, the Post-Move Monitor indicated that she reviewed the signed in-service training sheet in the file and was present during the in-service training. To confirm staffing was in place, observations and interviews with staff should have been conducted to ensure their understanding of the requirements. Another essential support was listed as "Continue Positive Behavior Support program." The evidence was listed as "Copy of PBSP and documentation of PBSP training." This appeared to be what the Post-Move Monitor reviewed. However,	

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		this was inadequate to determine if the PBSP continued to be implemented. At a minimum, this would have required review of behavioral data and observations. An essential support was listed as "Dining Plan." The evidence was also listed as the dining plan, and the Post-Move Monitor's comments stated: "Copy of dining plan given to [provider staff] on day of move. Signed inservice is in file. Observed at home and day hab at time of 7 day monitoring." However, based on the notes in the summary section, it appeared that the Post-Move Monitor had observed staff implementing the dining plan, which was an appropriate way to assess compliance with this requirement. The Post Move Monitor had identified a few issues as a result of the monitoring efforts. However, the documentation provided did not substantiate consistently that adequate follow-up had occurred. The following provides some examples of situations in which it was not clear that the Facility had developed adequate action plans to address the issues identified: ▪ For Individual #11, there was a notation on seven-day report that her communication device was broken and returned to LBSSLC. However, no plan was identified for follow-up. Moreover, there were notations on the 45-day report regarding problems in current home, including threats from her housemates due to noise issues, and a potential move to another location. Despite the fact that these issues potentially threatened her well being, no plan was described to ensure for her immediate protection, or for the LBSSLC team to be involved in the transition to another location, including visiting the location, ensuring essential supports were in place at new home, training of new staff, etc. ▪ For individual #54, the 45-day review indicated that he was not using his communication device. Although it was stated that he put is on a shelf and "has no interest in it at all," there was no discussion documented regarding whether or not additional training or support should be provided to assist him in using it. The 90-day review indicated that he had not had a neurology appointment, due to a "mix up with his Medicaid card." The Post-Move Monitor indicated she would contact the Foster Care provider agency to discuss the issue. However, no documentation was included regarding an action plan to address any underlying issues related to Medicaid coverage.	
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	No post-move monitoring visits occurred during the week of the review. As a result, this provision of the Settlement Agreement has not been rated.	Not Rated

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	10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.		
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
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	At a parties' meeting on December 2 and 3, 2010, it was agreed that in addition to the categories listed in the Settlement Agreement, other circumstances of an individual moving from a SSLC might fall under the category of "alternate discharges." For example, reasons such as a LAR choosing to discharge an individual from the Facility, or an individual transferring to another SSLC would be considered alternate discharges. These would be situations in which the Facility would be expected to follow the Centers for Medicare and Medicaid (CMS) discharge procedures. However, since the previous review, there had been no alternate discharges of individuals served by the Facility. As a result of no alternate discharges having occurred, this provision of the Settlement Agreement was not rated.	Not Rated

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

Recommendations: 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. 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.
3. With regard to the revised Community Living Discharge Plan template and process:
    a. Because the CLDP is a document that would need to be updated at many stages of the process, dates should be included each time the document is revised. For example, such dates could be added to the first page, or placed in the footer.
    b. Given that the new process requires the teams to meet multiple times, sign-in sheets should be maintained with the CLDP document that show the attendance at the various meetings held.
    c. Psychiatry should be added to the list of summaries and assessments.
    d. Likewise, if the PNMT has conducted specific assessments, and/or made recommendations, these should be included.
    e. The PST can, and should, make certain action plans (e.g., training objectives and/or service objectives) essential or non-essential supports if the PST believes that implementation of any of these plans is important. DADS should remove the statement on page 12 related to the team only being able to recommend the implementation of action plans, because it appears to be at odds with the State's desire for transition to grow out of the PSP process.
    f. The pre-move site review also should include the list of standard items on page six (e.g., provision of 30-day supply of medication, current physician orders, etc.). This could be added to the list on page 23.
    g. The pre-move and post-move monitoring forms should be revised to clearly indicate the presence of absence of an essential or non-

essential protection, support, or service (i.e., Yes, No, N/A).

