United States v. State of Texas

Monitoring Team Report

Dates of Review: October 3, 2011 through October 7, 2011

Date of Report: January 16, 2012

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

Table of Contents

I. Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor 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.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

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 the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents, as well as request additional documents for off-site review.
(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.
(c) **Observations** – While 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, Personal Support Team (PST) 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 addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement.

This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;

(c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;

(d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and

(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

(g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

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 previous reviews, and to comply with the Settlement Agreement. Most importantly, these efforts had begun to show improved outcomes for individuals the Facility supported.

Also of significant importance, LBSSLC had come a long way in developing systems to self-identify its own areas in need of improvement and to develop formal corrective action plans, as well as less formal mechanisms for addressing issues. This was evidenced through the interdisciplinary and collaborative discussions during the Quality Assurance/Quality Improvement meetings, as well as throughout many facets of the organization. Direct support professionals were able to talk to the Monitoring Team about efforts underway to improve the quality of supports they provided. Ultimately, the ability to identify areas needing attention, and taking action to correct them is a key to compliance.

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. As discussed while the Monitoring Team was on site, at this point in the life of the Settlement Agreement, focused efforts need to be placed on some of the key requirements where adequate progress has not been seen. It also is important to sustain efforts in areas in which progress has begun, but further action is needed to reach compliance. 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 their assistance during the onsite 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.

The following is a brief summary of LBSSLC's status with regard to relevant the sections of the Settlement Agreement:

Restraints

- There was clear evidence that LBSSLC has worked diligently to monitor and evaluate the use of restraint and to design and implement alternative interventions. Dramatic decreases in restraint use had occurred for several individuals with lengthy histories of challenging behavior. These changes had resulted from creative approaches, and enhanced instruction and monitoring of residential staff.
- Multiple forums had been established to review the use of restraint. The Incident Management Review Team Meetings, the Restraint Reduction Committee meetings, and the Quality Assurance/Quality Improvement meetings continued to be effective forums for discussion, problem identification, and follow-up. LBSSLC had initiated multiple activities to ensure a thorough assessment of the use of restraint. These activities included self-auditing tools and extensive review of data on an individual basis. However, these discussions appeared to have focused more on the individual at risk of restraint, and less on the environmental factors that contributed to problematic behavior.
- Extensive effort had occurred to ensure that employees met the training requirements related to the use of restraint. The Monitoring Team found LBSSLC in substantial compliance with Section C.3.
- Serious deficiencies continued to be noted in the timely attendance of a licensed health care professional within 30 minutes of the initiation of restraint. This was a recurring deficiency that required heightened attention.
- Review of sampled restraint reports questioned whether or not less restrictive, alternative strategies as prescribed by PBSPs were attempted prior to use of restraint(s). In addition, inadequate interdisciplinary team

(IDT) monitoring following the use of more than three restraints in a rolling 30-day period for individuals sampled was found.

- Initial progress was noted in the development of Desensitization Plans for a small number of individuals who required sedation for dental services. As noted, these plans were an improvement over previous desensitization plans, but concerns were raised regarding specific aspects of the newly developed plans.

Abuse, Neglect and Incident Management

- DFPS and the Facility had made notable progress in a number of areas, including the completion of all requisite investigator training, increased inclusion of written extensions by DFPS, and greater attention to the development of recommendations. The investigation reports continued to comply with the standardized format. All sections of the format generally were found to be complete.
- The Director of the Facility indicated that the appointment of an Incident Management Coordinator was pending. In the meantime, the Interim Incident Management Coordinator had initiated the analysis of data available to him about the nature of the serious incidents/allegations and the status of investigations. Although there was additional work to be done, this was a very positive step.
- Although the investigations generally included a statement regarding previous allegations for both the alleged perpetrator and the individual, there was no indication that a detailed analysis of these facts had been completed as part of the investigative process. Furthermore, the review of investigation reports highlighted continuing deficiencies in timely reporting and commencement of the investigation within 24 hours.

Quality Assurance

- The Facility clearly had taken a series of specific actions towards both meeting the requirements for an effective Quality Assurance process, and achieving the outcome mandated by the Settlement Agreement. Since the Monitoring Team's last review, the following quality assurance processes had been updated or implemented: the establishment of monthly monitoring protocols; the restructuring of the Quality Assurance Council; and the use of Root Cause Analyses to review, for example, peer aggression in Residence 520. Monthly monitoring was conducted in a collaborative manner between the clinical/professional departments and Quality Assurance staff. A second Quality Assurance Nurse was hired in 4/11 to expand the resources available to conduct monthly monitoring.
- Data were discussed at the Quality Assurance/Quality Improvement Council meetings and at Departmental forums. The Safety Committee had continued its analyses of injuries. There was progress in the analysis of information related to the investigations of abuse and neglect.
- Inter-reliability continued to be unresolved. The Quality Assurance Director continued to explore resolution of this methodological issue.
- Although numerous completed monitoring forms were submitted as documentation, and although the summaries of the monthly monitoring results provided useful information, more detailed analysis of the Quality

Assurance staff's monitoring would be helpful in evaluating areas in which the Facility had made progress, and areas still needing improvement.

- In addition, corrective action plans needed to clearly establish expected outcomes in measurable terms to allow decisions to be made with regard to their success or the need for the plans to be revised.

Integrated Protections, Services, Treatments and Supports

- Since the last review, QDDPs had undergone additional training on meeting facilitation, and consultants for the State had begun to train teams on the philosophical and historical context of individual planning, as well as on some of the logistics of the development of sound plans. The State consultants had begun to provide technical assistance to teams at LBSSLC during annual planning meetings. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show positive changes with regard to facilitation skills, more productive meetings, and a more person centered focus. As would be expected, significant changes had not yet occurred in the ISP documents themselves.
- LBSSLC had completed ISPs in the new format for all 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 ISPs 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.
- Documentation did not confirm that monthly reviews of programs and supports were occurring consistently. The QDDP, as the team's facilitator, should ensure this occurs. To close the loop, however, the QDDP 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.
- Since the previous review, the ISP monitoring group continued to support teams through coaching, training, and providing feedback on integration of the ISP and risk process. The process continued to provide an additional level of oversight through which issues with the planning process could be identified more easily, and then actions developed to address them.

Integrated Clinical Services

- Although the Facility was non-compliant with both sub-sections of Section G, there had been progress. As the Facility noted, integrated care had begun to take place through a variety of committees that were the forums for interdisciplinary discussions, including the Medication Safety and Systems Committee, the morning medical provider meetings, the Physical and Nutritional Management Team (PNMT), the Psychotropic Polypharmacy Committee, and the interdisciplinary team (IDT). Through interdisciplinary discussions, the steps for researching and resolving medication variance had begun. However, considerable need remained for the continued development of integrated processes for each of these teams, and for other teams and committees on campus. The following provide some examples in which progress had been made, but full integration was not yet occurring:
    - The physical and nutritional management plans (PNMPs) were included in the Medication Administration Records (MARs). However, the recommendations of the PNMT were often not incorporated in the care plans, and the Nursing Department appeared to consider them optional.
    - An Enteral Feeding Workgroup was to meet monthly to resolve feeding tube concerns and provide education and training. However, the minutes of three meetings were submitted, and the ongoing role of this committee was not clear, nor could it be determined if the original goal was accomplished.
    - Several key departments' attendance at the morning medical provider meetings provided the forum for interdisciplinary discussions. The need remained to streamline the minutes concerning discussion about areas in which follow-up was needed, and to track these areas until closure occurred. The first step in the process had begun through the identification of clinical concerns, such as missed lab draws, and changes in health status of those hospitalized. A new policy was in place that required the Unit RN Managers to take the information from the morning medical provider meetings to the Qualified Developmental Disabilities Professional (QDDP) in order for a meeting of the IDT to be called to determine if changes were needed in the individual's level of risk and/or risk action plans. Some critical questioning had begun to be part of the meetings, with assignment of duties and follow-up for items requiring closure. However, the needed level of critical questioning concerning acute care issues, and prevention of hospitalizations remained an untapped potential.
    - Although the IDT remained the forum for the most encompassing level of integrated services, the IDTs' risk discussions required further critical thinking and preparation by the various team members. During the week of the review, one IDT for a medically complex individual demonstrated the potential for integrated risk management, but the ability to replicate the vision and team spirit of this team remained a challenge across the campus.
- Although a database had been created to track the primary care practitioner (PCP) response to consultant recommendations, the analyses and action plans based on this information did not appear to have had an impact

on the practice patterns of the PCPs. The PCP agreement or not with the consultant recommendations remained undocumented in many instances.

Minimum Common Elements of Clinical Care

- Routine periodic reviews were essential to care of those residing at LBSSLC. However, the Facility still struggled with completing annual medical evaluations in a timely manner. Unfortunately, the timely completion of quality quarterly medical progress notes could not be confirmed through the records submitted and remained an area of concern.
- Medical response to acute care needs appeared to be appropriate. The quality of evaluations remained focused on stabilizing and resolving the acute care problems. However, there was a continued paucity of clinical questioning of the many potential reasons for recurrent acute illnesses or hospitalizations, and logically analyzing the differential diagnosis and treatment options.
- The Facility had begun to aggressively approach individuals' health status changes. An educational program had been implemented to train the direct support professionals on changes in health status, because staff in the home were often the first to notice changes in an individual's health or behavior. This has the potential to greatly benefit the health and safety of those residing at LBSSLC, and is a required component of Sections H.1 and H.3 in order for the PCP s to be notified in a timely manner of health status changes. Additionally, the morning medical provider meeting was pivotal in discussing new clinical concerns, and forwarding this information to the QDDP/IDT for a review of risk ratings and risk action plans.
- Evidence was found in the PCP notes of appropriate testing, evaluation of results of tests, and diagnoses based on these reports and physical findings along with consultant findings. However, the Facility awaited the State Office clinical guidelines to identify acceptable clinical indicators to determine the efficacy of treatments and interventions for the common conditions found in the IDD population, and to determine the need for changes in treatment or interventions based on the clinical indicators. By standardizing care throughout the SSLC through the use of clinical indicators, they also could be used to monitor the impact of these common conditions on the health status of the individuals over time.

At-Risk Individuals

- Although the Facility had begun implementing many positive steps, a significant amount of work had yet to be done to achieve compliance regarding the requirements of the Settlement Agreement addressing at risk individuals. Some positive advancements included:
    - The PSTs used the State Office risk guidelines, and had begun to document the rationale for the rating determinations.
    - Progress was noted with the results of the interdisciplinary dialogue during team meetings concerning the risks and action plans.
    - The Facility recently compared the current risk ratings regarding aspiration pneumonia and respiratory compromise to data from the pneumonia tracking system for the past 12 months. Any rating

discrepancies were then referred to the Interdisciplinary Teams (IDTs) for further evaluation and revisions of these risk ratings. The Facility had implemented the same process addressing weight in October 2011, and planned to identify and assess other risk categories for which the Facility had data to support risk ratings.
    - Consultants also had been tasked with working with the IDTs to create quality risk ratings and risk action plans.
    - During the week of the Monitoring Team's onsite review, one individual's IDT that revised the risk action plans demonstrated a far greater potential than what was seen in the documents provided. As was discussed, more of this type of integrated planning and action plan development should occur.
- Although improved documentation was noted with regard to the rationale for the team decisions related to risk ratings for the various risk categories, there was concern about the quality of information and various team members' preparation for the ISP annual or addendum meetings. In addition, although the Facility indicated that all individuals had integrated risk ratings performed and risk action plans developed, the records the Monitoring Team randomly chose did not confirm that this was the case. There were many missing risk ratings and risk action plans. Wide variation also was noted with regard to the risk action plans based on the team's assessment of risk, and areas that that might have benefited the individual were not consistently addressed. In addition, the PNMT, although a valuable resource for the most medically complex individuals, struggled with ensuring that its recommendations became part of the risk action plan(s).

<u>Psychiatric Care and Services</u>

- LBSSLC had continued to make progress toward fulfilling the provisions of the Settlement Agreement related to psychiatric services. The efforts to recruit an additional full-time and/or Consulting Psychiatrist continued. In addition to the Director of Psychiatry, the Facility had been able to contract with a local Psychiatrist for four hours per week. This continued to be inadequate psychiatric staffing.
- The Facility had continued the initiative to prepare comprehensive psychiatric assessments (CPAs) that more closely followed the outline specified in the Settlement Agreement. However, this had been completed for only 37 of the 126 individuals who received psychotropic medication (29%). The completion of the CPAs will be an integral part of the Facility's eventual compliance with the Settlement Agreement, because they provide a format that prompts the discussion of many aspects of the Settlement Agreement, including the risk-benefit analysis, the description of the symptoms that support the psychiatric diagnosis, and the derivation of those symptoms as either stemming from a biologically determined psychiatric disorder, or from a learned behavior. The CPA also provides a format for describing the historical data that documents the efficacy of a psychotropic medication.
- The Psychology Department, working in conjunction with the Dental Office, had made some very limited progress in the development of Desensitization Plans and other strategies to reduce the need for pre-treatment sedation for dental and medical procedures.

- The Director of Psychiatry had continued to work with the Director of Behavioral Services to more clearly define which of the monitored behaviors that an individual presented with were derived from a biologically determined psychiatric disorder, as opposed to being present on a behavioral basis. In those cases where an individual's presentation was effected by both factors, an attempt had been made to clarify this dual etiology.
- A related area in which the Facility had shown progress was the documentation of the behavioral symptoms that justified the psychiatric diagnosis. Discussions of the risk versus benefit considerations related to the use of psychotropic medication also were found to be both more detailed and individually specific. However, these risk versus benefit considerations had not been integrated into the informed consent process, and as a result, information still was not being provided to ensure the Facility was obtaining adequate consent for the administration of psychotropic medication.
- LBSSLC continued to make progress in the reduction of polypharmacy, a process that began in earnest in 2005. Since that time, the longitudinal data on this subject illustrated considerable progress over the ensuing years. The Monitoring Team's prior report discussed the possibility of tracking the data on newly admitted individuals separately, because they frequently had been prescribed large numbers of medications in the community, and it could take several months after they were admitted to simplify these regimens. The Psychiatry Department had implemented this recommendation. There also were a number of individuals whom the Psychiatry Team believed were on three psychotropic medications, each of which could be documented to be both effective and necessary. LBSSLC should begin to assemble the necessary historical documentation to demonstrate their efficacy. If this exercise was successful, it could reduce the number of individuals considered to be on unnecessary polypharmacy even further.
- During this review, the Psychiatry Clinic that was observed was consistent with similar observations during prior reviews, in that it involved a number of different disciplines, as well as the individual. Ample time was available for discussion, and there was no sense of time pressure.

<u>Psychological Care and Services</u>

- Despite the losses of two Board Certified Behavior Analyst (BCBA) level staff since the Monitoring Team's last review, noted progress of the remaining Psychological Services staff in pursuing credentialing was observed. That is, one staff passed the BCBA exam, and three others took the exam just prior to the onsite visit, and were awaiting their scores. According to reports, three additional staff were expected to complete necessary coursework and supervision, and would be ready to take the exam next spring.
- Since the Monitoring Team's last review, the foundation for peer review, especially external peer review, had expanded and become more robust. Overall, Behavior Support Peer Review Committee meetings continued to be held regularly, and appeared helpful in improving the nature of behavioral services. However, participation by critical members of the committee, especially the more inexperienced Psychologists, could be improved. A formal interagency cooperation contract between LBSSLC and Texas Tech University recently was extended, and additional participation by other external reviewers appeared to benefit current behavioral programming.

- Continued improvement in the quality of Positive Behavior Support Plans (PBSPs) was observed. Specific areas for improvement, however, continued to be noted. These included: 1) specification of previously attempted interventions, including descriptions of changes to behavioral programming and explanations regarding why these changes were made (other than medication changes); 2) operational definition of replacement behaviors, especially within staff instructions; 3) complete behavioral objectives that facilitated efficient and accurate determination of progress, especially for identified replacement behaviors; 4) data display, including baseline date, especially for replacement behavior(s); 5) conspicuous integration of reinforcers identified through the Structural and Functional Assessment Report (SFAR) (beyond verbal praise) within antecedent and consequence-based strategies; and 6) plans or considerations to reduce the intensity of identified interventions (i.e., beyond the planned fading of the use of psychotropic medication). Progress was observed in ensuring that PBSPs could be understood and implemented by staff through careful examination of readability levels.
- Continued progress was noted in the area of regular monitoring of Positive Behavior Support Plans. Monthly PBSP progress notes more effectively displayed target and replacement behavior data, and contained ongoing weekly review by Psychologists. This system appeared likely to benefit from a recently implemented more timely supplemental data card system that allowed staff to record data "on the go."
- Although some limited progress in updating standardized tests of intelligence and adaptive behavior was noted, this progress appeared to have ceased due to changes in responsibilities of Behavioral Services staff. However, progress with regard to the completion of improved Structural and Functional Assessment Reports continued to be noted.
- Since the Monitoring Team's last review, collection of inter-observer agreement (IOA), as well as completion of PBSP Competency/Integrity Training assessments was expanded. However, concerns regarding the adequacy of IOA data, as well as how some items were scored and summarized within the integrity assessments were observed.
- Limited progress was noted in the provision and monitoring of psychological services other than PBSPs. This included slight improvement in reviewed counseling treatment plans that external counselors developed in collaboration with Behavioral Services Staff. Progress was noted, however, in developing procedures and methods to ensure that staff received competency-based training.

<u>Medical Care</u>

- Many of the essential components of a successful system were in place, but had not been developed to their full potential. The Medical Department had a complex, but user-friendly medical database system. However, little benefit from this system had been realized to date. No periodic reports had been generated to allow analysis of the data, and development and implementation of recommendations. Some of the databases required review to determine how to make them more practical and helpful to the department.
- The morning provider medical meeting had great potential as a forum for ensuring excellence in integrated care management. The morning medical provider meeting was the forum for succinct in-services by other

departments. However, a need remained for the group to focus on prevention of the recurrence of hospitalizations and adverse events negatively impacting individuals LBSSLC served. The group needed to ask critical questions, make assignments, and follow them until closure. Closure was difficult to track given the lack of structure in the narrative format of the morning meeting minutes.

- Death review recommendations were implemented in some areas, and remained theoretical for other areas of concern. Do Not Resuscitate (DNR) order status was precarious for some individuals, because routine yearly review signatures were not obtained.
- The external medical peer review and internal peer review continued to make progress. The non-facility medical peer review was currently in place and provided valuable feedback, but the results should be formalized into a written document through the State Office.
- According to the Plan of Improvement (POI), all of the routine, emergency and preventive issues were documented in the Integrated Progress Note (IPN) section of the active record. Despite being tracked through a medical database, a significant percentage of overdue or outdated annuals remained in the records, and quarterly medical progress notes were not identified in the submitted records.
- Preventive screening was monitored through a database for mammograms, colonoscopies, and DEXA scans. These were valuable tools, but the analysis of this information and meeting with the medical staff to create action plans for performance improvement had not occurred. The tracking of appropriate treatment for those with osteoporosis appeared to be problematic and incomplete. Preventive care flow sheets were incomplete or not available for some of the active records submitted.

Nursing Care

- Since July 2011**,** LBSSLC had stopped using agency nurses. This was significant, since at the time of the baseline review, they were using the services of seven agencies to cover vacant nursing positions. Some positions had been reallocated to perform important duties for the Medical Department and Physical and Nutritional Management Team. In addition, the Facility had 92% of the nursing positions filled, which was an increase from the previous review when 89% of nursing positions had been filled. These positive staffing advancements should assist the Facility in achieving improved clinical outcomes for the individuals residing at LBSSLC.
- Since the last review, LBSSLC's QA Nurses, and the Nursing Department made progress in the following areas: initial instructions were developed for the monitoring tools for nursing; the Facility implemented the use of the Statewide Medication Administration Observation tool; the State Office Nurse Practitioner Consultant provided in-service training on documentation to the Facility RNs and LVNs; Facility training was provided entitled "Observing and Reporting Clinical Indicators for Nursing and Direct Care Professionals;" different emergency scenarios had been developed, approved, and were currently being added to the Mock Code Drills; and Infection Control (IC) had developed a method to ensure data reliability regarding infectious and contagious disease processes data.

- In the area of Infection Control, the Facility had made progress in building some of the necessary infrastructure. Some of the progress noted specifically included: the IC Nurse outlined a procedure addressing data reliability, and implemented the use of Discrepancy Reports to track data reliability issues; the Facility was currently working on the development of a database for immunizations, which should be completed and implemented by the next review; competency-based training was provided to the Residential Coordinators regarding the Standard Precautions Monitoring Tool; and a structured format was implemented to organize and document actions taken in response to outbreaks that should increase the Facility's ability to analyze the events more clearly.
- Also, some progress was made regarding the Medical Emergency Response system, such as the recent implementation of different scenarios for the Mock Drills.
- However, consistent with the findings from the past reviews, no progress was made in the critical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in status, and the quality and timeliness of the quarterly and annual nursing assessments.

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

- Based on review of submitted documents, the pharmacy appeared to be processing new orders in accordance with the requirements of the Settlement Agreement.
- For the Quarterly Drug Regimen Reviews, the revision of the reviews over time made them a valuable tool in clinical care. The drugs for which blood levels were drawn were monitored through the QDRR process, to determine whether the level was within the therapeutic range. Lab values were reviewed, as well as monitoring of benzodiazepines, anticholinergics, polypharmacy, and new generation antipsychotic medication risks (endocrine and metabolic). The PCPs reviewed the QDRRs and signed off indicating agreement with recommendation, or providing justification if they did not agree.
- Section N.3 includes requirements related to the Pharmacy Department's role with chemical restraints. Monitoring of stat use of psychotropic medications as chemical restraints had improved, and all such use was communicated to the pharmacy. However, the documentation of pharmacy information on the chemical restraint form was incomplete. The pharmacy did not appear to be answering the concerns noted on the chemical restraint forms. This was an area that needed further review and documentation support.
- At the time of the review, Facility staff were undergoing training on the adverse drug reaction policy. It will take considerable effort to provide adequate training to the large numbers of staff that would need the training.
- The drug utilization evaluation process was a mature system, and the results provided a measurement of quality of care that the PCPs provided. The process also was having a positive impact on practice patterns.
- The task of determining the true medication error rate and the cause of the many returned medications will require continued diligence and attention. Obtaining complete data remained a challenge, as did accurate analysis of data.

Physical and Nutritional Supports

- The Facility hired a full-time PNMT Nurse and Clerk. The Chief Dietician had become a dedicated PNMT member. The PNMT Nurse made hospital visits. This provided the opportunity to interface with the Hospital Liaison Nurse and provide updates to PNMT members. The PNMT Nurse attended morning medical meetings, and provided updates to PNMT members and Habilitation Therapists on individuals' medical status.
- LBSSLC PNMT Guidelines were finalized in August 2011. However, individuals had inadequate risk action plans and/or no action plans, but had not been referred to the PNMT. Furthermore, individuals who experienced a health change status had not been referred to the PNMT in a timely manner. The Facility criteria for PNMT referral should be further defined for IDT members.
- The PNMT did not consistently review an individual's Integrated Risk Rating Form at the beginning of the evaluation to determine if rated risk factors were accurate. As a result, PNMT evaluations and action plans did not provide strategies to identify and/or address high and medium risk factors.
- No Facility policies memorialized the development and implementation of PNMPs. The Monitoring Team reviewed multiple PNMPs that did not provide adequate staff instructions to support safety for individuals at high risk, which reinforced the need for PNMP policy/procedures. Based on interview, the PNMT was in the process of revising PNMPs to incorporate triggers, risk factors, and outcomes. The incorporation of these components would result in positive additions to the PNMPs.
- The LBSSLC Mealtime Improvement Committee (MIC) had not made significant progress in completing competency-based training and testing of mealtime coordinators' competency in providing oversight in dining rooms. The MIC should formalize the mealtime curriculum for MTCs, develop and implement competency-based performance check-off forms to support compliance with the MTC mealtime curriculum, and establish a MTC validation process that therapists with mealtime expertise would implement.
- The HT Department had developed written tests and/or competency check-offs for completion with new employees, which was a positive development. However, many of the new employee core competency check-offs did not incorporate a demonstration component, which did not meet the standard for competency-based training.
- Individuals who received enteral nutrition were to receive an APEN evaluation, the purpose of which was to determine if receiving nutrition by tube was medically necessary, and, where appropriate, to implement a plan to return the individual to a less restrictive form of receiving enteral nutrition and/or to oral feeding. It was concerning that only 50% of the individuals in the Monitoring Team's sample had received an APEN evaluation. In addition, the APEN evaluations that were completed were not adequate to address the intention of the Settlement Agreement requirements.

Physical and Occupational Therapy

- The Director of Habitation Therapy, OTs, and PTs continued to revise the OT/PT evaluation template. In addition, a Therapy Consultant presented an evaluation modification to the State OT/PT evaluation template,

which the OTs/PTs were using. The Monitoring Team supported continued revisions to the OT/PT template. However, a review of multiple OT/PT evaluations showed they continued to include recommendations that were primarily service objectives. An absence was noted of individual-specific recommendations to enhance quality of life and function through skill acquisition and learned skill application.

- Thirteen (13) of the 225 individuals (6%) living at LBSSLC were receiving direct OT and/or PT services. Based on a review of a sample of these individuals, numerous issues were noted with regard to absence of functional, measurable outcomes; integration of the plan into the ISP; absence of skill acquisition programs; and plan implementation and documentation. Individuals' daily activities and/or schedules did not include opportunities to practice skills acquired or provide diverse opportunities for practice of new skills.
- The HT Department was to be commended for the development of multiple written and pictorial staff instructions for prescribed PNMP strategies, which reflected a significant investment of time. Competency-based training and performance check-offs had been completed for some of these PNMP strategies, but not all. Additional competency-based training and performance check-offs will need to be completed for PNM core competencies and individual-specific PNMP strategies.

<u>Dental Services</u>

- The Dental Department made considerable strides toward compliance. The creation of a practical information management system to meet the needs of the department had not been finalized. Consequently, such areas as determining the many reasons for a missed appointment remained difficult to analyze. Only a few months of data had been collected, and according to the Dental Department, sufficient data was not available to provide a trend analysis. The missed appointment rate in the Dental Department remained high.
- There was continued focus on oral hygiene, with the dental hygienist visiting each home and providing instruction in tooth brushing and positioning to the individuals and the staff. The oral hygiene index was considered fair to good for a majority of individuals.
- Desensitization plans or other strategies to reduce the need for pre-treatment sedation remained in the beginning stages of development. A new process was created providing the PSTs with more opportunities for input and more responsibility for decision-making. It was noted that 45 individuals were prioritized to receive dental desensitization plans, and 15 had completed plans. However, the degree of implementation was not clear. The structure that had been developed appeared to support the successful completion of quality desensitization plans.
- Under the guidance of the Dental Department, pre-treatment sedation assessment became a more rigorous process, with increased surveillance before the dental visit after the medication was dispensed.

<u>Communication</u>

- The Facility and the Habilitation Therapies Department should critically review concerns related to SLPs provision of necessary supports and services to individuals and IDT members, and the impact on compliance

with the Settlement Agreement. Vacant SLP positions cannot be a justification for not providing needed therapy supports to individuals that are of adequate quality.

- The Facility was to be commended for providing therapists with opportunities to attend relevant community continuing education courses.
- Eighty individuals had prescribed AAC systems, but none of these individuals received direct therapy supports. Review of samples of individuals' records substantiated that these individuals would have benefitted from receiving direct SL services to facilitate learning and practice opportunities for functional communication systems. Individuals had prescribed AAC systems, but no individual-specific functional, measurable outcome measures/objectives had been developed to provide formal learning opportunities to facilitate the use of individual-specific AAC systems.
- Competency-based training and performance check-offs were not consistently implemented for prescribed AAC systems.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>

- Initial progress had been noted in the area of habilitation services in the development of improved skill acquisition programs (SAPs). This included the identification of a new SAP format, including progress monitoring, and initial progress in developing plans that adhered to this format. Evidence had yet to be provided to demonstrate use of the new SAP progress monitoring format. Although improvement was noted, concerns regarding the adequacy of the SAPs remained.
- Estimates of engagement reflected less than desirable levels of engagement during brief on site observations. These observations also evidenced, at times, low staff-to-individual ratios at some sites.
- Continued changes within the ISP process included the recent revision and inclusion of several assessments, including the Personal Focus Assessment, Functional Skills Assessment, and Vocational Assessment. Although progress in completing improved vocational assessments was evident, concerns regarding their adequacy were noted.
- Efforts were also observed in the provision of competency-based training of direct support professionals in implementing active treatment, including SAPs. However, it appeared that training curriculum and on-going monitoring required additional specification and support.
- The provision of formal skill programming in the vocational and community-based settings remained a concern. This included the lack of improvement in opportunities for individuals in off-campus vocational settings.

<u>Most Integrated Setting</u>

- Individuals' ISPs 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 ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services.

- ISPs had begun to identify obstacles to individuals moving to the most integrated setting appropriate to meet their needs. Since the last review, teams had begun to discuss services or supports that either were unavailable or the teams believed did not exist in the community. Often these discussions revealed misconceptions about what was or was not available in the community. Training recently had been done with teams on the State Office list of obstacles. However, in the plans reviewed, teams had not yet used this list, and as a result, had not clearly summarized their conclusions related to obstacles. Given that teams were at this stage in the process, obstacles had not yet been analyzed, which will be an essential component of developing plans to overcome them on a more systemic level.
- The State Office directive that each SSLC team member include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need generally had not occurred in the plans reviewed. Occasionally, an assessment included this information. However, team discussions, as documented in a sample of recent ISPs, did not reflect that the staff had made an independent recommendation for discussion with the individual and his/her guardian. During some of the ISP meetings that members of the Monitoring Team observed during the onsite review, this process was beginning to occur.
- Since the last review, only two individuals had transitioned from the Facility to the community. The revised Community Living Discharge Plan process was resulting in better documentation of many of the planning efforts. The CLDPs reviewed included essential and non-essential supports. However, 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.
- Post-move monitoring had been completed in a timely manner for the small sample of 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, and for one individual for whom it was required, adequate follow-up was conducted to address the concerns that were identified.

<u>Consent</u>

- 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 no instrument or process was available to determine functional capacity. It was anticipated that the State Office policy would provide guidance with regard to this issue.
- In the absence of any formal instruments or processes to prioritize the needs of individuals for guardians, the LBSSLC Guardianship Coordinator had met with each of the IDTs on campus, and reviewed the teams' impressions of each individual's decision-making capacity, and using the criteria in a draft State Office policy, discussed the individual's priority level for guardianship. This was a substantial undertaking, and a good effort at further defining the priority list that LBSSLC had been maintaining.

- The updated prioritized list included names of 102 individuals served by LBSSLC. At the time of the review, Lubbock supported 225 individuals, of whom approximately 45% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, 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. During the Monitoring Team's onsite visit, a consultant with the State Office offered to work with Facility staff in trying to identify local social service agencies that might be willing to solicit grant money to start a nonprofit guardianship resource. Given the numbers of individuals potentially needing guardians, this would seem to be a worthwhile idea to pursue.
- Despite the limited guardianship resources, the Facility had had some success in identifying family members, friends, and former staff members to petition the court for guardianship. Since the previous review, guardians had been obtained for four individuals, and guardianships were pending for an additional six individuals. The persistence of staff in identifying and pursuing guardianship resources on an individual basis, and then working with interested people was the reason for the Facility's success in this area.

<u>Recordkeeping and General Plan Implementation</u>

- In its previous reports, 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. During this most recent review, a significant improvement was seen. Since the previous review, the Facility had finalized and implemented a policy entitled: LBSSLC Communication Process: Process for Submission and Timely Filing of Information in the Active Record, dated 8/11/11. The impact of this policy's implementation appeared to have been significant.
- Based on documentation provided, 52 procedures that were developed or revised since the previous compliance review. The Operations Procedure Manual (OPM) Committee had reviewed an additional 16 that were undergoing final edits. An additional 14 were pending review and approval.
- Although there was evidence that new policies were being disseminated, a system was not yet in place to track the training provided. As a result, it could not be determined whether or not adequate efforts were made to ensure staff had the necessary knowledge and skills to implement the policies.
- Although a brief lapse occurred while the Facility hired and trained a new staff member, at the time of the review, as required by the Settlement Agreement, at least five audits were being completed of records each month. These audits were identifying numerous problems with the records. The Facility was at the beginning stages of aggregating and analyzing this information.
- However, since the last review, a process had been developed to address problems identified with knowing the whereabouts of records. Once the new procedure was in place related checking records in and out, the Facility also had developed its own tool to determine compliance with the procedure. When this data showed that over several weeks, multiple residences were not complying with the new procedures, a plan was put in place to re-train staff. This plan was followed through to completion, including the tracking of training rosters, and multiple

reminders being sent. The Unified Records Coordinator continued to monitor compliance, with results showing marked improvement in the months following the training effort.

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**:
  - For Sample #C.1, complete restraint records for the last six months, including Restraint Checklists, Face-to-Face Assessments, Debriefing and Reviews for Crisis Intervention Restraint forms, Positive Behavior Support Plans (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 #4, Individual #33, Individual #124, Individual #221, and Individual #240, for the following dates and times:

Individual	Date of Restraint	Time of Restraint
Individual #4	6/9/11	6:45 p.m.
	6/11/11	3:05 p.m.
	6/26/11	5:57 p.m.
	7/4/11	8:20 p.m.
	8/23/11	9:36 p.m.
Individual #33	5/18/11	5:54 p.m.
	5/21/11	12:12 p.m.
	5/22/11	5:25 p.m.
	5/22/11	4:35 p.m.
	5/22/11	4:39 p.m.
Individual # 124	8/5/11	2:57 p.m.
	8/5/11	4:20 p.m.
	8/21/11	2:49 p.m.
	8/21/11	2:55 p.m.
	8/21/11	2:59 p.m.
Individual # 221	5/17/11	3:30 p.m.
	5/17/11	3:39 p.m.
	5/17/11	3:45 p.m.
	5/17/11	4:51 p.m.
	5/17/11	4:52 p.m.
Individual #240	7/25/11	4:54 p.m.
	7/25/11	4:59 p.m.
	7/25/11	5:04 p.m.
	7/28/11	10:15 p.m.
	7/28/11	10:22 p.m.

  - For Sample #C.2, the following documentation was reviewed for a sample of 40 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;

- Although medical restraint documentation was requested for eight individuals, for Sample #C.3, for the period from 4/11 to 9/11, the physicians' orders and the documentation of the monitoring that occurred was provided for only two individuals, including Individual #95 and Individual #184 for the following dates and times:

Individual	Date of Restraint	Time of Restraint
Individual # 95	6/10/11	1:15 p.m.
Individual#184	9/14/11	8:35 a.m.

- Sample #C.4 included restraint documentation for the following eight individuals who had experienced chemical restraint: Individual #288 on 5/9/11 at 9:05 p.m.; Individual #221 on 5/15/11 at 2:53 p.m. and 9:39 p.m., 5/16/11 at 5:08 p.m. and 5:53 p.m., 5/17/11 at 4:52 p.m., and 5/18/11 at 3:38 p.m. and 8:24 p.m.; Individual #126 on 5/28/11 at 3:08 p.m.; Individual #4 on 6/9/11 at 6:45 p.m., 6/11/11 at 3:05 p.m., 6/16/11 at 5:44 p.m. and 8:02 p.m., 6/21/11 at 5:42 p.m., 6/22/11 at 4:42 p.m., 6/23/11 at 11:34 a.m. and 11:17 p.m., and 6/26/11 at 6:01 p.m.; Individual #220 on 6/11/11 at 9:30 a.m.; Individual #124 on 7/29/11 at 6:45 p.m.; Individual #288 on 8/4/11 at 4:59 p.m. and 8/5/11 at 4:20 p.m.; and Individual #242 on 8/19/11 at 10:53 a.m., 9/13/11 at 8:30 a.m. and 4:03 p.m.
- Positive Behavior Support Plans for Individual #36, Individual #97, Individual #154, Individual #235, and Individual #288;
- Restraint records, including Restraint Checklists, Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms, Positive Behavior Support Plan, and Safety Plan for Crisis Intervention, and, for each restraint, the documentation of any and all reviews of this restraint information, as available for: Individual #4, Individual #221, and Individual #240;
- Positive Behavior Support Plans for: Individual #185, Individual #111, Individual #70, Individual #10, Individual #254, Individual #245, Individual #47, Individual #146, Individual #309, Individual #23, Individual #273, Individual #520, Individual #4, Individual #221, and Individual #240;
- Dental Desensitization Skill Acquisition Program Strategy Sheet and Monthly Progress Notes, as available, for: Individual #151, Individual #70, Individual #250, Individual #1, Individual #284, Individual #290, Individual #25, Individual #4, Individual #19, Individual #58, Individual #255, and Individual #51;
- Safety Plan for Crisis Intervention, as well as Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms (for identified date), as available, for: Individual #4, Individual #221, and Individual #240;
- Incident Management Review Team Meeting Minutes, dated August 4, 2011;
- QA/QI Data Sections C, J, K – Completed by Bob Robbins, PCM, dated March through May 2011, as well as June through August 2011;
- In-service Training for QMRPs on PSPA review following more than three restraints in 30-day period, dated 6/17/11;

	o Evaluation of PSPA Analysis of More than Three Restraints in 30-Day Period rubric; o Personal Support Plan (PSP) Addendum – Review of four or more restraints in any 30-day period rubric; o For Section C.7, restraint records, including 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, and Safety Plan for Crisis Intervention, as available, for: Individual #4, Individual #221, and Individual #240; o Minutes of the Restraint Reduction Committee meetings, dated 3/29/11, 4/27/11, 6/1/11, 7/7/11, and 8/25/11; o List of individuals (10) with Safety Plans; o Most recent "Do Not Restrain" list with the names of 129 individuals; o Completed Monitoring Tools for Section C; o Section C Compliance Data, completed by the Director of Behavioral Services based on restraint checklists, restraint debriefing documentation, and notes from Incident Management Review Team Meetings; o Sign-in sheets for in-service training entitled: "Guide for Restraints for Direct Support Professionals," dated 6/11 and 7/11; o LBSSLC Policy "Positive Behavior Support: Limitation of Restraint as a Crisis Intervention," dated 1/25/09 (R); o LBSSLC Policy "Health Services: Dental/Medical Sedation and Restraint," dated 1/14/10 (R); o Dental Desensitization Skill Acquisition Program Strategy Sheet for Individual #151, Individual #70, Individual #250, Individual #1, and Individual #284; o Plan of Improvement/Self-Assessment for Section C, dated 9/19/11; o Senate Bill No. 41; o Report of LBSSLC Restraint Trends through 8/11; o List of injuries (22) that occurred during the use of restraints; o Minutes of Incident Management Review Team meetings for each Monday, since the last site visit; and o Restraint Report for LBSSLC, dated 3/1/11through 8/31/11. ▪ **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; o Jim Forbes, Director of Behavioral Services, and Robert Robbins, on 10/6/11; and o Informal interviews/conversations with staff and individuals, including observation of Individual #33, Individual #60, and conversation with Individual #94. ▪ **Observations of**: o Incident Management Review Team meetings, on 10/3/11, 10/5/11, and 10/6/11; o Restraint Reduction Committee meeting, on 10/5/11;

	o Quality Assurance/Quality Improvement Committee meeting, on 10/4/11; o Human Rights Committee meeting, on 10/5/11; o Safety Committee meeting, on 10/6/11; o Interdisciplinary Team meeting regarding risks for Individual #33, on 10/5/11; and 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: LBSSLC's Plan of Improvement (POI)/Self-Assessment found substantial compliance with Section C.2, regarding the prompt termination of restraint, and Section C.8, the review of restraint use. The Facility made an assessment of non-compliance with the remaining provisions. The Monitoring Team agreed with the Facility's assessment that it was in compliance with Section C.2, but not Section C.8. However, the Monitoring Team also found the Facility in compliance with Section C.3. Based on the data included in the Facility's self-assessment, it was unclear why the Facility also did not make this finding. As the Facility expands its self-assessment processes, it is essential that the Facility use the data collected through internal audits, as well as other information gathered regarding ongoing activities to determine if compliance has been achieved, as well as to identify strengths and weaknesses within the system. The Facility should be using this information to expand best practice, and address areas requiring attention. At the time of the review, it was acknowledged that inter-rater reliability had not been established. There was a reliance on the data obtained from the analysis and monitoring of restraint checklists. The Director of Behavioral Services carefully tracked these checklists, and the ensuing discussions at the interdisciplinary team and Facility levels. The clarity of his analysis was instrumental in ensuring that the provisions of Section C remained a priority at every level of the organization. There was noted to be increased attention to the follow-up of corrective actions. In its POI, the Facility had identified appropriate action steps/plans and demonstrated continued progress towards compliance.
	Summary of Monitor's Assessment: There was clear evidence that LBSSLC has worked diligently to monitor and evaluate the use of restraint and to design and implement alternative interventions. Dramatic decreases in restraint use had occurred for several individuals with lengthy histories of challenging behavior. These changes had resulted from creative approaches, and enhanced instruction and monitoring of residential staff. Multiple forums had been established to review the use of restraint. The Incident Management Review Team Meetings, the Restraint Reduction Committee meetings, and the Quality Assurance/Quality Improvement meetings continued to be effective forums for discussion, problem identification, and follow-up. LBSSLC had initiated multiple activities to ensure a thorough assessment of the use of restraint. These activities included self-auditing tools and extensive review of data on an individual basis. However, these

	discussions appeared to have focused more on the individual at risk of restraint, and less on the environmental factors that contributed to problematic behavior. Extensive effort had occurred to ensure that employees met the training requirements related to the use of restraint. The Monitoring Team found LBSSLC in substantial compliance with Section C.3. Serious deficiencies continued to be noted in the timely attendance of a licensed health care professional within 30 minutes of the initiation of restraint. This was a recurring deficiency that required heightened attention. Review of sampled restraint reports questioned whether or not less restrictive, alternative strategies as prescribed by PBSPs were attempted prior to use of restraint(s). In addition, inadequate IDT monitoring (PSP Addendum meetings) following the use of more than three restraints in a rolling 30-day period for individuals sampled was found. Initial progress was noted in the development of Desensitization Plans for a small number of individuals who required sedation for dental services. As noted, these plans were an improvement over previous desensitization plans, but concerns were raised regarding specific aspects of the newly developed plans.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Based on information the Director of Behavioral Services provided, between 3/1/11 and 8/31/11: ▪ There was no use of mechanical restraint; ▪ A total of 53 individuals experienced a form of restraint; ▪ Thirty-seven of these individuals had medical restraint use only; ▪ More than 20 episodes of non-medical restraint were experienced by five individuals during this timeframe, including: Individual #4 (62), Individual #221 (55), Individual #33 (55), Individual #288 (38), and Individual #240 (22). Each of these individuals received heightened attention. Since 5/22/11, Individual #33 had not been restrained as a result of individualized approaches to habilitation. ▪ There were 29 chemical restraints used for the above five individuals, including: Individual #4 (13), Individual #221 (8), Individual #33 (6), Individual #288 (2), and Individual #240 (0). Using this same set of information, within the above timeframe, the Facility documented: ▪ 175 Programmatic* restraints; ▪ 53 Emergency personal restraints; and ▪ 35 Chemical restraints during a behavioral crisis. *Programmatic restraints were prohibited by policy. The terminology remained in the	Noncompliance

#	Provision	Assessment of Status	Compliance
		data system to describe restraints used in accordance with the individual's Safety Plan. There were a total of 263 episodes of these restraints documented. The majority of restraints were documented for Individual # 4 (62), Individual# 221(55), and Individual #33(55). A sample, referred to as Sample #C.1, was selected. This included all of the restraint records for five individuals, representing 20% of restraint records in the last three months. The individuals in Sample #C.1 included: Individual #4, Individual #33, Individual #124, Individual #221, and Individual #240. <u>Prone Restraint</u> As stated in previous reports, 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. There was no evidence to indicate that prone restraint was used at LBSSLC during the last six months. If staff were unable to hold an individual in the proper position during a restraint episode, they were instructed to release the restraint hold. Adherence to this directive was noted during the review of 25 restraint checklists for five individuals. This provision of the Settlement Agreement related to prone restraint appeared to be met. The Facility submitted 126 restraint checklists for the five individuals referenced above. Based on a review of 25 (20%) restraint checklists, five for each individual, none of the individuals in Sample #C.1 were subject to prone restraint. <u>Other Restraint Requirements</u> Based on document review, LBSSLC's 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 6/1/11 to 8/31/11, which included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ During this timeframe, 41 restraint episodes were documented for Individual #4; 16 restraint episodes were documented for Individual #33; five restraint episodes, occurring on two days, were documented for Individual #124. Documentation was only provided for 56 restraint episodes experienced by Individual #221 in 4/11 and 5/11. Lastly, five restraint episodes were noted for	

#	Provision	Assessment of Status	Compliance
		Individual #240. ▪ In 25 out of 25 records (100%), there was documentation stating that the individual posed an immediate and serious threat to self or to others. Examples of this included the repeated incidents of self-injurious behavior demonstrated by Individual #33, and the physical aggression displayed by Individual #221. Each of the debriefing forms reviewed confirmed that the restraint was properly initiated in response to this level of threat. ▪ For the 25 restraint episodes (100%) reviewed, there was no evidence that restraint was used as a punishment or for the convenience of staff. However, the Director of Behavioral Services noted in his Section C Compliance Data report that there was one restraint episode out of 216 where restraint was not used according to policy. No explanatory information was included in this report, however. As noted with regard to Section J.3, in order to assess the utilization of chemical restraint at LBSSLC, a request was made for the documentation related to administrations of chemical restraint during the most recent five months. This request yielded the completed Chemical Restraint Forms for May through September 2011, and is described in the documents reviewed section as Sample #C.4. All of the related documentation showed a consistent deficit with regard to the information reported in response to the prompt to: "Describe what led to the behavior that resulted in restraint." In all of the records reviewed, the overt behavior that actually precipitated the utilization of the chemical restraint was recorded in this section of the form and was not responsive to the prompt to "Describe what led to the behavior…" Because no indication was provided of what had precipitated the individual's aggressive response, it was impossible to determine if the chemical restraint was being used as a form of punishment for the behavior. For example, it could not be determined if the aggressive behavior was precipitated by a direct support professional making a demand, or when the individual was informed that they had lost a privilege, etc. A clear description of the antecedents to the aggressive behavior is necessary to accurately determine if the administration of the chemical restraint was, to some degree, a punishment and/or used in the absence of adequate treatment. Thus, although it did not appear that psychotropic medication was utilized as a punishment for noncompliant behavior at LBSSLC or for the convenience of staff, more complete documentation on the chemical restraint forms that involve the intramuscular injection of psychotropic medication against an individual's will was necessary to fully support this observation. The Facility should develop a system to ensure that all staff members involved in chemical restraints are instructed to describe the antecedents of the behavior that prompted the chemical restraint in a manner that will provide the information necessary to minimize the occurrence	

#	Provision	Assessment of Status	Compliance
		of these events in the future. A sample of three individuals' restraint records was reviewed, including the individuals' PBSPs and SPCIs. These included documents related to Individual #4, Individual #221, and Individual #240. Of the three restraint records sampled, none (0%) of the records provided evidence that less restrictive measures, as prescribed in PBSPs, were implemented as written prior to restraint(s) being implemented. Examples of which inadequate treatment was present included: ▪ The restraint record, dated 6/26/11, 2:13 p.m., for Individual #4 indicated that staff attempted coping skills, as well as interventions in the PBSP and Safety Plan. Such staff actions were reflected by multiple recorded responses (i.e., check marks) on items listed on the Restraint Checklist. Other "checked" items included verbal prompts, redirection, PMAB protection skills, removal of dangerous object, changing environment, trading out staff, and moving furniture. Although coping skills reportedly were utilized, the Monitoring Team could not find conspicuous coping skills outlined in the current PBSP, and the limited written descriptions in the restraint documentation did not provide any specific information on the nature of these attempted strategies. In addition, although multiple peers were targeted, it was not evident that staff "moved other(s) away" (this item was not checked) as prescribed by the PBSP. In addition, none of the documentation evidenced an attempt at prompting replacement behavior (i.e., using signs, etc.). Lastly, inconsistent responses across documents provided (i.e., the Restraint Checklist and the Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint form) questioned the correct application of "planned ignoring," as prescribed by the PBSP. That is, on the Restraint Checklist, staff indicated: "could not withdraw attention from these behaviors" which, given the nature of the maladaptive behavior described by staff, appeared prudent. However, when answering: "what worked?" on the Face-to-Face assessment, staff indicated: "withdrew attention." Upon reflection, these responses appeared incompatible. Consequently, the endorsed responses as well as the other cryptic written responses left considerable ambiguity regarding the application of prescribed interventions, including whether or not the approved strategies were implemented with integrity and, ultimately, if utilized correctly, if they would have been effective prior to needing restraint. ▪ The restraint record, dated 5/18/11 at 4:45 p.m., for Individual #221 provided little substantive information regarding the interventions attempted to avoid restraint. Indeed, in the "If PBSP, Replacement Behavior prompted" section, staff only documented "coping skills and verbal redirection." No other information was provided to demonstrate that other, less restrictive strategies (e.g., PMAB blocking techniques, limiting eye contact and conversation, etc.) were attempted prior to restraint. Upon examination of the PBSP, it appeared clear that coping	

#	Provision	Assessment of Status	Compliance
		strategies were only to be utilized once aggression stopped and the individual was cooperative with a request to make eye contact. Indeed, based on the limited descriptive information provided, it was unclear if the individual did calm and respond to these strategies prior to restraint. In addition, the general phrase "verbal redirection" was too vague to clearly understand what instructions or prompts were offered. In this case, the PBSP clearly prescribed limiting any conversation beyond telling him to "stop." ▪ The restraint record, dated 7/28/11 at 10:22 p.m., for Individual #240, included written descriptions of aggression toward staff and attempted property destruction, but surprisingly, indicated that the reason for restraint was aggression toward peer(s). Consequently, it was not entirely clear to the Monitoring Team what behavior(s) led to the restraint. Consistent with the PBSP, staff reported utilizing a verbal prompt as well as PMAB protection skills. However, staff also reported: "… asked [individual] to please calm down and let's talk about it or if he wanted to change staff." According to the current PBSP, communicating (problem solving) about the situation should only occur after aggression had ceased and Individual #240 was cooperative with staff requests. That did not appear to be the case as described. In addition, the PBSP did not prescribe changing staff as a consequence-based strategy. Indeed, as described, these strategies could be considered counter-therapeutic based on hypothesized functions outlined in the current SFAR. Overall, it appeared that staff likely used less restrictive, but inappropriate strategies that were likely to maintain problem behavior (potentially leading to restraint) over time. 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 adequately implement strategies prescribed within Behavior Support Plans to potentially prevent the need for restraint. As a result, a finding of noncompliance has been made. LBSSLC policies identified a list of approved restraints. Based on the review of 25 restraint episodes, 25 (100%) were approved restraints. There was evidence that restraints were terminated if the proper position could not be maintained. As noted in each of the Monitoring Team's reports, a number of significant environmental constraints continued to exist that potentially provoked problematic behavior. Although the leadership of LBSSLC had initiated several meritorious attempts to address the poor design of living space, the crowding of many individuals living together, and the lack of privacy, these issues remained as serious concerns during this site visit. There was an inherent difficulty in sustaining individualized approaches in this environment. It was highly probable that negative behavior was influenced, at least in part, by these factors, but teams had not fully explored this as a possibility.	

#	Provision	Assessment of Status	Compliance
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Ten individuals at LBSSLC had Safety Plans. Four of the five individuals included in Sample #C.1 (i.e., Individual # 4, Individual #33, Individual # 221, and Individual # 240) had Safety Plans that were reviewed and approved by the Human Rights Committee. Each of their Safety Plans defined the use of restraint. ▪ For each of the four individuals who had Safety Plans, four (100%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Safety Plan. In addition, the other episodes reviewed in Sample #C.1 were of brief duration. It was evident that the individual was released when no longer a danger to self or others. The analysis the Director of Behavioral Services provided indicated 100% compliance with this provision in a review of 186 incidents of restraint. This provision was determined to be in substantial compliance as it was in the last Monitoring Report.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall 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. Forty employees were selected randomly for review. A review of 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 38 out of 40 (95%) staff had been properly trained on restraints and its related topics. The two employees lacking documentation of training related to restraint were hired on 9/1/11 and 5/16/05. In addition, information the Director of Behavioral Services provided showed 99% compliance with Prevention and Management of Aggressive Behavior PMAB and restraint devices training in July, and 100% compliance in April, May, June, and August. The Director of Behavioral Services provided documentation that confirmed that since the last site visit, additional training on restraints had been conducted. The training included instruction on face-to-face assessment and debriefing. Training was provided individually or in small groups of restraint monitors. The requirements for each item of the Restraint Checklist, the Face-to-Face Assessment, Debriefing and Reviews for Crisis	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Intervention Restraint forms were discussed, with correct examples provided. The interactive training process was continued until each restraint monitor demonstrated competency on each item. Additional training was provided to direct support professionals in June and July 2011. This training focused on guidelines for restraint use, including the use of restraint as a last resort, communication with the individual at the start of the restraint, proper positioning, completion of the restraint checklist, and release from restraint. Sign-in documentation was provided. The Facility's Plan of Improvement/Self-Assessment indicated a finding of non-compliance with this provision. However, based on a review of policies, training curricula, and staff training records, the Monitoring Team has found the Facility to be in substantial compliance with this provision.	
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 the restraint episodes in Sample #C.1, evidence was found that restraint was used as a crisis intervention in 25 (100%) of the episodes. This was consistent with the Facility's policy. Based on the review of 15 Positive Behavior Support Plans, which reflected 10% of the total number of PBSPs (N=144), no evidence was found in 15 (100%) that restraint was prescribed for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of restraint for reasons other than crisis intervention. Improved descriptions within the PBSPs appeared to make the mistaken application of physical force over an individual's active resistance (i.e., restraint) less likely. For example, the consequence-based interventions for SIB demonstrated by Individual #111 clearly indicated "… use blocking (not restraint) to block SIB" and "… prevent [individual] from making contact by gently guiding his hands down to his side (do not hold his hands down)." This change in language appeared responsive to recommendations in the Monitoring Team's previous report. It would seem to be just as helpful to add this supplemental language, especially when describing reactive strategies including PMAB techniques, within all PBSPs, where appropriate. The Facility should consider identifying PBSPs that include reactive strategies that involve physical prompting, or include PMAB techniques that have the potential to lead to the escalation of physical interaction. These include, for example, the use of strategies where physical prompting (i.e., Individual #146), nonspecific prompting (i.e., Individual #245), or PMAB bite/object release procedures (i.e., Individual #240) might increase the likelihood of inappropriate use of restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In 25 of 25 (100%) of records reviewed, there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list. However, during an interview, the Director of Behavioral Services acknowledged that Individual #239, who is on the "Do Not Restrain" list due to an abnormality of the spine, had one restraint episode. According to the minutes of the Incident Management Review Team meeting, on 8/6/11, Individual #239 was restrained by "pulled" staff who were not aware that he was on the "Do Not Restrain" list. Direction was given that an immediate Corrective Action Plan be created to prevent a reoccurrence of this issue. Individuals included on the "Do Not Restrain" list had diagnoses of brittle bones, osteoporosis, emotional trauma or medical fragility, and restraint was prohibited. A total of 129 individuals were on the "Do Not Restrain" list, representing 57% of the 225 individuals living at LBSSLC. The Restraint Report for LBSSLC, dated 3/1/11to 8/31/11, documented medical restraint for pre-treatment sedation for 39 individuals. During the site visit, documentation was requested for the review of eight of these individuals (i.e., Individual #14, Individual #56, Individual #70, Individual #73, Individual #83, Individual #130, Individual #184 and Individual #317). However, after the site visit, the Monitoring Team was informed through a written statement that no pre-treatment sedation assessments were available for six of the individuals. This statement raised questions about the accuracy of documentation. LBSSLC submitted documentation for Individual #93 and Individual #184. However, neither pre-treatment sedation assessment form was fully completed. As noted in the Monitoring Team's last visit, a new Dental Desensitization policy had been implemented, dated 3/1/11, and a new Desensitization Committee had been initiated. According to this policy, the IDT would develop a desensitization plan for anyone requiring sedation for routine dental care, in collaboration with the Dental staff, and the Desensitization Committee would review it. As detailed in the Monitoring Team's previous report, this committee had started to develop a standard format for desensitization plans. At that time, two residences were selected as pilot homes (i.e., 521 and 523 Cedar) and plans were to be developed for select individuals. Since the Monitoring Team's last visit, according to documentation provided, a total of 12 Dental Desensitization plans had been developed for individuals across a larger number of residential programs than those initially identified for the pilot. These residences appeared to be those identified as pilot programs for the new skill acquisition programs (i.e., 518, 520, 523, 526, and 527 Cedar). Currently, all of the provided Desensitization Plans were reviewed and, although 12 plans	

#	Provision	Assessment of Status	Compliance
		were developed, their focus reflected a more restricted range of intervention targets. That is, some of the plans were similar in content and appeared to target five skill areas, including: 1) staying at the clinic for a certain duration once entering the building; 2) independently going to the clinic; 3) sitting in the dental chair for a certain duration; 4) opening mouth for a certain duration; and 5) tolerance to tooth brushing. Overall, plans typically included the following: a general goal and a more specific measurable objective; criterion for mastery; training shift and time; identified method of training and prompting; necessary materials and reinforcers; special instructions and staff guidance for incorrect responding; strategy for generalization; and identified steps and corresponding specific strategies. These programs incorporated many elements of skill acquisition programming that were not apparent in previously reviewed plans. Although these strategies were an improvement over previously reviewed skill acquisition plans, several concerns were noted. These included: ▪ Although specific objectives were identified, they rarely included operational definitions of the response targeted for acquisition (exceptions included the plans of Individual #51 and Individual #1). ▪ Although some plans included a vague discriminative stimulus (or Sd) within the objective, often described as a "verbal cue" or stated as "when cued," other plans did not. The integration of a specific discriminative stimulus in the objective would likely be helpful to staff and the individual when implementing teaching trials. An example, using the objective for Individual #1, would include: "By November 2011, following the statement '[individual], let's go to the clinic,' [individual] will independently go to the clinic for six consecutive sessions." ▪ At times, plans included redundant content in the strategies section across subsequent steps. In an attempt to be more efficient and clear, steps should only include content that is different from that already provided. For example, the plan for Individual #58 could eliminate considerable content within each step, if only the different locations were identified across steps. ▪ Plans often did not include a specific prompt level in the mastery criteria. If the objective was for the individual to complete a response independently following the Sd, it should specifically state "independently." If a specific prompt level was not desired, the mastery criteria might include, for example, a statement suggesting that mastery is met, following the Sd, when the step is completed at the "specified prompt level" for four out of five consecutive sessions. This specified prompt level could then be identified on the data sheet, and changed when appropriate, without having to change language in the plan. ▪ Instructions for incorrect responding should be clear and concise. In addition, it would be helpful if instructions clearly stated that incorrect responding should not be reinforced. It was unclear, for example, how the delivery of praise was being utilized differentially. That is, as written, praise was prescribed throughout the task but not necessarily offered differentially to reinforce longer	

#	Provision	Assessment of Status	Compliance
		durations of tooth brushing (i.e., the reinforcer is available whether or not the criterion is met). ▪ Instructions for incorrect responding should include more specific guidance to staff, including what should happen following an incorrect response. For example, this could include the use of a more intrusive prompt level (least-to-most) as well as guidance on when to NOT provide a reinforcer. Clear instructions were not evident, for example, in the instructions for incorrect responding for Individual #255. In the future, as more comprehensive assessments examining the nature of each individual's resistance to dental care are completed, desensitization plans are likely to be more individualized and include interventions more tailored to idiosyncratic strengths and needs. The quality of Desensitization Plans will need to improve, especially with regard to the development of individualized strategies. Depending on the needs of the individual other strategies outside of formal desensitization plans might need to be developed and implemented. In addition, plans will need to be implemented for all individuals who require medical restraints for routine medical or dental care for the Facility to attain compliance with this section of the Settlement Agreement. Overall, there was evidence of significant progress in meeting the requirements of this provision, particularly in the documentation of restraint and its use only as crisis intervention. However, the use of restraint on an individual on the "Do Not Restrain" list, due to the poor preparation of "pulled" staff, was very concerning from a protection from harm perspective. In addition, the Facility remained at the beginning stages of developing and implementing desensitization plans or other strategies to attempt to reduce the need for restraints used for dental or medical procedures. As a result, the Facility remained in non-compliance with this provision.	
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	Review of 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. Since the last site visit, additional training in the use and monitoring of restraint was documented for restraint monitors. The training focused on face-to-face assessment and was conducted individually or on a small group basis. The requirements for each item of the Restraint Checklist and the Face-to-Face Assessment were discussed, with correct examples provided. The interactive training process was continued until each restraint monitor evidenced competency on each item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	A list of trained restraint monitors was not included in the documentation received from the Facility. Based on a review of 25 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ In 23 out of 25 incidents of restraint (92%) by an adequately trained staff member. In two restraint episodes (7/28/11) involving Individual #240, the restraint monitor was not notified timely. ▪ In 23 out of 25 instances (92%), 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 two restraint episodes on 7/28/11 for Individual #240. ▪ In 25 out of 25 instances (100%), the documentation showed that an assessment was completed of the application of the restraint; and ▪ In 25 out of 25 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. It was important to note that the Director of Behavioral Services reviewed 216 restraint episodes that occurred between 4/11 and 8/11. He found a compliance level of 95% in the occurrence of timely notification and monitoring. Therefore, the findings between the Facility and the Monitoring Team were essentially comparable. There were no reports of alternative monitoring schedules. Based on a review of 31 restraint records for five individuals for restraints that occurred at the Facility (Individual #221, Individual #33, Individual #124, Individual #240, 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 11 (35%) of the instances of restraint. Records that did not contain documentation of this included: Individual #221 on 5/18/11 at 3:30 p.m., 3:35 p.m., 4:45 p.m., and 4:46 p.m.; Individual #33 on 5/22/11 at 4:35 p.m., 4:39 p.m., 4:47 p.m., 4:49 p.m., and 5:00 p.m.; Individual #240 on 7/25/11 at 4:54 p.m., 4:59 p.m., 5:04 p.m., and 7/28/11 at 10:15 p.m., and 10:22 p.m.; Individual #124 on 8/5/11 at 2:57 p.m.; and Individual #4 on 6/23/11 at 10:25 a.m., 11:17 a.m., 11:17 a.m., 11:34 a.m., and 6/26/11 at 2:13 p.m. ▪ Monitored and documented vital signs in 13 (42%). Records that did not contain documentation of this included: Individual #221 on 5/18/11 at 3:30 p.m., 3:35 p.m., 3:38 p.m., 8:19 p.m., and 8:24 p.m.; Individual #240 on 7/25/11 at 4:54 p.m., 4:59 p.m., 5:04 p.m., and 7/28/11 at 10:15 p.m., and 10:22 p.m.; and Individual #4 on 6/23/11 at 10:25 a.m., 11:17 a.m., 11:17 a.m., 11:34 a.m., and 6/26/11 at 2:13 p.m., 5:57 p.m., 6:01 p.m., and 6:01 p.m. Problematic issues that	

#	Provision	Assessment of Status	Compliance
		that resulted in noncompliance included vital signs not being recorded or marked as refused. To obtain respirations, the individual's cooperation is not required. ▪ Monitored and documented mental status in 17 (55%). Records that did not contain documentation of this included: Individual #221 on 5/18/11 at 8:24 p.m.; Individual #240 on 7/25/11 at 4:54 p.m., 4:59 p.m., 5:04 p.m., and 7/28/11 at 10:15 p.m., and 10:22 p.m.; and Individual #4 on 6/23/11 at 10:25 a.m., 11:17 a.m., 11:17 a.m., 11:34 a.m., and 6/26/11 at 2:13 p.m., 5:57 p.m., 6:01 p.m., and 6:01 p.m. Problematic issues that resulted in noncompliance included either the mental status not being recorded or being marked as refused. To obtain a mental status, the individual's cooperation is not required. The nurse should describe the status of the individual. For example, "Individual yelling, face red, spitting when talking with fists clenched." A description such as this clearly describes the individual's mental status without warranting any type of cooperation. In the Director of Behavioral Services' review of 216 restraint episodes, the failure of a licensed health care professional to conduct timely assessments was cited as a deficiency in 69 episodes (32%). Since the last site visit, no restraint episodes were documented off the grounds of the Facility. The one restraint episode that took place in a van took place at the Facility. Sample #C.3 was selected from the list of 37 individuals who had medical restraint in the last six months. Documentation was only provided for two of the eight requested individuals in the sample (20%), Individual #95 and Individual #184. In neither record reviewed (0%) did the physician specify the type of monitoring required.	
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 25 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 96%, the location of the restraint was documented. This information was not included for the restraint episode on 7/25/11 for Individual #240; ▪ In 96%, information about what happened before the restraint, including the change in the behavior that led to the use of restraint, was included. However, the quality of this description was not consistent. There were cursory, repetitive notes, especially when multiple episodes occurred in a short time. ▪ In 100%, the actions taken by staff prior to the use of restraint, in order to permit adequate review per Section C.8 of the Settlement Agreement, were	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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, but training dates and signatures were not always provided; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including: o In 100%, the documentation of observations 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. All restraints reviewed were of brief duration. Individual #33 was offered a meal after chemical restraint, but she refused (5/22/11). ▪ In 100%, the level of supervision provided during the restraint episode was described. The level of supervision was one-to-one; and ▪ In 100%, the date and time the individual was released from restraint was documented. According to BSC Tracking Grid (dated 8/25/11), there were 10 individuals with Safety Plans for Crisis Intervention (SPCIs). Of these SPCIs, three (30%) were reviewed to examine the nature of prescribed safeguards. In addition, Face-to-Face Assessment Debriefing and Reviews for Crisis Intervention Restraint forms (for specific dates) were reviewed to examine documented adherence to these strategies. 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. Also, 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. More specifically, one SPCI (i.e., Individual #4) did not identify the provision to utilize the toilet or bedpan, if needed. To examine whether or not documentation supported the implementation of the above	

#	Provision	Assessment of Status	Compliance
		strategies, Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms were examined for Individual #4 (dated 6/26/11), Individual #221 (dated 5/18/11), and Individual #240 (dated 7/28/11). Of the three forms reviewed, all (100%) included recorded documentation reflecting adherence to the above standards. Based on a review of 31 restraint records for five individuals for restraints that occurred at the Facility (Individual #221, Individual #33, Individual #124, Individual #240, and Individual #4): ▪ In 21 (68%), the results were found of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. Records that did not contain documentation of this included: Individual #221 on 5/18/11 at 8:19 p.m.; Individual #33 on 5/22/11 at 4:35 p.m., 4:39 p.m., 4:47 p.m., 4:49 p.m., 5:00 p.m., and 5:25 p.m.; Individual #240 on 7/25/11 at 5:04 p.m., and 7/28/11 at 10:15 p.m., and 10:22 p.m. This was due to this area being left blank, or the lack of appropriate nursing documentation regarding the specific descriptions of injuries. In a sample of 25 records (Sample #C.1), restraint debriefing forms had been completed for all (100%) 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 timeliness of nursing presence need to be addressed. These were recurring deficiencies. There were 35 episodes of chemical restraint documented from 3/31/11 to 8/31/11. In addition to the review of Sample #C.4 described above, documentation was reviewed for six episodes as follows: Individual #4 on 6/11/11 at 3:05 p.m.; Individual # 33 on 5/22/11 at 5:25 p.m.; Individual #124 on 7/29/11 at 6:45 p.m., and 8/5/11 at 4:20 p.m.; Individual #221 on 5/17/11 at 4:51 p.m.; and Individual #288 on 8/4/11 at 4:59 p.m. In four out of six episodes (67%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional either contacted the psychologist, or the psychologist was present. There was no detailed documentation provided of the discussion at this immediate point of contact. For the restraint episodes involving Individual # 33 and Individual # 221, there was no documentation regarding contact with the psychologist	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than		

#	Provision	Assessment of Status	Compliance
	medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	As noted in the Monitoring Team's previous report, a revised Restraint Checklist as well as a new PSP Addendum format (i.e., for more than three restraints in any 30-day rolling period) had been developed with the intent of promoting the inclusion of more descriptive and targeted information from direct support professionals (following restraint), as well as to facilitate more comprehensive review and documentation by the PST. At the time of the review, as described below, although these rubrics were in place, their adequate and consistent use was not evident. According to the LBSSLC Restraint Report, seven individuals had more than three restraints in any rolling thirty-day period between 3/1/11 and 8/31/11. Of this group, three individuals, reflecting a sample of 43%, were selected for further review. They included Individual #4, Individual #221, and Individual #240. Selected Restraint Checklists, and Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms were reviewed for Individual #4 (four restraints, dated 6/26/11), Individual #221 (dated 5/18/11), and Individual #240 (dated 7/25/11 and 7/28/11). 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, only one (33%) of the individuals' PSTs met to discuss the restraints selected for the current review. More specifically: ▪ Since the last Monitoring visit, the PST for Individual #4 met approximately 14 times to discuss issues related to challenging behavior, as well as other potentially related issues. In addition, during this time period, the PST specifically met four times following "more than three restraints in any 30-day period." These meetings were held on 6/13/11, 6/20/11, 6/23/11, and 6/28/11). On 6/28/11, the PST discussed the restraints selected for review (dated 6/26/11). The following are examples of where teams failed to do this adequately: ▪ There was no evidence that the PST met as required following "more than three restraints in any 30-day period" that occurred on 5/18/11 for Individual #221. More specifically, restraint documentation indicated that seven physical restraints and two chemical restraints were utilized on 5/18/11 for Individual #221. However, no PSP Addendums were available within requested documentation. Indeed, a note provided with other requested documentation	Noncompliance

#	Provision	Assessment of Status	Compliance
		indicated: "[Individual #221] does not have any PSP Addendums available in his Individual Integrated Record." This suggested that either no meeting occurred, or that meeting minutes were not documented. ▪ There was no evidence that the PST met as required following "more than three restraints in any 30-day period" that occurred on 7/25/11 and 7/28/11 for Individual #240. Provided documentation did evidence four PST meetings since the last onsite visit. However, these meetings discussed issues related to level of supervision, sharps precautions, suicide threats, and unauthorized departures. Base on documentation provided, it did not appear the PST met following the five restraints that occurred across 7/25/11 and 7/28/11. The finding of insufficient IDT oversight as required following more than three restraints in a 30-day period was not necessarily surprising. Indeed, as reported, multiple QA/QI reviews consistently found insufficient follow-up (i.e., no PSPAs completed) across a substantial number of monitoring probes. Documentation provided indicated attempts by the Facility to address this problem. For example, subsequent trainings were held with QDDPs, and a new system was implemented as part of Incident Management Review Team Meetings (IMRT) that would help ensure that IDT meetings occurred following more than three restraints in any 30-day period. This system included an item on the IMRT meeting rubric that prompted the determination of whether or not an ISP Addendum meeting was held, if the above criteria had been met. It appeared that this system was implemented in August. Consequently, the effectiveness of this system to improve the IDT oversight of restraint usage will need to be evaluated at subsequent Monitoring Team visits. 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: ▪ Documentation for Individual #4, a PSP Addendum dated 6/28/11, provided a brief history of the individual and information about potential functions of behavior but did not examine the role of adaptive skills other than to report that "[individual] is nonverbal and has very poor social skills," and that "… he has learned this [challenging behavior] because he got his way when he exhibited this behavior in the past." The minutes lacked discussion about the role of teaching/training new adaptive skills (i.e., one of the identified replacement behaviors in the PBSP was "communication"), and related data did not appear to be presented. It is important that the PST review data and discuss the progress in teaching more adaptive, replacement behaviors. Of note, this section was just "cut and paste" from the previous three PSP addendum meetings (i.e., 6/13/11, 6/20/11, and 6/23/11). That is, the exact same content was in each of these sections over time indicating that the PST did not discuss any potentially new	

#	Provision	Assessment of Status	Compliance
		information, or the author of the report did not revise the sections to include any new information. ▪ There was no evidence that the PST met to review potential adaptive skills related to the multiple restraints that occurred on 5/18/11 for Individual #221. ▪ There was no evidence that the PST met to review potential adaptive skills related to the multiple restraints that occurred on 7/25/11 and 7/28/11 for Individual #240. Of the three individuals reviewed, none (0%) of the individuals' PSTs appeared to discuss potential biological/medical factors associated with the restraints. The following are examples of where teams failed to do this adequately: ▪ Documentation for Individual #4, a PSP Addendum dated 6/28/11, provided a brief health/medical history of the individual and information regarding previous medications. However, it should be noted that most of this section was cut and pasted from previous reports, and that only the final brief section contained new information. As written, it appeared that little new content was offered. This was significant, given the fact that the team had previously discussed (on 6/10/11) an "unidentified mass near his spleen" that could be "a possible source of [individual's] agitation." This ongoing medical issue should have been discussed, including progress or lack of progress on medical evaluation, and adequately reflected in this section. ▪ There was no evidence that the PST met to review potential biological/medical factors associated with the multiple restraints that occurred on 5/18/11 for Individual #221. ▪ There was no evidence that the PST met to review potential biological/medical factors related to the multiple restraints that occurred on 7/25/11 and 7/28/11 for Individual #240. Of the three individuals reviewed, none (0%) of the individuals' PST team appeared to discuss potential psychosocial factors associated with the restraints. The following are examples of where teams failed to do this adequately: ▪ Documentation for Individual #4, a PSP Addendum dated 6/28/11, provided a very brief history of factors related to past relationships and changes in placement. However, it should be noted that the entire section was cut and pasted from previous reports. This was unfortunate as a recent change in placement occurred (returned to LBSSLC in March 2011), that may have influenced rates of escalating behaviors, but was not mentioned within this section. ▪ There was no evidence that the PST met to review potential psychosocial factors related to the multiple restraints that occurred on 5/18/11 for Individual #221. ▪ There was no evidence that the PST met to review potential psychosocial factors	

#	Provision	Assessment of Status	Compliance
		related to the multiple restraints that occurred on 7/25/11 and 7/28/11 for Individual #240.	
	(b) review possibly contributing environmental conditions;	Of the three individuals reviewed, only one (33%) individuals' team reviewed the possibly contributing environmental conditions associated with the utilization of restraint. The following is an example where the PST completed this appropriately: ▪ Documentation for Individual #4, a PSP Addendum dated 6/28/11, indicated that the PST discussed several environmental variables that might have contributed to the agitation and aggressive behavior that led to restraint. The following are examples of where teams failed to do this adequately: ▪ There was no evidence that the PST met to review potential environmental conditions associated with the multiple restraints that occurred on 5/18/11 for Individual #221. ▪ There was no evidence that the PST met to review potential environmental factors that may have been related to the multiple restraints that occurred on 7/25/11 and 7/28/11 for Individual #240	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Of the three individuals sampled, only one (33%) individuals' PST met to review and/or performed structural and functional assessments of the behavior provoking restraints. The following are examples of where the PST did this appropriately: ▪ Documentation for Individual #4, a PSP Addendum dated 6/28/11, revealed that the PST team discussed potential variables occasioning target behaviors, as well as potential underlying functions of the challenging behavior. The PST process would have shown greater insight and thorough problem solving if issues discussed at previous PST meetings (e.g., the role of gall stones), and noted within this section in the previous report, were followed up on within this section in the subsequent report. The following are examples of where teams failed to do this adequately: ▪ There was no evidence that the PST met to review potential structural or functional analysis regarding the multiple restraints that occurred on 5/18/11 for Individual #221. Indeed, no evidence was provided to indicate that an SFAR had been completed. ▪ There was no evidence that the PST met to review potential structural or functional analysis regarding the multiple restraints that occurred on 7/25/11 and 7/28/11 for Individual #240. It should be noted, however, that a SFAR, dated 12/01/10, was in place at the time of the restraints.	Noncompliance
	(d) review or perform functional	See Section C.7.c above	Noncompliance

#	Provision	Assessment of Status	Compliance
	assessments of the behavior provoking restraints;		
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	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: ▪ Three (100%) specified the objectively defined behavior to be treated that led to the use of the restraint; ▪ One (33%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint; ▪ Three (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint The following are examples of where the alternative, positive adaptive behaviors identified in the PBSP appeared to be inadequate: ▪ The replacement behavior (daily scheduling) did not appear to be an appropriate replacement for aggression (targeted behavior for decrease) as described in the PBSP for Individual #221. Other responses outlined in the PBSP, for example, deep breathing, counting, and problem solving, appeared to offer perhaps a more functional and adaptive replacement to aggression. ▪ The replacement behavior (problem solving training), although seemingly appropriate as an alternative, adaptive skill was not adequately operationally defined for Individual #240. 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.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	As presented with regard to Section K.11 of the Settlement Agreement, since the Monitoring Team's last visit, examination of treatment integrity had continued to improve. However, based on the summary treatment integrity documentation provided, identification of a specific individual was not possible. Consequently, at the current time, evidence to support that selected individuals' PBSPs were implemented with integrity was not available.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(g) as necessary, assess and revise the PBSP.	Of the three individuals sampled, documentation was available for one individual (33%) indicating that the PSTs had reviewed their PBSPs. The following is an example of an individual for whom this was done appropriately: ▪ Documentation provided (PSP Addendum, dated 6/28/11) reflected the PST's decision to not modify or revise the PBSP of Individual #4 at the current time. The following are examples of where teams failed to do this adequately: ▪ There was no evidence that the PST met to assess or review the current PBSP following the multiple restraints that occurred on 5/18/11 for Individual #221. ▪ There was no evidence that the PST met to assess or review the current PBSP following the multiple restraints that occurred on 7/25/11 and 7/28/11 for Individual #240	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	As in previous reports, through interview, record review and observation, it was documented that LBSSLC had 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. The minutes from multiple such meetings indicated that review and discussion occurred as expected. During the onsite monitoring visit, Incident Management Review Team meetings were observed, and discussion of restraint was evident on the day after the episode. Follow-up to restraint episodes was noted as being tracked more thoroughly and consistently. 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. His analysis, as documented in the report "Section C Compliance Data," indicated that 216 out of 216 restraint episodes (100%) were reviewed within three business days during the period from 4/11 through 8/11. The Restraint Reduction Committee continued to meet 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 five individuals (Individual #213, Individual #4, Individual #221, Individual #266, and Individual #124) with either a higher frequency of restraint use or a revised medication regime. 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. There was a discussion of the barriers to supported employment opportunities and the ways in which LBSSLC could develop this programmatic initiative. In addition, problems with restraint	Noncompliance

#	Provision	Assessment of Status	Compliance
		documentation were discussed, including the late notification and arrival of nursing personnel. Information was provided to the Monitoring Team that documented monitoring initiatives undertaken by the Quality Assurance staff, in concert with the Director of Behavioral Services, during the months since the last site visit. The findings from this set of monitoring activities mirrored the strengths and weaknesses examined in the above narrative related to Section C. A sample of documentation related to 25 incidents of non-medical restraint was reviewed (Sample #C.1), including the restraint checklists and the debriefing forms. This documentation showed that: ▪ In 25 incidents (100%), this review occurred within three days of the restraint episode. ▪ In 25 incidents (100%), the circumstances under which it was used was determined; ▪ There was clear evidence that the Director of Behavioral Services, the clinical staff and the members of such Committees as the Restraint Reduction Committee and the Incident Management Review Team attempted to conduct a thorough review of each restraint episode. Minutes from the Committee meetings. The Trend Analysis for restraint episodes through 9/11 documented the cessation of restraint use for Individual #33, Individual # 221, and Individual # 4, and the sharp decline in restraints for Individual # 240. Individual #124 was admitted in 2/11, and the use of restraint had been escalating. Each of these individuals had been the focus of concerted attention and effort to design and implement more individualized approaches. However, as discussed in detail with regard to Section C.7, individualized teams were not meeting as required to consider necessary changes to ISPs, particularly for individuals for whom restraint had been used more than three times in a 30-day period. The review and modification of individuals' ISPs, including the examination of a variety of factors, is a key element of compliance with this provision. During the site visit, recommendations were made during Committee meetings for the implementation of supported employment and other initiatives to expand the range of individualized alternatives to restraint. The Facility was examining the obstacles to the implementation of these initiatives.	