4. Essential and non-essential supports should be better defined in Community Living Discharge Plans. More specifically:
    a. The role of the Facility staff in the transition and discharge process needs to be defined better;
    b. Given that generally, an individual's needs do not change on the day he/she transitions to the community, needs reflected in the individual's PSPs, and related plans and assessments should be reflected in the CLDPs;
    c. CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community; and
    d. Particular attention needs to be given to adequately defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc.
5. 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.
6. 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.
7. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based.
8. 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.
9. 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.
10. With regard to pre- and 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.
11. 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.
12. 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.
13. With regard to monitoring activities, the Facility should:
    a. Continue its efforts to establish inter-rater reliability; 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 Policy: Rights – Guardianship Process, dated 3/3/11; o LBSSLC Final prioritized list of those persons needing guardians based on information obtained from the QMRPs, revised 2/23/11; 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.2; o Statement in response to record request number TX-LB-1009-XVII.3; o List of individuals for whom an Legally Authorized Representative (LAR) has been obtained, since 10/07; o Contact Log regarding guardianship from 3/5/10 through 2/24/11; o Presentation Book for Section U of the SA; o Materials related to Guardianship Meeting, held on 2/3/11, including invitation, agenda, sign-in sheet, and minutes; o Blank monitoring forms for Section U, including: ▪ Settlement Agreement Cross Referenced with ICF/MR Standards – Section U, dated, 12/10; and ▪ Settlement Agreement Section U: Consents, undated. ▪ **Interviews with**: o Carla Prell, Admissions/Placement Coordinator; o Annette Webster, Post-Move Monitor and Guardianship Coordinator; and o Shelia Powell, Human Rights Officer.
	Facility Self-Assessment: The Facility self-assessment showed that it continued to be in noncompliance with the provisions included in Section U of the SA. This was consistent with the findings of the Monitoring Team. The Facility's assessment was summarized largely as a narrative description of actions that had been taken

	to comply with the Settlement Agreement. The Facility indicated that since the last review, two individuals had obtained guardians. As the Facility's self assessment process becomes more established, it will be important to include additional data, such as the numbers of individuals who require guardians, and data from audits that the Facility has conducted of individuals' records. Once screening and assessment process are in place, it will be important to show, based on data from audits, whether or not teams are accurately determining individuals' functional capacity, and whether individuals' needs for guardians are being prioritized appropriately.
	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 Settlement Agreement 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 103 individuals served by LBSSLC. At the time of the review, Lubbock supported 227 individuals, of whom approximately 45% 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 and continued to take a number of steps to attempt to identify guardians for individuals whose teams had identified a need for a guardian. The Facility had held one "brainstorming" session to address way to find guardians for individual who needed them, as well as identifying funding mechanisms to assist with the costs of guardianship proceedings. In addition to staff from LBSSLC, staff from the local MRA and DADS attended, as well as a representative from a local private guardianship agency, a parent/guardian, and a local attorney. This group brought with it a number of different connections and contacts, and had generated a number of ideas, which were in different stages of development. One promising possibility that required further cultivation was the 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	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	Noncompliance

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	full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	regard to the implementation of these SA requirements. In a document produced with regard to the pre-review document request (TX-LB-1009-XVII.2), 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. Since the previous review, the Facility had developed a policy entitled LBSSLC - Rights: Guardianship Process, dated 3/3/11. This policy set forth the basic definitions, the role of guardians, as well as processes, and procedures for pursuing and obtaining guardianship. It described some of the assistance that the Facility could provide to individuals, as well as potential guardians in pursuing guardianship. It identified the PSTs' role in identifying the need for a guardian in general terms, but did not define a specific screening or assessment process. QMRPs had been provided initial training on this policy. This was a positive step forward, and Facility staff were aware that once the State Office issued its guardianship process, changes would need to be made to the Facility policy. As discussed in the Monitoring Team's previous reports, 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. Since the previous review, the Guardianship Coordinator, who the Human Rights Officer was now assisting in the completion of guardianship related duties, had attempted to further define individuals' priority status. The level of involvement of family, friends, primary correspondents, and others outside of the Facility was calculated as a factor in determining the priority level of the individual. A review had been completed of all individuals' most recent rights assessments to determine this information. Approximately 13 to 15 individuals had been identified as having no one involved in their lives in any meaningful way. This group was seen as having a higher priority for guardianship. The Assistant Director of Programs had asked that this be taken back to the PSTs. At each annual meeting, teams were being asked to review and determine this level of involvement. LBSSLC had continued to maintain 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 2/23/11. This list included names of 103 individuals served by LBSSLC. At the time of the review, Lubbock	