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

1. Direct support professionals should receive further training on how to use clear, descriptive, and specific information when documenting events, including their responses, prior to restraint. General comments like "verbal redirection and coping skills" are vague and not helpful in examining how to support and keep individuals and staff safe in the future. In addition, if targeted behavior is so extreme and immediate that staff cannot attempt less restrictive strategies, they need to document this on the restraint form (i.e., check the item "None due to unanticipated severe dangerous behavior"). (Section C.1)
2. Restraint Monitors should receive training on how to review restraint checklists to ensure that provided information is adequate, clear, and comprehensive. As these monitors are primarily psychologists, their aim should be to determine if the restraint report provides sufficient description to evaluate if the PBSP and SPCI were implemented as written, and determine the corresponding effectiveness of attempted interventions. (Section C.1)
3. Clear methodologies should be developed and implemented to ensure the all staff, including "pulled" staff know which individuals cannot be restrained due to medical or other contraindications. (Section C.4)
4. The quality of desensitization plans should be improved by: 1) ensuring that the targeted skill(s) is specifically defined; 2) including a specific discriminative stimulus within the objective, at least initially until the skill is performed consistently; 3) avoiding redundancy of content across steps by only including information or criteria that is unique to a particular step; 4) if desired, including in the objective and mastery criteria the acceptable prompt level to meet criterion; 5) ensuring that instructions for incorrect responding are clear, can be easily generalized across steps, and specify when reinforcement is <u>not</u> delivered; and 6) individualizing each plan. (Section C.4)
5. 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 ISP Reviews (i.e., along with other skill program data). (Section C.4)
6. 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. Timely review requires prompt notification of the health care professional. (Section C.5)
7. The Facility should ensure that nursing staff assess and appropriately document any restraint-related injury. (Section C.5)
8. The Facility should ensure that IDTs meet following the use of more than three restraints in a 30-day period. When the IDT does meet, the team should closely examine current factors that might influence the expression of target behaviors leading to restraint. (Section C.7)
9. To address the issue of PSP Addendums that appeared to "cut and paste" a substantial amount of information from previous reports, and lacked follow-up on previously identified issues, the Facility should consider dating sections of content if it is "cut and paste" from previous reports, and clearly indicate recently added content. (Section C.7)
10. Sections of the "four or more restraints in 30 days" PSP Addendum rubric should include more data and review of progress of adaptive skills (i.e., the skills being taught as replacement behaviors, including data on progress), as well as any potential current factors (e.g., psychosocial, medical, etc.). If the IDT does not observe any current issues, this determination should be documented within the ISP addendum. (Section C.7)
11. 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 C.8)
12. The Facility Director should consider granting the Director of Behavioral Services access to the videotapes of restraint episodes. Review of video footage would permit greater analysis of restraint use, including the antecedents to problematic behaviors. (Section C.8)
13. As the Facility identified, certain individuals with a history of challenging behaviors have indicated considerable interest in employment. As a means to further reduce the means of restraint for these individuals, the Facility should consider implementation of more opportunities for community-based supported employment. (Section C.8)

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 [A/N/E]," revised 4/20/11; "Incident Management: Critical Incident Team," draft revised 8/24/11; and "Communication Process: Administrator on Duty;" o Sample #D.1 included a sample of 21 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: #39080488, #39177607, #39263147, #39275288, #39310927, #39546568, #39620148, #39669807, #39681707, #39742567, #39744427, #39751168, #39788967, #39815368, #39821887, #39948227, #40107467, #40208160, #40219075, #40241866, and #40245846; o Sample #D.2 included a sample of 19 investigation reports completed by the Facility only or by the Facility in conjunction with DFPS. Sample D.2 included cases: #11-04-159, #11-04-160, #11-04-164, #11-05-179, #11-05-184, #11-05-187, #11-05-191, #11-05-192, #11-06-206, #11-06-218, #11-06-221, #11-06-231, #11-06-234, #11-06-239, #11-07-240, #11-07-241, #11-07-265, #11-08-280, and #11-08-281; o Analysis of Peer-to-Peer Aggression at 520 Cedar, dated 7/17/11; o Rights Booklet, dated 2009; o Personal Support Plans (PSPs) for Individual #4, Individual #170, Individual #221, and Individual #288; o Personal Support Plan Addenda (PSPAs) re: injury for Individual #2, Individual #33, Individual #73, Individual #125, Individual #183, Individual #185, Individual #203, Individual #298, and Individual #315; o Consultation Reports by Dr. S. Carter regarding Individual #124, Individual #239, Individual #240, and Individual #288; o List of Individuals (1) for whom Adult Protective Services Conducts "Streamlined Investigations;" o List of Staff (2) who failed to report A/N/E and actions taken; o Background check spreadsheets; o Rights Poster; o Training records/transcripts for Facility investigators; o Training records/transcripts for DFPS investigators; o Statements acknowledging reporting obligations signed by 40 employees; o Statements acknowledging reporting requirements for foster grandparents; o Training transcripts for 40 employees regarding training on the reporting of abuse, neglect, and exploitation; o Presentation Book for Section D; o Minutes of Quality Assurance/Quality Improvement (QA/QI) Council meetings, dated

	6/13/11 through 8/18/11; o Incident Investigation file for DFPS Case #499099 reviewed by surveyors on 6/10/11; o Sample #D.3, including, incident investigation files for: DFPS Case #39941171; DFPS Case #40134216; DFPS Case #40133088: DFPS Case #40092507; DFPS Case #40147827; DFPS Case #39815368; DFPS Case #40111929; DFPS Case #38720254; Facility Case #11-06-221; Facility Case #11-06-228. (These investigations all related to individuals living either in Sparrow or Quail.) o List of individuals (10) with Safety Plans; o Minutes of Incident Management Review Team (IMRT) meetings for each Monday since the last site visit; o List of injuries by individual; o Trend Analysis Report for the 4th Quarter; o Plan of Improvement/Self-Assessment for Section D, dated 9/19/11; o Minutes of the Human Rights Committee (HRC), from 4/6/11 to 9/7/11; and o Background check information for employees and volunteers. ▪ **Interviews with**: o Libby Allen, Facility Director; o Melinda Voight, Risk Manager; o Rodney McWilliams, Interim Incident Management Coordinator; o Juli Ann Brown, Investigator; o Amanda Ellis, Investigator; o Jim Forbes, M.Ed, C.B.A., Director of Behavioral Services; o Dawn Ripley, Director of Quality Assurance; and o Informal interviews/conversations with staff and individuals. ▪ **Observations of**: o 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; o Incident Management Review Team Meetings, on 10/3/11, 10/5/11, and 10/6/11; o Safety Committee meeting, on 10/6/11; o Abuse/Neglect/Exploitation workgroup meeting, on 10/6/11; o Quality Assurance/Quality Improvement Committee meeting, on 10/4/11; o Joint meetings with LBSSLC staff and Monitoring Team members to discuss risk identification and intervention strategies for Individual #33, and Individual #136, on 10/5/11 and 10/6/11, respectively; and o PSP meeting for Individual #170, on 10/5/11.
	Facility Self-Assessment: In its Plan of Improvement/Self-Assessment, LBSSLC concluded that it was in Substantial Compliance with the following 17 provisions: D.1 (policy implementation); D.2.b (prompt removal of alleged perpetrators); D.2.c (competency based training); D.2.d (acknowledgement of obligation

	to report); D.2.e (education of individuals and guardians, etc.); D.2.f (posters); D.2.g (referral to law enforcement); D.2.h (retaliation); D.3.a (qualified investigators); D.3.b (cooperation with outside entities); D.3.c (coordination with law enforcement); D.3.d (safeguarding of evidence); D.3.f (standardized reporting format); D.3.g (supervision of report); D.3.h (written report); D.3.j (record access); D.5 (background checks). The Monitoring Team agreed that there was substantial compliance with the following 12 provisions: D.1, D.2.c, D.2.d, D.2.f., D.2.g, D.2.h, D.3.a, D.3.b, D.3.c, D.3.d, D.3.j, and D.5. In addition, the Monitoring Team concurred with continued noncompliance findings that the Facility cited. The Facility confirmed that it was not in compliance with the provisions related to immediate reporting of serious incidents (D.2.a); the semi-annual auditing of the investigation of significant resident injuries (D.2.i); commencement of each investigation within 24 hours (D.3.e); tracking and documentation of disciplinary and programmatic actions (D.3.i); and the tracking and trending of unusual incidents and investigations (D.4). For each of these areas of noncompliance, a summary of actions taken to implement the requisite provisions was provided in chronological order. The name of the responsible person, the projected completion date and the current status was included in the summary. The Facility identified a series of accomplishments and progress since the last site visit, including the installation of a new Incident Management module within the Avatar/CWS system; the expansion of Campus Administrator staffing (i.e., two new positions), and schedules on the weekends in order to ensure a continuous presence; and the creation of two Root Cause Analysis workgroups by the Quality Assurance/Quality Improvement Council to address Abuse/Neglect/Exploitation, and Serious Injuries. These workgroups were initiated on 6/13/11 and 9/9/11, respectively The Facility had begun incorporating some of the data from its self-assessment processes into Section D of its POI. However, at times, it was unclear whether the samples chosen for the audits were appropriate, and/or adequate to provide a valid picture of the strengths and weaknesses of the system. One example of this related to Section D.2.d, which requires that staff be informed of the reporting requirements related to abuse and neglect, and sign a statement acknowledging their responsibility. In its assessment, the Facility cited that 100% of the staff were trained, but did not cite the source of this information, and/or how this had been validated. The Facility also included data from monthly audits that were completed, presumably of investigation files, but this was not specifically stated. These sample sizes were small, consisting of approximately four per month. Just as the Monitoring Team has done, the Facility should select various samples from various sources of information, depending on the requirement being measured. For D.2.d, for example, the Monitoring Team pulls an additional sample of signed statements from the newly hired, as well as tenured staff. As the Facility expands its self-assessment processes, it will be important to ensure that the samples selected properly represent the overall population of what is being measured.
	Summary of Monitor's Assessment: The Facility's prioritization of the investigation of serious incidents is recognized and commended. DFPS and the Facility had made notable progress in a number of areas described below, including the completion of all requisite investigator training, increased inclusion of written extensions by DFPS and greater attention to the development of recommendations. The investigation reports continued to comply with the standardized format. All sections of the format

	generally were found to be complete. The Director of the Facility indicated that the appointment of an Incident Management Coordinator was pending. In the meantime, the Interim Incident Management Coordinator had initiated the analysis of data available to him about the nature of the serious incidents/allegations and the status of investigations. Although there was additional work to be done, this was a very positive step. Although the investigations generally included a statement regarding previous allegations for both the alleged perpetrator and the individual, there was no indication that a detailed analysis of these facts had been completed as part of the investigative process. Furthermore, the review of investigation reports highlighted continuing deficiencies in timely reporting and commencement of the investigation within 24 hours.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	As discussed in earlier reports, the Facility's policies and procedures: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals within one hour, or as soon as possible. These policies were reflective of policies at the State Office level. There was clear evidence that the Facility was working in good faith to implement the mandated policies. The Facility's leadership continued to set firm expectations regarding the prevention of abuse, neglect, and exploitation. During the site visit, it was evident that the Director and her key staff had begun to establish multiple safeguards. For example, staff training on the reporting of abuse and neglect was a priority; the discussions at Incident Management Review Team meetings were substantially more detailed and focused on follow-up; video footage was used effectively in the investigation of allegations; and, when allegations were confirmed, disciplinary action was applied consistently. The review of over 40 investigation reports documented that employees were terminated for the failure to report abuse and/or neglect, as well as for the act itself. All staff interviewed during the monitoring visit knew that abuse, neglect or exploitation would not be tolerated, and stated that they were familiar with reporting requirements. There appeared to be a strong reporting trend among the most recently hired employees. Their actions helped to validate the effectiveness of staff training.	Substantial Compliance
D2	Commencing within six months of		

#	Provision	Assessment of Status	Compliance
	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. In contrast to previous site visits, the Interim Incident Management Coordinator had made considerable progress in analyzing and reporting data about serious incidents, and allegations of abuse, neglect, or exploitation. He and the Risk Manager had worked closely to provide detailed information about the occurrence of serious injuries. This analysis was presented at the Safety Committee meeting conducted during the site visit. Injuries were tracked by individual, type, cause, location, and shift. Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and would need to review carefully whether incidents were preventable, and whether adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The Facility's progress in analyzing data collected and in addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement. According to Facility data provided in response to Document Request TX-LB-1108-III.16, the numbers of Unusual Incidents included:	Noncompliance

#	Provision	Assessment of Status	Compliance

	1/1/10 to 12/31/10 (12 months)	1/1/11 to 6/30/11 (6 months)
Deaths	10	5
Serious Injuries	36	24
Sexual Incidents	Not provided	2
Suicide Threat (credible)	Not provided	1
Unauthorized Departure	Not provided	20
Choking	2	1
Other	Not provided	6

In order to implement corrective actions, the Facility had appointed the Risk Manager to conduct a root cause analysis of serious injuries. This group reported monthly to the Quality Assurance/Quality Improvement Council. Specific actions also were being implemented for individuals at higher risk. The individuals' interdisciplinary teams developed these plans/supports, and they were documented in the Personal Support Plan Addenda. Efforts had been initiated to analyze the causes of falls, and remedial actions were beginning to be implemented.

Although a significant improvement since earlier site visits, analysis of the data regarding the allegations of abuse, neglect and exploitation appeared to be less refined. For example, documentation provided to the Monitoring Team indicated:

- There were 124 allegations of abuse, neglect, or exploitation.
- Of these, 25 were confirmed (20%), 77 were unconfirmed (62%), five were inconclusive (4%), and two were unfounded (1%).

Further analysis had not been completed at the time of the site visit. However, an A/N/E workgroup had been formed and were expected to address the issues seen as contributing factors.

Based on an interview of 15 staff responsible for the provision of supports to individuals, 15 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.

Based on an interview of 15 staff responsible for the provision of supports to individuals, 15 (100%) were able to describe the reporting procedures for other serious incidents.

Two samples of investigations (20% of the total number 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:

#	Provision	Assessment of Status	Compliance
		#39080488, #39177607, #39263147, #39275288, #39310927, #39546568, #39620148, #39669807, #39681707, #39742567, #39744427, #39751168, #39788967, #39815368, #39821887, #39948227, #40107467, #40208160, #40219075, #40241866, and #40245846. ▪ Sample #D.2 which included a sample of Facility investigations. Some of these were investigations that had been referred to the Facility by DFPS, while others were investigations the Facility completed related to serious incidents. This sample included the following investigations: #11-04-159, #11-04-160, #11-04-164, #11-05-179, #11-05-184, #11-05-187, #11-05-191, #11-05-192, #11-06-206, #11-06-218, #11-06-221, #11-06-231, #11-06-234, #11-06-239, #11-07-240, #11-07-241, #11-07-265, #11-08-280, and #11-08-281. In addition to the investigation reports contained in Sample #D.1 and D.2, additional incident reports were selected for review (Sample #D.3). This Sample included ten investigation reports of incidents that occurred on either the Sparrow or Quail living units. The investigations included in Sample #D.3 included: DFPS Case #39941171; DFPS Case #40134216; DFPS Case #40133088: DFPS Case #40092507; DFPS Case #40147827; DFPS Case #39815368; DFPS Case #40111929; DFPS Case #38720254; Facility Case #11-06-221; and Facility Case #11-06-228. Based on a review of the 40 investigation reports included in both Sample #D.1 and Sample #D.2: ▪ 22 out of 38 (58%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. (Incident # 39815368 was a false allegation by a disgruntled spouse, and Incident #11-06-231 was an allegation that did not involve LBSSLC. These two investigations are not included in this analysis.) Investigation reports that documented delays in reporting included: #39310927, #39546568 (two days late), #39669807 (five days late), #39681707 (two days late), #39742567 (almost two hours late), #39744427(22 days late), #39788967 (10 days late), #40208160 (could not determine), #40107467 (could not determine), #11-04-159 (could not determine), #11-05-179 (could not determine), #11-05-184 (seven days late), #11-06-206 (three weeks late, but was a replication of an earlier report), #11-06-218 (referred by Incident Management meeting), #11-06-234 (could not determine - self-report), and #11-06-239 (could not determine - self report). However, some of the reports in this sample were most likely made by individuals themselves, and there was no requirement that they report timely, nor was there any way to ascertain that it was the individual and not someone else who was making the allegation. The identity of reporters was protected, precluding any inquiry into who made reports. ▪ 40 (100%) included evidence that allegations of abuse, neglect, and/or	

#	Provision	Assessment of Status	Compliance
		exploitation were reported to the appropriate party as required by Facility policy. Based on a review of 10 incident reports included in Sample D.3: ▪ Four out of eight (50%) showed evidence that serious incidents were reported within the timeframes required by Facility policy. Incidents not reported timely included: #11-07-246 (26 hours), #11-03-140 (18 hours), #11-07-251 ("a few weeks"), and #11-06-228 (unknown). Two allegations were false and are not included in this analysis. ▪ Ten (100%) showed evidence that serious incidents were reported to the appropriate party as required by Facility policy. ▪ The Facility did a standardized reporting format. As discussed in earlier reports, the format met generally accepted standards and included the criteria required by the Settlement Agreement, including information for adequate tracking and trending of incidents. Based on a review of 40 investigation reports included in Sample #D.1 and Sample #D.2, 40 (100%) contained a copy of the report utilizing the required standardized format. Based on a review of 10 incident reports included in Sample #D.3: ▪ Ten (100%) utilized the standardized reporting format; and ▪ Ten (100%) were completed fully.	
	(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: Reassigning Staff Due to ANE," issued on 5/6/11, 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 40 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. It was the policy/practice of LBSSLC to assign alleged perpetrators away from the site of the allegation until the investigation is completed, and they were cleared. Alleged perpetrators were assigned administrative or foodservice tasks. Since the last site visit, the Facility had begun to track the date of return to duty or the final action, if any, taken against the employee. However, some problems had been identified, and the Interim Incident Management Coordinator was redesigning the database. The progress of this initiative will be reviewed again during the next monitoring visit to corroborate its timeliness and comprehensiveness. The establishment of a reliable information system to ensure that appropriate and timely action has been taken will be necessary in order for a finding of substantial compliance to be made. Without such information, it could	Noncompliance

#	Provision	Assessment of Status	Compliance
		not be confirmed that the staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation, or the conclusion of the investigation allowed their return to direct contact duties. Based on a review of the above investigation reports, it was documented that adequate additional action was taken to protect individuals who were the alleged victim in an investigation. The Incident Management Review Team minutes indicated that the completion of follow-up actions by the Interdisciplinary Team or other assigned staff was being tracked. Examples of Personal Support Plan Addenda were reviewed. These documents confirmed that team meetings were convened in a timely manner to review serious incidents and allegations.	
	(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," during new employee orientation and every 12 months thereafter, all staff were obligated to attend competency-based training on preventing abuse and neglect. 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. A review of the training curricula related to abuse and neglect was reviewed for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: ▪ In relation to the requirement that training be competency-based, the training did include quizzes to determine whether the employee had mastered the knowledge and performance criteria. These competencies also were spot-checked during the monitoring visits by Quality Assurance staff; ▪ The training provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of records for 25 staff hired in August and September 2011 indicated that these 25 staff (100%) had completed competency-based training on abuse and neglect prior to working directly with individuals. In addition, a sample of 15 employees with longer employment tenure was selected for review. Each of these employees had also completed their annual training. The Facility provided copies of a statewide document, issued on a monthly basis, to verify that staff training had been completed as required. The documentation for 4/11 through 7/11, and for 9/11 reported 100% compliance. (The documentation for 8/11 was missing.)	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		During the informal site visits to the living units, direct support professionals were queried about the process of reporting allegations of abuse, neglect, exploitation, or other serious incidents and their comfort level with these obligations. One employee had reported an allegation and confirmed that the process worked as expected. 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. Posters reminding employees of this duty were posted throughout the Facility's buildings.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	As described in earlier reports, the Facility's policy and practice required that all employees sign a statement confirming the obligation to report abuse, neglect, and exploitation. The statement was first signed at new employee orientation and, then, annually thereafter. A sample of 40 employees was selected for review. The first group of 25 employees was hired within the last two months, and the second group consisted of employees with a longer tenure. All (100%) of the employees reviewed had evidence of the acknowledgement of the obligation to report located in their personnel records. All 15 employees queried informally about this obligation were able to describe their responsibility. All 15 employees wore a name badge with the reporting instructions printed on one side. The Monitoring Team was provided documentation of disciplinary action against two employees who failed to report. The first received a letter of reprimand for failure to report an allegation of verbal/emotional abuse. The second employee was terminated for failing to intervene in an incident of physical abuse.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report	As in earlier reports, a review was conducted of the materials used to educate Legally Authorized Representatives (LARs), or others significantly involved in the individual's life. The letter attached to the Resource Guide clearly articulated zero tolerance for abuse, neglect, or exploitation. Correspondents were asked to acknowledge receipt of this information. During the next site visit, a sample of any responses will be reviewed. The Facility stated that it utilized the annual ISP meetings to educate individuals, primary correspondents, and LARs about the means to identify and report unusual incidents,	Noncompliance

#	Provision	Assessment of Status	Compliance
	unusual incidents, including allegations of abuse, neglect and exploitation.	including allegations of abuse, neglect, and exploitation. However, at the annual meeting, held on 10/5/11, for Individual #170, it was noted that the QDDP went over the reporting process for him prior to the meeting. No reference was made to any information provided to his mother. At this same meeting, the injury, abuse, and neglect data from the last year was referenced. However, detailed information was not provided to the IDT, and, thus, a meaningful discussion could not occur. The discussion of such data is a significant positive addition to the annual meeting. However, a process now must be initiated to share relevant information. This is discussed in further detail with regard to Section F of the Settlement Agreement. ISPs were examined for Individual #4, Individual #221, and Individual #288. Information regarding his rights was included for Individual #4. However, there was no documentation provided that confirmed that Individual #221 and Individual #288 received instruction on the reporting of unusual incidents, including allegations of abuse, neglect or exploitation. (The review of investigation reports for Individual #288 in earlier reports did indicate that he had reported allegations of abuse.)	
	(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.	As described in the last report, LBSSLC had taken actions to comply with its own policy requiring the posting of information on individual rights. As noted in the previous report, 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. Posters were located in all residential units and vocational/day program areas. The majority of the posters was visible and placed at the appropriate eye level with the exception of posters in 527, 519, and 518. When asked, employees working in the residences and the workshop were able to identify the location of the poster and to describe, in general terms, how they were used to teach individuals about their rights. A Team Leader in 528 was notably articulate about this issue. Although not a requirement of the Settlement Agreement, the most meaningful instruction about the exercise of rights appeared to take place in the two self-advocacy groups at LBSSLC. The Self-Advocacy Group continued to meet monthly, and discussed the "right of the month." The members of the group now had chosen officers. The Human Rights Officer continued to provide her substantial support.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Since the last report, the "Mustang Aktion Club" had been formed. The Club had 11 members, including four Club Officers. The Club had initiated two community-based projects, including a canned food drive and a recycling program. Both of these projects provided opportunities for interaction with local businesses and neighborhoods.	
	(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. The Director, or her designee, was to report allegations involving "sexual exploitation" committed by a mental health services provider to the prosecuting attorney, and the appropriate state licensing board. Upon request during the site visit, documentation was provided to the Monitoring Team of nine allegations that were referred to and investigated by a law enforcement agency. Those cases included: #11-03-146, #11-05-186; #11-05-198; #11-06-214, #11-06-215, #11-06-224, #11-07-245, #11-07-248, and #11-09-023. All but one case (#11-06-224) involved allegations of physical abuse. The exception was an allegation of false reporting. All allegations were substantiated, and all cases were referred to the District Attorney's office. In addition to describing the allegation and the finding from the investigation, the law enforcement reports periodically cited a risk factor that required attention by the Facility. For example, in #11-03-146, it was documented that the shift supervisors had not conducted random visits to the residential units, as required by the Facility's protocol. One of the Facility investigations, #11-04-159, reviewed as part of Sample #D.2, was referred to a law enforcement agency. Referral was not necessary in any of the other incidents.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling,	As indicated in the last report, 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 (OIG), 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 a law enforcement authority. Any employee or agent found to have engaged in retaliatory action was subject to disciplinary action.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	Based on interviews with the Director, the Acting Incident Management Coordinator, and one of the Facility Investigators, no staff had reported a fear of retaliation. However, while visiting a residence, one employee informed a Monitoring Team member that she would be worried about reporting staff who spoke too loudly to the individuals in her unit. Another employee expressed a fear of retaliation during the informal interviews conducted throughout the site visit. She was concerned that retaliation could occur outside of the confines of the Facility, for example, in the parking lot at WalMart. This concern was discussed with the Facility Director and an attorney with the State Attorney General's Office. The Monitoring Team was assured that employees would be informed during training that the issue of any off-site retaliation connected to an incident at LBBSLC would be thoroughly investigated and prosecuted, if necessary. In all, two out of 15 staff (13%) expressed some concern about retaliation for reporting abuse, neglect or exploitation. According to the Director, a number of actions had been taken to reduce any fear of retaliation. These actions included: ▪ Discussion of retaliation at town hall meetings; ▪ Discussion with security officers to be alert to this possibility; and ▪ Expanded communication with employees, including queries on the residential units by the Assistant Ombudsman. In addition, since 5/11, clinical/professional staff were assigned as mentors to all but one residential unit. Part of their roles as mentors was to encourage staff to talk to them about concerns, and provide an additional mechanism for staff to raise issues outside of their direct line of supervision. Based on a review of 50 investigation files (the 40 investigations in Samples D.1 and D.2, plus the 10 investigations involving the Sparrow/Quail units), no concerns were noted related to potential retaliation.	
	(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 actually were reported for investigation. The turnover in the Incident Management Coordinator position appeared to have delayed efforts to achieve compliance with this requirement. It was reported, in the Plan of Improvement/Self-Assessment, that, during the month of 8/11, Campus Coordinators	Noncompliance

#	Provision	Assessment of Status	Compliance
		and Campus Administrators performed a 20% sample (at least five per residence) of individual records. The findings from these reviews were to be integrated into the Facility database that was under development.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DADS Policy Number 002.2: Incident Management, dated 6/18/10, governed the investigation of abuse, neglect, exploitation, theft, serious injury, and other serious incidents involving individuals residing in State Supported Living Centers. DADS Policy Number 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 and transcripts were reviewed for DFPS and Facility investigators. This review revealed the following: ▪ Training curricula was reviewed for the Department of Family and Protective Services and Facility investigators. This review was described in detail in previous monitoring reports. The curricula for the Facility and the DFPS	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		investigators were generally determined to be adequate. As indicated in previous reports, with regard to the DFPS training, 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. Although the training covered the basics of investigations, ongoing training should cover additional topics, such as these. ▪ DFPS provided transcripts regarding the training provided to its eight investigators. According to the information provided, all investigators (100%) had received training in fundamentals of investigations, and in working with people with mental retardation. ▪ Both Facility Investigators (100%) had direct experience in working with individuals with mental retardation/developmental disabilities. Both of their training transcripts (100%) indicated that they had been trained in the courses the LBSSLC policy required. The Interim Incident Management Coordinator did not conduct investigations. He had completed a training session on "Conducting Serious Investigations," taught by Labor Relations Alternatives.	
	(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. When requested, this included deferring and/or coordinating 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. As described in D.2.g., law enforcement officials conducted nine investigations regarding physical abuse and a false allegation with the cooperation of LBSSLC leadership and staff. In addition, in #11-04-159, law enforcement investigated a theft of funds ($91) from a staff person's backpack at the Facility. These funds were to be used for recreational activities. No one was identified as the perpetrator. In an effort to increase interagency collaboration, the Director of LBSSLC had continued to convene meetings 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		relationships with DFPS, local law enforcement, 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 (MOU), 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." As discussed above with regard to Section D.3.b, there was evidence of cooperation between the Facility and law enforcement agencies, including the local police, and the OIG.	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), no incidents required 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 important evidence that resulted in disciplinary action, including termination from employment. 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.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being	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;	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	▪ 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 twenty-one DFPS investigations: ▪ Ten out of 21 (48%) 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 #40241866; Investigation #40245846; Investigation #39177607; Investigation #39310927; Investigation #40219075; Investigation #39821887; Investigation #39744427; Investigation #39815368; Investigation #39080488; and Investigation #39546568. o The following were investigations for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary, based on the documentation provided: ▪ Investigation #39275288, an allegation of physical abuse/neglect; ▪ Investigation #39751168, an allegation of neglect; ▪ Investigation #39742567, an allegation of physical abuse; ▪ Investigation #40208160, an allegation of verbal abuse; ▪ Investigation #39620148, allegation of neglect; ▪ Investigation #39681707, allegation of physical abuse/neglect; ▪ Investigation #39948227, an allegation of neglect; ▪ Investigation #40107467, an allegation of neglect; ▪ Investigation #39788967, an allegation of physical abuse; ▪ Investigation #39669807, an allegation of neglect; and ▪ Investigation #39263147, an allegation of physical abuse.	

#	Provision	Assessment of Status	Compliance
		Based on the Monitoring Panel's discussions with DFPS in December 2010 and June 2011, DFPS was 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. ▪ Eighteen out of 21 (86%) were completed within 10 calendar days of the incident, including sign-off by the supervisor, or had appropriate extensions granted. The investigations without supervisory signature were Investigation #39275288 and #39263147. The investigation without a written extension in the file was Investigation #39177607. ▪ All investigations resulted in a written report that included a summary of the investigation findings. ▪ In four of the investigations (19%) reviewed (#39275288, #39751168, #40219075, and #39669807), recommendations for corrective action were included. In these investigations, the recommendations were adequate to address the findings of the investigation. 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 IDTs 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 greater extent since the last site visit, in the daily Incident Management Review Team meeting. In some of the investigation files, evidence was found that ISP Addenda were developed or that in-service training was provided to staff. Although these follow-up actions were important and, in certain cases, had very positive results, the Facility should continue to consider ways to prevent incidents from occurring in the first place through the development and implementation of proactive strategies at the individual and programmatic levels. 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 nineteen Facility investigations: ▪ Eleven out of 19 (58%) 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	

#	Provision	Assessment of Status	Compliance
		hours of the Facility being notified of the serious incident. The following are examples of the investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: o Investigation #11-04-159 regarding a theft; o Investigations #11-04-164, #11-07-241, and #11-08-280, regarding unauthorized departures; o Investigations #11-05-179, #11-05-191, #11-05-192, #11-07-240, and #11-08-281, regarding serious injuries; ▪ Twelve out of nineteen (63%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. One investigation (#11-06-221) was completed on time, but the signature was late. Six investigations did not have written extensions (i.e., Investigations #11-04-159, #11-04-160, #11-05-184, #11-06-206, #11-06-218 and #11-06-231); ▪ All but one investigation (#11-04-159), or (95%) resulted in a written report that included a summary of the investigation findings. ▪ In 10 of the 19 investigations reviewed (53%), 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.	
	(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 had been trained on the preparation of the investigation report, and, in general, there was a thorough response to each of the required sections. Although	Noncompliance

#	Provision	Assessment of Status	Compliance
	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, no analysis was provided 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: ▪ In all of the investigations, or 100%, the contents of the investigation reports reviewed were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 21 out of 21 (100%), each serious incident or allegations of wrongdoing; o In 21 out of 21 (100%), the name(s) of all witnesses; o In 21 out of 21 (100%), the name(s) of all alleged victims and perpetrators; o In 21 out of 21 (100%), the names of all persons interviewed during the investigation; o In 21 out of 21 (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 21 out of 21 (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 investigating agency. Detailed information was referenced but not analyzed in the investigation reports. In meetings in December 2010 and June 2011, 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.	

#	Provision	Assessment of Status	Compliance
		o In 21 out of 21 (100%), the investigator's findings; and o In 21 out of 21 (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 18 out of 19 investigations reviewed (95%), 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 19 out of 19 (100%), each serious incident or allegations of wrongdoing; o In 19 out of 19 (100%), the name(s) of all witnesses; o In 19 out of 19 (100%), the name(s) of all alleged victims and perpetrators; o In 19 out of 19 (100%), the names of all persons interviewed during the investigation; o In 19 out of 19 (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 19 out of 19 (100%), all documents reviewed during the investigation; o Although the previous histories of both the individual and the alleged perpetrator often were listed, it was unclear how much analysis actually occurred in reviewing these facts. As a result, it could not be concluded reliably 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 19 out of 19 (100%), the investigator's findings; and o In 19 out of 19 (100%), the investigator's reasons for his/her 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	Based on review of the DADS and LBSSLC policies referenced above, they included 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The Incident Management Coordinator played a critical role in this process of review. Unfortunately, there had been turnover in that position at LBSSLC, and, although the Interim Incident Management Coordinator was playing a significant role in addressing critical issues, the lack of stability continued to be of concern. A permanent appointment was expected to occur shortly after the site visit. With the exception of this current problem, LBSSLC had a comprehensive process for the review of investigations. Although instances were noted where timely review had not been 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 19 out of 21 investigation files reviewed (90%), evidence was present that the supervisor had conducted a review of the investigation report. The two investigations where this was not the case were Investigation #39275288 and #39263147. ▪ In none of the investigations was there evidence of any changes being recommended and/or completed. However, there was evidence of the Facility Director's review, and of her Review Team's attempts to clarify or correct certain conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In 16 out of 19 (84%) investigation reports reviewed, evidence was found that the supervisor had conducted a timely review of the investigation report. The Investigations where this was not the case included #11-05-184, #11-06-218, and 11-06-221.	
	(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	In its investigation report files, the Facility included copies of correspondence related to	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	disciplinary action. The review of 40 files in Samples #D.1 and #D.2 indicated the termination of five employees confirmed to have committed abuse or neglect, or for the failure to report such an incident. In the review of ten investigations focused on Sparrow and Quail, information in those files documented the termination of six employees for improperly lifting an individual with complex medical needs. Since 8/11, as recommended during the last site visit, the Facility had begun to track the reassignment of alleged perpetrators and any ensuing disciplinary actions. During the months of August and September, eight employees were terminated. The lack of a reliable tracking mechanism, as identified by the Facility itself, has led to the finding of noncompliance. For 30 out of 35 of the applicable investigations reviewed (86%), prompt and thorough programmatic action had been taken and documented. For example, the following programmatic actions had been taken: ▪ There was prompt and thorough review by the Interdisciplinary Team of the unauthorized departure reported in Incident #11-08-280. ▪ There was a very careful review documented regarding the unauthorized departure of another individual as described in Incident # 11-07-265. ▪ There was a very thorough review of the serious injury investigated in Incident #11-05-179. Staff training was documented. ▪ Incident #39751168 resulted in staff training about pica behavior and the requirements of Individual # 203's PBSP. One staff was terminated for allowing him to eat food off the floor. The following provide examples of investigations for which it did not appear prompt and thorough programmatic action had been taken: ▪ It was of concern that a formal peer review was not conducted as recommended for Incident #11-07-251. This incident was one of eleven reviewed that occurred on either the Sparrow or Quail living units. ▪ It also was of concern that, as documented in Incident #39941171, the employees who failed to conduct mandated checks of the diapers/briefs of the individuals on Sparrow and Quail were retrained rather than disciplined, and that there was no documentation of disciplinary action for the supervisor who instructed these employees to simply mark the observation log as if the individuals were dry. Although there were continuing concerns noted during site visit observations of Sparrow and Quail, the Facility is to be commended for the multiple initiatives it had implemented to review investigation reports, and to develop programmatic interventions, as appropriate. The review of the minutes of Incident Management Meetings documented	

#	Provision	Assessment of Status	Compliance
		the attention to follow-up at the unit and Facility levels. In each of the above incidents where recommended actions were implemented, there appeared to be evidence that the outcome had been accomplished to the extent possible in this setting. For 28 out of 35 applicable investigations (80%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action. The following are examples of where this was the case: ▪ Eight staff were terminated as a result of findings from the investigations where abuse and/or neglect was confirmed. One employee, in Incident #39310927, was reported to the Employee Misconduct Registry. It was not clear, however, if any of the remaining seven were also reported. ▪ One individual (Individual # 174) was moved to another home where "he might be happier." The following are examples of outcomes that did not appear to have been achieved through the implementation of the programmatic and/or disciplinary action: ▪ Although a prompt review was initiated by the ADOP, there was no documentation to indicate that the problems were resolved in Incident #11-05-191 involving Individual #283.	
	(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.	Earlier reports have provided details about the Facility's storage of investigation files. Based on observation and interview with the personnel of the Incident Management office, since the last site visit, no changes had occurred in the process for or the location of this storage space. This space was secure and accessible to the investigators as needed.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly	As referenced above, LBSSLC had made progress in the analysis of data related to allegations of serious incidents, and allegations of abuse, neglect and exploitation. In September, a statewide Avatar database was implemented. This new system should be very useful in the systematic collection and retrieval of important information. The Incident Management Coordinator, the Risk Manager, and the Director of Quality Assurance had worked together to produce more detailed reports regarding serious injuries. Injuries were tracked by individual, type, location, cause, staff involved, and time of day. Discussions at the Incident Management Review Team meetings were noted to be more thorough, and focused on identifying the causes of injuries. A system to track	Noncompliance

#	Provision	Assessment of Status	Compliance
	involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	follow-up in individual cases was being initiated. Responsibility and timeframes were identified in each case. Despite this attention and concerted action, the system for trending and tracking remained embryonic. Insufficient attention had been devoted to the findings from investigations. As a result, a finding of noncompliance has been made with regard to this provision. It is expected, however, that by the next site visit, progress will continue to be made. The Facility had convened two workgroups to conduct root cause analyses of serious injuries and abuse, neglect, and exploitation. The results of an additional root cause analysis of peer-to-peer aggression in Residence 520 also had been completed and the recommendations were being implemented.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	As discussed in earlier reports, the State Office and the Facility Director had worked together to implement a stringent process to track the investigation of the backgrounds of Facility employees and volunteers. Extensive documentation was provided to verify that each employee and volunteer was screened for any criminal history. 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 random drug testing. New employees were required to undergo fingerprint checks. The Facility received a "rap back" providing any updated information regarding current employees who had been fingerprinted previously. The Facility submitted documentation indicating that there was a 10.09% failure to pass criminal background checks in FY10, and a rate of 5.45% in FY11. No active employees had been terminated based on the results of background checks conducted in the fall of 2010. This year's results were not yet due. The combination of background checks, enhanced training of new employees, and disciplinary action, including termination, against those staff confirmed of abuse or neglect, has contributed to the reduction of the risk of harm at LBSSLC. The Monitoring Team found LBSSLC to be in substantial compliance with this provision.	Substantial Compliance

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

1. 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. Efforts should be made to ensure that QDDPs discuss and provide the abuse, neglect, and exploitation handouts to individuals at ISP meetings. In addition to reminding, QDDPs about this responsibility, the monitoring tool for ISPs should include an indicator to check to ensure it is done consistently.
b. The provision of this information to the individual should be documented in the ISP. (Section D.2.e)

2. As discussed during the onsite review, to address specific fears of retaliation expressed to the Monitoring Team, training of staff should include explanation that any retaliation related to the good faith reporting of abuse or neglect at LBSSLC or involvement in a related investigation, whether such alleged retaliation occurred onsite or offsite, would be investigated, and prosecuted, if appropriate. (Section D.2.h)
3. 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. (Section D.3.e)
4. More in-depth analysis about previous incidents involving both the victim and the alleged perpetrator should be completed in the formulation of conclusions and the development of recommendations, and this analysis should be documented. (Section D.3.f)
5. The Facility should continue its efforts to finalize a tracking and trending system to allow Facility Administration and others to ensure that appropriate disciplinary action has been taken in relation to investigations. (Section D.3.i)
6. 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. (Section D.4)
7. The findings from the Risk Manager's intensive review of incidents should continue to 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 expand its root cause analyses to explore risks in the residences, and to propose remedial actions from both the individual and systemic level. (Section D.4)

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, including blank monitoring forms for each of the Sections, Trend Analyses, and Corrective Action Tracking Plans; o LBSSLC Policy: "Communication Process: Quality Assurance and Improvement Council," dated 9/1/11; o Quality Assurance/Quality Improvement Council meeting minutes, dated from 6/13/11 to 8/18/11; o Plan of Improvement/Self-Assessment, dated 9/19/11; o Quality Assurance Plan, dated 8/22/11; o Corrective Action Plan Tracking, dated 9/1/11; and o Completed Monitoring Forms for restraint for the months of 4/11 and 8/11. ▪ **Interviews with**: o Libby Allen, Facility Director; o Robin Seale, Assistant Director of Programs (ADOP); o Dawn Ripley, Director of Quality Assurance (QA); o Melinda Voight, Risk Manager; o Jim Forbes, M.Ed., C.B.A., Director of Behavioral Services; o Lola Walker, QDDP Coordinator; and o Rodney McWilliams, Interim Incident Management Coordinator. ▪ **Observations of**: o Safety Committee meeting, on 10/6/11; o Incident Management Review Team meetings, on 10/3/11, 10/5/11, and 10/6/11; o Quality Assurance/Quality Improvement Council meeting, on 10/4/11; and o Restraint Reduction Committee meeting on 10/5/11.
	Facility Self-Assessment: The Facility's Plan of Improvement/Self-Assessment was dated 9/19/11. For Section E of the Settlement Agreement, the Facility had determined that it was not in substantial compliance with the requirements of the Settlement Agreement. This was consistent with the Monitoring Team's findings, except that the Monitoring Team found the Facility in compliance with Section E.3. This section required the dissemination of Corrective Action Plans to those responsible for their implementation. The Facility provided a narrative description 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. In the Section E presentation on 10/3/11, the Quality Assurance Director summarized accomplishments and progress. Since the last site visit, the Facility has hired a second QA Nurse and implemented monthly monitoring of the Medical, Nursing, Pharmacy and Dental Sections of the Plan of Improvement; completed

	four Corrective Action Plans; updated the Quality Assurance Plan; and restructured the agendas for the QA/QI Council meetings in order to ensure timely review of data. In addition, a direct support professional now has been included on the Quality Assurance/Quality Improvement Council.
	Summary of Monitor's Assessment: The Facility clearly had taken a series of specific actions towards both meeting the requirements for an effective Quality Assurance process, and achieving the outcome mandated by the Settlement Agreement. Since the Monitoring Team's last review, the following quality assurance processes had been updated or implemented: the establishment of monthly monitoring protocols; the restructuring of the Quality Assurance Council; and the use of Root Cause Analyses to review, for example, peer aggression in Residence 520. Monthly monitoring was conducted in a collaborative manner between the clinical/professional departments and Quality Assurance staff. A second Quality Assurance Nurse was hired in 4/11 to expand the resources available to conduct monthly monitoring. Data were discussed at the Quality Assurance/Quality Improvement Council meetings and at Departmental forums. The Safety Committee had continued its analyses of injuries. There was progress in the analysis of information related to the investigations of abuse and neglect. Inter-reliability continued to be unresolved. The Quality Assurance Director continued to explore resolution of this methodological issue. Although numerous completed monitoring forms were submitted as documentation, and although the summaries of the monthly monitoring results provided useful information, more detailed analysis of the Quality Assurance staff's monitoring would be helpful in evaluating areas in which the Facility had made progress, and areas still needing improvement. The Quality Assurance/Quality Improvement Council should play a lead role in assisting the QA Department, as well as the other departments to prioritize the need for such detailed analyses. Such priorities might be derived from a number of sources, including, for example, findings from external reviews, basic trends identified through monitoring activities, complaints, areas that management staff have targeted for improvement, etc. In addition, corrective action plans needed to clearly establish expected outcomes in measurable terms to allow decisions to be made with regard to their success or the need for the plans to be revised.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals	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, related to incidents and allegations, it had not yet developed a set of key indicators. This is important for a few reasons, including	Noncompliance

#	Provision	Assessment of Status	Compliance
	receiving services and supports.	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, references are 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; and outcomes 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 type 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. The Facility had updated its Quality Assurance Plan prior to the site visit. The Plan continued to include a monitoring matrix to designate the various responsibilities for monitoring throughout the Facility. As discussed in earlier reports, the matrix specified the audit tool, the sample size, the staff person responsible, and the frequency of the review. Responsibility for analyzing the data, generating reports, reviewing the results and developing Corrective Action Plans, as appropriate, was assigned to the appropriate Departmental professional. The Quality Assurance Division continued to provide technical assistance and oversight. The Quality Assurance/Quality Improvement Council continued to be the primary forum for the discussion of data and the recommendation of supplemental corrective actions. Its meeting schedule had been expanded to permit thorough and timely review of all information across disciplines. The meeting minutes documented the substantial work underway at the Facility as it strived to come into compliance with policy and Settlement Agreement criteria. In addition, the Facility Director has used the Council meetings to establish a sense of teamwork and shared accomplishment. The addition of a direct support professional was a meaningful step towards ensuring that the perspective of the staff that work most directly with the individuals at LBBSLC was both included and welcomed. During the Monitoring Team's onsite review, it was evident that a clear and continuous process now had been implemented to ensure the prioritization of Quality Assurance/Quality Improvement obligations. In addition, the hiring of a second nurse had increased the staffing of the Quality Assurance Department. This additional position permitted monthly monitoring of the work performed by the Nursing, Medical, Dental, and Pharmacy Departments. As a whole, the Quality Assurance Division now included five employees who conducted monitoring activities.	

#	Provision	Assessment of Status	Compliance
		The Facility used State mandated monitoring tools to conduct its reviews. A random sample of three percent was selected for review each month. According to the Quality Assurance Director, the sample size was to be increased. Both the Facility and the Monitoring Team continued to identify the issue of inter-rater reliability as a concern. Although the Facility had continued to examine this issue and had continued its monthly meetings to review the congruence of raters' scores, the State expected to provide further instruction. Work still needed to be done to refine these tools for the Facility's use and their implementation, including enhancing the guidelines or instructions associated with each tool, ensuring inter-rater reliability and accuracy of monitoring, ensuring that quality was measured as opposed to the mere presence or absence of items, as well as identifying the priorities for the tools' implementation so as to not overwhelm the system with data that could not be used effectively. The tools were not weighted, and were not designed to produce overall scores. 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 discussed with regard to Sections C and D, the Facility has progressed in its capability to gather and analyze certain data sets, including the use of restraint, serious and non-serious injuries, and allegations of abuse, neglect and other serious incidents. The analysis of this information is discussed in further detail with regard to Section E.2.	
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, as summarized above, the Facility had established processes and protocols to collect data through various monitoring activities conducted collaboratively by the Quality Assurance Division and the clinical/professional staff in the various Departments. To a limited degree, the Facility also was collecting data related to outcomes (e.g., number of individuals employed). However, the analysis and use of these varying data sources remained in the development stage. As discussed above, the Facility has progressed in its capability to gather and analyze certain data sets, including the use of restraint, serious and non-serious injuries, and allegations of abuse, neglect and other serious incidents. However, based on the documentation provided and the discussions that occurred in various meetings during the site visit, there was wide variability in the depth of analysis among these areas of review. For example, the information regarding restraint use was very detailed and showed evidence of extensive discussion at the individual, living unit, and Facility-wide level. The data produced regarding the nature and extent of injuries also was comprehensive. However, the data about allegations of abuse and neglect were still fairly	Noncompliance

#	Provision	Assessment of Status	Compliance
		rudimentary. The reoccurring vacancies in the Incident Management Coordinator position contributed to this; the Interim Incident Management Coordinator was working diligently to resolve this area of weakness. After reviewing fifty investigation reports, the Monitoring Team noted that there were additional efforts required to comprehensively track and analyze information regarding both alleged perpetrators and the occurrence of serious incidents in certain residential units. For example, the investigation reports consistently identified all alleged perpetrators and cited their past involvement in allegations of abuse or neglect. However, although information documented was about each incident of involvement, there was no evidence that a thorough analysis had been completed of the information or any action taken as a result of repeated allegations. Similarly, the Quality Assurance staff had documented deficiencies in adherence to lifting protocols in Sparrow and Quail. Specifically, staff on those residential units knew the proper lifting techniques, but were not using them. There was no evidence that this information was analyzed and utilized in a proactive manner to prevent the later incidents of neglect that were documented in the investigation reports. The implementation of the new database module for capturing information about each unusual incident might be helpful in this regard. To a varying degree, as discussed above, findings were reviewed and included in reports distributed and discussed at the Quality Assurance/Quality Improvement Council meetings and in forums conducted at the Departmental level. Corrective Action Plans were being developed in response to the reports generated from the monitoring reviews, and as a result of concerns identified at the Quality Assurance/Quality Improvement meetings. A standardized monthly meeting schedule has been established for Quality Assurance and Department head staff to review the results of data, discuss inter-rater reliability, determine the need for Corrective Action Plans, and determine the effectiveness of current Corrective Action Plans and/or the need for revision. On 8/23/11, the State Office provided additional direction regarding the process to ensure timely notification, completion and follow-up of needed corrective actions. In her presentation, the Quality Assurance Director stated that twenty Corrective Action Plans had been implemented. Of these, four had been successfully completed, one was discontinued due to other priorities, and seven were discontinued due to the implementation of new processes. A Corrective Action Plan regarding the appropriate engagement of individuals commenced in 9/11. A Corrective Action Plan regarding the improper restraint of Individual #239 was still in the implementation stage. This incident is discussed above	

#	Provision	Assessment of Status	Compliance
		with regard to Section C. According to the minutes from an Incident Management Meeting, uninformed "pulled" staff restrained an individual on the "Do Not Restrain List." The ADOP urged that a Corrective Action Plan be initiated promptly. While this element was not yet in substantial compliance due to the need for more extensive analysis of additional information, and the development of Corrective Action Plans to address identified issues, some progress had been made.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The Corrective Action Plans were disseminated to entities/personnel responsible for implementation. The Quality Assurance Plan delineated who was responsible for the development of a Corrective Action Plan, for example, the Chief Psychologist for Section C, and who was responsible for its monitoring. The Facility appeared to have implemented a standard process for disseminating Corrective Action Plans to those responsible for their implementation. As a result, the Facility was found to be in substantial compliance with this provision.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	In an interview, the Director of Quality Assurance stated that she personally checked on the follow-up outlined in the Corrective Action Plans generated as a result of monitoring activities. The Corrective Action Plan tracking log was scheduled to be discussed at the second Quality Assurance/Quality Improvement Council meeting each month. Corrective action plans need to be written to allow determinations to be made regarding their effectiveness. Without this, Facility Administration and the QA/QI Council cannot be assured that issues have been resolved, and the need to take modify plans or take further action cannot be determined. For example, the Facility had opened another residence in order to reduce crowding and to alleviate potentially disruptive and injurious behavior. This was a very positive development. Yet, there was no indication that the outcomes from this set of changes were being measured or documented on an individual or programmatic basis. If the QA/QI Council had asked for a Corrective Action Plan for this project that included measurable outcomes (e.g. decreased injuries, or increased engagement), and documented results along the way, it would be possible to determine if the desired outcomes were achieved. Or, in the absence of a Corrective Action Plan with such documentation, indicators of success could be derived from data on restraints (more/fewer being used in the home), injuries, unusual incidents, etc. When corrective actions are put into place, it is important to track the expected outcomes to determine if the changes have been effective, or if additional changes are needed. It was not clear how the Facility planned to evaluate the outcomes. Although some corrective action plans had measurable outcomes associated with them, many did not have outcomes identified, or they were not measurable. For example, one plan clearly set for the expectations for an increase in engagement, and specified the	Noncompliance

#	Provision	Assessment of Status	Compliance
		expected level. However, for other plans (e.g., those related to improving the risk action plan) limited outcomes were listed, and it was unclear how success would be measured, particularly with regard to improving the quality of the process.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Corrective Action Plans were scheduled to be discussed at the second monthly meeting of the Quality Assurance/Quality Improvement Council. The Council had responsibility for determining whether the Corrective Action Plan was effective or whether modifications were to be made. In addition, the status of the Corrective Action Plans was to be reviewed at the monthly meetings of the Quality Assurance and Departmental heads. However, as noted above, the Facility should focus on ensuring that clear measures are defined, including outcome measures, to allow the QA/QI Council to determine when a plan has been successful, and when one needs to be modified.	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. (Section E.1.)
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. (Section E.1.)
3. As has been recommended previously, 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. (Section E.1.)
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. (Section E.1.)
5. As recommended in previous reports, the valuable information already being collected through monitoring, trending, and tracking, and other quality enhancement efforts should be used more rigorously to actually eliminate potential risk for individuals served by LBSSLC. The information the QA Department gathers should be analyzed further to identify problematic trends and/or individual issues, and action plans should 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). (Section E.2)
6. 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. (Section E.2 and E.3)
7. For each corrective action plan, clear measures should be defined, including outcome measures, to allow the QA/QI Council to determine when

a plan has been successful, and when one needs to be modified. (Section E.4 and E.5)

8. 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. (Sections E.4, and E.5)
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. (Facility Self-Assessment)

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: Personal Support Plan Process – Supporting Visions," dated 4/14/11; o LBSSLC Policy "IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring," revised 6/28/11; o LBSSLC Policy "IDT Process – Program Development: Personal Support Plan – At Risk Individuals Process," revised 8/24/11; o Blank and completed monitoring forms, including: ▪ LBSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 9/1/10; ▪ LBSSLC Personal Support Plan Facilitation Checklist, revised 3/21/11; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section F, with guidelines, revised 12/10; and ▪ Settlement Agreement Section F: Integrated Protections, Services, Treatments, and Supports, revised 12/10; o Last 10 monitoring tools completed by QDDP Coordinator, various dates; o Supporting Visions: Personal Support Planning, including lesson plans, dated 9/10; o Q Construction: Facilitating for Success – QMRP Facilitation Skills Performance Tool sample, dated 6/4/11; o List of QDDPs deemed competent using the "QMRP Facilitation Skills Performance Tool," undated; o Alphabetical list of each individual's home address, PSP dates, and file date for PSPs, undated; o LBSSLC QMRP Coverage Plan, undated; o Individual Support Plans (ISPs), related assessments, and monthly/quarterly reviews for: Individual #210, Individual #8, Individual #7, Individual #58, Individual #151, Individual #267, Individual #238, Individual #197, Individual #1, Individual #213, Individual #19,

	Individual #137, Individual #201, and Individual #320; o ISP for Individual #140; and o Plan of Improvement/Self-Assessment for Section F, dated 9/19/11. ▪ **Interviews with**: o Lola Walker, Qualified Developmental Disabilities Professional (QDDP) Coordinator; Marisol Gonzales, ISP Coordinator; Rodshadi Moore, Active Treatment Supervisor; Christina Sosa, Psychologist; Tracey Snow Murphy, Director of Residential Services; Sandra Kennedy, Unit Director and QDDP Educator; Jim Forbes, Director of Behavioral Services; and Deborah Burgett, DADS, on 10/4/11. ▪ **Observations of**: o ISP meetings for the following: Individual #269, and Individual #170; 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 detailed 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 sub-sections of Section F, which was consistent with the Monitoring Team's findings. In addition to these narrative descriptions, the Facility also had begun to use some of the data it collected through its various monitoring activities. However, often this data was an overall score. Given that the monitoring tools were not designed to provide a composite score, this made the information fairly meaningless. It appeared that staff had attempted to analyze some of the more specific data. An example of this was included in the discussion regarding Section F.2.g, where some of the trends that the data showed were briefly discussed. As the Facility moves forward with its self-assessment activities, data should be used regularly to identify both strengths and weaknesses, and use such information to improve the system. 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: Since the last review, QDDPs had undergone additional training on meeting facilitation, and consultants for the State had begun to train teams on the philosophical and historical context of individual planning, as well as on some of the logistics of the development of sound plans. The State consultants had begun to provide technical assistance to teams at LBSSLC during annual planning meetings. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show positive changes with regard to facilitation skills, more productive meetings, and a more person centered focus. As would be expected, significant changes had not yet occurred in the ISP documents themselves. During the week of the onsite visit, one of the State's ISP consultants, as well as the State's Nurse

	Practitioner Consultant worked with an interdisciplinary team and the PNMT to develop what were the beginnings of a truly integrated plan for an individual with complex medical needs. Further development of action plans was needed, but this was an impressive effort that is discussed in further detail in other sections of this report. LBSSLC had completed ISPs in the new format for all 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 ISPs 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. Documentation did not 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 QDDP, as the team's facilitator, should ensure this occurs. To close the loop, however, the QDDP 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. Since the previous review, the ISP monitoring group continued to support teams through coaching, training, and providing feedback on integration of the ISP and risk process. The group consisted of the Assistant Director of Programs, QDDP Coordinator, two QDDPs, the Human Rights Officer, and the Program Compliance Monitor for Section F. The process continued to provide an additional level of oversight through which issues with the planning process could be identified more easily, and then actions developed to address them.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two	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 ISP planning, including the focus on the individual, the role of the QDDP, and the use of the Personal Focus Assessment. The policy addressed ISP monitoring, staff training and	

#	Provision	Assessment of Status	Compliance
	years, the IDT for each individual shall:	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 ISP 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: Personal Support Plan Process – Supporting Visions," dated 4/14/11; ▪ LBSSLC Policy "IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring," revised 6/28/11 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 ISPs was requested, along with related assessments, sign-in sheets, and monthly and/or quarterly reviews. This sample included ISPs for 10 individuals, including Individual #210, Individual #8, Individual #7, Individual #58, Individual #151, Individual #267, Individual #238, Individual #197, Individual #1, and Individual #213. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and PSTs had been responsible for the development of the plans. In addition, the Monitoring Team was asked to review an ISP that had been developed using a new format. As appropriate, comments are provided on the ISP for Individual #140.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and	Progress had been made and/or sustained with regard to the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included: ▪ DADS Policy #004 at II.C.1.b continued to indicate that the QDDP would plan and facilitate the PSP meeting. The LBSSLC Policy "IDT Process Program	Noncompliance

#	Provision	Assessment of Status	Compliance
	supports.	Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11, clearly identified the QDDPs' role in coordinating and facilitating the team's activities. ▪ The QDDP Coordinator confirmed that QDDPs facilitated the teams, including team meetings. Reviews of ISPs also suggested that the QDDP was the team leader and responsible for ensuring team participation. ▪ With regard to staffing, in addition to the QDDP Coordinator, a QDDP Educator had been hired, and was in the process of transitioning from another position on campus. This administrative structure was in place to assist in providing QDDPs with needed oversight and training. At the time of the review, there were 14 QMRPs. This generally allowed one QMRP to be assigned to each residence. The overall goal of maintaining a ratio of approximately 1:16 was being achieved, with a range of 1:13 to 1:21. There had been some turnover in QMRP staff, resulting in three new QDDPs. ▪ The QDDP Coordinator and QDDP Educator were certified trainers for the Q Construction Facilitating for Success training that a workgroup coordinated by State Office developed. Beginning in May 2011, the QDDPs had completed the classroom portion of the training. At the end of the training sessions, the QDDPs took a written test. The competency-based component of the training is discussed in further detail below. ▪ In addition, State Office had hired consultants to provide training and technical assistance to QDDPs and teams on the PSP process. They had provided classroom training to LBSSLC teams, which is discussed in further detail with regard to Section F.2.e, and had begun to sit in on team meetings and provide technical assistance. ▪ During the week of the review, the Monitoring Team observed a number of team meetings, and met with two teams related to the risk rating and action plan development process. Progress definitely had begun to occur with regard to the facilitation of meetings. Based on these limited observations and review of ISPs, some of the areas in which progress had begun included: o At annual PSP meetings, an agenda was clearly set forth, along with ground rules. o Efforts were made to include the individual, and focus the discussion on him/her. o Paper hung on the walls or white boards were used to track key components of the ISP process, such as the agenda, the individuals' preferences, and action plans that needed to be developed. This in addition to having a staff person designated to take typewritten notes during the meeting helped ensure that important discussion was documented, while still allowing the QDDP Coordinator to facilitate the meeting.	

#	Provision	Assessment of Status	Compliance
		o More efforts were made than in the past to elicit information from all team members. However, not all team members participated to the extent they should have. o Due to the significant risk that Individual #136 faced, the Monitoring Team suggested that his team meet to revise his risk action plans with the assistance of State consultants. As is discussed with regard to Sections I, M, and O, the IDT illustrated the ability at LBSSLC to develop truly integrated plans. The team successfully harnessed the knowledge, expertise, and commitment of its various members, and identified a set of supports that appropriately required continuous involvement of the entire team. As is recommended elsewhere, other individuals, particularly those at highest risk, should be prioritized for similar planning sessions. As was discussed when the Monitoring Team was on site, it is important to continue to approach such change efforts in a methodical and measured approach, so as to not overwhelm the system. Based on review of ISPs as well as during observations of meetings held the week of the onsite review, facilitation of team meetings was improving, but for none of the plans reviewed or meetings observed was it resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. Areas in which improvements should be made in order to achieve compliance, included: ▪ The Q Construction: Facilitating for Success training included a competency-based component. At the time of the review, the QDDP Coordinator, and QDDP Educator had conducted baseline competency checks for a small number of QDDPs. This process was assisting in identifying areas in which all of the QDDPs needed to improve their meeting facilitation skills. Three QDDPs had been deemed competent using this tool. The QDDP Coordinator indicated that additional competency checks were being completed for remaining QDDPs. ▪ In addition, the Facility had developed its own Facilitation Checklist that members of the ISP monitoring group completed. This tool was completed in conjunction with the Personal Support Plan Meeting/Documentation Monitoring Checklist. The group consisted of the Assistant Director of Programs, QDDP Coordinator, two QDDPs, the Human Rights Officer, and the Program Compliance Monitor for Section F. Review of a sample of these reviews showed thoughtful commentary on ways in which the QDDPs could improve their facilitation skills and the meetings in general. The QDDP Coordinator recognized that this would be an ongoing process until the QDDPs had reached the necessary level of competence. ▪ Based on review of PSPs as well as during observations of meetings held the week of the on-site review, missed opportunities continued to be noted with	

#	Provision	Assessment of Status	Compliance
		regard to: o Although all plans reviewed had preferences listed, the depth of the preferences was often limited to items, food, or activities. QDDPs should continue to challenge teams to define what it is the individual prefers about such items, foods, or activities to allow teams to offer the individual new experiences, and to expand the discussion to include preferences related to work, relationships, past experiences, future opportunities, etc. o As is discussed below, ISPs did not consistently show adequate incorporation of preferences into action plans. o During onsite observations, as well as in ISPs reviewed, although some improvement was noted, adequate integration of supports, and services continued to be lacking. QDDPs should continue to challenge team members to offer their expertise in problem-solving or developing action plans, even when the action plan does not fall squarely within their domain (e.g., psychologists should assist with addressing mealtime issues, such as fast eating pace, as well as toileting issues, refusals to attend day/vocational programs, and dental refusals; nursing staff, habilitation therapies staff, and dental staff should discuss strategies related to physical and nutritional management supports to ensure adequate coordination; speech/communication staff should provide expertise, including, for example, replacement behaviors for PBSPs, integration of communication devices throughout an individual's programing, choice-making, etc.); o Although some minimal improvements were seen, QDDPs should seek data from various team members to assist in decision-making, and justify the teams' conclusions. For example, in ISPs reviewed, data was not cited consistently, such as test/lab results, or data from PBSPs and skill acquisition programs. In addition, historical information or causation was not always investigated fully enough by teams (e.g., causes for falls or fractures, history of issues related to previous failed community placements, etc.). This is essential information to inform planning for future training, treatment, supports, and services. o Little discussion occurred or was documented regarding prevention, particularly with regard to health risks/issues. Much of team's focus on these areas appeared to be reactive, once an issue occurred (e.g., constipation, weight, skin integrity, infections, etc.). o Teams discussion of action plans was limited. Problems were noted with regard to the scope and number of action plans discussed, as well as detail with which teams discussed action plans. More specifically, sufficient action plans were not discussed/developed to ensure the	

#	Provision	Assessment of Status	Compliance
		integration in PSPs of all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual, as required by Section F.2.a.3 of the Settlement Agreement. o Methodologies often were absent. In other words, teams did not discuss how outcomes would be accomplished. o Likewise, teams generally did not discuss measurable, functional objectives during team meetings, and, as a result, they often were not included in PSPs. o Teams continued to struggle with articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., individual will participate in vocational center), rather than as a change in the individual's life (e.g., individual will obtain a job for at least 10 hours per week in one of her stated areas of preference). o With more cross-disciplinary discussion and participation by the individual, it was sometimes difficult for the QDDP to control the length of the meeting. One way to address that would be to establish estimated time boundaries for each topic at the outset. Another way is for much more preparation to be done before team meetings. Progress had been made. However, based on observations as well as review of ISPs, while some meetings were much improved, the meetings were not consistently resulting in the adequate assessment of 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 as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, 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. Some progress had been made with regard to tracking attendance at ISP meetings. Specifically, the ISP Coordinator maintained a database that was populated with information related to team members' attendance at meetings. The data was entered based on sign-in sheets for each meeting. Facility staff explained that at the third quarterly meetings, teams were to delineate which team members should be present at the annual meetings. However, it was unclear what criteria teams had been given to determine whether a team member's attendance was required or not. This is a key element to this process. Although this is an issue that should be carefully coordinated with the State Office, now that risk levels were being established for individuals, this might be one mechanism that teams could use to determine which team members should attend the annual planning meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In an effort to increase participation of team members at meetings, the ISP Coordinator had rescheduled ISPs, so that they were held on Tuesdays, Wednesdays, and Thursdays, at specified times. Efforts were underway to ensure to the extent possible that QDDPs did not have more than two annual meetings per month. This was a significant undertaking, but should result in better attendance from all team members. Reportedly, accommodations were being made to ensure the participation of individuals, guardians, and their families. Based on the sample of 10 ISPs the Monitoring Team reviewed, for one (10%) it appeared that a duly constituted team was in attendance (i.e., Individual #58). Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. Examples of concerns related to team composition have been provided in previous reports, and issues were similar during this review. Although some progress had been made in developing a database to track attendance as well as to develop a reasonable schedule for ISP meetings, the Facility remained out of compliance with this provision.	
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.	Progress had been made and/or sustained with regard to the conduct of assessments. Positive developments included: ▪ 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. ▪ LBSSLC had convened a workgroup to discuss and develop potential solutions to issues related to assessments. The group met twice in June and July, and some steps were taken to improve and track the timeliness of assessments. A database had been initiated to track assessments. However, some issues with it were being addressed at the time of the onsite review. Although the group discussed quality of assessments, specific actions were not identified to improve them. As far as the group came was identifying staff or processes in most departments responsible for reviewing assessments. ▪ In an effort to ensure assessment documentation was available in a timely manner, folders had been developed on the Facility's server in which assessments were placed. This allowed access for all team members. The ISP Coordinator was responsible for checking the folders 10 days prior to each annual meeting to determine if necessary assessments have been submitted. If not, she would send an email to the responsible staff person(s). ▪ Based on information that State Office staff and consultants provided during the	Noncompliance

#	Provision	Assessment of Status	Compliance
		onsite review, plans were underway to develop and provide specific training for disciplines regarding assessments. This would be an important development, given the centrality of assessments to adequate planning processes. ▪ In addition, at the State Office level, the PFA had been reformulated to focus on some broader preferences, providing teams, for example, with more information with which to discuss where the individual wanted to work and/or live. The revised version included more open-ended questions, but overall fewer and more targeted questions. LBSSLC staff had been trained on the new format, and reportedly had begun using it as of 9/1/11. The results of the new process were not yet evident in the plans reviewed. However, reportedly, the goal would be for a staff member who knew the person well to review the questions with the individual, and bring this information back to the team. At LBSSLC, a direct support professional was assigned to complete the PFA, and then the QDDP was responsible for finalizing it. ▪ As recommended in previous reports, one assessment that would prove useful for some individuals would be an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment was not found in any of the ISPs reviewed. However, based on a review of the new ISP shell, it appeared that this would be a standard discussion topic for teams. However, at the time of the review, little improvement was noted with regard to the quality of the assessments or the completeness of the assessments used in developing ISPs. Areas in which improvements should be made in order to achieve compliance, included: ▪ In none of 10 (0%) PSP files reviewed, adequate assessments were present. At times, medical assessments were close to a year old. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. This was particularly true for vocational assessments, which provided little analysis of information that would lead the teams to discuss alternatives beyond the typical activities offered in the Facility's work centers. As the Facility had identified, assessments did not consistently and concisely list individuals' strengths, needs, and preferences. Examples of concerns related to assessments have been included in previous reports, and were similar for this review. ▪ Generally, no justification was provided regarding whether or not a particular assessment was needed. This made it difficult to determine if teams had made appropriate decisions in requesting assessments. The Facility should consider defining in policy a key set of assessments that should be conducted regularly, and the expected timeframes for reevaluation. Teams should be required to provide a justification for veering from this schedule. Optional assessments also should be defined with criteria/guidelines to assist teams in determining if such	

#	Provision	Assessment of Status	Compliance
		assessments would be beneficial to the individual. ▪ At LBSSLC, some further direction had been provided to staff responsible for assessments, including that each assessment should include a statement regarding whether or not an individual could transition to the community. If not, the assessor needed to identify the reasons. However, based on the review of sample plans, this was not occurring. ▪ 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 vocational, 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. 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 bring the Facility into substantial compliance.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As indicated in previous reports, although the new ISP process had been specifically designed 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 ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ In none of the 10 plans (0%) were all recommendations resulting from assessments addressed in the PSPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. In fact, in each of the plans reviewed, multiple recommendations had not been addressed. ▪ Often, recommendations were discussed in the narrative section of the report, and the team appeared to agree that the recommendation needed to be implemented, but a corresponding action plan was not developed to implement the recommendation. ▪ Two major factors negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, a ISP that outlined the protections, services and supports provided to the individual were: 1) based on observations and review of documentation in ISPs, there was a lack of consistent interdisciplinary discussion and coordination in the development of ISPs. This limited teams' ability to utilize assessment	Noncompliance

#	Provision	Assessment of Status	Compliance
		information to develop integrated protections, supports, and services; and 2) as is noted in other sections of this report, many of the assessments and evaluations being conducted were inadequate. Examples of this include inadequate nursing assessments, vocational assessments, psychiatric assessments, and assessments of individuals' physical and nutritional management support needs. The Facility needs to address these two issues to ensure that appropriate assessment information is available, and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans required by the Settlement Agreement. The State and the Facility should ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Person-centered planning is not a reason to not have plans that are adequate. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive PSPs, while focusing on the individual and his/her preferences, strengths, etc.	
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. To highlight some of the issues of concern: ▪ Teams were not providing independent assessments of individuals' ability to transition to a more integrated setting. In none of the nine plans reviewed (0%) of individuals with guardians did teams offer a recommendation independent of the guardian. ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. In summary, the Facility was at the very initial stages of complying with this component 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		

#	Provision	Assessment of Status	Compliance
	years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Policy #004 at II.D.4 indicated that the Action Plan should be based on prioritized preferences, strengths and needs. The policy further indicated that the "PST will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." This provision of the Settlement Agreement address a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. <u>Identification and Use of Individuals' Preferences and Strengths</u> As noted in the last report, teams were making efforts to identify individuals' preferences. The 10 ISPs reviewed generally included more information regarding the individual's preferences. However, the following concerns were noted with regard to the identification and incorporation of preferences and strengths into ISPs: ▪ Although all 10 of the ISPs reviewed included a listing of individuals' preferences, none (0%) had effectively incorporated their preferences into related action plans. For example, none of the individuals' teams had used these preferences in creative ways to address individuals' needs (e.g., building in incentives for individuals who refused to attend vocational or day programs) or to expand individuals' horizons. ▪ As noted above with regard to Section F.1.a, most of the preferences identified for individuals related to items, food, or activities. It will be important for teams to define what it is the individual prefers about such items, foods, or activities to be able to offer the individual new experiences based on this information. It also will be essential to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, routines, interactions with others, etc. ▪ Little, if any, information about individuals' specific strengths was discussed in PSP documents. Strengths were not regularly built upon to address other need areas. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> Clear prioritization of the individual's specific needs (e.g., one daily living skill as opposed to another, or which specific medical supports took priority over other needs or preferences, etc.), or careful delineation of barriers to addressing needs was generally not found. More specifically, in none of the 10 PSPs reviewed (0%) were priorities	Noncompliance

#	Provision	Assessment of Status	Compliance
		clearly defined, or barriers identified and addressed. <u>Identification of Supports Needed to Encourage Community Integration</u> In reviewing objectives related to individuals' involvement in the community, some improvement was noted. However, many individuals' ISPs still included general community participation objectives as opposed to skill building objectives to assist individuals in accessing and utilizing community offerings. In the six (60%) of plans where community integration activities were included as action plans, they all were extremely general in nature (e.g., "encourage activities in the community), and most were not measurable, because they included timeframes such as "as available." One of the 10 PSPs (10%) reviewed included specific skill acquisition action plans for implementation in the community. Examples of concerns have been provided in other reports, and were similar to the concerns identified for this review. Despite some limited progress in this area, the Facility remained out of compliance with this provision.	
	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;	This continued to be an area in which substantial effort was needed in order for LBSSLC to comply with the Settlement Agreement. The action plan section of the ISP was where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. Facility staff recognized that action plans were not adequate. The Monitoring Team agrees with this assessment. The following summarizes the concerns related to action plans: ▪ As noted in the last monitoring report, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. At LBSSLC, these generally related to skill acquisition plans and daily activities (e.g., day/vocational program, recreation, etc.), and in some cases, medical care. ▪ However, none of the 10 plans reviewed (0%) included a full complement of measurable goals or objectives to address the array of supports and services the individual required. This negatively impacted the intensity of individuals' active treatment, the supports they were provided, and the teams' ability to measure progress, or lack thereof. More specifically, when such supports were identified in the action plans they often were not measurable. For example, many plans indicated that individuals would be "encouraged" to engage in activities ranging from community activities, day/vocational programs, to weight loss initiatives. Without defining what encouragement meant, and/or how often it would be done, these were meaningless objectives. They also provided the team with no	Noncompliance

#	Provision	Assessment of Status	Compliance
		way of measuring success or failure. Most of the time, necessary objectives, supports, and services simply were not included in action plans. For example, few, if any, objectives were seen in relation to the implementation of psychiatric care plans, and, although some plans included objectives to implement PNMPs, nursing care plans, or PBSPs, they often were incomplete, and/or were not measurable. ▪ In reviewing the action plans that had been developed to address individuals' risk areas, measurable objectives generally were not included. This is discussed in further detail with regard to Section I of the Settlement Agreement. ▪ Individualized, measurable goals and objectives were not defined in individuals' ISPs to support the implementation of essential plans, such as nursing plans, psychiatric treatment plans, and physical and nutritional support plans. For example, in order to provide health care supports to individuals served, direct support professionals as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is repositioned every two hours should be specified in measurable ways in individuals' ISPs. In addition, ISPs should include measurable, observable objectives to determine the efficacy of these plans. In other words, objectives should be designed to allow the team to determine if the individual is doing better or worse, or remaining stable. As is discussed elsewhere in this report, deficits in plans that specific disciplines had developed prevented the teams from fully identifying the full array of the measurable objectives necessary for the team to provide needed supports and services, and measure the outcomes of those supports. For example, PNMPs did not include measurable objectives, and nursing assessments often did not include individualized objectives. Even when plans, such as PBSPs, included objectives, teams did not consistently incorporate them into the overall ISP. The Facility remained out of compliance with this provision.	
	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 ISPs. ISPs 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 10 plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. Although it was clear the teams were attempting to include more objectives in action plans that related to these various supports, action plans did not comprehensively address the plans in a way that showed integration was occurring. For example, the health services portion of the plan, similar to the PBSP and PNMP,	Noncompliance

#	Provision	Assessment of Status	Compliance
		frequently still were separate plans that were not integrated in any measurable way into the ISP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Examples of issues related to the lack of integration were found between nursing and physical and nutritional supports to incorporate PNMPs with medication administration, and dental and psychology to develop and implement desensitization plans. There was little evidence that PBSPs were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, etc.). All of these are examples of coordination and integration that should be occurring as part of the individual planning process. Numerous examples of these concerns have been provided in previous reports. On a positive note, as discussed above, while the Monitoring Team was on site, the IDT for Individual #136 successfully developed the beginnings of an integrated plan. In addition, the Monitoring Team reviewed the plan for Individual #140. This plan showed some good examples of integration. For example, preferences clearly were integrated with some of the skill acquisition programs; the BCBA, Speech Therapist, and vocational staff were tasked with working together to develop task analyses for the vocational component of the program; and the Speech Therapist, BCBA, and Dental Hygienists were tasked with working together to develop pictorial task analysis for tooth brushing. These various team members' expertise and skills, as well as the integration of the individual's preferences and strengths increased the likelihood of successful planning and programming.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Generally, for the action items identified by teams, timeframes and staff responsible were identified. Often, timeframes were weak, though, referencing "as requested," or "as available," or "ongoing." Such undefined terms make it difficult to ensure that supports and services are provided based on the individual's needs. Whenever possible, specific timeframes should be delineated, or some form of measuring staff's level of involvement should be included. For example, if it is the individual's choice to send cards or call family when desired, a mechanism for measuring when staff have offered to assist with such tasks might be appropriate. In addition, methods for implementation were not always adequate or present. In other words, the "how" was not provided. In none of the 10 plans reviewed (0%) was the methodology sufficiently described for the action plans included. For example, action steps that read: "will increase weight to within desired weight range," or "will encourage participation in day/vocational activities" did not provide a methodology for accomplishing the implementation phase. In addition, as is discussed with regard to Section I, action plans for individuals identified	Noncompliance

#	Provision	Assessment of Status	Compliance
		as being at risk did not include adequate methodologies to reduce to the extent possible the at-risk factors. The plans included in individuals' ISPs often repeated that plans already in place would be implemented, or set forth plans that were not sufficiently aggressive to either further evaluate and/or address individuals' high and medium risk levels. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified. In addition, staff responsible often did not include direct support professionals, when they should have been identified. For example, although health management plans were mentioned in action plans, when they were, the staff responsible were listed as medical and nursing staff, and the QDDP. Even when they were mentioned, their specific role was not identified. Direct support professional often play a key role in implementing portions of health management plans, and notifying medical personnel of medical issues. Likewise, direct support professionals play a key role in the implementation of PBSPs and PNMPs, but action plans generally listed the clinical staff as responsible. The role of direct support professionals in plan implementation should be set forth in the action plans.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Although all of the plans included some practical and functional interventions, none of the 10 plans reviewed (0%) effectively addressed the individual's full array of needs for services and supports. Such issues are discussed elsewhere in this report 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. In addition, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at LBSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. In addition, many individuals at the Facility had part-time schedules for work or day activities, and teams did not appear to view timeliness and attendance issues as priorities to be resolved (i.e., in an integrated fashion with assistance from psychology staff, when appropriate). Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be	Noncompliance

#	Provision	Assessment of Status	Compliance
		expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community.	
	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. Generally, PSPs and the resulting skill acquisition programs contained data collection methods, frequency with which data should be collected, and identified a person(s) responsible. 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' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., health management plans, PNMPs, psychiatric treatment plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Even when plans included objectives, such as PBSPs, individuals' ISPs did not consistently identify the data to be collected, the frequency, and/or the persons responsible for such data collection. In addition, the ISPs did not make a distinction between the person responsible for collecting the data, and the person responsible for data review. Often, it was assumed that these would be two different people. For example, with PBSPs, direct support staff often are responsible for collecting data, but psychology staff are responsible for reviewing the data. The current format of the ISP did not make this distinction, and often when two positions were listed, it was not clear what each one's responsibilities were. None of the 10 ISPs reviewed appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. In fact, very little, if any data was included in any of the ISPs reviewed. Data that should have been included, but was not, would relate to test/laboratory results, skill acquisition goal data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, nursing care plans, weights, numbers of seizures, etc.), and information related to past events, such as causes of fractures or falls, details regarding individuals' successes or failures, etc. 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.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	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 ISPs generally showed a multidisciplinary as opposed to interdisciplinary approach.	
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 ISP to be accessible and comprehensible to staff who must implement it. At the time of the review, the ISP was located on the residential unit, but locked in a cabinet or office for security reasons. Given privacy and security requirements, this was appropriate. It appeared that if staff needed access to the locked records, a key was easily available. The training objectives were located on the unit and accessible to staff, usually in folders or notebooks. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. Another issue related to comprehensibility of the 10 ISPs 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 ISPs as written and determine what his/her responsibilities were for the individual during the course of the 24-hour day. Given the way most of the action items or objectives were written, any team member would have had difficulty determining specifically what their responsibilities were. In addition, the ISPs 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., PBSPs, 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 ISP. 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
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	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 ISPs. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	written reports." Since the last review, the mechanism for doing this had been established for QDDPs. Specifically, a format had been designed for inclusion each month in the Integrated Progress Notes (IPNs). Other team members played a role in this process 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 ISPs did not consistently clearly define these parameters. Based on interviews with Facility staff, monthly reviews were not being completed consistently. This was confirmed through document review. For the sample of 10 individuals, documents were requested of the last six months of monthly reviews, and the previous two quarterly reviews. For seven of these individuals (70%), some monthly reviews were available. However, none had a full six months of reviews. Four had two, and three had one. Even for those individuals for whom monthly or quarterly reviews had been conducted, this was not consistently a full review of each program or support. Due to the fact that many plans, such as PNMPs, nursing care plans, psychiatric medication plans, and PBSPs, 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. According to the QDDP Coordinator, many disciplines completed their own reviews, and documented the results in the Integrated Progress Notes. As the team facilitator, it was unclear how or if the QDDP reviewed this information, incorporated it into the monthly report, and took action to call together a team meeting, as necessary. In addition, the quality of all of these reviews was inadequate. Data was not provided for skill acquisition programs. The comments were general, such as "progressed," "objective initiated," or "regressed." Often, quarterly or monthly reviews indicated that an individual was not progressing, or data had not been available for review. However, frequently, no information was provided about changes made to programs, investigation into causes for lack of progress, and/or follow-up to ensure programs were being implemented correctly. Moreover, examples are provided in various sections of this report of individual experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to nursing care. In addition, as noted below with regard to Section O.3, there were times when a team member(s) identified a need for a change, but individuals' ISPs were not consistently modified to reflect such changes.	