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		supported approximately 227 individuals, of whom approximately 45% had been identified as needing 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. Once the State policy is issued, the Facility might need to reconsider the prioritization of individuals on the list. As noted in past reports, 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 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.	According to the Facility's POI, since the previous monitoring visit, two individuals had guardians appointed. Staff reported that both individuals had family members appointed as guardians. According to a list provided by the Facility, the numbers of guardians identified for and/or appointed to individuals at LBSSLC had declined over recent years. The following numbers were provided: between 10/07 and 10/08, 11 individuals had guardians appointed; between 10/08 1n 10/09, 11 individuals had guardians appointed; and between 10/09 and 10/10 three individuals had guardians appointed. As noted above, since 10/10, two individual had guardians appointed, and two were pending appointments. As noted above, the list provided by the Facility showed that a total of 103 individuals of the 227 individuals served by the Facility (45%) had been identified as needing guardians. Based on staff interview as well as review of a contact log listing attempts that had been 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. During the last review, one of the most promising possibilities had been 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. However, it appeared that this meeting did not occur until 2/3/11. The goal of the meeting was described as a "brainstorming" session to address way to find guardians for individual who needed them. In addition to staff from LBSSLC, staff from the local MRA and DADS attended, as well as a representative from a local private guardianship agency, a parent/guardian, and a local attorney. Some ideas or plans that were generated from the meeting included: ▪ The use of funds from the county treasury to pay for guardianship fees was discussed as an option for some families or others interested in becoming	Noncompliance

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		guardians. ▪ Holding a meeting of families who are not currently guardians was discussed as an option, including having the attorney present information that might assist in easing some of the apprehension that families have about the guardianship role. ▪ The Family Association was identified as an entity through which a user-friendly brochure on guardianship could be developed and disseminated. The Family Association subsequently agreed to fund such a project, and an initial draft had been developed. ▪ A for-profit guardianship agency provided a presentation on the services they offer, including cost. The concern related to this option was that it was cost-prohibitive. The costs incurred by the individual would leave them with little to no funds for any of their other needs or preferences. ▪ The group agreed to look into potential grant money for guardianship. During the previous review, 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 was a very creative way of addressing the lack of guardianship resources. The Guardianship Coordinator was supposed to do a presentation at the next local MRA meeting. Although it did not appear that much, if any, progress had been made in this regard, the Facility is encouraged to continue to pursue this option. 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: ▪ Along with PSP invitations, a letter continued to be 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; ▪ Staff continued to work with families and other interested people to dispel myths about guardianship, and to attempt to identify funding and/or legal resources to assist with the guardianship process; and ▪ As reported in the baseline report, numerous groups and individuals had been approached to determine their interest in identifying people to become	

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		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. 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. As the Monitoring Team reported in its previous reports, 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, as well as 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 (HIPAA), as well as other federal and state privacy laws. On 2/18/11, the Facility received clarification on this issue. DADS State Office provided information from its HIPAA expert, who indicated that for the purposes of identifying guardians for individuals, it was appropriate to share "basic information about these individuals, including basic health information, to help the potential guardian decide whether he or she could perform the guardianship function." However, the Facility was cautioned that information related to alcohol or drug abuse treatment, or information related to HIV or AIDS would need to be handled differently. Although it took quite a while for the Facility to obtain this information, it was a positive step forward, and should assist in facilitating the sharing of necessary information. 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	