#	Provision	Assessment of Status	Compliance
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 revised.	DADS Policy #004.IV addressed staff training on the ISP process that comports with the Settlement Agreement 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 reported in previous reports, training on PSPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. As indicated above, since the last review, additional training sessions and resources had been initiated. These included: ▪ The current QDDP Coordinator and QDDP Educator were certified trainers for the Q Construction: Facilitating for Success training. All QDDPs had participated in the initial training. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. The competency checklist generally provided a good format for reviewing a number of planning and facilitation skills. As is discussed further below, as the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. However, its implementation already was providing some valuable information to assist QDDPs in refining their skills. At the time of the review, initial checklists had been completed for three of the 14 QDDPs. Based on interview with the QDDP Coordinator, all of the QDDPs had areas in which work was needed. The ISP Monitoring group also was reviewing competency based on a facilitation checklist that LBSSLC had developed, in conjunction with the Personal Support Plan Meeting/Documentation Monitoring Checklist. Through this process a number of QDDPs had been identified as requiring various levels of technical assistance, ranging from mentoring to co-facilitation of meetings. ▪ The State had hired consultants to provide training, and work hands-on with teams on the PSP process. The consultants had provided some basic training to LBSSLC PSTs. It included an overview of the philosophical and historical context of individual planning, a discussion about differences in ICF/MR and Settlement Agreement requirements related to individual planning, and some of the logistics of planning. The specific planning topics included preferences, strengths, and needs; the cycle of planning, including assessment, planning, implementation, re-evaluation, and more planning; developing action plans; the Integrated Risk Rating form; community referrals; and barriers to	Noncompliance

#	Provision	Assessment of Status	Compliance
		implementation. The consultants also provided some training just to the QDDPs. In addition, they had begun to sit in on PSP meetings, and provide technical assistance to QDDPs and teams. They had begun to develop a number of resources for teams to use, such as lists of questions to ask when reviewing risk categories, a description of what the third quarterly meeting should include, hints about identifying individuals' preferences, the Supreme Court's *Olmstead* decision, and lists of acronyms and definitions of frequently used terminology. These efforts appeared to be having a positive effect, and were well received by Facility staff. ▪ The Admissions Placement Coordinator (APC) had provided teams with training on the State Office's categories for obstacles to an individual transitioning to the community, and the action plans that needed to be developed for each obstacle identified. ▪ As noted previously, based on a limited number of observations of ISP meetings while onsite, improvements had begun to be seen with regard to the team process. As would be expected, the results of this training were not yet reflected in the ISP documents that the Monitoring Team reviewed. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QDDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. As noted above, work was underway to address the facilitation component of competency-based training. At the time of the review, the Facility reported that three of the QDDPs had successfully completed the competency check-off. As the QDDP Coordinator recognized, this would be an ongoing process until each QDDP demonstrated competency in this area. In an effort to ensure inter-rater reliability, the QDDP Coordinator and/or the QDDP Educator were observing the same ISP meetings and completing the competency check-off forms. As is discussed in further detail below with regard to Section F.2.g, the establishment of inter-rater reliability is essential. As the facilitation skills performance tool evolves: o The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" should be clarified. o Evidence should be related directly to the indicator, and guidelines should be provided as necessary to support reviewers' understanding of the indicators. o Two areas related to quality that should be added to the checklist include: the QDDP's ability to solicit discussion of the individual's comprehensive set of strengths, preferences, needs, and supports; and	

#	Provision	Assessment of Status	Compliance
		to facilitate the adequate integration of the various disciplines to problem-solve, where appropriate. ▪ The Facility had not yet begun to implement competency-based measures for the writing of PSPs. ▪ Competency measures for other team members had not yet been identified. Such measures should be identified and used to evaluate whether additional training is needed. ▪ As recommended in the previous report, additional training should be provided on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. This was an area that the State consultants had identified as a priority. ▪ As noted above, the State consultants as well as the QDDP Coordinator had begun to sit in on team meetings and provide technical assistance in real time. These efforts should continue, because they likely will have the greatest impact on improving the process. ▪ As noted in several other sections of this report (e.g., Sections K, O, P, R, and S) adequate processes were not in place to ensure that staff had successfully completed competency-based training on the implementation of components of the ISPs, such as behavior support plans, physical and nutritional management plans, indirect therapy plans, use of alternative and augmentative communication, and/or skill acquisition plans. Progress was being made on training staff, but the Facility remained out of compliance with this provision. In addition to focusing efforts on providing additional training and technical assistance to improve the team process during team meetings, competency measures needed to be developed and implemented for the development of the ISP documents, and the Facility needed to ensure that staff responsible for the implementation of the plans successfully completed competency-based training.	
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	The Monitoring Team requested: "An alphabetical list of each individual at the Facility, with the most recent PSP meeting date, the date on which the PSP document was completed/filed, and the date of the previous PSP meeting date." However, the list that the Facility provided was not responsive to this request. It provided the 2010 date for individuals' ISPs, and the 2011 date. For many individuals, the 2011 date had not yet occurred (i.e., in October through December 2011). As a result, it could not be	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	determined what the actual dates were of the "most recent" and "previous" ISP meetings. It appeared what was provided was the scheduled dates versus actual dates. Examples were provided of individuals for whom extensions had been sought. One of the individuals was one of the three noted to have had overdue meetings. The reason provided related to ensuring her family could participate in the meeting, which was a legitimate reason for an extension. The other two were related to illnesses/hospitalizations. One was listed as having had the meeting on time, and the other was deceased. Based on the list the Facility provided, many ISPs appeared to have been completed/filed more than 30 days after 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 ISP is the document that should drive the delivery of protections, supports, and services. It is essential that it be available for implementation within 30 days. As is noted in other sections of this report, IDTs did not consistently meet to make changes to PSPs for individuals who experienced changes in status, or whose circumstances should have resulted in modifications being made (e.g., multiple restraints, requiring modifications to PBSPs; hospitalizations resulting in changes to status, etc.). The Facility should continue to monitor the timeliness in which ISP meetings are held, ensure that the documents are available for timely implementation, and make changes as needed.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Progress had been made and/or sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that PSPs are developed consistent with this section of the Settlement Agreement. Positive developments included: ▪ DADS Policy #004.V continued to address quality assurance processes to ensure PSPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ The LBSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist tool was used to review of the ISP meeting. As noted above, the ISP Monitoring group, which included the ADOP, QDDP Coordinator, QDDP Educator, Human Rights Officer, and Program Compliance Monitor used this tool. Based on the work of this group, QDDPs that required co-facilitation of meetings with an experienced QDDP, as well as those who required mentoring had been identified so that additional supports could be provided.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ 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 QDDP Coordinator and the QA staff were conducting monitoring. Since the previous review, the QDDP Coordinator had been meeting monthly to discuss the results of the reviews. According to the POI, this included discussion about particular indicators for which low scores had been attained. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff responsible for conducting audits. The Facility had recognized this need based on the varied results of the auditing that had been completed thus far. As is discussed with regard to Section E, the procedures being used to establish inter-rater reliability needed modification. It was positive, however, that the QA Department had begun to meet monthly with the Department staff with one goal being to attempt to resolve discrepancies in monitoring. ▪ As discussed in previous reports, the guidelines/instructions for the audit tools required modification. This will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). Instructions also need to clearly direct auditors to review the quality of the ISPs, assessments, objectives, etc., and not just their presence or absences. For example, 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 ISP, 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 ISP.	

#	Provision	Assessment of Status	Compliance
		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 to these guidelines, as necessary. ▪ As a result of inadequate instructions or criteria for auditing, many of the completed review tools that the Facility submitted for review did not appear to have captured relevant issues with ISPs. Many of them found compliance with close to 100 percent of the indicators, which was inconsistent with the Monitoring Team's findings related to ISPs it reviewed. Given the lack of adequate instructions, this is not surprising. ▪ The Facility had begun to analyze the data. As noted above, the QDDP Coordinator and Program Compliance Monitor met monthly to review data. On a quarterly basis, the QA Department as well as the QDDP Department analyzed the cumulative data, and reports were provided to the QA/QI Committee. This group made decisions about the need for formal corrective action plans to be developed and implemented. Although it was positive that these actions were occurring, until valid and reliable data are available, the QA/QI Committee will be limited in its review and action plan development. In its POI the Facility recognized that it remained out of compliance with this provision, which was consistent with the Monitoring Team's findings. Progress was being made in setting up the infrastructure for the quality assurance processes, including more formalized processes for conducting audits, and reviewing and analyzing data. In order for compliance to be achieved, the Facility will need to fully implement these processes, and identify and implement appropriate corrective action plans to address deficiencies identified.	

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

1. Based on the ongoing competency checks for all QDDPs, as necessary and appropriate, the QDDP Coordinator should provide QDDPs with additional technical assistance or training on group facilitation, particularly as is relates to the interdisciplinary team process. (Section F.1.a)
2. The criteria for determining when a team member's attendance at an annual ISP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability. Although this is an issue that should be carefully coordinated with the State Office, now that risk levels were being established for individuals, this might be one mechanism that teams could use to determine which team members should attend an individual's annual planning meeting. (Section F.1.b)
3. As indicated in other sections of this report, focused efforts should be made to improve the quality of assessments that are used in the development of individuals' PSPs. (Section F.1.c)
4. The Facility should consider defining in policy a key set of assessments that should be conducted regularly, and the expected timeframes for reevaluation. Teams should be required to provide a justification for veering from this schedule. Optional assessments also should be defined with criteria/guidelines to assist teams in determining if such assessments would be beneficial to the individual. (Section F.1c)

5. The LBSSLC vocational assessment should continue to be revised and expanded upon and/or alternatives to the vocational evaluations/assessments should be identified and implemented. Vocational evaluations should focus on potential work that is interesting to the individual, and on how that kind of work could be made available to the individual. The evaluation should create a vocational profile based on, for example, objective data, situational assessments, a thorough work history, and/or interest inventories. (Section F.1.c)
6. ISPs should integrate the recommendations from assessments, not just reference them, and make the health care, and therapeutic plans a part of the ISP, rather than stand-alone documents. These other plans should be integrated further with other protections, supports, and services. (Sections F.1.d, F.2.a.2, and F.2.a.3)
7. 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. (Sections F.1.d, F.2.a.1, F.2.a.2, and F.2.a.3)
8. 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. (Section F.2.a.1)
9. Additional training should be provided on how to 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. (Sections F.2.a.2, F.2.a.3, F.2.a.4, F.2.a.5, F.2.a.6, and F.2.e)
10. Individualized, measurable goals and objectives should be defined in individuals' ISPs to support the implementation of essential plans, such as behavior support plans, nursing care/health management plans, psychiatric treatment plans, and physical and nutritional support plans. For example, in order to provide health care supports to individuals served, measurable goals and objectives should be included to define the roles of direct support professionals as well as nursing staff. The same is true for all of these other various plans. In addition, ISPs should include measurable, observable objectives to determine the efficacy of these plans. In other words, objectives should be designed to allow the team to determine if the individual is doing better or worse, or remaining stable. (Section F.2.a.2)
11. 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. (Section F.2.a.3)
12. Whenever possible, specific timeframes should be delineated in action plan. For action plans that involve service objectives, some form of measuring staff's level of involvement should be included. (Section F.2.a.4)
13. The Facility should be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking, cleaning, and realistic community safety skills, become a regular part of training programs for individuals served. (Section F.2.a.5)
14. PSPs should delineate clearly: 1) persons responsible for data collection; and b) persons responsible for data review. (Section F.2.a.6)
15. 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. (Section F.2.c)
16. With regard to the completion of monthly reviews:
    a. The process for ensuring that each team member conducts monthly reviews of the programs which he/she is responsible should be formalized, and it should result in easy access to all team members to the information;
    b. Monthly reviews should incorporate data, as appropriate, to allow the QDDP and the team to assess the efficacy of the plans and programs in place, and determine if changes are needed, staff need to be retrained, more monitoring needs to occur, etc.; and
    c. QDDPs should document clearly follow-up activity and/or changes that are made to PSPs. (Section F.2.d)
17. QDDPs 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. (Section F.2.e)

18. As the facilitation skills performance tool evolves:
    a. The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" should be clarified.
    b. Evidence should be related directly to the indicator, and guidelines should be provided as necessary to support reviewers' understanding of the indicators.
    c. Two areas related to quality that should be added to the checklist include: the QDDP's ability to solicit discussion of the individual's comprehensive set of strengths, preferences, needs, and supports; and to facilitate the adequate integration of the various disciplines to problem-solve, where appropriate. (Section F.2.e)
19. Ongoing training and technical assistance should be provided to address gaps in knowledge regarding the new ISP process, as well as to enhance the various team members' skills. (Section F.2.e)
20. Consideration should be given to adding examples of ISPs that are well done, while protecting the identity of the individual, to the training manual to assist in teaching QDDPs and teams what is expected. (Section F.2.e)
21. 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. (Section F.2.f)
22. The guidelines/instructions for the audit tools should be modified to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). (Section F.g.2)
23. Staff responsible for conducting monitoring activities should be provided with necessary training, adequate guidelines and criteria should be included in the audit tools, and inter-rater reliability should be established. (Section F.2.g and Facility Self-Assessment)
24. As the Facility expands its self-assessment activities, the POI should include the results of data analysis to substantiate the Facility's findings of noncompliance or substantial compliance. The POI also should indicate how the Facility has used this data to identify problematic trends, and develop corresponding corrective actions. (Facility Self-Assessment)

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 For one individual from each residence for the past month, copies of all consultant reports (medicine and subspecialty) since the Monitoring Team's last visit, and all Integrated Progress Notes (IPNs) commenting on consultant reports: Individual #318 - neurology consults 3/18/11, 7/15/11, cardiology consult 5/9/11, and endocrinology consult 6/30/11; Individual #6 - gastroenterology consults 5/26/11, 5/31/11, 6/21/11, neurology consults 3/18/11, 4/22/11, and surgery consults 4/18/11, 6/20/11, 8/8/11, 9/15/11; Individual #199 - hematology consult 7/8/11, and neurology consults 3/16/11, 6/29/11; Individual #184 - surgery consults 3/30/11, 4/20/11, 4/26/11; Individual #66 - surgery consult 4/5/11, vision clinic 5/6/11, and gynecology consult 6/8/11; Individual #284 - neurology consults 3/30/11, 5/11/11, 6/22/11, 9/7/11, orthopedics consult 6/20/11, endocrine consult 8/31/11, and vision clinic 6/3/11, 7/1/11; Individual #238 - podiatry consults 2/16/11, 5/18/11, Ear, Nose, and Throat (ENT) consult 6/10/11, ophthalmology consult 6/6/11, and vision clinic 7/1/11; Individual #237 - vision clinic 5/6/11, rheumatology consult 5/16/11, and endocrine consult 6/28/11; Individual #161 - neurology 3/18/11, radiology report 3/19/11, and gastroenterology consult 4/1/11; Individual #134 - gastroenterology consults 2/11/11, 8/1/11, neurosurgical consults 2/15/11, 3/8/11, 3/22/11, 7/7/11, endocrinology consult 3/31/11, 6/30/11, ENT consult 6/8/11, cardiology consult 3/16/11, 6/15/11, and vision clinic 2/4/11; Individual #310 - neurology consult 8/17/11, nephrology consults 4/8/11, 7/29/11, gynecology consult 2/16/11, endocrinology consult 4/28/11, and dental consults 4/4/11, 4/6/11; Individual #202 - endocrinology consults 3/31/11, 6/30/11, vision clinic 7/1/11; Individual #130 - gastroenterology consults 7/12/11, 7/26/11, 8/15/11, 8/31/11, dental consult 5/17/11, and pulmonary medicine consult 8/18/11; Individual #29 - ENT consults 7/8/11, 8/19/11, neurology 6/29/11, and pulmonary medicine consult 4/29/11, 8/2/11; Individual #241 - ENT consult 4/8/11, podiatry consult 5/18/11, cardiology consults 3/12/11, 5/9/11, and cardiology report 5/2/11; Individual #89 – pulmonary medicine consult 7/11/11, gastroenterology report 4/27/11, gastroenterology consult 4/6/11, and neurology consults 4/27/11, 6/22/11; o Attendance roster for Medication Safety and Systems Committee, dated 8/17/11, and 10/3/11; o Copy of one Physical and Nutritional Management Plan (PNMP) from each home; o Presentation Book for Section G; o Enteral Work Group meeting minutes for 2011; o Monthly polypharmacy review attendance roster; o LBSSLC Policy - Health Services: Administration of IV fluids and IV antibiotics, dated 5/23/11; o LBSSLC Policy – Communication Processes: Active Record Check out/Check in Process,

	dated 6/10/11; o Medical database snapshots of computer screen options/drop down menus; and o Texas Settlement Agreement Monitoring Instrument - Section G. ▪ **Interviews with**: o Glenn Shipley DO, MPH; and o Leah Shults, RN, BSN, MPCN.
	Facility Self-Assessment: The Facility determined it was noncompliant with Section G. This was consistent with the Monitoring Team's findings. The POI focused on narrative content. Although the narratives were helpful in describing actions the Facility had taken to move towards compliance with Section G, the Facility provided no data in the POI to show whether or not these actions were resulting in the desired changes. With the development of complete processes and mature systems, the Facility should begin to focus on evidence and data to substantiate compliance in this area. The POI included an important action plan. It involved ensuring that individuals' teams held PSPAs, as necessary, to address recommendations resulting from external medical consultations.
	Summary of Monitor's Assessment: Although the Facility was non-compliant with both sub-sections of Section G, there had been progress. As the Facility noted, integrated care had begun to take place through a variety of committees that were the forums for interdisciplinary discussions, including the Medication Safety and Systems Committee, the morning medical provider meetings, the Physical and Nutritional Management Team (PNMT), the Psychotropic Polypharmacy Committee, and the PST/IDT. Through interdisciplinary discussions, the steps for researching and resolving medication variance had begun. The morning medical provider meeting provided an integrated approach to clinical care on campus. The PSTs/IDTs, especially the at-risk identification and prevention planning, focused on integrated care. However, considerable need remained for the continued development of integrated processes for each of these teams, and for other teams and committees on campus. The PNMT, the PSTs, and the morning medical provider meetings still had challenges to resolve in order to demonstrate integrated care. The following provide some examples in which progress had been made, but full integration was not yet occurring: ▪ The PNMPs were included in the Medication Administration Records (MARs). However, the recommendations of the PNMT were often not incorporated in the care plans, and the Nursing Department appeared to consider them optional. ▪ An Enteral Feeding Workgroup was to meet monthly to resolve feeding tube concerns and provide education and training. However, the minutes of three meetings were submitted, and the ongoing role of this committee was not clear, nor could it be determined if the original goal was accomplished. ▪ There was a new policy for provision of intravenous (IV) fluids and IV antibiotics at LBSSLC. However, it appeared to remain in the early stages of review and implementation.

	▪ A new medical program compliance nurse position was created in the Medical Department. This position had the potential to assist in documentation of integrated services, as well as provide quality review and interpretation of data and follow-through on a number of areas of medical care. This position started approximately four months prior to the Monitoring Team's visit. One of the roles of this position was to track the concerns of the morning medical provider meeting. Several key departments' attendance at these meetings provided the forum for interdisciplinary discussions. The need remained to streamline the minutes concerning discussion about areas in which follow-up was needed, and to track these areas until closure occurred. The first step in the process had begun through the identification of clinical concerns, such as missed lab draws, and changes in health status of those hospitalized. A new policy was in place that required the Unit RN Managers to take the information from the morning medical provider meetings to the QDDP in order for a meeting of the PST to be called to determine if changes were needed in the individual's level of risk and/or risk action plans. Some critical questioning had begun to be part of the meetings, with assignment of duties and follow-up for items requiring closure. However, the needed level of critical questioning concerning acute care issues, and prevention of hospitalizations remained an untapped potential. ▪ Although the PST remained the forum for the most encompassing level of integrated services, the PSTs' risk discussions required further critical thinking and preparation by the various team members. During the week of the review, one PST for a medically complex individual demonstrated the potential for integrated risk management, but the ability to replicate the vision and team spirit of this team remained a challenge across the campus. ▪ Although a database had been created to track the primary care practitioner (PCP) response to consultant recommendations, the analyses and action plans based on this information did not appear to have had an impact on the practice patterns of the PCPs. The PCP agreement or not with the consultant recommendations remained undocumented in many instances.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility provided several forums that were beginning to provide integrated clinical services. Attendance at the 8/17/11 and 10/3/11 Medication Safety and Systems Committee meetings included representatives from the Pharmacy Department, Medical Department, QA department, Facility Administration, Nursing Department, and residential services. This reflected the need for many departments to participate in reducing the medication error and variance rate, as well as the large number of returned medications. The discussion represented integrated participation. The morning medical provider meeting provided a forum for integrated clinical services, with interchange and communication of information and ideas. It included the PCPs, psychiatry, the medical program compliance nurse, clinic manager, Dental Department, Pharmacy Department, the Chief Nurse Executive, Nurse Operations Officer, Unit RN Managers, Hospital Liaison Nurse, Infection Control Nurse, one or more members of the	Noncompliance

#	Provision	Assessment of Status	Compliance
		habilitation therapy department, PNMT, and QA Department. Some critical questioning had begun to be part of the meetings, with assignment of duties and follow-up for items requiring closure. However, the needed level of critical questioning concerning acute care issues, and prevention of hospitalizations remained an untapped potential. In addition, the need remained to streamline the minutes concerning discussion about areas in which follow-up was needed, and to track these areas until closure occurred. Although it was a maturing system, the morning medical provider meeting process also allowed for potentially rapid response from the IDT, because the Unit RN Managers communicated the information to the QDDP. The QDDP was supposed to consider the need to call an IDT meeting to review changes in status and review risk ratings and action plans. The IDT also was notified when an off-campus consultation occurred, and the results of the consultation, which were discussed at the morning medical provider meeting. Additionally, the PST would receive information if the appointment were not kept. When consultant reports were reviewed at the morning medical provider meeting, this information was recorded in the database, documenting the date of discussion. The Unit RN manager then would take this information to the QDDP to set up a meeting of the IDT. The tracking allowed the response time of the QDDP and the IDT to be determined. The end result should be an integrated approach to care, as well as improved efficiency in response and communication. The IDT remained the forum for the most encompassing level of integrated services. The PNMT had a potentially more important role for those individuals with medically complexities. However, based on a record review completed while the Monitoring Team was onsite that included Facility Administration, nursing, and PNMT representation, the PNMT recommendations had not been included routinely in nursing care plans. PNMT recommendations should be considered relevant to be the domain of nursing care. The Nursing Department should review and implement them, or if not implemented, the reasons should be documented. Recommendations requiring a physician order also should be tracked to ensure orders are written, or the physician provides a rationale for not completing the recommendation. The Facility determined that it needed an integrated approach to enteral feeding, and convened a work group to address this issue. It included members from the Dietary, Active Treatment, Medical, Nursing, and Pharmacy Departments. The goal was to review and ensure appropriate supports were in place for enteral feeding, including evaluation of nursing protocols and supports, equipment needs were in place, and staff instruction was provided. Meetings were held on 4/18/11, 5/23/11, and 6/20/11. However, the minutes of three meetings were submitted, and the ongoing role of this committee was not clear, nor could it be determined if the original goal was accomplished.	

#	Provision	Assessment of Status	Compliance
		One interdisciplinary program that expanded services at LBSSLC was the administration of IV fluids and antibiotics at LBSSLC when selected criteria were fulfilled. This was memorialized in a policy entitled: LBSSLC – Health Services: Administration of IV Fluids and IV Antibiotics, dated 5/23/11. The focus was to be on those in the hospital requiring IV fluids or antibiotics, but that could otherwise benefit from an early return to the Facility. The hospital liaison nurse was to be the conduit of information back to LBSSLC in order for the Pharmacy, Nursing, and Medical Departments to allow preparation for the individual's transfer back to LBSSLC, and to ensure the next dose of IV medication or fluid was given in a timely manner. This process required an integrated approach to care. No examples were submitted to show that this new expanded service had actually occurred as of the date of the Monitoring Team's visit. Another meeting which was interdisciplinary and from which the decisions influenced the ISP process was the monthly polypharmacy review. This included members of Psychiatry and Medical Departments, Pharmacy, dentist, behavioral services, and quality assurance. An area needing improvement and that potentially impacted all departments was access to the active record. The Facility identified this as an issue, especially with the Dental Department, when the record did not accompany the individual. A policy was created to resolve this concern entitled: LBSSLC – Communication Processes: Active Record Check out/Check-Out Process, dated 6/10/11.	
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.	The Facility submitted consultant reports for one individual from each residence, as well as any IPNs commenting on the consultant reports. Consultations for 16 individuals were submitted, with a range of three to 12 consultations per individual. A total of 84 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 84 reviewed, 75 (89%) had the PCP initial and date, indicating review by the PCP. ▪ Recently, the Medical Department began to stamp the consult reports with boxes for the PCP to check whether there was agreement with the consultant's recommendations, or if disagreement, to refer to the IPN for further information. To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs were reviewed, as well as the presence of the stamp that was implemented between 7/1/11 and 9/1/11. Of the 84 reviewed, 48 (57%) consults included documentation of agreement or not with the consultant recommendations. Additionally, the Medical Department expanded the database to include whether the PCP	Noncompliance

#	Provision	Assessment of Status	Compliance
		agreed or disagreed with the consultant recommendations. Tracking of response to consultations was part of the medical database. One area needing clarity concerned radiologic procedures such as DEXA and mammogram reports, which often included recommendations. If not already done so, these should be included in the database.	

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

1. PNMT recommendations should be considered relevant to be the domain of nursing care. The Nursing Department should review and implement them, or if not implemented, the reasons should be documented. Recommendations requiring a physician order also should be tracked to ensure orders are written, or the physician provides a rationale for not completing the recommendation. (Section G.1)
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. (Section G.1)
3. If not already done so, the medical database tracking PCP response to recommendations should include diagnostic tests that might include a recommendation, such as DEXA scan results and mammograms. (Section G.2)
4. 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. (Section G.2)
5. In addition, a tracking system should be developed to ensure that if there are recommendations with which the PCP agrees that there is a follow-up order, and that the order is completed in a timely manner. (Section G.2)

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 In-service training for PCPs on International Classification of Diseases (ICD) and Diagnostic and Statistical Manual (DSM) diagnostic criteria in the last six months; o Presentation Book for Section H, including examples of Quarterly MD progress notes, annual assessments, 90-day medication orders, 90-day medication reviews, Medical Department database for tracking annual physicals and clinic visits, and PCP IPN SOAP notes; o "Observing and Reporting Clinical Indicators of Health Status Change," program taught by LBSSLC Nurse Educator; o Number of direct support professionals trained on "Health Status Change" in-service and number of direct support professionals remaining untrained; o LBSSLC – Health Services: Coding Requirements, dated 4/18/11 (R); o Professional claim form, Medicare part B documentation for clinic; o Lubbock SSLC – Positive Behavior Support Prevention and Treatment of Pica, dated 12/14/10 (R); o Visit Frequency, from 4/1/11 to 6/30/11, dated 8/26/11; o LBSSLC – Health Services - Adverse Drug Reaction Reporting, dated 7/22/11, and in-service attendance roster, dated 8/26/11; o LBSSLC – IDT Process – Program Development: Personal Support Plan – At risk Individuals Process, dated 8/24/11 (R), and attendance roster, dated 8/25/11; o LBSSLC – Health Services: Tracking System for Consultations, dated 8/29/11 (R); o LBSSLC-Health Services: Tracking System for lab/radiology department, dated 8/29/11 (R); o LBSSLC – Communication Process: Quality Assurance and Improvement Council, dated 9/1/11 (R); o LBSSLC – Health Services: Pre-Treatment and Post-sedation Monitoring: Nursing Protocol, dated 8/11/11; and o Settlement Agreement Monitoring Tool for Section H. ▪ **Interviews with**: o Glenn Shipley, DO, MPH; and o Leah Shults, RN, BSN, MPCN.
	Facility Self-Assessment: The Facility determined it was noncompliant with all sub-sections of Section H. This was consistent with the findings of the Monitoring Team. However, the POI was generally narrative in focus, with little data or measurable evidence to confirm the degree of progress. When data was referenced, such as tracking completion of annual and quarterly medical assessments, the Facility's narrative indicated compliance with timeliness, but the evidence

	submitted did not support campus wide completion of timely annual medical assessments or quarterly medical progress notes. There was a medical database that recorded all medical visits, as well as evaluations. However, it was not clear whether the Medical Department analyzed the data available, and if so, what the action steps, if any, were taken based on the results of the analysis. At the time of the review, this information did not appear to have an impact on improving the completion rate of the annual or quarterly medical assessments.
	Summary of Monitor's Assessment: The Facility continued to strive toward comprehensive quality care. Routine periodic reviews were essential to care of those residing at LBSSLC. However, the Facility still struggled with completing annual medical evaluations in a timely manner. Unfortunately, the timely completion of quality quarterly medical progress notes could not be confirmed through the records submitted and remained an area of concern. Medical response to acute care needs appeared to be appropriate. The quality of evaluations remained focused on stabilizing and resolving the acute care problems. There was a continued paucity of clinical questioning of the many potential reasons for recurrent acute illnesses or hospitalizations, and logically analyzing the differential diagnosis and treatment options. The Facility had begun to aggressively approach individuals' health status changes. An educational program had been implemented to train the direct support professionals on changes in health status, because staff in the home were often the first to notice changes in an individual's health or behavior. This has the potential to greatly benefit the health and safety of those residing at LBSSLC, and is a required component of Sections H.1 and H.3 in order for the PCP s to be notified in a timely manner of health status changes. Additionally, the morning medical provider meeting was pivotal in discussing new clinical concerns, and forwarding this information to the QDDP/IDT for a review of risk ratings and risk action plans. A system was in place for rapid dictation, with the document available for the medical provider's review and signature in approximately three to four hours. Evidence was found in the PCP SOAP notes of appropriate testing, evaluation of results of tests, and diagnoses based on these reports and physical findings along with consultant findings. However, the Facility awaited the State Office clinical guidelines to identify acceptable clinical indicators to determine the efficacy of treatments and interventions for the common conditions found in the IDD population, and to determine the need for changes in treatment or interventions based on the clinical indicators. By standardizing care throughout the SSLC through the use of clinical indicators, they also could be used to monitor the impact of these common conditions on the health status of the individuals over time.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The Medical Department completed annual and quarterly medical assessments on all individuals residing at LBSSLC. However, as noted with regard to Section L, delays occurred in completing the annual assessments. Delays also were noted in the completion of the quarterly MD progress notes. In a review of 12 records, none (0%) included quarterly progress notes. As part of routine clinical care, clinic visits were available for those with acute problems or change in condition. If the individual was unable to attend the clinic, the PCP examined the individual in the home. A computerized database was used to track annual physicals and clinic visits. Entries also were made for the reason for an acute care (health status change) visit. It remained unclear if or how the Facility was using this information to develop action steps to address areas of concern. For example, it was not clear if a red flag system was used to indicate an approaching due date. Implementation of such a system would be useful in ensuring that the PCP completes the documents in a timely manner, and would greatly reduce the significant number of annual and quarterly assessments that remained overdue. Also, a review was completed every 90 days of the orders for medications. A "90 day medication review" also was completed that included a focus on non-medication orders. This included diet orders, nursing orders, lab testing to be ordered, and adaptive equipment needs. Both the PCP and the RN case manager reviewed this order document. The results of the non-Facility medical peer review indicated a need for improvement in documenting smoking history in the annual exam, and in providing a continuously updated active problem list. Once these issues were identified, an in-service training session was provided to the PCPs. Results of a review of 12 records included an analysis of these areas, which is discussed in further detail with regard to Section L.1. During a nursing record review by a member of the Monitoring Team, it was noted that important changes in physiological parameters were not detected, nor did nursing staff communicate in a timely manner with the PCP. Once the PCP was notified, there was timely intervention. However, nursing monitoring and assessments to detect changes in health status remained a challenge. The Nurse Educator provided ongoing training to the non-nursing staff, concerning clinical indicators. The focus was on recognizing early health status change. The target audience was the direct support professionals, who would be the first to observe subtle changes in an individual's health. Some of the clinical guidelines being developed might include responsibilities of the direct support professional, and recognizing early changes	Noncompliance

#	Provision	Assessment of Status	Compliance
		and warning signs would be foundational to the guidelines. As is illustrated throughout other sections of this report, issues remained with regard to assessments and evaluations being completed regularly, and in response to development or changes in an individual's status, as well as being of adequate quality. Some examples of this included nursing assessments, particularly with regard to individuals who experienced acute illness, psychiatric assessments, psychological assessments, PNMT evaluations, individuals who might benefit from communication systems; and individuals being considered for enteral nutrition. For example, based on a review of records of 13 individuals, which is discussed in greater detail with regard to Section M.1, who had been sent to an emergency room and/or hospitalized for an acute illness, nursing assessments were not conducted on a regular basis or in response to changes in individuals' status. Since the initial baseline review, this has been a consistent finding. During the current review, the Facility was found to have made no progress in addressing these issues.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The Medical Department underwent in-service training for the PCPs on the revised policy LBSSLC - Health Services Coding Requirements, dated 4/18/11, that emphasized the importance of utilizing the ICD-9 and DSM-IV diagnoses and diagnostic criteria. The dentist was expected to utilize the codes in the American Dental Association (ADA) guidelines. The in-service was completed on 4/19/11. All PCPs attended, as well as the staff psychiatrist and staff dentist. On-site specialty clinics also utilized the ICD-9 codes for diagnoses. One of the more difficult medical/behavioral diagnostic categories is pica. The policy: Lubbock SSLC – Positive Behavior Support: Prevention and Treatment of Pica, dated 12/14/10(R), include the definition to be used in the policy, which included the diagnostic criteria for pica from the DMS-IV. This ensured consistency in correctly identifying and interpreting pica actions. 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. Although some progress had been seen in this area, the Facility remained out of compliance.	Noncompliance
H3	Commencing within six months of	The individuals residing at LBSSLC had ready access to the PCP or on-call PCP. Statistics	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	were provided for the number of individual medical visit encounters for the individuals at LBSSLC from 4/1/11 through 6/30/11. During this time, 946 PCP/specialty visits occurred on site. Additionally, there were 57 emergency room visits and 25 hospitalizations. Adverse drug reactions were of importance in timely and clinically appropriate response by the PCP. The Pharmacy Department recently developed a policy entitled: LBSSLC-Health Services: Adverse Drug Reaction Reporting, dated 7/22/11. On 8/26/11, an in-service was provided to the PCPs. As is discussed in further detail with regard to Section L.1, once the PCP was notified, timeliness for interventions related to acute problems was considered appropriate. The PCP made the appropriate clinical assessment, interpretation, and intervention. However, more difficult to measure were the potentially significant diagnoses that might have been missed in relation to chronic illness. For instance, an important focus had been placed on dysphagia as a cause of aspiration pneumonia. However, GERD appeared to not be as thoroughly reviewed as a potential contributor to aspiration pneumonia and/or episodes of respiratory distress. In another area of chronic disease, osteoporosis and osteopenia, integrated risk ratings indicated outdated DEXA scans by several years, in some instances. These examples indicated a lack of a consistent and thorough approach to the non-acute problems. In order to determine whether or not treatments and interventions are up-to-date, appropriate to the cluster of signs and symptoms and the individual's clinical history, and provided in a timely manner, clinical guidelines are needed that address all of these areas for the common conditions that affect the Intellectual Disability/Developmental Disability (ID/DD) population. At the time of the review, the State Office was developing and finalizing clinical guidelines for some of the common clinical conditions. It was anticipated that incorporated into these guidelines would be recommended diagnostic testing, as well as options for timely treatment.	
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.	As part of the SOAP note, the PCPs documented the pertinent historical information (i.e., for an acute care visit, follow-up visit, or routine exam), the clinical exam findings, the labs, and other test results. An assessment was made based on this information. Clinical indicators in the SOAP notes included the pertinent physical findings, and test results. Using this information, the PCP then documented the assessment/rationale and plan. The many SOAP notes reviewed indicated good documentation of this process for PCP visits. For standardization of common conditions across the SSLC and SSLC system, the clinical guidelines are expected to include parameters that can be used as clinical indicators for	Noncompliance

#	Provision	Assessment of Status	Compliance
		such areas as osteoporosis, GERD, pneumonia, etc. These clinical indicators should be documented in the same format using the SOAP format, outlining the clinical indicator, the reason for the interpretation, and the action step. Clinical indicator development for clinical guidelines remained in the initial phase of development. However, the guidelines are not the only source for clinical indicators, and many could be chosen from the literature and clinical experience of the PCPs. Until the clinical guidelines are finalized, one or more clinical indicators on a common diagnosis should be piloted in order to create a process. In this way, when clinical indicators are available from the clinical guidelines, a system for their use already will be in place. Additionally, initial information will have potentially been collected for review of one or more diagnoses, which would assist in choosing the clinical indicators to be used. A database, or system for collecting and analyzing this information, will need to be developed. Clinical indicators also need to be developed for disciplines other than medicine. 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 clinical indicators or functional outcomes to be measured.	
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.	As indicated in the last report, DADS Draft Policy #005 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, LBSSLC had not yet developed or implemented such a system, although, as discussed below, some basic pieces of such a system were in place. As is discussed above with regard to Section E.1, such indicators need to be incorporated into the QA/Risk Management systems to identify individuals, residences, and/or departments that need attention, as well as to detect and address systemic issues that impact the Facility's adequate response to clinical indicators. The Facility was beginning to monitor the health status of individuals at LBSSLC at periodic intervals. The Medical Department had considerable systems/structure in place to monitor health status, including the annual assessment, quarterly PCP progress notes, and a database system to monitor timely completion of these documents. However, as discussed with regard to Section L, a lack of timeliness was noted with these assessments	Noncompliance

#	Provision	Assessment of Status	Compliance
		in some instances. Although the structure was present for periodic review, it was not clear that the monitoring process was identifying issues related to timeliness. The morning medical provider meeting monitored acute care, hospitalizations and ER visits, clinic visits, consult reports, and health status change (i.e., fevers, behavioral challenges, medication errors leading to illness, etc.). The PST was responsible for determining the effect of health status change, and making decisions to revise the risk rating and risk action plans of the individual. The PST also was scheduled to meet quarterly to review each individual's health and safety, and revise plans as needed. The PNMT was often consulted for the individuals with the most complex medical needs. One role of the PNMT was monitoring to ensure action steps were completed, were completed correctly, and were reviewed at intervals to determine need for change or not in the recommendations. However, as noted with regard to Section O, the PNMT was not yet completing adequate monitoring.	
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." The SOAP notes often reflected a change in treatment (e.g., change in medication, or length of course of medication was to be given, change in orders for tests to be performed, etc.) in response to clinical information provided to the PCP. The non-facility medical peer review did not consider this area a significant problem at the Facility, but concluded that treatment was appropriate and timely, and clinical testing was followed up appropriately. The clinical guidelines for common diagnoses were expected to provide guidance for clinical indicators, but also the options for further treatments or interventions based on these clinical indicators. Once established, 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. At the time of the Monitoring Team's visit, this aspect of clinical care had not been developed.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three	A number of policies were created in the prior six months that assisted in building the structure for integrated clinical care and services at LBSSLC. These included: ▪ LBSSLC - Health Services: Tracking System for Consultations, revised 8/29/11;	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	▪ LBSSLC - Health Services: Tracking System for Lab/Radiology Department, revised 8/29/11; ▪ LBSSLC – Communication Process: Quality Assurance and Improvement Council, revised 9/1/11; ▪ LBSSLC – Health Services: Pre-Treatment and Post-Sedation Monitoring Nursing Protocol, revised 8/11/11; and ▪ LBSSLC – IDT Process-Program Development: Personal Support Plan – At Risk Individuals Process, revised 8/24/11. Although there was much yet to be done, these represented important structural components imperative to the process.	

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

1. Within the medical database, a red flag system should be used to indicate an approaching due date. Implementation of such a system would be useful in ensuring that the PCP completes the documents in a timely manner, and would greatly reduce the significant number of annual and quarterly assessments that remained overdue. (Section H.1)
2. The State Office should finalize, distribute, and implement clinical guidelines, especially for pathological conditions common to the IDD population residing at LBSSLC. (Sections H.3, H.4, H.5, and H.6)
3. The clinical guidelines being developed should include clinical indicators in order to guide the SSLCs in measuring success of treatment. (Sections H.3, H.4, H.5, and H.6)
4. Until the clinical guidelines are finalized, one or more clinical indicators on a common diagnosis should be piloted in order to create a process. In this way, when clinical indicators are available from the clinical guidelines, a system for their use already will be in place. Additionally, initial information will have potentially been collected for review of one or more diagnoses, which would assist in choosing the clinical indicators to be used. A database, or system for collecting and analyzing this information, will need to be developed. (Sections H.3, H.4, H.5, and H.6)
5. Once clinical guidelines are developed, the Medical Director should develop/select 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.). (Sections H.3, H.4, H.5, and H.6)
6. 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. (Sections H.3, H.4, H.5, and H.6)

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS SSLC "Risk Guidelines" laminated record; o LBSSLC Presentation Book for Section I; o LBSSLC Personal Support Plan - At Risk Individuals Process, dated 8/24/11; o LBSSLC POI and Action Plan for Section I; o LBSSLC Assessment Workgroup minutes, dated 6/2/11, and 7/19/11; o LBSSLC At Risk Individuals policy; o Settlement Agreement Cross referenced with ICF- MR standards, revised 2/11; o LBSSLC At Risk List by Home; o List of individuals' level of risk for aspiration; o List of individuals' risk level for pneumonia/aspiration; o List of individuals' risk level for chronic respiratory infections; o List of individuals' risk level for contractures; o List of individuals' risk level for gastroesophageal reflux disease (GERD)/gastrointestinal (GI) concerns; o List of individuals' risk level for choking; o List of individuals' diagnosed with dysphagia; o List of individuals' risk level for falls; o List of individuals' risk level for weight loss/weight gain; o List of individuals' risk level for skin breakdown/decubitus; o List of individuals' risk level for impaction/constipation; o List of individuals' risk level for dehydration; o List of individuals with pica, including risk level; o List of individuals' risk level for seizures; o List of individuals' risk level for osteoporosis; o List of individuals' risk level for poor dental status; o List of individuals receiving enteral feeding; o The following documents: Integrated Risk Tracking Forms, Action Plans for Risk Assessments, Aspiration Pneumonia Enteral Nutrition Evaluations (APENs), ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans for the following 23 individuals: Individual #193, Individual #175, Individual #239, Individual #315, Individual #304, Individual #13, Individual #147, Individual #254, Individual #73, Individual #131, Individual #127, Individual #109, Individual #134, Individual #313, Individual #257, Individual #166, Individual #240, Individual #322, Individual #213, Individual #171, Individual #19, Individual #146, and Individual #63; o Medical records, integrated risk rating forms, and risk action plans for the following individuals: Individual #70, Individual #7, Individual #41, Individual #34, Individual #17, Individual #279, Individual #72, Individual #8, Individual #112, Individual #118, Individual #3, and Individual #128;

	○ Integrated risk rating form, risk action plan, most recent ISP and subsequent ISPAs, BSP, and most recent comprehensive nursing assessment for Individual #33; ○ Integrated risk rating form, risk action plan, most recent ISP and subsequent ISPAs, integrated health care plan (10/6/11), most recent comprehensive nursing assessment hospital liaison nursing reports, and PNMT assessment for Individual #136; ○ The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) and Registered Dietician (RD) evaluations, Aspiration Pneumonia/Enteral Nutrition (APEN) evaluation, OT/PT/SLP consultations for the last year, Individual Support Plan (ISP) and ISP Addendums (ISPAs) for the last year, including ISPAs for Integrated Risk Rating Form and risk action plan, Physical and Nutritional Management Plan (PNMP) with pictures, Interdisciplinary Team (IDT) Integrated Risk Rating Form, IDT action plan for risk assessment, person-specific monitoring for past six months, competency-based training for staff, supporting documentation for implementation of IDT risk evaluation and action plan, Nursing Care Plan, Aspiration Trigger sheets for past six months, and Daily Schedule for six individuals, including: Individual #109, Individual #6, Individual #211, Individual #267, Individual #315, and Individual #175; ○ The following documents: APEN evaluation, Head of Bed Elevation (HOBE) evaluation, Physical and Nutritional Management Team (PNMT) evaluation, PNMT action plan, ISP and ISP Addendums including integration of PNMT evaluation and action pan, PNMP with pictures, Integrated Risk Rating Form, competency-based staff training for staff related to PNMT action plan, individual-specific monitoring for PNMT action plan for the past six months, supporting documentation for implementation of PNMT evaluation and action plan, PNMT Discharge Plan/Summary, Daily Schedule, Aspiration Trigger sheets for past six months, and Nursing Care Plans for five individuals, including: Individual #258, Individual #89, Individual #72, Individual #196, and Individual #29; and ○ The following documents: OT/PT Evaluation and Update, HOBE Evaluation, Wheelchair Evaluation, supporting documentation for implementation of direct/indirect therapy programs; OT/PT Consultations for the past year, ISP and ISPAs for the past year, PNMP with pictures, Dining and Diet Card, PNMP Clinic documentation for the past year, PNMP and individual-specific monitoring for the past six months, staff competency-based training, daily schedule, Community Living Discharge Plan (CLDP), Integrated Risk Rating Form, Risk Action Plan and Modified Barium Swallow Study (MBSS) for six individuals, including: Individual #213, Individual #48, Individual #147, Individual #199, Individual #34, and Individual #203. ▪ **Interviews with**: ○ Don Minnis, RN, BSN, Chief Nurse Executive (CNE); ○ Connie Horton, Family Nurse Practitioner (FNP), State Consultant; ○ Robin Seale, Assistant Director of Programs; ○ Glenn Shipley, DO, MPH; ○ Leah Shults, RN, BSN, MPCN; and ○ Linda Thomas, OT, Director of Habilitation Therapy and PNMT member.

	▪ **Observations of**: o ISP Meeting for Individual #269, on 10/3/11; o ISP Meeting for Individual #258, on 10/4/11; o ISP Meeting for Individual #170, on 10/5/11; o PNMT Meeting, on 10/6/11; and o At risk meeting with PST review for Individual #33 on 10/5/11, and Individual #136 on 10/6/11.
	Facility Self-Assessment: The Facility determined it was noncompliant with all sub-sections of Section I. This was consistent with the findings of the Monitoring Team. The Facility had begun to conduct some self-assessments, and included some of the related data in its POI. However, based on the Monitoring Team's review, questions arose with regard to both the accuracy of the data, as well as its comprehensiveness. For example, according to the POI, a record audit was completed to ensure the active record included a copy of the risk rating form and the risk action plan was in the record. The results indicated that 82.2% of the records had this information. However, data submitted to the Monitoring Team suggested significant problems existed with these forms being filed in the records. For nearly half, the integrated risk rating form was not present, and for 75% the risk action plan was missing. In addition, the self-assessment information included in the POI did not address the quality of the risk rating forms (i.e., was the risk screening process adequate, or the quality of the more in-depth assessments, or resulting risk action plans). As the Facility continues to expand its self-assessment processes, it will be essential for the Facility to assess the quality of risk-related activities and documents. The Facility's POI included an action plan related to changes of status for individuals that might necessitate review of their risk ratings and related action plans. Based on the updated "at risk" policy, dated 8/23/11, the PSTs were to have rapid communication from the morning medical provider meeting concerning change of health status for individuals who had been hospitalized or had acute health problems. This was an important action plan for the Facility to implement.
	Summary of Monitor's Assessment: Although the Facility had begun implementing many positive steps, a significant amount of work had yet to be done to achieve compliance regarding the requirements of the Settlement Agreement addressing at risk individuals. Some positive advancements included: ▪ The PSTs used the State Office risk guidelines, and had begun to document the rationale for the rating determinations. ▪ Progress was noted with the results of the interdisciplinary dialogue during team meetings concerning the risks and action plans. ▪ The Facility recently compared the current risk ratings regarding aspiration pneumonia and respiratory compromise to data from the pneumonia tracking system for the past 12 months. Any rating discrepancies were then referred to the IDTs for further evaluation and revisions of these risk ratings. The Facility had implemented the same process addressing weight in October 2011, and planned to identify and assess other risk categories for which the Facility had data to support risk ratings.

	▪ Consultants also had been tasked with working with the PSTs to create quality risk ratings and risk action plans. ▪ During the week of the Monitoring Team's onsite review, one PST that revised the risk action plans demonstrated a far greater potential than what was seen in the documents provided. As discussed, more of this type of integrated planning and action plan development should occur. Although improved documentation was noted with regard to the rationale for the team decisions related to risk ratings for the various risk categories, there was concern about the quality of information and various team members' preparation for the PSP annual or addendum meetings. In addition, although the Facility indicated that all individuals had integrated risk ratings performed and risk action plans developed, the records the Monitoring Team randomly chose did not confirm that this was the case. There were many missing risk ratings and risk action plans. Wide variation also was noted with regard to the risk action plans based on the team's assessment of risk, and areas that that might have benefited the individual were not consistently addressed. The PNMT, although a valuable resource for the most medically complex individuals, struggled with ensuring that its recommendations became part of the risk action plan(s).

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Since the last review, LBSSLC's POI indicated that the following steps had been implemented regarding the At Risk process: ▪ "04/01/2011: When there is a change in an individual's health status such as when an individual returns to the facility after a hospital admission, or returns from an in-town appointment, the QDDP (Qualified Developmentally Disabled Professional)/PST is notified of their return by the campus coordinator and the Unit RN. If the individual returns to the facility after working hours, the campus coordinator leaves a voice message for the QDDP. The PST reconvenes to re-rate the categories of risk, to determine the level of risk and incorporate any changes into the risk rationale, PSP-A (personal support plan - addendum) and risk action plan. The QDDP notifies the ISP (individual support plan) coordinator of any changes in risk status. Follow up meetings are scheduled as needed based on condition and risk and individuals are referred to PNMT (physical nutritional management team) and/or BSC (behavior support committee) as needed for complex cases and when additional expertise is needed. ▪ 05/31/2011: The risk action plans are developed at the respected Personal Support Team meetings and/or at the Risk meetings. ▪ 08/02/2011: Discussion group/meeting was held between ADOP (Assistant Director of Programs), QDDP director, ISP Coordinator, Medical Director and MPCN (Medical Program Compliance Nurse) to determine systemic issues within the At Risk system. The systemic issue identified during monthly monitoring was that the Risk Rationales were not present in the Active Record. Because of the Risk Rationales not being present in the Active Record, it was impossible to	Noncompliance

#	Provision	Assessment of Status	Compliance
		do any sort of useful monitoring of the At Risk procedures. The team identified 4 individuals whose Risk meetings had not yet been completed. (4 individuals residing on 525). ▪ 08/03/2011: The 4 remaining Risk meetings were completed. ▪ 08/03/2011: Corrective action plans (CAP) were put in place to address the systemic issues identified within the risking system. The corrective action plans were developed out of the 08/02/2011 Section I meeting between ADOP, QDDP director, ISP Coordinator, Medical Director and MPCN. The CAP address (sic) getting the Risk Rationales for every individual into their active record by doing a complete record audit and assigning typing to various division clerical staff to get the hand-written risk rationales into typed, electronic format and then onto the active record. The objective of the second CAP is to provide supports to improve the ease of use of the risk rationale form as well as improve the quality of the risk rationale form. This CAP includes steps like: developing additional rationale information for each risk category to prompt teams to make decisions based upon data, training the QDDP's (sic) on the new form and then monitoring the quality of those revised, risk rationale forms. A (sic) objective of the third CAP is to increase the competence of staff in implementing the risk process. This CAP is based upon steps that the Lubbock ADOP (assistant director of programs) would consult with other ADOP's (sic) regarding the contents of the PST training to determine if the risk is addressed and a PST consultant would provide training to the personal support team members regarding the at risk process. ▪ 08/04/2011: A complete record audit was performed of every individual's active record to determine if the risk assessment tools as well as the risk action plans were present and filed correctly. The results from the audit indicate that 185 out of 225 individuals (82.2%) did have their risk rationales filed in the active record. ▪ 08/05/2011: The LbSSLC\IDT Process\Program Development\Personal Support Plan\At Risk Individual's Process Policy has been revised by the QDDP Director. The At Risk Individual's Process policy is scheduled to go through OPM Committee on 08/23/2011. ▪ 08/19/2011: The second discussion group/meeting occurred between ADOP, QDDP director, Medical Director and the MPCN to review the status of the action steps in the Section I corrective action plans. ▪ 08/23/2011: PSP\At Risk Individual policy is approved with revisions as well as the revised bulleted risk rationale form (with revisions also). The recommendations are to revise the draft of the bulleted risk rationale form to add additional space for a detailed comment or narrative for risk recommendation under each category, update the risk database to include an additional box to check when a risk action plan is completed, to be utilized for tracking purposes.	

#	Provision	Assessment of Status	Compliance
		▪ 08/23/2011: A 2nd complete record audit of every individual's active record was completed to determine what rationale forms were present and located in the correct section of the active record. The results are not yet available from the ISP Coordinator. ▪ 08/23/2011 & 08/24/2011: All personal support team members participated in a full day of Personal Support Team training which included: the components of a PSP, the role of the PST collectively and the role each discipline\team member plays in planning their risk rationales and recommendations. Jim Sibley, a PST consultant with state office, conducted the training. ▪ 08/25/2011: An in service was given in the morning provider meeting for the Revised PSP Policy mentioned above. Attendance is documented in the morning provider meeting minute's dictation." Although the Monitoring Team found that most of the above steps were in various stages of implementation, the Facility's systemic interventions addressing changes in health status were not reflected in the documentation reviewed for the at risk individuals for Section I, or the individuals that were hospitalized and reviewed with regard to Section M.1 (i.e., Individual #323, Individual #63, Individual #312, Individual #136, Individual #6, Individual #181, Individual #193, Individual #281, Individual #210, Individual #147, Individual #138, Individual #300, and Individual #72). From discussions with the CNE, the Facility had determined that re-evaluating the risk rating process and the ISP/IDT training took priority, since these areas were basic to the At Risk system. In addition, to further evaluate the Risk Ratings by the Interdisciplinary Teams (IDTs), the Facility recently compared the current risk ratings regarding aspiration pneumonia and respiratory compromise to data from the pneumonia tracking system for the past 12 months. Any rating discrepancies were then referred to the IDTs for further evaluation and revisions of these risk ratings. The Facility had implemented the same process addressing weight in October 2011, and planned to identify and assess other risk categories for which the Facility had data to support risk ratings. As mentioned with regard to Section L, a new risk policy was entitled: "LbSSLC – IDT Process – Program Development: Personal Support Plan – At Risk Individuals Process," dated 8/24/11. It required that changes in health status discussed at the morning medical provider meetings be rapidly communicated to IDTs. In-service training for this policy and process was completed on 8/23/11 and 8/24/11. The attendance of the unit RN managers at the morning medical meetings allowed the morning discussion of health status changes to be conveyed the same morning to the QDDP. The QDDP then was expected to call a PST meeting to discuss the information, including whether a change in risk rating was indicated for one or more categories, whether the risk action plan needed revision, and/or whether implementation steps needed revision. This process, if	

#	Provision	Assessment of Status	Compliance
		successful, would allow timely review of risk, and timely changes in risk prevention. Based on a meeting on 6/2/11 (Assessment workgroup), administration had an awareness for the need for each member of the PST to bring completed quality assessments to the PSP meetings to allow completion of an integrated risk rating form and risk action plan. However, based on review of documents, this was not consistently occurring yet. Although the Facility had begun implementing the many positive steps listed above, a significant amount of work had yet to be done to achieve compliance regarding the requirements of the Settlement Agreement addressing At Risk Individuals. To assess the Facility's risk screening process, members of the Monitoring Team observed three individuals' ISPs meetings (Individual #269, Individual #258, and Individual #170) while on site. Specifically, the observations of the ISPs indicated that: ▪ All appropriate disciplines were present at all (100%) of the observed ISPs. ▪ The staff present at the ISPs meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for all three (100%) of the ISPs. ▪ The individual was present at all three (100%) of the ISPs meetings, although two individuals had to leave the meetings before they were completed. ▪ The PST consistently used the Risk Level Guidelines when determining risk levels at two (67%) of the ISP meetings. The individual's PST that did not consistently use the Risk Level Guidelines when determining risk levels included: Individual #258. ▪ The PST consistently used supporting clinical data when determining risks levels for none of the ISPs observed (0%). The Monitoring Team did note overall improvement for this indicator. However, compliance scores for this indicator reflect the consistency of the use of specific supporting clinical data when designating risk levels. ▪ Overall, based on information and data provided by the PSTs, the risk levels the PSTs designated were appropriate for each category for none of the ISPs observed (0%). Due to all the observed PSTs' inconsistent use of clinical data to determine risk levels, the Monitoring Team could not validate many of the risk levels that these PSTs assigned. ▪ Appropriate clinical discussion among appropriate team members in decisions regarding risk levels occurred in all three (100%) of the ISPs meetings observed. Although the Monitoring Team noted positive improvement for this indicator, the PSTs should continue to expand the depth and scope of the clinical discussions related to the risk indicators and risk levels using clinical data. Future compliance scores will reflect the adequacy of these clinical discussions.	

#	Provision	Assessment of Status	Compliance
		▪ Team disagreements regarding risk levels were noted in two of the ISPs, and they were appropriately resolved for Individual #269, and Individual #170 (100%). No team disagreements were noted in the PSP for Individual #258. For this indicator, the Monitoring Team evaluated the process of resolution based on the use of specific clinical data, the use of the Risk Guidelines, appropriate clinical judgment, and the use of a person-centered focus. ▪ The ISP facilitator kept the team focused in two (67%) of the ISPs meetings observed. The individual's PSTs facilitator that did not consistently keep the team focused included was for Individual #258. The Monitoring Team noted overall improvement for this indicator. Areas for continued focus include time management since the ISPs observed were exceptionally lengthy and keeping discussions focused and productive could be difficult. In addition, other positive observations from the Monitoring Team included: ▪ For Individual #269, the QDDP played a strong role in facilitating the ISP meeting and appeared to be further assisted with the use of a new format for ISP meetings that the State Office ISP consultants developed. ▪ The PST for Individual #258 appropriately discussed the PNMP during the ISP. ▪ The team for Individual #269 had a lot of good clinical discussion, while also looking at ways to ensure that the individual's needs and preferences were met. For example, the team discussed ways to enhance the individual's environment through the identification of items that the individual both liked, and would provide increased stimulation (e.g., mobiles with family pictures, older music that might bring back memories of past events). ▪ The PST for Individual #269 solicited input regarding information and decisions from the Individual's sister and brother/guardian who were present, and very actively involved. ▪ The PST for Individual #170 was supportive of community placement with the appropriate supports. ▪ The team for Individual #269 helped to explain to family members a number of somewhat complicated treatments that various team members had proposed, explaining the processes in easy-to-understand terminology, and listing the potential risks versus benefits of each treatment. ▪ The QDDP for Individual #259 used the ISP Guide during the meeting. Problematic areas needing focus or improvement included: ▪ The PSTs did not consistently use specific clinical data when determining risk levels. ▪ The PST for Individual #258 did not integrate the PNMP into the Risk Action Plan. ▪ The PSTs for Individual #258, Individual #170, and Individual #269 lacked discussions regarding measurable objectives. Although the teams discussed a	

#	Provision	Assessment of Status	Compliance
		number of action plans to address the risk areas identified, no measurable or functional outcomes were discussed, nor were triggers specifically identified for inclusion in action plans to identify problems. ▪ The PST for Individual #258 lacked sufficient knowledge regarding referrals for community placements. ▪ The PST for Individual #170 did not aggressively discuss the need for guardianship when family members had not been actively involved since 1993. ▪ The team for Individual #269 would have benefited from expertise on Down's Dementia/Alzheimer's Disease. ▪ The PST for Individual #258 did not have a discussion of skill acquisition programs for OT/PT, and skill acquisition programs did not support the individual's preferences. ▪ The lack of clinical data and clinical content presented at the ISP misrepresented risks areas, such as PICA for Individual #170. ▪ Most of the interventions mentioned during the PSPs addressing high/medium risks did not reflect the clinically intensity in alignment with the level of risk designated by the teams. ▪ When discussing interventions for high-risk indicators, the PSTs did not focus on proactive measures to include in the action plans. To further assess the routine risk screening, assessment and management process, the Integrated Risk Rating Form and Risk Action Plan were requested for the 12 records referenced in Section L (i.e., Individual #70, Individual #7, Individual #41, Individual #34, Individual #17, Individual #279, Individual #72, Individual #8, Individual #112, Individual #118, Individual #3, and Individual #128). Seven of the Integrated Risk Rating Forms were submitted, one of which was incomplete and undated. Responses to the other five document requests indicated the forms were not available. For the risk action plans, only three were submitted. Additionally, not all responses included rosters of attendance, which also were requested. The Monitoring Team's analysis is based on submitted information, recognizing that this was incomplete information. One of the components of the corrective action plan submitted for Section I, stated: "ensure that all risk rationale forms are available in the record." As noted above, several of the submitted records indicated the Integrated Risk Rating Forms and Risk Action Plans were not available. The Facility's inability to provide requested copies suggested these documents were not available in the active record, which inferred that they were not available as a reference and a guide to the PST members. This component of the corrective action plan should be monitored more closely. From the various PSPs and PSPAs, most referenced risk categorization, indicating that the teams had met. However, the PSPs did not reflect the rationale, but simply stated the	

#	Provision	Assessment of Status	Compliance
		category of risk. For the Risk Action Plans, it was unclear if these were completed. Action plans were submitted that were part of the PSPs, but they focused on overall goals in the risk areas, and did not focus on actual next steps to be taken. For the seven Integrated Risk Rating Forms submitted, the following information was determined: ▪ Four out of seven (57%) had evidence of appropriate disciplines being present at the PSP meeting in which risk and action plans were discussed. ▪ The individual was present for three out of seven (43%) of the meetings in which risk was assessed during the PSP or PSPA. ▪ From the review of the Integrated Risk Rating Form and review of the record, it was determined that six out of seven (86%) records used the Risk Level Guidelines provided by the State Office. ▪ From the review of the Integrated Risk Rating Form, there was supporting clinical data when determining risk levels in seven out of seven (100%) of the forms. ▪ Designated risk levels were appropriate for each category in four out of seven (57%) of the integrated risk rating forms. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this provision. This comports with the findings of the Monitoring Team. However, from the Monitoring Team's observations, some promising progress had been made regarding the structure, and process of the ISPs regarding the At Risk process. LBSSLC should continue its efforts to ensure that risk levels are accurate, and develop, and implement a system addressing the reassessment of risk factors for individuals experiencing significant changes in status. The Facility also should continue to provide training and mentoring for the IDTs regarding the At-Risk process with an increased focus on the development and implementation of appropriate Risk Action Plans that reflect the needed clinical intensity in alignment with the designated risk levels.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In	Based on a review of records for 23 individuals determined to be at risk (Individual #193, Individual #175, Individual #239, Individual #315, Individual #304, Individual #13, Individual #147, Individual #254, Individual #73, Individual #131, Individual #127, Individual #109, Individual #134, Individual #313, Individual #257, Individual #166, Individual #240, Individual #322, Individual #213, Individual #171, Individual #19, Individual #146, and Individual #63), 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. <u>Nursing Assessments</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Based on a review of 23 individuals' records for which assessments were to be 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 #193, Individual #175, Individual #239, Individual #315, Individual #304, Individual #13, Individual #147, Individual #254, Individual #73, Individual #131, Individual #127, Individual #109, Individual #134, Individual #313, Individual #257, Individual #166, Individual #240, Individual #322, Individual #213, Individual #171, Individual #19, Individual #146, and Individual #63. From a review of the documentation for individuals the Facility identified at high or medium risk for aspiration, nursing staff were using the Aspiration Pneumonia Enteral Nutrition Evaluation as the nursing assessment for risk. However, the APEN did not include a nursing assessment, but rather a listing of the individuals' history of aspiration pneumonias, and other respiratory infection/conditions, and related hospitalizations. For individuals with designated risk indicators other than aspiration, the Chief Nurse Executive reported that nursing was using the last quarterly or annual Comprehensive Nursing Assessment to meet the nursing assessment requirement noted in the current At Risk Individuals policy, even if it had been completed months prior to the meeting determining risk levels. A review of either the APENs or Comprehensive Nursing Assessments for the above 23 Individuals found that none of them (0%) were adequate assessments of the specific high-risk health indicators identified by the PSTs. From interviews with Chief Nurse Executive during the review, no specific procedure outlined the process regarding nursing assessments for risk indicators. Consequently, nursing staff were still unclear regarding the nursing assessment requirements related to the At-Risk process since the last review. Thus, when individuals had been identified as being at risk with regard to specific health indicators and a risk assessment was warranted, nursing had only provided a summary of the problematic issues related to these areas, and not a clinical assessment. Based on interviews with the State Office Nurse Practitioner Consultant, the State was in the process of reviewing and redefining the "assessment" requirement noted in the At Risk Individuals policy in an effort to clarify the expectations of conducting an assessment as opposed to merely providing information regarding risk indicators. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. <u>Physical and Nutritional Management, and/or OT/PT/SLP Assessment</u> Based on a review of records none of the five individuals determined to be at risk (Individual #258, Individual #196, Individual #89, Individual #48, and Individual #72), documentation was available to show that the IDT and/or the PNMT started the assessment process as soon as possible, but within five working days for none of these (0%) individuals, nor was the PNMT and/or OT/PT/SLP assessment adequate to assist	

#	Provision	Assessment of Status	Compliance
		the IDT in developing an adequate plan. Records that did not contain documentation of these requirements included: ▪ Individual #258's PNMT Evaluation, dated 3/3/11, 3/5/11, and 3/15/11, stated he had been referred to the PNMT due to reduced oral intake resulting in electrolyte imbalance, but no IDT referral date was presented in the evaluation. He had been hospitalized four times in the past six months. His Integrated Risk Rating Form, dated 1/31/11, placed him at high risk for aspiration, respiratory compromise, fluid imbalance, osteoporosis, urinary tract infections, dental choking, weight, constipation/bowel obstruction, and GI problems. The PNMT did not update his Integrated Risk Rating Form during the evaluation process to determine if his risk ratings had changed due to his health status changes. The PNMT evaluation did not adequately assess his high and medium risk indicators. The Monitoring Team could not determine if the PNMT initiated their evaluation within five working days. ▪ Individual #196's PNMT evaluation, dated 8/24/11, did not document the date of the IDT referral. Her HOBE evaluation was completed on 6/20/11, approximately two months prior to the date of the PNMT evaluation. Her HOBE evaluation did not address her high and/or medium risk indicators. Individual #196's Integrated Risk Rating Form was updated on 7/13/11 following a hospitalization on 6/22/11 with discharge diagnoses of bradycardia, hypotension, and hypothermia. Her high risk factors were aspiration, respiratory compromise, and hypothermia. The Monitoring Team could not determine if the PNMT initiated the HOBE and/or PNMT evaluation within five working days. The PNMT evaluation was not adequate as it did not address her medium risk factors. ▪ Individual #89's PNMT Evaluation, dated 7/11/11, documented that Individual #89 participated in a HOBE evaluation on 6/13/11 secondary to a request from the IDT during a Risk/ISP meeting. The Monitoring Team could not determine if the PNMT initiated the HOBE and/or PNMT evaluation within five working days. The PNMT evaluation did not adequately identify her high and medium risk factors. ▪ Individual #48 was hospitalized four times from February through March 2011. On 3/29/11, she was admitted to the hospital, and a feeding tube was placed during this hospital stay. On 4/7/11, she was admitted to Quail. The IDT did not complete an updated Integrated Risk Rating Form to address her health change status from these multiple hospitalizations. No Risk Action Plan had been developed. Individual #48's feeding tube placement should have alerted the IDT to refer her to the PNMT for evaluation, which did not occur. ▪ The high risk factors identified on Individual #72's Integrated Risk Rating Form, updated 8/26/11, were aspiration, respiratory compromise, diabetes, and GI problems. Medium risk indicators were identified as choking, circulatory,	

#	Provision	Assessment of Status	Compliance
		constipation/bowel obstructions, osteoporosis, skin integrity, falls, fractures, urinary tract infections, and dental. His PNMT evaluation, dated 8/25/11, did not adequately assess his high and medium risk factors. No HOBE evaluation had been conducted to identify safe ranges of elevation for bathing, medication administration, personal care, wheelchair and alternate positioning, and tooth brushing to address his high risk status for aspiration, respiratory compromise, and GI problems. <u>Medical Assessments</u> A review was conducted of 12 individuals' records, including Individual #70, Individual #7, Individual #41, Individual #34, Individual #17, Individual #279, Individual #72, Individual #8, Individual #112, Individual #118, Individual #3, and Individual #128. As mentioned with regard to Section I.1, only three Risk Action Plans were submitted from the 12 records. It could not be determined if they were not completed, incomplete, or not available in the record. However, a Risk Action Plan should have been available in the record for implementation and review by any staff, and unavailability or lack of a completed Risk Action Plan undermines the risk action process. Based on the three Risk Action Plans that were submitted, documentation was included of action steps to be taken. However, timely follow-up on the action steps related to additional assessments was not consistently found. For one individual, the action steps did not include additional assessment steps, and the action plan was immediately effective at the time of completion. The other two had great delays in obtaining additional assessment information, but it appeared there was a start to the process within five days for one of these. Compliance with starting the assessment process within five working days was two out of three (67%). More specifically, in two of the Risk Action Plans, physician orders were noted for DEXA scans, but several months later, no results could be found in the records submitted, nor in a list of DEXA scans the Medical Department submitted. For one individual, consideration was given to prescribing Reclast IV, suggesting the DEXA scan had been completed, but no information was available to confirm it was ordered, completed, or what the T score results were to confirm the diagnosis or potential worsening of osteoporosis. The information submitted for Individual #118 did not include a follow up order for a DEXA, nor a review and updating of the prior risk for choking. The Integrated Risk Rating Form was dated 1/28/11, and revised 2/9/11, but there was no information to suggest the PST met to review a choking incident in March 2011. Based on a review of the records of three individual for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate medical assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included:	

#	Provision	Assessment of Status	Compliance
		▪ Individual #17, Individual #118, and Individual #128. The following provides examples of assessments that were not comprehensive: Individual #17 was identified as needing a DEXA scan, and the order was completed 3/23/11, and it was scheduled for 6/7/11. However, no results could be found in the record or in the osteoporosis database submitted. ▪ Individual #128 had a diagnosis of GERD, had a feeding tube, and was allowed one meal daily orally. There was no discussion of the need for assessment of the degree of GERD to determine if her lack of eating was impacted by her GERD, or any need for a GERD evaluation. Given her history of GERD, she was taking Alendronate for osteoporosis, which might aggravate GERD. There was no discussion of alternative medications. The PST also requested a DEXA scan in the next 60 days, but there was a completed DEXA dated 10/21/10,indicating osteoporosis. ▪ Individual #118 was identified as needing a DEXA scan, but no subsequent order was found, nor any test result. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this provision. This comports with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	Based on a review of 32 records for individuals determined to be at risk (Individual #193, Individual #175, Individual #239, Individual #315, Individual #304, Individual #13, Individual #147, Individual #254, Individual #73, Individual #131, Individual #127, Individual #109, Individual #134, Individual #313, Individual #257, Individual #166, Individual #240, Individual #322, Individual #213, Individual #171, Individual #19, Individual #146, Individual #63, Individual #211, Individual #199, Individual #48, Individual #34, Individual #203, Individual #109, Individual #6, Individual #267, and Individual #29), there was documentation that the Facility: ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the (0%) cases. ▪ 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 cases (0%). ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in none of the cases (0%). ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ For none of the plans (0%) were appropriate, functional, and measurable	Noncompliance

#	Provision	Assessment of Status	Compliance
		objectives incorporated into the ISP 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 action plan process was reflected in several of the PSPs reviewed. Risks were often listed. However, the action plans of the PSPs focused on overall goals to be achieved, but did not incorporate the steps needed to achieve the goal. Preventative steps were not specifically listed for any risk factor. Potentially, this was an area for which guidance from the morning medical provider meeting would have been beneficial, with follow up in the PST process. Specific focus was needed to begin to incorporate preventive steps, as well as to identify other assessments that might be required to ensure all preventive steps had been taken. Additionally, little information was included in the action plans concerning clinical indicators to measure success or progress in reaching a clinical goal, which would guide the PST to determine if further steps were necessary. The following are examples of plans that were inadequate to address the at-risk factors identified for the individuals: ▪ Individual #29's Integrated Risk Rating Form was completed on 1/6/11. On 4/25/11, the PNMT completed a HOBE evaluation for Individual #29. His ISPA meeting was not conducted until 7/6/11, which far exceeded the 14-day timeframe for the development and implementation of a plan. ▪ Individual #211's Integrated Risk Rating Form, dated 3/23/11, rated him at high risk for aspiration and respiratory compromise. His medium risk indicators were choking, weight, constipation/bowel obstruction, gastrointestinal (GI) problems, osteoporosis, skin integrity, falls, fractures, and dental. On 12/27/10, Individual #211 was hospitalized with a diagnosis of aspiration pneumonia, and on 3/23/11 with a diagnosis of respiratory distress. His IDT had not developed a risk action plan, nor had the IDT referred him to the PNMT to seek assistance for the development of a risk action plan. ▪ The high risk factors listed on Individual #199's Integrated Risk Rating Form, dated 2/16/11, were aspiration, GI problems, osteoporosis, and polypharmacy. Medium risk factors were constipation/bowel obstruction, seizures, infections, falls, fractures, and dental. His IDT had not developed a Risk Action Plan. The Facility should provide training to IDTs on the PNMT Guidelines with emphasis on criteria for referral to the PNMT. Separately, the Monitoring Team met with the PSTs for two individuals to review their Integrated Risk Rating form, Risk action plan, and implementation of the plan. The goal	

#	Provision	Assessment of Status	Compliance
		was to determine the strengths and weaknesses of the process of identification and prevention of risk. For one of these individuals, Individual #33, the Monitoring Team had met with the PST during the prior visit. At that time, a considerable lack of information impeded development of a rigorous action plan. Improvements were noted in this regard. Updated information was available in most, if not all areas of risk. However, during this most recent review, the PST engaged in considerable discussion about her weight, which was interpreted by various members as weight loss or no significant change over time. This indicated the need for further integration of historical information and discussion. Her eating habits remained a challenge, and it was not clear if the intake was nutritionally adequate or balanced. The dietitian would have a major role to play in this aspect of risk. Another challenging area was her risk of constipation. It was noted that she required enemas three times a week, and for the one three-day period before the enema, she became more irritable and displayed challenging behaviors. Two strategies were not discussed. Specifically, the reason for not simply giving an enema every two days instead of three days weekly was not pursued, but if the observations of staff were correct, this would reduce her irritability. Moreover, the longer view of her health was not considered. Given that this young individual required enemas for bowel movements, her risk for complications in the future were significant. It was noted that her medication regimen was not maximized, either by prescribing the maximum dosage of current medication or adding medications, or maximizing fiber content to promote bowel motility. Maximizing her medications for constipation might allow her bowel to function without enemas. For Individual #136, who was medically complex, the IDT met the day before to review the integrated risk rating form results and action plan(s), along with the State's consultants. In a meeting with the Monitoring Team, the IDT presented its findings. Through this process, the team members learned that each brought to the meeting a unique mix of information, and a successful plan required integration of all this information. This occurred through a substantial amount of brainstorming. The team also learned that the inclusion of PNMT recommendations, insight, and expertise in training and monitoring were imperative to the success of the action plan, reduction of risk, and improved health and safety of the individual. Additionally, the team placed an emphasis on areas such as competency-based training before staff would be assigned care for this individual. The scope of the action plan was broad, including such factors as environmental issues that increased the risk of hypothermia. Further, each action step had a staff member assigned to complete follow-up, and individuals assigned were not	

#	Provision	Assessment of Status	Compliance
		simply completing a task in isolation, but were accountable to the team at frequently scheduled follow-up meetings. This meeting demonstrated an integrated approach to development and implementation of an action plan. The team recognized that the next step was adding more measurability to the plan, including the development of measurable and/or functional outcomes through which the team could measure the individual's progress. The Facility should continue to focus its efforts on the process of developing specific and clinically appropriate risk action plans for each individual by the next review. The Risk Action Plans should meet the Individuals' needs, contain functional, and measurable objectives, include clinical indicators to be monitored and the frequency of that monitoring, include preventative interventions, and be fully integrated into the ISPs. At the time of the review, LBSSLC indicated it was not in compliance with the requirements of the Settlement Agreement for this provision. This also was consistent with the findings of the Monitoring Team.	

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

1. The Facility should ensure a copy of the Integrated Risk Rating Form and Risk Action Plan is available in the active record. (Sections I.1, and I.2)
2. The State Office should consider the need for an additional high-risk category, a "stable high risk" category for those chronic conditions meeting the criteria of high risk. However, teams should focus on the "active" high-risk categories needing further discussion and intervention. Separating the two would allow teams to prioritize their attention, yet not lose track of the other high-risk categories. (Section I.1)
3. The State Office should consider expanding the "infection" category to provide additional options to provide guidance to the PSTs. Currently, the description of high risk for infection requires two or more Multiple drug resistant organism (MDRO) infections, or an open wound. It would be helpful to expand this to any hospitalization for an infection (e.g., sepsis, UTI, diverticular abscess, empyema, meningitis, etc.), because infections requiring hospitalization indicate the need for intense review for risk reduction, not only those with MDRO or a surgical wound. (Section I.1)
4. As detailed in the Monitoring Team's Austin report, the risk guidelines should be reviewed to determine if further subcategories are needed to address the diverse topic of challenging behavior. (Section I.1)
5. Additional training on the at-risk process and the on the PNMT Guidelines with emphasis on criteria for referral to the PNMT 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. (Sections I.1, I.2, and I.3)
6. 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. (Section I.1)
7. Each PST member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
8. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
9. 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. Particularly, when an individual is hospitalized and subsequently discharged home, the PST should meet promptly address any changes in health and functional status. (Sections I.1, I.2, and I.3)

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. (Sections I.2 and I.3)
11. The areas that the At Risk Individuals policy designates that nursing is to assess should be reviewed to determine which discipline is the most appropriate to conduct those assessments. (Section I.3)
12. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
13. Given that PSTs, at times, do not realize when more assessment is indicated, and department heads should review PST findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Section I.1, and I.2)
14. As individuals' risks are identified, and risk action plans are developed, teams should ensure that measurable objectives or indicators are 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. (Section I.3)
15. The Facility should monitor the PSPs to ensure the risk ratings and action plans are integrated into individuals' PSPs. (Sections I.1, I.2, and I.3)
16. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the POI to substantiate compliance or noncompliance with the Settlement Agreement. Such data could come from a variety of sources, including audits, as well as other data sources, such as databases or outcome indicators. In addition, it will be essential for the Facility to assess the quality of risk-related activities and documents. (Facility Self-Assessment)

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 Supporting materials from the 10/5/11 Pharmacy and Therapeutics (P&T) Committee Meeting; o List of individuals who received Reglan; o Alphabetical list of individuals psychiatrically hospitalized during the last year; o Reiss Screening instrument spreadsheet, dated 8/4/11; o A table entitled, "Comparative on Polypharmacy," which provided historical data for 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 Example of recent Behavioral Desensitization Plans for dental/medical appointments for ten individuals; o Supporting documentation related to the Positive Behavior Support Committee Meeting, on 10/6/11; o Agenda and related documents reviewed during the 10/5/11 P&T Committee Meeting; o Policy for psychiatric services, revised 4/27/11; o Policy for psychiatric assessments, dated 9/1/08; o Policy for prescribing psychoactive medication, revised 6/8/10; o The following documents were in the Presentation Book related to Section J of the Settlement Agreement, dated 10/11; ▪ The Plan of Improvement/Self-Assessment for the Psychiatry section, dated 10/11; ▪ Quality Assurance Monitoring Reports for the last six months; ▪ Document entitled "Psychiatry – Section J: Progress Since Monitoring Visit," 10/11; o A spreadsheet entitled "MOSES/DISCUS Monitoring Form for Nursing/Psychiatry/ Pharmacy," dated 8/30/11; 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 8/30/11; o List of individuals prescribed benzodiazepines, revised 8/30/11; o Restraint Report for LBSSLC for the last six months; o Report on the use of Chemical Restraints at LBSSLC for the last six months; o List of employees who have received mental health/mental retardation (MH/MR) dual

	diagnoses training, provided twice a month by Dr. Weddige, from 3/11/11 to 8/30/11; o List of individuals prescribed anticholinergic medication, dated 9/8/11; o List of individuals prescribed intra-class polypharmacy, dated 9/8/11; o List of individuals monitored for tardive dyskinesia, dated 9/8/11; o List of individuals prescribed an anticonvulsant medication for psychiatric reasons, dated 9/8/11; o List of meeting and rounds attended by the Psychiatrists, undated; o Curriculum vitae (CV) of Richard Weddige, M.D.; o Curriculum vitae of Boris Porto, 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, for the prior six months; o Pre-treatment Sedation Checklist for Dental Appointments; o Policy for Dental Desensitization," dated 3/20/11; o The following sections of the medical record: Demographic Information (e.g., Profile Sheet – Photograph and Identifying Information Sheet); Social History Evaluation; the Personal Support Plan (PSP) section; the Positive Behavior Support Plan (PBSP) section, including Addendums, the Psychological Assessment, and the Functional Analysis; Annual Medical Summary, including the Active Problem List, Inactive Problem List, and 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 (CPA); Monitoring of Side Effects Scale (MOSES)/DISCUS Dyskinesia Identification System: Condensed User Scale (DISCUS) Side Effects Screening section; Quarterly Drug Regimen Reviews; Neurology Consultation section; any documentation and consultations regarding the use of pre-treatment 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 that the Facility selected in response to the pre-review document request and considered to be psychiatrically stable: Individual #250, Individual #1, Individual #299, Individual #254, Individual #161, Individual #300, Individual #114, Individual #162, Individual #72, and Individual #111; o The same set of records was requested for the following individuals, who had recently been admitted to LBSSLC: Individual #22, Individual #131, and Individual #7; o The same set of records was requested for the following individuals due to their clinical acuity: Individual #33, Individual #240, Individual #124, and Individual #25; and o The same set of records was requested for the following individuals who had been psychiatrically hospitalized within the last year: Individual #4, Individual #242, and Individual #221. ▪ **Interviews with**: o Dr. Richard Weddige, Director of Psychiatry, on 10/3/11; o John McCullen, Psychiatric Assistant, on 10/3/11;