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		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. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.
3. Once the State policy is finalized, LBSSLC should modify its policy on guardianship to reflect the State policy.
4. Once the State identifies the tools and processes to be used to assess individuals' decision-making capacity, teams should screen/assess all individuals served by the Facility.
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. In addition, LBSSLC staff should collaborate with staff from other SSLCs to identify and implement potential initiatives and resources for identifying guardians.
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 3/5/10; o LBSSLC Communication Process: Recordkeeping, revised 8/9/10; o List of Persons Responsible for Record Maintenance; o Table of Contents (TOC) for Active Record, revised 8/6/10; o Master Record Index, undated; o Individual Notebook TOC and Guidelines, revised 2/14/11; o Quality Assurance monitoring for last 10 records reviewed; o Statement that: "Currently, there are no Corrective Action Plans resulting from record audits;" o List of new or revised Facility procedures implemented since last compliance visit, undated; o Communication regarding policies changes, including emails with various dates; o Presentation Book for Section U; o Draft LBSSLC Submission and Filing Tracking Sheet; o Draft LBSSLC – Communication Processes: Active Record Check Out/Check In Process; o LBSSLC Protected Health Information and Confidentiality of Records Policy and Procedure, dated 10/20/03; o Draft LBSSLC Communication Processes: Documenting in Shift Home Logs; and o Various individuals' records. ▪ **Interviews with**: o Cheryl Lutzen, Unified Records Coordinator; o Martha Castillo, Lead File Clerk; and o Dawn Ripley, Director of Quality Assurance.
	Facility Self-Assessment: The Facility's POI indicated that it was not in compliance with any of the requirements of Section V of the Settlement Agreement. This was consistent with the findings of the Monitoring Team. The POI included helpful descriptions of a number of actions the Facility had taken to move towards compliance. It was unclear, though, if the Facility used data from its record auditing process to determine its compliance status. Based on interviews with staff and review of documents, LBSSLC had continued to conduct regular reviews of individuals' records. As is described in further detail below with regard to Section V.3 of the Settlement Agreement, the Unified Records Coordinator had been conducting five record reviews per month. Information gathered from these self-assessment processes should be utilized in future POIs to substantiate findings of compliance for Sections V.1, V.3, and V.4 of the Settlement Agreement.

	Summary of Monitor's Assessment: Since the last review, all of the remaining records had been converted to the new Active Record Table of Contents. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department. The Facility provided a list of 40 procedures that were developed or revised since the previous compliance review. The OPM Committee had reviewed an additional 10, nine of which were undergoing final edits, and would be implemented. The remaining policy was undergoing more substantive changes. Although there was evidence that new policies were being disseminated, no information was provided with regard to the training provided, or whether or not adequate efforts were made to ensure staff had the necessary knowledge and skills to implement the policies. As required by the Settlement Agreement, five audits were being completed of records each month. These audits were identifying numerous problems with the records. However, the Facility had not formally aggregated and analyzed this information. No action plans had been developed yet based on this data. Although no formal action plans had been developed, two workgroups had been created, which represented multiple departments/disciplines. These workgroups had developed creative solutions to addressing issues related to timely submission and filing of documents, as well as tracking the location of records that were removed from the residences temporarily. At the time of the review, the workgroups were finalizing draft procedures that would then require approval from the policy oversight committee. Based on observations of team meetings, teams were not consistently using data, and other information contained within individuals' records, to make care, treatment, and training decisions. In addition, issues related to the timely and accurate filing of information, and the maintenance of complete data, had the potential to impact negatively on teams' decision-making ability.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	As noted in the previous report, 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. It was completed on 10/15/2010. One Unified Records Coordinator, a Lead File Clerk, and four File Clerks were assigned to the Quality Assurance division. Their primary responsibilities related to the maintenance of records. For a period of time, one file clerk had been out on leave, and there was one vacancy due to a file clerk retiring. At the time of the review, the vacancy had been filled, and the clerk who had been out on leave had returned. At the time of the review, staff reported that each individual had an Active Record, a	Noncompliance