	○ Dr. James Forbes, Director of Psychology Services, on 10/3/11; ○ Dr. Russell Reddell, Director of Dental Services, on 10/4/11; ○ John Todd, R.PH., Clinical Pharmacist, on 10/3/11; ○ Glen Shipley, D.O., Medical Director, on 10/4/11; ○ Jennifer Smith, QDDP, and back-up Human Rights Officer, on 10/5/11; and ○ John McCollum, Psychiatric Assistant, and Bob Robbins, Program Compliance Monitor, on 10/6/11. ▪ **Observations of**: ○ The Polypharmacy Committee Meeting, on 10/4/11; ○ Morning Provider Meeting, on 10/5/11; ○ Pharmacy and Therapeutics Committee Meeting, on 10/5/11; ○ Interdisciplinary Team Risk Assessment Meetings, on 10/5/11 and 10/6/11; ○ Psychiatric Clinic, on 10/6/11; ○ Positive Behavior Support Committee Meeting, on 10/6/11; ○ Neurology Clinic with Dr. Daniel Hurst, on 10/5/11; and ○ During visits to the residences at LBSSLC, the following individuals were observed: Individual #314, Individual #109, Individual #199, Individual #322, Individual #7, Individual #126, Individual #92, Individual #94, Individual #221, Individual #279, Individual #310, Individual #320, Individual #75, Individual #50, Individual #276, Individual #116, Individual #22, Individual #25, Individual #213, Individual #34, Individual #36, Individual #237, Individual #155, Individual #82, Individual #106, Individual #10, Individual #143, Individual #235, Individual #140, Individual #38, Individual #202, Individual #108, Individual #242, Individual #28, Individual #27, Individual #79, Individual #245, Individual #183, Individual #178, Individual #86, Individual #220, Individual #173, Individual #288, Individual #251, Individual #279, Individual #137, Individual #230, Individual #84, Individual #291, Individual #271, Individual #103, Individual #313, Individual #175, Individual #309, Individual #74, Individual #269, and Individual #161.
	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 were 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 10/6/11. During that meeting, the methodology and results of the internal Facility reviews of the Psychiatry Department were discussed in considerable detail. The team that completed the QA reviews consisted of the Psychiatry Assistant, the Director of Psychiatry, and the Program Compliance Monitor assigned to the Psychiatry Department. The Program Compliance Monitor selected a monthly sample of individuals' records randomly. The Psychiatry Assistant performed a review of four of these, the Director of Psychiatry reviewed one, and the Program Compliance Monitor reviewed three. The Program Compliance Monitor also chose which of the five would be used for the determination of inter-rated reliability. This monthly process resulted in 60 reviews per year, or slightly less than one-half of the individuals who were prescribed psychotropic medication. The data that was generated was reviewed quarterly in the Facility's QA/AI meeting, and discussed monthly

	with the Psychiatry Department. The Program Compliance Monitor also attended the Psychiatric Polypharmacy Meetings, as well as the Behavior Support Committee Meetings in order to become more familiar with the clinical aspects of psychiatric care that were required to appropriately perform the QA review of an individual's psychiatric record. The Facility's compliance rating for each provision in Section J of the Settlement Agreement was reviewed during the meeting of 10/6/11. At that time, the Monitoring Team had not finalized its review of the Facility's compliance with Section J. In reviewing the Facility's findings in the context of the Monitoring Team's completed review of the 15 provisions of Section J, it was clear that the fundamental discrepancies between the two sets of ratings continued to relate to the interpretation of the quality aspects inherent in the provisions. This particularly applied to the following Sections: J.2, J.3, J.6, J.8, J.9, J.10, J.11, J.12, and J.14. For example, with regard to J.14, the Facility's QA review focused on whether the consents had been signed, but did not investigate whether there was sufficient information to determine if this consent was truly "informed" through the provision of a sufficient amount and quality of clinical information to the individual who was providing the consent. The Monitoring Team's review and the Facility's QA analysis were congruent for those items that relied more on the presence or absence of specific factors, such as the "Substantial Compliance" rating for provision J.1, and the "Noncompliance" rating for Section J.4. There also was agreement between the two assessments of "Noncompliance" for J.13, and "Substantial Compliance" for J.15. Those individuals at the Facility who performed the internal QA Reviews were aware of these discrepancies and their etiology. Future internal reviews would be more beneficial to the Facility if they also took into account the relevant quality indicators.
	Summary of Monitor's Assessment: LBSSLC had continued to make progress toward fulfilling the provisions of the Settlement Agreement related to psychiatric services. The efforts to recruit an additional full-time and/or Consulting Psychiatrist continued. The Facility had been able to contract with a local Psychiatrist, who was Board Certified in both Adult and Child Psychiatry. This individual was onsite four hours per week, on Friday afternoons. His time was allocated to performing CPAs, and providing second-opinion consultations for the Director of Psychiatry. The Facility had continued the initiative to prepare CPAs that more closely followed the outline specified in the Settlement Agreement. The completion of the CPAs will be an integral part of the Facility's eventual compliance with the Settlement Agreement, because they provide a format that prompts the discussion of many aspects of the Settlement Agreement, including the risk-benefit analysis, the description of the symptoms that support the psychiatric diagnosis, and the derivation of those symptoms as either stemming from a biologically determined psychiatric disorder, or from a learned behavior. The CPA also provides a format for describing the historical data that documents the efficacy of a psychotropic medication. The current status of the Facility's progress in this regard is described in detail below with regard to Section J.2. The Psychology Department, working in conjunction with the Dental Office, had made some progress in the

	development of Desensitization Plans for dental and medical procedures. Currently, this process involved a group of individuals who were selected from five of the 15 residences. However, this process was still in the initial phases of development. The Director of Psychiatry had continued to work with the Director of Behavioral Services to more clearly define which of the monitored behaviors that an individual presented with were derived from a biologically determined psychiatric disorder, as opposed to being present on a behavioral basis. In those cases where an individual's presentation was effected by both factors, an attempt had been made to clarify this dual etiology. The related documentation appeared in both the Psychology section of the report as well as in the Psychiatry section. A related area in which the Facility had shown progress was the documentation of the behavioral symptoms that justified the psychiatric diagnosis. Discussions of the risk versus benefit considerations related to the use of psychotropic medication also were found to be both more detailed and individually specific. LBSSLC continued to make progress in the reduction of polypharmacy, a process that began in earnest in 2005. Since that time, the longitudinal data on this subject illustrated considerable progress over the ensuing years. The Monitoring Team's prior report discussed the possibility of tracking the data on newly admitted individuals separately, because they frequently had been prescribed large numbers of medications in the community, and it could take several months after they were admitted to simplify these regimens. The Psychiatry Department had implemented this recommendation. There also were a number of individuals whom the Psychiatry Team believed were on three psychotropic medications, each of which could be documented to be both effective and necessary. The provision in the Settlement Agreement that relates to polypharmacy clearly states that if an individual's medication regimen meets the criteria for polypharmacy, but the individual's medications are justified, this is an acceptable resolution. Accordingly, it had been recommended that the team create a category for these individuals, and then also begin to assemble the necessary historical documentation to demonstrate their efficacy. If this exercise was successful, it could reduce the number of individuals considered to be on unnecessary polypharmacy even further. During this review, the Psychiatry Clinic that was observed was consistent with similar observations during prior reviews, in that nursing, psychology, direct support, and residential management staff and the QDDP actively participated. Ample time was available for discussion, and there was no sense of time pressure. During the tour of the residences and workshops, a member of the Monitoring Team was able to directly observe 46 percent of the individuals who received psychotropic medication. All of the individuals who were observed were alert, did not appear to be overly medicated, and did not exhibit any motor side effects of medications. In summary, the Facility had made incremental progress in relation to a number of the provisions of Section J of the Settlement Agreement, and significant improvement in a few others.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Dr. Richard Weddige, Director of Psychiatry, was Board Certified in Psychiatry by the American Board of Psychiatry and Neurology. He served on the Faculty of Texas Tech University Health Sciences Center School of Medicine, Department of Psychiatry, full-time for 27 years. He retired in 2001. Following his retirement from the Faculty, he began consulting to LBSSLC on a part-time basis, and worked full-time at the Facility for the last nine years. Approximately six weeks prior to the onsite review, the Facility had contracted with Dr. Boris Porto to provide additional psychiatric services. His Curriculum Vitae indicated that he was Board Certified by the American Board of Psychiatry and Neurology in both Adult Psychiatry, and Child and Adolescent Psychiatry. Dr. Porto provided consulting psychiatric services to the individuals who resided at LBSSLC through a four-hour block of time on Fridays. He performed second-opinion consultations for Dr. Weddige, general consultations as the need arose, and also contributed to the initiative to complete Comprehensive Psychiatric Assessments to comply with the formatting and content requirements of the Settlement Agreement. In the course of preparing these documents, he performed a thorough review of the records and met with the individual, the individual's team, and the individual's family, when possible. The extent of Dr. Porto's prior clinical work with individuals with intellectual disabilities was not clearly specified in his CV, and he was unavailable for interview during the review. However, a Child Psychiatry Residency would have included extensive training in the area of developmental disabilities, and the Child Psychiatry Board Examination would have assessed for competence in this area. LBSSLC also was continuing to actively recruit for additional full-time and part-time Psychiatrists who were either Board Certified or Eligible in Psychiatry.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	As noted with regard to Section J.1, both psychiatrists who were responsible for the completion of psychiatric assessments were board-certified. 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 CPAs, as well the Monthly and Quarterly Psychiatric Review Notes. A review was conducted of the records of 20 individuals (16%) of the 126 who received psychotropic medications at the time of the review. These individuals are listed above in the section on documents reviewed. This review found that a CPA had been completed within the past 18 months for 17 of the 20 individuals (85%). The individuals for whom a current CPA was not present were:	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #300, Individual #299, and Individual #22. However, Individual #22 had been admitted to the Facility only a few weeks prior to the onsite review. The 17 CPAs that had been completed within the last 18 months also were reviewed with regard to whether they met the content and quality requirements set forth in the Settlement Agreement. The quality standards were not met for the following four individuals: Individual #72, Individual #162, Individual #254, and Individual #161. Although these CPAs did not meet the specific requirements outlined in Appendix B of the Settlement Agreement, they contained a great deal of useful information, which could be expanded upon and updated to meet the requirements specified in the Settlement Agreement. The specific deficiencies identified in these documents were primarily in the form of missing required sections, such as Family History, Substance Abuse History, and Developmental History. Content also was deficient in important sections, such as Mental Status Examination, Psychiatric Diagnosis, and Bio-Psycho-Social-Spiritual Formulation. The latter was an especially important component of the CPA, because it provided a forum for the Psychiatrist to expand upon the psychiatric diagnosis, discuss the interface between biological and psychological contributions to the individual's maladaptive behavior, as well as the risk versus benefit considerations related to the use of specific psychotropic medications. Thirteen of the 20 individual records (65%) reviewed contained CPAs that were both current and conformed to the outline contained in Appendix B of the Settlement Agreement. These included those for the following individuals: Individual #114, Individual #111, Individual #1, Individual #250, Individual #4, Individual #242, Individual #221, Individual #131, Individual #7, Individual #240, Individual #25, Individual #33, and Individual #124. This represented an improvement over the corresponding frequency of 40%, which was identified in the Monitoring Team's prior report. The Staff Psychiatrist, who worked in conjunction with the new Consulting Psychiatrist, began a systematic review of all individuals who received psychotropic medication, with the goal of ensuring that all of these individuals had the benefit of an updated CPA that met the content and quality standards described in the Settlement Agreement. This process had involved completing new CPAs for those individuals for whom one had not been completed within the last year, and revising those that had been done, but did not follow the outline specified in the Settlement Agreement. This process began in June 2011, and to date, the CPAs of 37 of the 126 individuals (29%) who received psychotropic medication had been subject to this review. The percentage (65%) of individuals in the Monitoring Team's sample of 20 individuals who were determined to have CPAs that met the standards of the Settlement Agreement exceeds this number, because this sample included newly admitted individuals, as well as individuals with high	

#	Provision	Assessment of Status	Compliance
		degrees of psychiatric acuity who would have been prioritized for updated evaluations. The Facility should maintain the initiative described above, to ensure that every individual who receives psychotropic medication has undergone a CPA that meets the content and quality standards set forth in the Settlement Agreement. The Psychiatry Department also should complete a CPA on each newly admitted individual who receives psychotropic medication within 30 days of their admission. The justification and evidence for the individual's psychiatric diagnosis of record, as it related to treatment planning, is also a central component of Section J.13, and is discussed in detail there. The justification for the Psychiatric Diagnosis is also alluded to in the discussion related to Section J.6, and the data related to the co-identification of behaviors as being both a symptom of a psychiatric disorder and learned behavior is extensively reviewed with regard to Section J.9. The analysis of the sample of records related to compliance with the requirement for Quarterly Psychiatric Reviews is also discussed with regard to Section J.13. Thus, although the Facility had made noticeable progress in completing CPAs that are consistent with the specifications outlined in the Settlement Agreement, they continued to be out of compliance with this provision. As discussed above, a number of the existing CPAs continued to be missing sections of the CPA that were specified in the Settlement Agreement, and the discussion sections of some the older CPAs were inadequate.	
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.	One of the issues that this provision addresses is the non-specific use of psychotropic medication to manage aberrant disruptive behaviors in the absence of an active Positive Behavior Support Plan (PBSP). All of the records reviewed indicated that individuals who received psychotropic medication had an active PBSP. However, issues related to the quality of the PBSPs are discussed in detail with regard to Section K.9. All of the individuals who were prescribed psychotropic medication also had an Axis I psychiatric diagnosis. The appropriateness of these diagnoses is discussed in detail with regard to Section J.13. The description of a behavior that was listed as a target of psychotropic medication and was also present on a learned or behavioral basis was problematic, because it could give the impression that the medication was being used to suppress a learned behavior. However, it also was conceivable that such a behavior could be derived from both biological and psychological factors. During the prior reviews, the Director of Psychiatry and the Director of Psychological Services indicated that the efforts to address this issue continued to be expanded. Discussions with these Directors during the current review indicated that these efforts had continued, and included joint reviews of relevant individuals by the Psychiatry and Psychology Departments, case-based discussions at the Behavior Support Committee Meetings, and inclusion of the relevant information on the master spreadsheet, which listed the	Noncompliance

#	Provision	Assessment of Status	Compliance
		individuals' names, psychotropic medications, and psychiatric diagnoses. In addition, the revised CPAs that adhered to the specifications of the Settlement Agreement also discussed the issue in the section entitled, "Bio-Psycho-Social-Spiritual Formulation." The derivation of the behaviors described as targets of the psychotropic medication are discussed in further detail with regard to Sections J.8 and J.9. No indication was found that the prescribed daily psychotropic medications for the individuals who resided at LBSSLC were being utilized for the convenience of staff and/or for punishment. However, inappropriate use of chemical restraint could be construed as punishment. This can occur if an intramuscular (IM) injection of a psychotropic medication is administered to an individual against their will, following an aggressive event that is unlikely to be repeated in the near future, based on a thorough knowledge of their historical pattern of aggression. This topography of aggressive episodes is commonly referred to as, "one and done," meaning that the individual's aggressive episode is usually time-limited, spontaneously resolved, and not likely to be repeated in the near future. Thus, the appropriate administration of chemical restraint should take into account not only the immediate circumstances of the current aggressive event, but a thorough knowledge of the specific details of the individual's prior aggressive episodes, including the frequency, precipitants, hierarchy of escalating behaviors, as well as both the range and average elapsed time between the onset of an episode and its spontaneous resolution. No indication was found in the available documentation that the decisions to utilize chemical restraint took into account this type of detailed analysis of the history of their aggressive behavioral incidents. In order to assess the utilization of chemical restraint at LBSSLC, a request was made for the documentation related to administrations of chemical restraint during the most recent five months. This request yielded the completed Chemical Restraint Forms for May through September 2011. The specific documentation that was generated for the following eight individuals who had experienced chemical restraint during this timeframe was as follows: Individual #288 on 5/9/11 at 9:05 p.m.; Individual #221 on 5/15/11 at 2:53 p.m. and 9:39 p.m., 5/16/11 at 5:08 p.m. and 5:53 p.m., 5/17/11 at 4:52 p.m., and 5/18/11 at 3:38 p.m. and 8:24 p.m.; Individual #126 on 5/28/11 at 3:08 p.m.; Individual #4 on 6/9/11 at 6:45 p.m., 6/11/11 at 3:05 p.m., 6/16/11 at 5:44 p.m. and 8:02 p.m., 6/21/11 at 5:42 p.m., 6/22/11 at 4:42 p.m., 6/23/11 at 11:34 a.m. and 11:17 p.m., and 6/26/11 at 6:01 p.m.; Individual #220 on 6/11/11 at 9:30 a.m.; Individual #124 on 7/29/11 at 6:45 p.m.; Individual #288 on 8/4/11 at 4:59 p.m. and 8/5/11 at 4:20 p.m.; and Individual #242 on 8/19/11 at 10:53 a.m., 9/13/11 at 8:30 a.m. and 4:03 p.m. The primary chemical restraints utilized for these individuals were Ativan 2 milligrams (mg) IM; Zydis 10 mg; Zyprexa 10 mg IM; or Haldol 10 mg IM coupled with Benadryl 50 mg IM.	

#	Provision	Assessment of Status	Compliance
		The documentation on the related forms indicated that appropriate observations and physical monitoring were performed following the administration of the chemical restraint. However, a consistent deficit through all of the documentation related to the information reported in response to the prompt to: "Describe what led to the behavior that resulted in restraint." In all of the records reviewed, the overt behavior that actually precipitated the utilization of the chemical restraint was recorded in this section of the form and was not responsive to the prompt to "Describe what led to the behavior…" Because no indication was provided of what had precipitated the individual's aggressive response, it was impossible to determine if the chemical restraint was being used as a form of punishment for the behavior. For example, it could not be determined if the aggressive behavior was precipitated by a direct support professional making a demand, or when the individual was informed that they had lost a privilege, etc. A clear description of the antecedents to the aggressive behavior is necessary to accurately determine if the administration of the IM medication was, to some degree, a punishment and/or used in the absence of adequate treatment. Thus, although it did not appear that psychotropic medication was utilized as a punishment for noncompliant behavior at LBSSLC or for the convenience of staff, more complete documentation on the chemical restraint forms that involve the intramuscular injection of psychotropic medication against an individual's will was necessary to fully support this observation. The Facility should develop a system to ensure that all staff members involved in chemical restraints are instructed to describe the antecedents of the behavior that prompted the chemical restraint in a manner that will provide the information necessary to minimize the occurrence of these events in the future. The Facility was found to be out of compliance with this provision. In addition to needing to improve documentation related to chemical restraint, improvements also were needed with regard to the clinical justification of diagnoses, ensuring medication was not used to suppress behaviors that were present on a learned or environmental basis, and the quality of behavioral programming.	
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-	The Human Rights Department at LBSSLC maintained a comprehensive database concerning the use of pre-treatment sedation in the form of a spreadsheet. This document listed all individuals who were prescribed pre-treatment sedation, whether the medication was used for a dental or medical procedure, or both. The specific agent being utilized also was listed. In order to determine if the data on this spreadsheet was correctly interpreted, it was reviewed with the Director of Dental Services. The categories of intervention listed on this spreadsheet were "Dental Restraint," "Dental Sedation," and "Medical Sedation." There was also a sub-category for "General Anesthesia." The total number of individuals listed on this spreadsheet was 138 of the total census of 225 individuals who resided at LBSSLC (61%). Of these 138 individuals,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	129 required pre-treatment sedation for dental procedures. Within the group who required sedation for dental procedures, 42 also had consents for general anesthesia. Pre-treatment sedation for medical procedures was required for 26 individuals. Only three individuals were listed who required pre-treatment sedation for medical procedures and not also for dental procedures. The Director of Dental Services pointed out that some overlap existed within the two categories of pre-treatment sedation and general anesthesia for dental procedures, as some individuals only required pre-treatment sedation for dental hygiene interventions, such as cleanings, but required general anesthesia for more invasive procedures, such as extractions. However, this degree of clinical specificity was not noted on the spreadsheet. The data on the spreadsheet indicated that the primary medication utilized for both dental and medical pre-treatment sedation was Ativan, in the range of 1 mg to 3 mg. Seven individuals received Zydis (a rapidly dissolving sublingual form of the antipsychotic agent Zyprexa) in the range of 5 mg to 15 mg. One individual received Haldol 10 mg and Benadryl 50 mg for medical procedures. The Director of Dental Services indicated that the Director of Psychiatry would be consulted wherever an agent other than Ativan was utilized. However, these consultations were usually verbal, informal consults that were not documented. Despite the relatively high number of individuals contained on the aforementioned spreadsheet, a relatively small number of individuals actually received pre-treatment sedation in any given month. The specific data related to the monthly administration of both dental and medical pre-treatment sedation (reported separately) was reviewed in both tabular and graph form for the time period of September 2010 through August 2011. This data indicated that, for the past year, the number of individuals who received pre-treatment sedation for dental procedures had ranged from a low of zero during the months of June, July, and August 2011, to a high of five individuals during the months of November 2010 and January 2011. However, the Director of Dental Services explained that the figures for June, July, and August were artificially low, because the Dental Hygienist was out on leave during that time period. The frequency with which pre-treatment sedation was used for medical procedures ranged from a high of 16 in October 2010, 14 in June 2011, and 10 each in March and April 2011 to a low of two each in July and August 2011. A total of 31 dental pre-treatment sedations were used in this 12-month period, for an average of 2.6 per month. However, as noted above, this frequency was affected by the three months of zero use, when the Dental Hygienist was out. The corresponding yearly total for pre-treatment sedation for medical restraints was 103, for an average of 8.6 per month. A request also was submitted for the documentation of the pre-and post-monitoring of the individuals related to the use of pre-treatment sedation. Specifically, these forms were requested for the last six months. This request produced the monitoring packets for six individuals. The "Pre-Sedation Assessment" was a detailed five-page form with a	

#	Provision	Assessment of Status	Compliance
		cover page that included an outline of a seven-step process, which extended from the administration of the medication, to the final review by the Incident Management Team, and a sign-off from the staff member responsible for each item. The first two pages, which included the physiological monitoring, were completed for all individuals. However, the complete five-page packet, which included a follow-up review of the procedure, was only completed for two individuals, and the complete seven-steps were not completed for any of the sample, although all were discussed in the morning medical meeting the day after the administration of the medication. The Facility should ensure that information deemed to be essential is completed uniformly for all individuals. The status of the initiative to develop Pre-treatment Desensitization Plans in order to reduce the Facility's reliance on the use of psychotropic medication for pre-treatment sedation was discussed with both the Director of Behavioral Services and the Director of Dental Services. The current status of this initiative involved prioritizing a list of individuals selected from five of the 15 residences, who were thought to be candidates for behavioral desensitization strategies. These individuals were then placed in hierarchal order, based on both their need and suitability. This list contained the names of 46 individuals. A request for a list of individuals that actually had dental Desensitization Plans produced a list of 12 names. The actual quality and appropriateness of these Plans was discussed with regard to Section C.4. A similar request for data related to Medical Desensitization Plans indicated that none had been developed. LBSSLC had only made incremental progress in the development of Desensitization Plans or other strategies to reduce the need for pre-treatment sedation for dental procedures, and an initiative for the development of Desensitization Plans or other strategies for medical procedures had not yet begun. These initiatives will need to be expanded for compliance to be achieved. In addition, the documentation for review after the use pre-treatment sedations required improvement.	
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 review, LBSSLC employed one full-time Psychiatrist and a Consulting Psychiatrist, who was at the Facility for one four-hour block of time on Fridays. The full-time Psychiatrist provided all of the direct psychiatric services, while the Consulting Psychiatrist provided consultations and contributed to the completion of the individuals' CPAs. The Facility had worked under the assumption that two full-time Psychiatrists, or the equivalent amount of consulting time, would be sufficient to provide adequate psychiatric services to the individuals who resided at LBSSLC. Given that approximately 126 individuals were prescribed psychotropic medication, this would equate to a caseload of approximately sixty individuals for each full-time Psychiatrist. During the review of the Facility, the Medical Director was asked how this number was determined, as well as the mathematical basis for its formulation. His answer was that a national	Noncompliance

#	Provision	Assessment of Status	Compliance
		professional consulting firm that provided consultation to the Facility during 2005 determined the psychiatric staffing needs. He did not know the mathematical basis for their calculation. In general, a caseload of 60 individuals appeared to be reasonable, given the acuity of the individuals who resided at LBSSLC, and the additional demands on the Psychiatrist's time. The Psychiatrist was also required to attend meetings of the Interdisciplinary Team, as well as clinical and administrative meetings. The recruitment efforts underway should continue.	
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 staff. Within the two months prior to the onsite review, the Facility also had contracted with another Psychiatrist, who was Board Certified in both Adult and Child and Adolescent Psychiatry. This individual provided second-opinion consultations for the Director of Psychiatry, and was responsible for the completion of CPAs. He did not have an active caseload of individuals for whom he was responsible for direct treatment. In the course of completion of the CPAs he consulted with Psychology staff and other disciplines, such as Nursing and direct support professionals, whenever necessary. The Monitoring Team's previous reviews found 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 Psychiatry Department had implemented a number of initiatives designed to improve the quality of the psychiatric diagnostic process with a view to making the clinical justification for each diagnosis more obvious and comprehensive. A key ingredient of this process had been the revision and updating of the CPAs so that they adhered to the specifications set forth in the Settlement Agreement. The results of this process are described in detail with regard to Section J.2. As noted in the discussion of that provision, recently completed CPAs were identified in 17 of the sample of 20 individual records reviewed (85%), and 13 of these (65% of the sample of 20) met the specification delineated in the Settlement Agreement. The successful completion of the CPA played an important role in the justification of the individual's psychiatric diagnosis, because the Bio-Psycho-Social-Spiritual Formulation section, which immediately followed the psychiatric diagnosis, provided a forum for the Psychiatrist to discuss the rationale for the psychiatric diagnosis. As noted with regard to Section J.2, the process of completing assessments that were consistent with Appendix B of the Settlement Agreement began in June 2011. To date, the CPAs of 37 of the 126 individuals (29%) who received psychotropic medication had been subject to this review. Based on the review of the new CPAs that were contained in the sample of 20 individual records, they did conform to the Appendix B format, and were of adequate quality. The details of this review are contained in the discussion related to Section J.2.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Psychiatry Department also had developed a form entitled: "Psychiatric Consultation – Diagnostic and Treatment Plan," which performed a number of functions, one of which was to list the symptoms of the psychiatric diagnosis. This description of symptoms was also carried over into the documentation for the Quarterly Psychiatric Reviews. The degree to which this effort had contributed to the improvement in individuals' treatment, and in the documentation in the individuals' records, was assessed through the review of the records of the sample of 20 (16%) of the individuals who received psychotropic medication. This review indicated that symptoms that were congruent with the psychiatric diagnosis of record could be identified in 16 of the 20 records contained in the sample (80%). These results represent continued improvement when compared to the frequency of 52% reported in the Monitoring Team's prior report. These 16 individuals were as follows: Individual #25, Individual #162, Individual #114, Individual #254, Individual #161, Individual #111, Individual #1, Individual #250, Individual #4, Individual #242, Individual #221, Individual #131, Individual #7, Individual #240, Individual #33, and Individual #124. This number slightly exceeds the number of individuals who had satisfactory CPAs, because now the relevant information was included in multiple places in the individual records. The four individuals for whom the symptoms of the psychiatric diagnosis could not be identified were as follows: Individual #72, Individual #300, Individual #299, and Individual #22. However, Individual #22 had been admitted to LBSSLC a few weeks prior to the onsite review and, thus, the psychiatric team had not yet had sufficient time to develop a valid psychiatric diagnosis that would take into account their direct observations of the individual over a sufficient amount of time. LBSSLC should continue their efforts to ensure that there is a clear description of the manifest symptoms that justify the psychiatric diagnosis of record, and that these symptoms are consistently documented appropriately in more than one place in the record. In addition, full assessments utilizing the format included in Appendix B of the Settlement Agreement need to be completed for the remaining individuals prescribed psychotropic medication in order for compliance to be achieved.	
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,	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 CPA, as specified in the Settlement Agreement (as discussed with regard to Sections J.2). Thus, the Reiss Screen should have been administered to those individuals who did not receive psychotropic medication. The spreadsheet that was revised on 8/4/11 entitled: "Reiss Screen for Maladaptive	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Behaviors" listed individuals who had been administered the Reiss Screen beginning in 2008, and virtually all of the individuals listed had been screened during the 2008 to 2009 time period. The most recent Reiss evaluation entered on that spreadsheet was dated 8/8/11, for Individual #112. The only other individual who had a Reiss Examination performed in 2011 was Individual #170 on 3/4/11. However, the pre-review document request contained a request for any Reiss Examinations that had been performed during the past year, and the response was that none had been performed. During the review, an initial request was made for the names of any newly-admitted individuals that had received a Reiss Exam. This produced a response that all of these individuals were prescribed psychotropic medication and, thus, would have undergone a CPA, rather than a Reiss Screening. As noted above, a discrepancy was noted between the information on the spreadsheet and the responses to the document requests. An additional request made during the review for any CPAs that had been performed during the past six months, which were precipitated by an elevated Reiss Evaluation, produced a CPA for Individual #8, dated 9/27/11, who was admitted on 9/21/11. This request also produced a copy of the Reiss Screen for this individual, dated 9/26/11. The results indicated mental health issues that would prompt a CPA that, as noted above, was performed the following day. It is unclear why the Reiss Screening was performed, because at the time of admission, this individual received Risperdal 0.5 mg per day, and Trazodone 25 mg to 50 mg at bedtime and, thus, would not have been a candidate for a Reiss Screening based on the usual protocol. For each of the prior reviews, the Monitoring Team requested a sample of 20 percent of the Reiss screening assessments listed in the spreadsheet. The validity of the information contained in the spreadsheet was verified by comparing the results of the actual Reiss Screens with the information contained in the spreadsheet. Each of these reviews verified the accuracy of the information listed in the spreadsheet. The prior review identified a number of individuals whose scores on the Reiss Screen were above the clinical cut-off that should have precipitated a CPA, as specified in this provision of the Settlement Agreement. The documentation concerning the follow-up that was performed by the Psychiatry Department in response to these Reiss scoring results indicated that an Interdisciplinary Team Meeting (which usually included the Psychiatrist) was held to review the individual's status in light of these results, but a CPA was not routinely performed. Accordingly, the Facility was not found to be in compliance with this provision. At the time of the prior review, the Director of Behavioral Services also indicated that each individual who resided at LBSSLC would be receiving an updated psychological evaluation, and that those individuals who were not receiving psychotropic medication would be administered the Reiss Screen again, because several years had elapsed since the initial screening with the Reiss instrument. During the current review, the Director	

#	Provision	Assessment of Status	Compliance
		of Behavioral Services indicated that this initiative had not been implemented as planned, due to personnel shortages within the Psychology Department, which necessitated the redeployment of the designated staff member to a clinical caseload. Thus, the Reiss Screens that were first administered in the 2008 to 2009 timeframe had not been updated. This provision also indicates that the administration of the Reiss Screen is required for newly admitted individuals who were not receiving psychotropic medication. The other circumstances which would require the administration of a Reiss screening would be a significant change in the individual's status, which could precipitate an alteration in their behavioral/psychiatric status, such as a cerebral vascular accident (CVA), major interpersonal loss, a significant environmental move, the onset of a major medical illness, and/or the onset of dementia. During the review, a member of the Monitoring Team discussed these potential occurrences with the Facility's Psychiatrist, as situations that should prompt the use of the Reiss Screen and possibly a CPA, depending on the results of the Reiss. However, at the time of the review, this was not occurring. The psychiatric team was asked to occasionally perform consults on individuals who had had a behavioral change that had prompted the individual's team to consider the possible utility of psychotropic medication. The Director of Psychiatry, working in conjunction with the Director of Behavioral Services, should formulate a strategy for the administration of the Reiss Screen that would consider both the potential opportunity to utilize the Reiss Screening instrument in the circumstance described above, as well as on some regular basis (e.g., every two years).	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Interviews with the Director of Psychiatry and the Director of Behavioral Services indicated that there was a close working relationship between the Departments of Psychiatry and Psychology. This collaboration also was apparent in the observations of the individuals' psychiatric team reviews that occurred during the review. 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). Observation of these meetings indicated that the Psychiatrist relied on the Psychology Staff for 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 have affected the individual's behavioral presentation. The direct support professionals, Nursing staff, and the QDDP also provided input into these meetings. The individual whose medication was being reviewed was also present,	Noncompliance

#	Provision	Assessment of Status	Compliance
		and participated in the meetings according to their ability to do so. Prior reviews indicated that ongoing problems existed with the co-identification of behaviors that were present both on a learned/operant basis, and as target behaviors for the psychotropic medication. The existence of this co-description of the function of the challenging 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. The Psychiatry and Psychology Departments had actively addressed this matter, and although problems with this issue continued to exist, noticeable progress had been made. This issue is discussed in more detail with regard to Section J.9. This provision also makes reference to the integration of pharmacological treatments with behavioral "and other interventions." The latter phrase would include communication strategies, occupational therapy, physical therapy, dietary consultation, and environmental considerations. During the Psychiatry Clinic reviews, extensive discussion occurred related to environmental factors that might be relevant. However, professionals representing these other disciplines were not present. An inquiry was made as to whether or not representatives from these disciplines were ever able to attend these meetings and the answer was that they were not. An expert in communication strategies routinely attended the Behavior Support Committee, which was a forum where Behavioral Treatment Plans, including those involving the use of psychotropic medication, were reviewed. The Psychiatrist also attended the meeting of this Committee that took place during the October 2011 review, which a member of the Monitoring Team observed. The Director of Psychiatry was attempting to arrange his schedule so that he would be able to attend some selected Personal Support Team meetings in order to be able to interact with all of the relevant disciplines. However, it was not clear how feasible this plan would be until additional psychiatry services could be obtained. The initiative to enable the individual's treating Psychiatrist to also attend their Annual Personal Support Team Meeting should be supported, particularly for individuals at high or medium risk in relation to their behavioral challenges and/or use of psychotropic polypharmacy.	
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 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 an individual's challenging behaviors.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 rationale for this assessment was that if the identified behavior was a symptom of an established Axis I psychiatric disorder, it would most likely not be amenable to behavior modification techniques. Conversely, those behaviors that were identified in the Functional Analysis as having been 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 reviews, 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 were also 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 that addressed the derivation of the identified target behaviors to the master spreadsheet that addressed the origin 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 received psychotropic medication. In addition, the Psychiatry Department had developed a document entitled: "Psychiatric Consultation – Diagnostic and Treatment Analysis." This document included information relevant to a number of factors specified in the Settlement Agreement, including the derivation of the target behaviors of the psychotropic medications. The Bio-Psycho-Social-Spiritual Formulation of the CPAs also contained information relevant to this factor. The Positive Behavior Support Plans developed by the individual's Psychologist also had been modified so that this issue was addressed more thoroughly. The reviews of the records of the sample of 20 individuals receiving psychotropic medication indicated that these efforts had produced meaningful changes in the treatment provided and the related documentation. The co-existence of the same behavior in both categories was identified in 10 (50%) of the records that were reviewed. The records in which the dual description of a specific behavior as having been present both on a behavioral basis and as an identified target of psychotropic medication were those of the following individuals: Individual #299, Individual #72, Individual #162, Individual #111, Individual #1, Individual #240, Individual #25, Individual #33, Individual #124, and Individual #300. 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 nine (45%) of the 20 individual records reviewed. This included the	

#	Provision	Assessment of Status	Compliance
		following individuals: Individual #114, Individual #254, Individual #161, Individual #250, Individual #4, Individual #242, Individual #221, Individual #131, and Individual #7. Individual #22 had only recently been admitted to the Facility and, thus, there had not been sufficient time to make this important distinction. The corresponding frequency with which adequate differentiation between these two categories of behaviors was identified in the prior review was 32%. Thus, the combined efforts of the Psychiatry and Psychology Departments had produced incremental improvements in this area. The determination of the least intrusive intervention also related to adequate risk-benefit assessments, which was discussed with regard to Section J.10. The Facility should maintain and expand the combined efforts of the Psychiatry and Psychology Departments to clearly delineate which behaviors are primarily related to a biological psychiatric illness, as opposed to learned behaviors, so that the least intrusive strategies can be determined.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	Risk-benefit analysis, as it relates to the use of psychotropic medication in individuals with developmental disabilities, involves a number of 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 step in this assessment relates to the likelihood that the proposed medication would be effective in diminishing the 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 should be based on actual perceived side effects and realized benefits, rather than hypothetical probabilities. Previously, 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 current review found that the documentation of these considerations had been expanded to include a review of these factors in the: a) Bio-Psycho-Social-Spiritual Formulation section of the CPAs; b) the Quarterly Psychiatry Review documentation; c) the recently developed "Psychiatric Consultation – Diagnostic and Treatment Analysis;" and d) the risk assessment discussion contained in the sections of the Behavior Support Plan pertaining to psychotropic medications. These discussions were now more individualized when examining both the side effects of the medications, and the potential or actual harm produced by the target behavior. Previously, these discussions had been more formulaic in nature, and suggested the use of templates.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The side effect listing of the medications were also more specific, although they did not provide information with regard to the frequency with which those side effects had been reported to have occurred in large populations. In the prior reviews, these deficits made it impossible to conclude that any of the Treatment Plans contained an adequate risk versus benefit analysis. In the current review, an adequate discussion of the risk-benefit considerations was found in ten (50%) of the individual records reviewed. The individual records for whom an adequate analysis could be found were those of the following individuals: Individual #124, Individual #131, Individual #72, Individual #162, Individual #114, Individual #254, Individual #161, Individual #250, Individual #4, and Individual #242. As noted above, the relevant discussions were found in four different sections of the record for these individuals. However, as noted below in the discussion related to Section J.14, this level of documentation was not carried over to the consent process and it does not appear that those individuals who were responsible for actually providing the consents for the medications to be administered were aware of this information. Those individuals for whom a sufficiently detailed discussion could not be located were: Individual #33, Individual #25, Individual #240, Individual #299, Individual #111, Individual #1, Individual #300, Individual #221, Individual #7, and Individual #22. However, Individual #22 had been admitted to the Facility recently. Therefore, an adequate analysis had not yet been completed. The current finding of an adequate risk versus benefit discussion in 50% of the sample of records reviewed represented significant improvement in this area. As noted above, the progress that had been made also was reflected in more sections of the individuals' records, which would suggest that these issues were now considered in a number of different contexts and were, thus, more fully integrated into the clinical assessment process. This process should be maintained and expanded.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of	This provision relates to the degree of inter-class and intra-class polypharmacy, as well as the attempts to reduce polypharmacy. The Facility's current status with regard to polypharmacy was summarized in a graph covering the time period of September 2010 through August 2011. The data contained in the graph indicated that currently, 25 of the 126 individuals who received psychotropic medication had medication regimens that met the criteria for polypharmacy. However, five of these individuals were admitted from the community on multiple psychotropic medications within the last year. Adjusting for these individuals, the frequency rate of polypharmacy at the Facility was 16 percent. LBSSLC also had maintained tabular data that illustrated the yearly reductions in the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 who received six or more psychotropic medications had been maintained at zero since 2008, and the number who received five psychotropic medications had decreased from seven in 2005 to a range of 0 to 25 since that time, with the current frequency being one. This frequency did not include individuals who were admitted within the last year. The number of individuals who received four psychotropic medications had decreased from 18 in 2003, to four in 2/11, and three in 8/11. The number of individuals who received three psychotropic medications had gradually decreased from 44 in 6/05, when monitoring began, to 15 in 2/11, and 18 in 8/11. The number of individuals who received two psychotropic medications (57 in 8/11) was in the same range as the prior four reporting periods (53 in 3/09, 56 in 9/09, 56 in 9/10, and 62 in 2/11). The data for individuals who received one psychotropic medication indicated an initial decline from 57 in 6/05, and 52 in 09/08, to the lower range of 38 in 9/09, 40 in 3/10, 44 in 9/10, 41 in 2/11, and most recently 40 in 8/11. 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 six reporting periods, including 8/11. The most significant decline with regard to intra-class polypharmacy was the use of two mood stabilizers, which had decreased from 20 in 6/05, to two in the 9/10 and 2/11 reviews. The current frequency was four. 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 and 8/11. It should be noted that the sum of the numbers of individuals described in the discussion of the subcategories of polypharmacy exceeds the total number of individuals identified as being prescribed medication regimens that constituted polypharmacy. This is due to the fact that those individuals who are prescribed both three or more psychotropic medications and two medications from the same class (intraclass polypharmacy) were only counted once, and a number of individuals met both criteria. The review of the documentation from the "Monthly Facility Review of Psychoactive Medication Polypharmacy Meetings" from March through August of 2011 indicated that a thorough review of multiple individuals who received 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, Director of Psychiatry, Program Compliance Monitor for Psychiatry, and the Psychiatric Assistant. A member of the Monitoring Team attended the Polypharmacy Committee Meeting on	

#	Provision	Assessment of Status	Compliance
		10/4/11. Team members indicated that the format and content of this meeting was representative of prior meetings, and included a brief clinical review of each individual whose psychotropic medication regimen met the criteria of polypharmacy, as described above. The primary focus of these case-centered reviews related to the continued efforts to decrease the individual's medication, as well as which of the individual's current medications were considered to be essential to their stability. 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 often were prescribed multiple psychotropic medications while in the community. For example, an individual who was recently admitted to the Facility, after a number of failed community placements and numerous psychiatric hospitalizations, had been prescribed six psychotropic medications at the time of admission. This number already had been decreased to five, and an active taper of another medication was in progress. This individual also was reviewed in the Psychiatric Clinic on 10/6/11, and was an active participant in that meeting. During that meeting, the individual articulated which of the multiple psychotropic medications that had been prescribed while in the community had been helpful from his/her perspective. The psychiatric team clearly valued this opinion, and based on the individual's opinion, agreed not to challenge the single medication that the individual felt had been beneficial. At the time of the prior review, a recommendation was made to consider tracking polypharmacy related to the newly admitted individuals in a separate database, as they were usually admitted from the community on multiple psychotropic medications, and it could take several months to sequentially challenge and remove those medications that were not beneficial. The Facility had implemented this recommendation and the progress in reducing the medications of these individuals was tracked in a separate database for one year. The progress in simplifying these complicated medication regimens was reviewed at each monthly meeting of the Polypharmacy Committee. During the case-centered discussions that occurred during the Polypharmacy Committee Meeting on 10/4/11, it became clear that there were a number of individuals for whom the Psychiatry team believed the current medications were justified, and without them, the individual's psychiatric status would significantly deteriorate. The terminology contained in this provision clearly indicates that medication regimens that meet the criteria of polypharmacy could be maintained if there was sufficient evidence that each medication had independently been determined to be clinically necessary and, thus, its continued use could be "justified." Accordingly, a recommendation was made to identify these individuals, and then to begin to assemble the necessary historical empirical evidence that would support these opinions in order to ensure compliance with the	