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		Master Record, and an Individual Notebook. The Active Record was organized according to the Table of Contents the State Office had developed, with some modifications specifically approved for LBSSLC. The Master Record contained legal documents, original documents, and correspondence. Based on guidance from the State Office, LBSSLC had modified the contents of the Individual Notebooks. It included copies of Health information, including a blank seizure record, and menstrual record; the individual's PNMP; level of supervision information and acknowledgment form; a profile sheet, the individual's daily schedule; the PBSP and Safety Plan; skill acquisition plans; and observation notes. Due to concerns that information would get lost, most data had been removed from the Individual Notebooks. Based on interview, data sheets were maintained in Group Books, which were kept in a central location. The Home Team Leaders were responsible for pulling out the data from the Group Books on a monthly basis, summarizing the data, and submitting the data sheets to the File Clerks for filing in the Active Record. Observation Notes were maintained in the Individual Notebooks, and, according to the Individual Notebook and Guidelines document, were moved to the Active Record monthly. Behavioral Data was maintained on the Home Shift Log, which included information about everyone living in the home. A workgroup had recently proposed changes to the Home Shift Log procedures. Appendix D of the Settlement Agreement defines Individual Notebooks as "A portion of the Active Record that accompanies the individual to ensure more reliable delivery of services and, when possible, immediate documentation of significant events." This is an area that requires further consideration. The format LBSSLC was using still required staff to go to multiple places to document data. The Monitoring Team recognizes that this should be done in the least cumbersome, and most normative fashion. However, LBSSLC's current methodology did not appear to address fully the requirements of the Settlement Agreement. The State Office should provide additional guidance on this issue. In its last report, the Monitoring Team noted that in reviewing records onsite, a number of documents were not in the records, and had to be obtained from the units. This was consistent with the findings during the baseline review, as well as this most recent review. However, the Facility had developed a workgroup to address this issue. The workgroup had been meeting since early February 2011. Based on discussions with staff as well as review of the minutes of the workgroup, a proposed process was in the final stages of discussion, and a procedure would be drafted for the Operating Procedure Manual (OPM) Committee to review. At the time of the review, the procedure the group had discussed involved identifying a central location near the switchboard for all departments to place documents needing to be filed. The File Clerks would collect the documents daily, and return to their offices to date stamp and prepare the documents for	

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		filing. Once the documents were organized, the File Clerks would bring them to the residences, and utilize designated space to complete the filing. A process also had been discussed for ensuring accountability of the departments submitting the documents. Specifically, a log sheet had been drafted to track when documents were sent/received and when they were filed. The timeframe the group was proposing for information to be filed was three days, unless it was information that required more expedited filing. The workgroup appeared to have considered different options, and developed a reasonable proposal to address the need for timely and accurate filing of information. Another workgroup had been created to define the process for signing records in and out of the residences. At times, when records were needed, they could not be located, because a staff member had removed them from the residence, but no system was in place to identify who had the record, or where it had been taken. This workgroup had developed a written process, which the OPM Committee had approved. However, it was later determined that a process needed to be added to ensure that at the end of each day, all of the records were back in the residence. Again, it appeared that this workgroup had thoughtfully developed a process to ensure the availability of records to assist in treatment decision-making. As was discussed in the Monitoring Team's last report, 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 Settlement Agreement were in various stages of development. For some sections of the Settlement Agreement, the State Office had not yet finalized its policies. Once these are finalized, Facility policies likely will need to be developed, or reviewed and revised. As previously reported, the OPM Committee was meeting to review and approve policies and procedures. The group included the Director of the Facility, the Assistant Directors for Programs and Administration, the Director of Quality Assurance, and various department heads. The group reviewed any draft policies that crossed departments 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.	Noncompliance

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		The Facility provided a list of 40 procedures that were developed or revised since the previous compliance review. The OPM Committee had reviewed an additional 10, nine of which were undergoing final edits, and would be implemented. The remaining policy was undergoing more substantive changes. Comments on a number of these policies are included in other sections of this report. The OPM Committee was not currently reviewing departmental manuals, which included procedures for each department. For example, it would not review a nursing procedure manual or the Psychology Department's manual. It will be important to ensure that there are clear instructions to guide the development of all policies and procedures, adequate approval processes, and regular review to ensure that they meet the requirements of the Settlement Agreement, as well as all applicable regulations. The OPM Committee should define the review and approval requirements for departmental manuals. In defining the review and approval requirements, the Committee should delineate who has responsibility for reviewing and approving them, as well as the frequency of review. The Director of Quality Assurance had identified policies that had not been updated within three years. A list was sent out, and a request was made for these policies to be reviewed and revised, as appropriate. Given the number of policies that fall into this category, it was recognized that this process would take some time. This was an important endeavor, however, to ensure congruence with the newer policies, as well as to update older information. In its document request, the Monitoring Team asked for a list of each new or revised policy since the last review, and "a copy of communication to staff to inform them of the policy, a description of training provided (with a copy of training materials), and/or blank competency evaluation tools." In response to this request, a series of emails was provided. These emails clearly showed that the new policies/procedures were disseminated to management staff, and the emails identified which categories of staff required training on them (e.g., direct support professionals, PSTs, nurses, Administrators on Duty, etc.). However, no information was provided with regard to the training provided, or whether or not efforts were made to ensure staff had the necessary knowledge and skills to implement the policies. This is an essential component to ensure compliance with this section of the Settlement Agreement, which requires that "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" (emphasis added). In speaking with one Residential Coordinator, it appeared that new policies often were placed in a communication log for staff to read and sign off that they had read the policies. As this Residential Coordinator recognized, depending on the content of the policy, this was frequently inadequate.	

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		The Facility was making progress in updating and/or developing policies to address the various requirements of the Settlement Agreement. However, it was not yet in compliance with this provision. In addition to continuing to develop and revise policies in concert with the issuance of State Office policies, the Facility also should develop standardized processes for training of staff on new or revised policy requirements.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	At the time of the review, the Lead File Clerk was responsible for completing 14 record audits per month. The Unified Records Coordinator subsequently completed a review of a sample of five of these 14 records. As noted above, for a period of time, two File Clerk positions were not available due to leave and a vacancy. During this time, the Lead File Clerk needed to assist with filing duties. As a result, she was not able to complete the 14 record reviews per month. However, the Unified Records Coordinator continued to complete the five reviews the Settlement Agreement requires. Based on interview and the Facility's POI, beginning on 1/1/11, LBSSLC began using the monitoring review tool the State Office developed entitled Recordkeeping and General Plan Implementation for Sections V.1, V.3, and V.4. The Facility continued to use its own review tool for monitoring records, and the results were reflected on the State Office tool. In response to the Monitoring Team's request for the 10 most recent record reviews conducted, LBSSLC submitted five reviews completed in December 2010, and five reviews completed in January 2011. For most of these reviews, numerous issues were identified, for which detailed comments were provided regarding issues identified. At the time of the review, information gathered from these reviews was not being aggregated and analyzed. However, based on document reviews and interviews, although no formal action plans had yet been developed, the Facility was taking steps to address some of the issues identified. As noted above, with regard to Section V.1 of the Settlement Agreement, some systemic issues included problems related to the submission and filing of documents, and the lack of a tracking system for instances in which records were removed from the residences. Some of the actions the Facility was taking are outlined in the section of this report that addresses Section V.1. The issue related to adequate submission of documents and timely filing was a high priority, as was ensuring that the record could be located when it was needed. Once systems are in place to better address these issues, it will be important for the Facility to focus on analyzing the data gained through record reviews further, and addressing other systemic issues related to the quality of the records. Some of the other issues LBSSLC staff had identified informally involved legibility of the records, accuracy of information included in the records, and ensuring that the skill acquisition plans were updated to reflect the current objective.	Noncompliance

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		Although progress continued to be made with regard to this provision of the Settlement Agreement, LBSSLC was continuing to refine its monitoring processes, and integrating the State Office monitoring tools with its own. The Facility also was still in the process of looking more formally at aggregated results of monitoring data, and developing, and implementing actions necessary to correct deficiencies identified systemically.	
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: ▪ Observation of individual planning meetings showed mixed results with regard to staff's use of information in the records to make care, medical treatment, and training decisions. For example: o At a PSP meeting for Individual #92, at which the team also discussed and developed plans related to her at-risk conditions, her record was present. Frequently, team members used the record effectively to inform the group's decision-making. For example, her physician used the record as a reference several times to clarify issues or identify information necessary to assist the team in its decision-making. Other members of the team also referenced the record, particularly during the at-risk discussion. One point at which her team should have used the record, but did not was in discussing skill acquisition programs. As opposed to referencing data when discussing her past performance, the team made statement such as "she's doing well," or "she's not doing well." ▪ The Monitoring Team met with the Medical Director and PCPs to review the current health status of several individuals. The physicians appeared to be knowledgeable about the various cases, but there were times when documents were not filed in the Active Record, dating to at least 30 days prior to the meeting. This made it difficult for the PCPs to provide details and clarity to the updates. It also was potentially problematic in that a PCP or covering PCP would have needed information to answer a clinical concern as it occurred. ▪ Additionally, the Medical Department estimated that 50% of the time the Active Records did not arrive with the individual at the clinic visit, creating potential problems in adequate care of the individual. ▪ From the review of a number of records onsite, it was noted that a number of documents were not in the Active Records, and had to be obtained from the units. This was consistent with the Monitoring Team's findings during the previous two reviews. There also continued to be a number of Nursing Quarterly Assessments, Nursing Annual Assessments, Nursing Care Plans, and	Noncompliance

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		Hospital Liaison Nurse's notes that were not found in the records. From discussions with the CNE, there appeared to be two issues related to these findings. Specifically, some of these documents were not being completed, and those that were completed, often were not being filed in the records in a timely manner. ▪ Recording of data is a key part of recordkeeping, and the integrity of such data collection is key to the clinical decision-making process. In reviewing the collection of data for Positive Behavioral Support Plans and skill acquisition goals, it was determined that staff might not have been consistently and timely documenting data, and processes were not in place to ensure data reliability. ▪ Legibility was sometimes an issue. For example, all of the entries in the dental progress note/treatment record were hand written. It was difficult to determine the meaning of some of the notes due to legibility. It is recommended that the dentist have dictation and transcription services, which would both provide a document that can be read by all departments, but also provide better use of the dentist's time in his daily schedule. The Facility was awaiting guidance from State Office on methodologies for monitoring this component of the Settlement Agreement. As was discussed while the Monitoring Team was onsite, this will require a number of different methodologies, including, for example, interviewing staff (e.g., clinical staff, QMRPs, etc.) about the usefulness of the records in conducting their job responsibilities, observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, PSP meetings, etc.), and reviewing documents such as medical consultations to ensure that key information from the record has been considered. All of these indicators might not be reviewed by the Unified Records Coordinator and Lead File Clerk, but might be distributed in other monitoring tools.	

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

1. The State Office should provide additional guidance with regard to Individual Notebooks. Consideration should be given to limiting the information included in the Individual Notebook to the basic information related to the safety of the individual, the programs for which direct support staff are responsible for running and the related data collection sheets, and blank incident report forms.
2. The workgroups developed to address the issues negatively impacting the quality and availability of records should finalize their work, including the development of procedures for filing information in the records and checking records in and out. Once approved, the revised procedures should be implemented to ensure that pertinent clinical information is readily available to clinicians and others needing this information when making decisions regarding treatments and health care services.
3. 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.
4. 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.

5. The Facility should develop a standardized system to train staff, and ensure staff have the necessary knowledge and skills to implement the new or revised policies.
6. Monitoring of records should result in action steps/plans to address individual as well as systemic issues as they are identified.
7. The dentist should have dictation and transcription services, which would both provide a document that can be read by all departments, but also provide better use of the dentist's time in his daily schedule.

The following is offered as an additional suggestion to the State and Facility:

1. The OPM Committee should define the review and approval requirements for departmental manuals. In defining the review and approval requirements, the Committee should delineate who has responsibility for reviewing and approving them, as well as the frequency of review.

List of Acronyms

Acronym/ Symbol	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ADA	American Dental Association
ADR	Adverse Drug Reaction
AED	Anti-epileptic Drugs
AED	Automatic External Defibrillation
ALS	Amyotrophic lateral sclerosis
APC	Admissions/Placement Coordinator
APEN	Aspiration Pneumonia/Enteral Nutrition
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ART	Administrative Review Team
AT	Assistive 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
CARE	Client Assignment Registration System
CBC	Complete Blood Count
cc	Cubic Centimeter
C-Diff	Clostridium difficile
CEU	Continuing Education Unit
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid
CNE	Chief Nursing Executive
COPD	Chronic Obstructive Pulmonary Disease
COTA	Certified Occupational Therapy Assistant
CPA	Comprehensive Psychiatric Assessment
CPT	Chest Physical Therapy

CRIPA	Civil Rights of Institutionalized Persons Act
CPR	Cardiopulmonary Resuscitation
CT	Computed tomography
CTD	Competency Training and Development
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
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
DSM	Diagnostic and Statistical Manual
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EGDs	*Esophagogastroduodenoscopy*
EIRS	Estacado Industries Residential Services
EIWS	Estacado Industries Workshop
ENT	Ear, Nose and Throat
ER	Emergency Room
FAST	Functional Analysis Screening Tool
FTE	Full-time Equivalent
GE	Gastroesophageal
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
HSM	Health Status Meeting
HST	Health Status Team
HT	Habilitation Therapies
IAC	Interagency Cooperation Contract
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
IDD	Intellectual/Developmental Disability
IDT	Interdisciplinary Team

IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IOA	Inter-observer Agreement
IPN	Integrated Progress Note
IQ	Intelligence Quotient
ISP	Individual Support Plan
IV	Intravenous
J-tube	Jejunostomy Tube
LAR	Legally Authorized Representative
LBSSLC	Lubbock State Supported Living Center
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
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
MT	Mealtime
MTC	Mealtime Coordinator
N/A	Not Applicable
Na	Sodium
NEO	New Employee Orientation
NM	Nutritional Management
NMT	Nutritional Management Team
NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OH	Oral Health
OIG	Office of Inspector General
OPM	Operating Procedures Manual
ORSA	Oxacillin Resistant Staph aureus
OT(R)	Occupational Therapist

P&T	Pharmacy and Therapeutics (Committee)
PA	Physician Assistant
PALS	Positive Assessment of Living Skills
PBS	Positive Behavior Support
PBSP	Positive Behavior Support Plan
PCM	Program Compliance Monitor
PCP	Primary Care Provider
PEG	Percutaneous Endoscopic Gastrostomy
PFA	Personal Focus Assessment
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
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
RNCM	Registered Nurse Case Manger
RNP	Registered Nurse Practitioner
RT	Respiratory Therapist
RWR	Recommended Weight Range
SA	Settlement Agreement in U.S. v. Texas
SAMS	Self-Administration of Medications
SAP	Skill Acquisition Plan
SFAR	Structural and 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
s/p	Status Post
SPCI	Safety Plans for Crisis Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor Antidepressant
STAT	Immediately or Without Delay
STD	Sexually-transmitted disease
TBOTE	Texas Board Of Occupational Therapy Examiners
TID	Three times a day
TOC	Table of Contents
TSHA	Texas Speech Language Hearing Association
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UIR	Unusual Incident Report
USPSTF	United States Public Health Task Force
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulators
VOCA	Voice Output Communication Aide
VTE	Venous Thromboembolism
WBC	White Blood Count
WNL	Within Normal Limits