#	Provision	Assessment of Status	Compliance
		Settlement Agreement.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The Director of Psychiatry indicated that nursing staff performed the 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 sample of 20 individual records was conducted. A current DISCUS (within the last three months), and evidence of quarterly evaluations over the past year were identified in 16 of the 20 records reviewed (80%). Those individuals for whom there was not a DISCUS within the last three months (and the most recent DISCUS date) were as follows: Individual #162 (5/25/11); Individual #254 (5/24/11); Individual #111 (5/24/11); and Individual #300 (5/23/11). This documentation also was analyzed with regard to whether or not the prescribing physician had reviewed the DISCUS instrument within seven to 10 days following the completion of the evaluation. This review indicated that the DISCUS had been reviewed in a timely manner for 18 of the 20 individuals (90%). The DISCUS also was performed on those individuals who received Reglan for gastroesophageal reflux disease (GERD), 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 9/8/11, was obtained which listed all individuals who were prescribed Reglan. This list was then compared and cross-referenced with the list of individuals who received psychotropic medication. Those individuals who received both Reglan and psychotropic medications were then deleted. The compilation of names that resulted from this process of elimination contained only individuals who received Reglan for GERD. A random sample of this list (20%) produced the following seven individuals: Individual #226, Individual #181, Individual #74, Individual #225, Individual #191, Individual #139, and Individual #29. 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 six of the seven individuals (86%) within the most recent three months, and quarterly for the prior year. The only exception was Individual #74, whose most recent evaluation was on 6/19/11. These records also were reviewed for documentation that the prescribing physician had reviewed these evaluations within seven to 10 days of completion. This analysis indicated that for three of the seven individuals (43%), documentation had been reviewed in a timely manner. The delay for the other four individuals was approximately two weeks.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The review of the sample of 20 records also indicated that the MOSES was completed as specified in the Settlement Agreement for 18 of the 20 individuals (90%). The two individuals for whom this documentation was not present were Individual #131 for whom no MOSES forms were found in the record, and Individual #22. Although Individual #22 only recently had been admitted to the Facility, a baseline examination should have been performed. The MOSES forms also were examined for the timeliness with which the prescribing physician had reviewed and signed the documents. This analysis indicated that the prescribing physician reviewed the clinical information contained in the MOSES regarding side effects within seven to 10 days of completion for only six of the individuals in the sample of 20 (30%). The delay for the other individuals ranged from two to three weeks. The greater delay in the review of the MOSES, as compared to the DISCUS, might have been due to the fact that the Psychiatry Assistant performed the DISCUS evaluations. This staff member's office was contiguous to that of the Psychiatrist, who reviewed the documentation. The primary Nurse performed the MOSES evaluations, and thus, the processing of the forms for the physicians' review was logistically more complicated. Nevertheless, the Facility will need to develop strategies to ensure that the prescribing physician reviews these important side effect monitoring tools in a timely manner. 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 seven individuals: Individual #226, Individual #181, Individual #74, Individual #225, Individual #191, Individual #139, and Individual #29. This review indicated that the MOSES was current and had been completed as specified for 100 percent of this sample. These records also were reviewed to determine if the prescribing physician had reviewed the evaluations within seven to 10 days of completion. This analysis indicated that this documentation had been reviewed in a timely manner for only one of the seven individuals (14%). The duration of the latency before the remaining forms were reviewed was in the range of two to three weeks. The Facility should develop systems to ensure that the prescribing physician reviews side effect monitoring forms in a timely manner.	
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	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 20 records was performed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	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 related analysis indicated that adequate justification for the individual psychiatric diagnosis could be identified in 80% of the individual records reviewed. The discussion related to Section J.2 also is relevant, as it reviewed the Facility's compliance status with regard to the completion of the CPAs. 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 by the routine purging of records, so that data was only available for the last few years. Thus, baseline data for a medication that was begun five or more years ago was not present. This review indicated that empirical evidence that the prescribed psychotropic medication was effective in diminishing the identified behavioral symptoms of the psychiatric disorder was identified in seven of the 20 records (35%). The records where this determination could be made were those of Individual #162, Individual #114, Individual #254, Individual #161, Individual #1, Individual #250, and Individual #300. As discussed in the Monitoring Team's prior reports, the maintenance of more longitudinal data would greatly benefit the determination of efficacy. A related strategy would be to develop a system to carry forward historical evidence that substantiated that a specific medication was necessary to maintain an individual's stability. This recommendation also relates to the justification of polypharmacy, which was discussed with regard to Section J.11. The purpose of maintaining the longitudinal data in an accessible manner is to inform decisions about changes in the individual's psychotropic medication, as well as to aid in the determinations of efficacy. The latter point is especially relevant in terms of justifying medication profiles that meet the criteria for polypharmacy. Thus, a summary statement would seem to be adequate, as long as it was detailed enough to provide the type of information on which one could reliably base clinical decisions, and the source was cited so that another clinician or consultant could refer back to the original data if necessary to draw their own conclusions. The additional factors that made it difficult to determine if the psychotropic medications had been effective were the lack of adequate baseline data, and the co-existence of multiple psychotropic medications, which made it impossible to discern differential	

#	Provision	Assessment of Status	Compliance
		effects. The final stipulation contained in this provision of the Settlement Agreement discussed 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." The review of the sample of 20 individuals indicated that there had been monthly and quarterly psychiatric reviews for 18 of the 20 individuals (90%). Those individuals for whom this documentation was not found were Individual #254 (most recent quarterly review 5/23/11), and Individual #240 (most recent quarterly review 6/22/11). The Quarterly Psychiatric Review Form contained a section entitled, "Mental Status," where the Psychiatrist documented his/her direct observations of the individual. This section was uniformly completed in all of the records reviewed and, thus, there was verification of direct observation on a quarterly basis in all of the records, except those of Individual #254 and Individual #240. There also was 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 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 12 (60%) of the individual records reviewed. LBSSLC served a number of individuals whose teams had identified that they were not competent to make an informed decision relating to the inherent risks and benefits of the proposed psychotropic medication, and who did not have a family member or other individual who was serving as 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 in the Monitoring Team's prior reports. 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. This information should have been relatively easy to incorporate into the informed consent process, with the assistance of the Psychiatry Department.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted in the discussion related to Section J.10, the Facility had made noticeable progress in the documentation of clinical considerations involved in the risk versus benefit assessment related to the utilization of specific psychotropic medications. This documentation primarily resided in the Psychiatric Section of an individual's record, but also was complemented by corresponding material in the portion of the Behavior Support Plan that was devoted to the Pharmacological Treatment Plan. This more specific information replaced documentation that had previously appeared to be formulaic in nature, and suggested the use of templates. This more individually specific information was not reflected in the actual Consent Forms and related information that was provided to the individual's Guardian or Facility Director who was providing the consent. The Human Rights Department, working in conjunction with the Psychiatry and Psychology Departments, should develop strategies to incorporate the more specific information now contained in these sections of the individual's record, into the informed consent process. Although consent forms were being signed consistently, the lack of adequate information provided to decision-makers resulted in a lack of informed consent. As a result, the Facility remained out of compliance with this provision.	
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.	On 10/5/11, the Neurologist, Director of Psychiatry, Medical Director, the individuals' Primary Care Practitioner (PCP), and the Clinical Pharmacist attended the neurology clinic. A member of the residence's nursing staff accompanied the individuals to the clinic, and an additional nurse, who was assigned to the Clinic, helped to coordinate the flow of the individual reviews. The format was consistent with that observed during the prior reviews. The individual's primary 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, and involved the Neurologist, Psychiatrist, the PCP, and the Clinical Pharmacist. Also, where appropriate, there was a discussion of the relevant published literature. During the Neurology Clinic on 10/5/11, consultations for the following four individuals, who had both a seizure disorder and a complicated psychiatric presentation, were directly observed: Individual #314, Individual #109, Individual #199, and Individual #322. An extensive discussion of the issues related to these individuals followed the case presentation, and included the Neurologist, Psychiatrist, and the PCP. 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 in the records of the 14 individuals within the sample of 20	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		individuals who required and received neurological consultation within the last year. The review of records indicated that the following individuals were periodically reviewed by the Neurologist: Individual #72, Individual #162, Individual #114, Individual #161, Individual #299, Individual #111, Individual #1, Individual #250,Individual #4, Individual #242, Individual #240, Individual #25, Individual #33, and Individual #124. The Neurology Consultation Note documented the attendance of the Psychiatrist in 12 of the 14 individual records (86%). A Consultation Note, dated 4/26/11, for Individual #161, and the Consultation Note, dated 3/18/11, for Individual #1 did not indicate that the Psychiatrist was present. However, the corresponding Neurological Consultation Note for all of these individuals alluded to their psychotropic medications. The summary, which described the substance of the Neurology Consultation, also was discussed in the Psychiatry section of the record. There was also an ongoing longitudinal summary of each Neurological Consultation in the individuals' annual medical summaries. These summaries were not purged, and contained valuable longitudinal information, which extended back for several years in some cases. 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 two instances in the sample of records reviewed. In addition, documentation that appeared in the Neurology Consultation Notes, the Psychiatry section of the record, and the Annual Medical Summary documented the ongoing collaboration between the Departments of Psychiatry, Neurology, and Primary Care. The Clinical Pharmacist also had recently implemented a policy that documented and briefly summarized each Neurological Consultation in the Quarterly Pharmacy Medication Review for that individual. The current plan was for that information to also be carried forward on an ongoing basis. The Medical Director at LBSSLC was asked if the Facility had engaged in an empirical analysis to determine if there was enough Neurological consultation time available to provide adequate services to the residents. His answer was that such a specific calculation did not exist, but that instead, the Facility relied on the feedback of the Consulting Neurologist, as well as the other clinicians who were actively involved in the Neurological Consultation process to determine if adequate consultation time exists. His impression was that, based on this feedback, there had been adequate time, but that if circumstances were to change in the future, it would be relatively easy to add additional Neurological Consultation time. Currently, Dr. Daniel Hurst provided Neurological Consultation two afternoons per month, and Dr. Benjamin Williams provided an	

#	Provision	Assessment of Status	Compliance
		additional afternoon per month. Dr. Hurst's primary focus was on the treatment of individuals with seizure disorders, while Dr. Williams' focus was on other neurological issues, such as movement disorders, changes in an individual's mental status, and the range of other neurological problems that can develop in individuals with intellectual disabilities. The observations of the Neurology Clinics during the current and prior reviews, coupled with the extensive review of the related documentation described above, suggested that there was ample Neurological consultation time available to meet the needs of the individuals who resided at LBSSLC.	

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

1. LBSSLC should increase its efforts to recruit additional Psychiatrists who are Board Certified or Board Eligible in Psychiatry. (Sections J.1, and J.5)
2. The Psychiatry Department should maintain and expand the new initiative to ensure that each individual who received psychotropic medication has an updated CPA that meets the criteria and content requirements of the Settlement Agreement. (Sections J.2, and J.6)
3. The Facility should establish a goal of completing a CPA on each newly admitted individual who receives psychotropic medication within 30 days of their admission. (Sections J.2, and J.6)
4. LBSSLC should ensure that all staff members involved in the use of chemical restraints are trained to and describe the antecedents to the behavior that prompted the chemical restraint, in a manner that will provide the information necessary to minimize the occurrence of these events in the future. (Sections J.3)
5. The Facility should ensure that the current group of forms that are to be completed to monitor an individual's status after the administration of pre-treatment sedation for dental procedures are completed as specified, and that all of the action steps are uniformly carried out. (Section J.4)
6. The initiative to develop Desensitization Plans and/or other strategies to reduce the need for pre-treatment sedation for dental procedures should be accelerated and expanded to include the development of corresponding plans for medical procedures. (Section J.4)
7. LBSSLC should ensure that there is a clear description of the manifest symptoms that justify the psychiatric diagnosis of record, and that these symptoms are consistently documented in more than one place in the record. (Section J.6)
8. The Director of Psychiatry, working in conjunction with the Director of Psychology, should develop a strategy for the use of the Reiss Screening instrument that takes into account potential changes in individuals' status that would necessitate the use of the screening tool, as well as a schedule for regular screening of any individuals not prescribed psychotropic medication. (Section J.7)
9. The initiative to make it possible for the individuals' treating Psychiatrist to attend their annual Personal Support Team Meeting should be supported. (Section J.8)
10. The Psychiatry and Psychology Departments at the Facility should delineate which challenging behaviors were derived from a biologically-based psychiatric disorder, as opposed to a learned behavior, so that the least intrusive interventions can be utilized (Section J.9).
11. The Facility's efforts to discuss clinical risk versus benefit considerations in a number of relevant sections of the individuals' records should be further developed and expanded. (Section J.10)
12. The necessary historical documentation should be assembled to substantiate the Psychiatry Department's opinion that current psychotropic medication regimens that meet the criteria for polypharmacy could be clinically justified. To the extent that this process can be successfully completed, the progress of these individuals could be tracked as a sub-category within the Facility's polypharmacy database. (Section J.11)
13. The database that had been established to track the progress of individuals who were admitted from the community on multiple medications should be monitored to ensure that the information for individuals who have resided at the Facility for more than one year is incorporated into

the main polypharmacy database. (Section J.11)

14. Potential mechanisms to retain 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. A summary statement would be adequate as long as it is detailed enough to provide the type of information on which one could reliably base clinical decisions, and the source is cited so that another clinician or consultant could refer back to the original data if necessary to draw their own conclusions. (Section J.11, and J.13)
15. LBSSLC should develop a mechanism to ensure that the prescribing physician reviews the MOSES and DISCUS side effects monitoring forms on a timely basis. (Section J.12)
16. 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. (Section J.14)
17. The Facility should evaluate quality, as well as presence or absence of an item, when performing the internal QA Reviews. (Facility Self-Assessment)

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 Section K Presentation Book, developed by Jim Forbes, Director of Behavioral Services; o LBSSLC Plan of Improvement/Self Assessment, dated 9/19/11; o Summary Listing of Behavioral Services Staff, as of 9/19/11; o BCBA Certificate for Ron Flint, dated 5/31/11; o Emails documenting scheduling of BCBA exams, dated 8/3/11 and 8/25/11; o Emails and registration documentation from University of North Texas, dated 8/1/11 and 9/19/11; o Vitae for Jim Forbes, M.Ed., BCBA, revised August 2011; o Interagency Cooperation Contract between LBSSLC and Texas Tech University, amendment signed on 7/15/11 and 7/20/11, respectively; o Behavioral Services Peer Review Log, dated 3/31/11 through 9/19/11; o Sample of Behavior Support Peer Review Committee (BSC) Meeting Notes, dated 4/5/11 through 8/26/11; o Sample of BSC Meeting Minutes and External Peer Review Notes, Emails, and Rubrics, dated 3/31/11, 7/1/11, 7/29/11, 8/5/11, and 8/26/11; o Root Cause Analysis of Peer-to-Peer Aggression at 520 Cedar Summary, dated 7/17/11, and subsequent Action Plan, dated 8/1/11; o For Section K.4, Positive Behavior Support Plans for: Individual #185, Individual #111, Individual #70, Individual #10, Individual #107, Individual #254, Individual # 245, Individual 47, Individual #146, Individual #309, Individual #221, Individual #23, Individual #271, and Individual #520; o For Section K.4, Monthly PBSP Progress Notes, as provided, for: Individual #185, Individual #111, Individual #70, Individual #10, Individual #107, Individual #254, Individual # 245, Individual 47, Individual #146, Individual #309, Individual #221, Individual #23, Individual #271, and Individual #520; o For Section K.4, Safety Plan for Crisis Intervention and Safety Plan Progress Note, as provided, for Individual #33 and Individual #221; o For Section K.5, Structural and Functional Assessment Report (SFAR), when available for: Individual #185, Individual #111, Individual #70, Individual #277, Individual #10, Individual #107, Individual #254, Individual #245, Individual #47, Individual #146, Individual #309, Individual #221, Individual #23, and Individual #273; o Structural and Functional Assessment Self-Monitoring Checklist rubric and provided examples; o For Section K.5 and K.6, Psychological Assessments, including the Inventory for Client and Agency Planning (ICAP) Evaluations, as available for: Individual #146, Individual #70, Individual #250, Individual #233, Individual #203, Individual #10, Individual #23, Individual #309, Individual #254, Individual #61, Individual #179, Individual #284,

	Individual #111, Individual #245, Individual #47, Individual #232, Individual #221, Individual #280, Individual #273, Individual #132, Individual #185, Individual #255, Individual #130, and Individual #84; o For Section K.6 and K.7, Psychological Assessments, including the Inventory for Client and Agency Planning Evaluations, as available for: Individual #7, Individual #131, Individual #22, Individual #325, Individual #79, and Individual #202; o For Section K.9, Positive Behavior Support Plans for: Individual #185, Individual #111, Individual #70, Individual #10, Individual #107, Individual #254, Individual #245, Individual 47, Individual #146, Individual #309, Individual #221, Individual #23, Individual #273, and Individual #520; o For Section K.9, onsite review of PBSP approval and consent forms (i.e., guardian consent, BSC, and Director approval) for: Individual #185, Individual #221, Individual #10, Individual #232, Individual #284, Individual #254, and Individual #132; o LBSSLC Behavioral Services Tracking Grid, updated 10/4/11; o Shift Home Log, revised 5/6/11; o Sample staff training documentation for PBSP data collection, dated June and July 2011; o New documentation/data collection system "new document as we go system," email dated 9/7/11; o Summary listing of PBSPs and readability levels, dated 5/4/11 and 8/26/11; o Summary of PBSP Competency/Integrity Training Aggregate Data, dated 7/1/11 through 9/29/11; o Summary of Responses to PBSP Competency/Integrity Training Weekly Percent Correct for Item Analysis, dated 7/1/11 through 9/29/11; o PBSP Competency/Integrity Training blank rubric; o Completed PBSP Competency/Integrity Training rubric for Individual #274; and o For Section K.8, counseling treatment plans and psychological assessments, as available, for: Individual #61, Individual #131, Individual #124, Individual #125, Individual #197. ▪ **Interviews and Meetings with the following**: o Jim Forbes, Director of Behavioral Services, and Sally Schultz, on 10/3/11; o Lola Walker, QDDP Coordinator; Marisol Gonzales, ISP Coordinator; Rodshadi Moore, Active Treatment Supervisor; Christina Sosa, Psychologist; Tracey Snow Murphy, Director of Residential Services; Sandra Kennedy, Unit Director and QDDP Educator; Jim Forbes, Director of Behavioral Services; and Deborah Burgett, DADS, on 10/4/11; o Rodshadi Moore, Active Treatment Supervisor, and other Active Treatment Coordinators, on 10/4/11; o At Risk Meeting for Individual #33, on 10/5/11; o Tracey Snow Murphy, Director of Residential Services, on 10/5/11; o Libby Allen, Facility Director; Robin Seale, Assistant Director of Programs; and Donna Jessee, DADS SSLC Director of Operations, on 10/5/11; o Psychologists including Carolyn Milton, Philip Kite, Christina Sosa, Krista Leubner, Joanna Molleca, and Beckie Crawford, as well as Psychology Assistants including Anna Shackelford, Amber Flores, Blake Perez, and R. Jamie Trevino, on 10/5/11;

	○ Jim Forbes, Director of Behavioral Services, and Robert Robbins, on 10/6/11; ○ Lola Walker, QDDP Coordinator; Tracey Snow Murphy, Director of Residential Services; and Marilynn Foster, QA/QI, on 10/6/11; ○ Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 10/6/11; ○ Sandra Kennedy, Unit Director, on 10/7/11; ○ Sandra Edge, Active Treatment, on 10/7/11; and, ○ Mary Ortiz, Director of Competency Training and Development (CTD), on 10/7/11. ▪ **Observations Conducted**: ○ Brief campus tour with the President of the Self Advocacy Group, Individual #237; ○ PICA Reduction Committee Meeting, on 10/4/11; ○ Behavior Support Committee Peer Review Meeting, on 10/6/11; ○ 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 QDDPs occurred throughout the day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Workshop (536), on 10/3/11; ▪ Canna (521), on 10/3/11; ▪ Violet (523), on 10/3/11 and 10/4/11; ▪ Aspen (513), on 10/3/11; ▪ Birch (514), on 10/3/11 and 10/6/11; ▪ Elm (515), on 10/3/11 and 10/6/11; ▪ Fir (516), on 10/3/11 and 10/6/11; ▪ Iris (527), on 10/4/11; ▪ Tulip (526), on 10/4/11; ▪ Rose (525), on 10/4/11; ▪ Willow (520), on 10/4/11, 10/5/11, and 10/6/11; ▪ Oak (518), on 10/5/11 and 10/6/11; ▪ Maple (517), on 10/5/11 and 5/6/11; ▪ Educational Building (511), on 10/7/11; and ▪ Pine (519), on 10/7/11.
	Facility Self-Assessment: The Facility had developed a Plan of Improvement and Self Assessment with regard to Section K of the Settlement Agreement. The POI/Self Assessment contained sections of each settlement agreement provision with the current Facility determination of noncompliance (N) or substantial compliance (S), as well as corresponding descriptions of ongoing status. 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. That is, based on the Monitoring Team's current review, the Facility was still in noncompliance with Section K.3. More specifically, although the current internal and external peer review systems continued to 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. If the noted level of progress continued, substantial compliance would likely be scored at the next Monitoring visit. As reported in the Monitoring Team's previous reports, the Facility had developed a self-assessment tool based on the Monitoring Teams' Section K rubric. Reports indicated that the Director of Behavioral Services and Psychologists for the Behavioral Services Department, as well as the Program Compliance Monitor (PCM) conducted reviews using the self-assessment tool. Each month, a total of 11 PBSPs were randomly selected for review, and four of these were selected for inter-rater agreement. Reported data indicated that compliance scores from March, April, and May were 73%, 56%, and 70% (average of 66%) for the PCM and 63%, 72%, and 71% (average of 69%) for Behavioral Services, respectively. Inter-rater agreement between the PCM and Behavioral Services for May was 62% (no inter-rater tools were completed for March and April). In addition, reported data indicated that compliance scores from June, July, and August were 77%, 72%, and 82% (average of 77%) for the PCM and 82%, 83%, and 83% (average of 88%) for Behavioral Services, respectively. Inter-rater agreement between the PCM and Behavioral Services for July and August were 85% and 78% (no inter-rater tool was completed in June). The Director of Behavioral Services and the PCM had met monthly since May to review completed assessment tools, ensure improved accuracy and inter-rater agreement over time, and discuss the strengths and weaknesses of the reviews. Although it was positive that reviews were being conducted, the POI provided only overall scores. It is unclear how the Facility calculated these, because the indicators within the tools were not weighted. In addition, in order for the data to be useful to the Facility in identifying areas in which strengths or needs exist, data should be reviewed per indicator. This will allow the Facility to identify and broaden best practices, and identify and address specific areas requiring correction. As the Facility expands it POI, it will be important for the POI to reflect the analysis completed, and the decisions made regarding areas requiring additional attention. In addition, the POI/Self Assessment included 23 action steps across six selected sections of the Settlement Agreement with corresponding descriptions of required evidence, the persons responsible, start dates, projected completion dates, and the completion status. According to provided documentation, out of 23 total action steps, the Facility reported that 16 had been completed, five were in progress, and two were not yet started.
	Summary of Monitor's Assessment: Despite the losses of two BCBA level staff since the Monitoring Team's last review, noted progress of the remaining Psychological Services staff in pursuing credentialing was observed. That is, one staff passed the BCBA exam, and three others took the exam just prior to the onsite visit, and were awaiting their scores. According to reports, three additional staff were expected to complete necessary coursework and supervision, and would be ready to take the exam next spring. Since the Monitoring Team's last review, the foundation for peer review, especially external peer review, had expanded and become more robust. Overall, Behavior Support Peer Review Committee meetings

	continued to be held regularly, and appeared helpful in improving the nature of behavioral services. However, participation by critical members of the committee, especially the more inexperienced Psychologists, could be improved. A formal interagency cooperation contract between LBSSLC and Texas Tech University recently was extended, and additional participation by other external reviewers appeared to benefit current behavioral programming. Continued improvement in the quality of PBSPs was observed. Specific areas for improvement, however, continued to be noted. These included: 1) specification of previously attempted interventions, including descriptions of changes to behavioral programming and explanations regarding why these changes were made (other than medication changes); 2) operational definition of replacement behaviors, especially within staff instructions; 3) complete behavioral objectives that facilitated efficient and accurate determination of progress, especially for identified replacement behaviors; 4) data display, including baseline date, especially for replacement behavior(s); 5) conspicuous integration of reinforcers identified through the SFAR (beyond verbal praise) within antecedent and consequence-based strategies; and 6) plans or considerations to reduce the intensity of identified interventions (i.e., beyond the planned fading of the use of psychotropic medication). Progress was observed in ensuring that PBSPs could be understood and implemented by staff through careful examination of readability levels. Continued progress was noted in the area of regular monitoring of Positive Behavior Support Plans. Monthly PBSP progress notes more effectively displayed target and replacement behavior data, and contained ongoing weekly review by Psychologists. This system appeared likely to benefit from a recently implemented more timely supplemental data card system that allowed staff to record data "on the go." Although some limited progress in updating standardized tests of intelligence and adaptive behavior was noted, this progress appeared to have ceased due to changes in responsibilities of Behavioral Services staff. However, progress with regard to the completion of improved Structural and Functional Assessment Reports continued to be noted. Since the Monitoring Team's last review, collection of inter-observer agreement (IOA), as well as completion of PBSP Competency/Integrity Training assessments was expanded. However, concerns regarding the adequacy of IOA data, as well as how some items were scored and summarized within the integrity assessments were observed. Limited progress was noted in the provision and monitoring of psychological services other than PBSPs. This included slight improvement in reviewed counseling treatment plans that external counselors developed in collaboration with Behavioral Services Staff. Progress was noted, however, in developing procedures and methods to ensure that staff received competency-based training.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of	Since the Monitoring Team's last review, progress continued to be observed within the	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Department of Behavioral Services by psychologists pursuing BCBA credentialing. That is, in April 2011, one Psychologist successfully passed the BCBA exam, and in September 2011, three other Psychologists took the BCBA exam just prior to the onsite visit, and were awaiting their results. Three additional psychologists were enrolled in coursework this fall. At the time of the review, three additional Psychologists were completing the remaining required coursework and necessary supervision this fall, and were expected to take the exam in the Spring 2012. According to the Director of Behavioral Services, the only new hire since the last visit (a bilingual Psychologist) had planned to begin the required coursework and supervision toward BCBA certification this Spring. Verbal reports from Psychology Assistants reflected a desire to pursue additional educational competencies, including BCBA certification. The Facility is encouraged to identify any potential obstacles that might inhibit current Psychological Assistants in pursuing coursework similar to that of current Psychologists. Indeed, this might be a way to continue to recruit and retain competent professionals with Behavioral Services. Although progress was noted, overall progression toward compliance on this item was somewhat diminished by a number of staffing changes that reduced the total number of BCBA-level staff within the department since the last visit. This is discussed in further detail with regard to Section K.2. The Facility was rated as being in noncompliance with this provision, 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 nine years, and had extensive experience 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. At the time of the previous review, it was observed that a change in administrative structure was initiated due to the reported challenge of adequately supervising Behavioral Services staff following the restructuring from a unit-based to a discipline-based model. At that time, two behavior analysts (i.e., BCBAs; Psychologist I positions)	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		had been repositioned within the current structure to provide professional and, in time, administrative supervision to the Associate Psychologists. This change appeared necessary and acceptable to both Director of Behavioral Services, as well as the two behavior analysts. Since the previous review, however, a number of staffing changes had occurred within the Department of Behavioral Services that consequently eliminated the professional oversight and administrative structure that was initiated at that time. More specifically, two BCBA-level staff that provided clinical and administrative oversight were no longer employed at LBSSLC. In addition, one Associate Psychologist and two Psychological Assistants had left employment with the Facility. The departure of these staff, especially the two BCBAs placed within leadership positions, had the potential to negatively impact the stability of psychological care throughout the Facility. However, according to verbal reports, the administrative and professional support provided to the Director of Behavioral Services as well as departmental staff, over the past six months had been made a priority. At the time of the recent onsite visit, the Facility Director and Assistant Director of Programs voiced the continuation of this support. As described above, staffing changes necessitated the return to the previous model of administrative oversight. That is, the Director of Behavioral Services had returned to providing professional and administrative oversight to the entire department, with the assistance of the BCBA-D who was providing requisite clinical supervision to staff pursuing BCBA certification. Verbal reports from the Director of Behavioral Services indicated a desire to identify a different model of professional support and administrative oversight in the future. Currently, efforts appeared to be primarily directed at hiring qualified staff for open positions. At the time of the review, the department had three open positions (i.e., two psychologist positions and one psychology assistant position). The recent hiring of an Associate Psychologist who was bilingual will likely offer assistance with the provision of psychological services to primarily Spanish-speaking individuals. Verbal reports continued to reflect support and confidence in the Director of Behavioral Services in maintaining a consistent level of psychological care throughout the Facility. Based on the current positive reports of executive leadership and Behavioral Services staff members, as well as the continued improvement in the provision of psychological services observed since the last visit, the Facility was found to be in substantial compliance with this provision.	
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year,	Continued progress was evident in peer-based systems to review psychological services. As previously reported, LBSSLC had a rigorous internal peer review system that now appeared to be increasingly supplemented through a more robust external peer review	Noncompliance

#	Provision	Assessment of Status	Compliance
	each Facility shall establish a peer-based system to review the quality of PBSPs.	system. The internal peer review occurred primarily through the Behavior Support Peer Review Committee Meetings attended by professionals from a diversity of disciplines and departments, including Psychologists, Psychology Assistants, medical representatives (RN or MD), a Psychiatrist, a QDDP, a Speech Language Pathologist (SLP), a human rights officer (HRO), quality assurance staff, and BCBAs. Review of the provided sample of BSC meeting minutes, from 3/31/11 to 8/19/11, revealed that the committee met approximately 25 times during this period. Overall, these meetings were very well attended by the Director of Behavioral Services, two select psychologists, as well as SLP, and QA staff. In addition, consistently since June 2011, at least one or more Psychological Assistants attended these meetings (approximately 60% of the time). However, limited attendance was noted for the HRO (16%) and Psychiatry (16%) staff. Surprisingly, although the Director of Behavioral Services and the most senior psychologist attended almost every scheduled BSC meeting, only one other psychologist attended a majority (over 50%) of the meetings. All of the other current psychologists attended less than 50% of the BSC meetings and, surprisingly, of these, four psychologists attended 12% or less of the BSC meetings. Unfortunately, these four psychologists were those who were still completing coursework and receiving required supervision toward certification. Seemingly, they would be those professionals most likely to benefit from attending the meetings. Improving the attendance of all psychologists would facilitate professional competencies and improved critical review of psychological programming in the future. As described in previous reports, the Monitoring Team's direct observation of the BSC continued to reflect diverse attendance and active participation by committee members, presentation of assessments and plans by their authors, and data-based review and decision making. Overall, the completed assessments, data collection systems, and developed plans that were presented appeared to be thoroughly and critically examined in a supportive atmosphere of learning and collegiality. Although attendance by a majority of psychologist appeared to occur during the onsite visit, the review of BSC meeting minutes indicated that this is not necessarily typical practice. In addition to internal peer review, external peer review continued to occur and appeared much more robust. That is, the frequency of critical external review, as well as the diversity of peer reviewers appeared to have increased. As previously described, a collaborative relationship with Texas Tech University had been established to provide both onsite and offsite consultation, peer review, and in-depth case review. An Interagency Cooperative Contract had been developed, originally dated 3/21/11. This arrangement involved the active consultation of an independent Doctoral-level Board Certified Behavior Analyst (BCBA-D) from Texas Tech University with expertise in Special Education and Applied Behavior Analysis, as well as two Texas Tech graduate	

#	Provision	Assessment of Status	Compliance
		students studying Special Education and Applied Behavior Analysis. This contract was recently amended to cover the time period of September 2011 to August 2012. Provided documentation indicated that during the time period described above, an external reviewer(s) attended the BSC meeting three times (12%). In addition to the peer review that Texas Tech University faculty and graduate students provided, colleagues, including multiple BCBAs from other Texas State facilities (i.e., State Central Office, Austin State Supported Living Center, and San Angelo State Supported Living Center) had provided additional external support and critique. This included multiple case reviews conducted via teleconference (at BSC), off-site document review and email communication, and specialized onsite consultation (i.e., forensic sexuality assessments). Documentation provided indicated an increasing trend of external reviewers providing case consultation in a variety of capacities in the last few months (i.e., during August and September). The current internal system as well as the flourishing external peer review system appeared to facilitate more frequent and improved opportunities for case consultation, as well as critical peer review. This was particularly evident with regard to the external review in the months of August and September. In order for the Facility to be found in substantial compliance with this component of the Settlement Agreement these systems need to demonstrate consistent contributions over a consistent and substantial amount of time (i.e., in this case, more than just a few months) and demonstrate that a majority of staff, particularly the psychologists, are actively and consistently involved in internal peer review.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored	Progress had been made in the area of standardized data collection and data review. To examine the nature of data collection, including standard procedures and methods typically utilized, a sample of 14 PBSPs implemented since the last Monitoring review were selected and reviewed. This sample of PBSPs reflected 10% of the total PBSPs (N=144) currently in place, as well as 15% of the PBSPs completed since the last onsite review (N=94). The individuals in this sample are listed above in the documents reviewed section. Of this sample, many PBSPs did not identify or adequately operationally define the target and/or replacement behaviors either in the PBSP or in the staff instructions sections (i.e., Individual #185, Individual #111, Individual #10, Individual #309, Individual #221, and Individual #273). In addition, several PBSPs did not include objective and measurable goals for replacement behaviors (i.e., Individual #185, Individual #10, Individual #47, and Individual #146). Regarding data display, of this sample, 13 (93%) displayed behavioral data within the PBSP. The sole exception was the PBSP for Individual #185,	Noncompliance

#	Provision	Assessment of Status	Compliance
	and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	where no data was displayed. Data display typically utilized line graphs which was a substantial improvement over previously noted data displays (i.e., those using bar graphs or tables). However, not all graphs were complete and some did not include data on replacement behaviors. More specifically, data on replacement behaviors was not included in four of the PBSPs sampled (i.e., Individual #70, Individual #254, Individual #245, and Individual #273). In addition, some PBSPs included graphs that displayed data on target behaviors that had not been identified or defined within the PBSP (i.e., Individual #47and Individual #10). In addition to the above PBSPs, the Monthly PBSP Progress Notes also were reviewed for those individuals in the sample. These notes appeared to be substantially improved, because data was more effectively displayed using appropriate graphing conventions. More specific information regarding improvements in graphing conventions is discussed with regard to Section K.10. In general, review of documentation provided indicated that all of the 14 individuals sampled had Monthly PBSP Progress Notes completed across a number of consecutive months, which reflected ongoing weekly data review and notation by the psychologist. In almost all graphs, data on both target and replacement behaviors was displayed. The one exception was for Individual #273 where replacement data was not included within the graph. Overall, it was evident that the quality of the data display within these monthly progress notes had improved. Behavioral services meeting minutes, dated 6/24/11, indicated a formal effort to improve the content of the comments section of the progress note. Review of sampled PBSP monthly progress notes offered some initial evidence that psychologists were providing more specific and descriptive comments regarding presented weekly data. Although improvement was noted, several concerns remained. One continuing issue was how to display or note the lack of data, when data collection did not occur. For example, several weeks of progress notes indicated: "no documentation regarding targeted behavior this week" for Individual #111 in May 2011. However, the line graph did not appear to reflect the absence of data. Rather, it showed a zero level of responding for target behavior. This problem appeared to occur across other graphic displays for other individuals as well (i.e., Individual #254, and Individual #245). There is a difference between an absence of data and zero level of responding. Therefore, psychologists need to carefully discriminate between these two situations, and accurately reflect this difference in data displays. In other instances, data was not graphed even though the narrative indicated that data was available for display (e.g., June and July 2011 monthly PBSP Progress Notes for Individual #254). Or, data was displayed that was not identified or defined in the PBSP (e.g., Individual #245 and Individual #47). For example, a recent Monthly PBSP Progress Note (i.e., Individual #47) displayed data on "outbursts," "aggression," and "tolerance,"	

#	Provision	Assessment of Status	Compliance
		even though these were not identified or defined in the current PBSP. In addition, data on one of the targeted behaviors for reduction (i.e., public masturbation) that was defined in the PBSP was not displayed. Another example of replacement behaviors not included in graphs was found in other documents (i.e., May to July 2011 monthly PBSP Progress Notes for Individual #254), or where only one target behavior was displayed despite the fact that additional target behaviors for reduction were identified and defined (i.e., Individual #254). Overall, the current review of data displayed within these documents evidenced continued improvement as compared with those reviewed during the Monitoring Team's previous visits. Psychologists appeared to consistently use the standardized Monthly PBSP Progress Note format utilized. This will likely lead to more responsive data-based decisions as psychologists continue to review and reflect on data on a weekly basis. To determine the nature of data collection related to the implementation of Safety Plans for Crisis Intervention, a sample of Safety Plan Progress Notes were examined. The current sample included the Safety Plan Progress Notes for two individuals with SPCIs (i.e., Individual # 33 and Individual #221). This reflected a 20% sample of the total SPCIs currently in place (N=10). These notes were examined in an attempt to estimate how data related to restraint was collected and displayed. Surprisingly, only monthly notes from March to May and June to August were provided for Individuals #33 and Individual #221, respectively. In 100% of the sampled SPCIs, the frequency of restraint, total and average duration (in minutes) of restraint, chemical restraint, and injuries related to restraint were displayed either in table or graphic format. However, as discussed with regard to Section K.10 of the Settlement Agreement, the graphic formats continued to be viewed as inadequate. It continued to be unclear why this information was redundantly displayed across both tabular and graphic display. In addition to the standardized data system that was previously implemented to facilitate data collection (i.e., on a single sheet of paper attached to the Shift Home Log) for each shift across all individuals within a residence, a new supplemental system was developed to allow each direct support professional to carry index cards and, when appropriate, record data "on the go," thereby ensuring the opportunity to record information in a more timely manner. The index cards listed the target and replacement behavior of each individual, and provided space to record relevant data. Direct support professionals were trained to pick up their cards at the beginning of each shift, complete as appropriate, and give them to the shift team leader at the end of the shift. Once collected, the team leader summarized the information on the standardized data card attached to the home shift log. Documentation provided evidenced an earnest attempt to train direct support professionals to use these cards and, consequently, to record behavioral data in a more timely manner. Subsequently, this recorded data could be transferred to	

#	Provision	Assessment of Status	Compliance
		standardized data sheet attached to the shift home log later in the shift. Documentation indicated a significant number of direct support professionals were trained using this new PBSP documentation methodology. Direct observation was conducted of the utilization of the new supplemental index card data collection system. More specifically, during random site visits, a member of the Monitoring Team approached available staff and asked about the cards and the system. If the cards were not conspicuously available, a member of the Monitoring Team asked residential staff if they were available. Overall, it appeared that the data cards were immediately available for use (i.e., carried by the staff) in approximately 75% of the residential programs visited. This estimate included two sites (i.e., Residences #518 and #516) where some staff appeared to carry the cards, but not others. According to verbal reports, staff members interviewed appeared to have positively adopted this system. Because it was still fairly new, it will be more closely examined during the Monitoring Team's next visit. Slight progress was made in the area of collecting inter-observer agreement (IOA) data. Documentation provided during the Monitoring Team's previous visit evidenced the initiation of IOA data collection that was facilitated through the use of standardized instructions and a structured data sheet. Staff used these forms when collecting required data on target and replacement behaviors and, at that time, some initial data across three programs had been collected. At the time of the most recent review, documentation provided indicated that additional data had been collected since the Monitoring Team's last review. This is further discussed with regard to Section K.10 of the Settlement Agreement. Currently, due to the continued, although improved, inadequacies as listed above (i.e., poorly defined replacement behaviors, lack of objectives for replacement behaviors, inconsistencies in data collection, insufficient data display, etc.), the Facility remained out of compliance with this provision of the Settlement Agreement.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs	As reported in the Monitoring Team's previous reports, LBSSLC policy required each individual residing at the facility to have a current psychological assessment. This 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 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. To examine adherence to these requirements, a sample of 24 psychological assessments	Noncompliance

#	Provision	Assessment of Status	Compliance
	that may require intervention.	were reviewed. This sample represented approximately 11% of the total number of individuals (N=225) expected to have a psychological assessment. The individuals included in this sample are listed in the documents reviewed section. Within this sample, 24 (100%) 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 21 (88%) of those sampled had an ICAP completed within the last three years. More specifically, although each psychological assessment noted an ICAP completion date within the last three years, requested ICAP documentation (i.e., the actual assessment reports) for three individuals was not provided (i.e., Individual #233, Individual #179, and Individual #111). Unfortunately, for these three individuals, the completion of the ICAP could not be confirmed. Of the sampled psychological assessments reviewed, 23 (96%) contained results of previously completed standardized tests of intelligence. These tests included, for example, the use of the Wechsler, Slosson, and/or Leiter. Only three (13%) had been completed within the last five years. With regard to the assessment of adaptive behavior, 23 (96%) of the sampled psychological assessments contained results of previously completed standardized tests of adaptive behavior, specifically utilizing either the Vineland Adaptive Behavior Scale or the American Association on Intellectual and Developmental Disabilities (AAMD) Adaptive Behavior Scales. The remaining psychological assessment included the use of the ICAP as the only measure of adaptive behavior. Although all of the psychological assessments included some standardized measure of adaptive behavior, only three(13%) of these assessments were completed within the last five years. All of the psychological assessments appeared to adhere fairly closely to a standardized format. However, the current sample revealed continued variability in the type and format of data displayed within these documents. As indicated in the Monitoring Team's previous reports as well as this report (with regard to Section K.6), standardization of data display within psychological assessments is strongly recommended. As described in the Monitoring Team's previous reports, individuals who received behavioral and/or psychopharmacological interventions are required, in addition to psychological assessments, to have a Structural and Functional Assessment Report (SFAR). To examine the nature of current SFARs, 14 SFARs were sampled from individuals who had SFARs updated since the Monitoring Team's last review. This sample reflected 10% of the total number of individuals (N=144) with PBSPs, and 22% of those individuals with SFARs (N=64) updated since the last Monitoring review. The quality of the SFARs appeared to continue to improve, reflecting a trend of	

#	Provision	Assessment of Status	Compliance
		improvement noted across the Monitoring Team's reviews. In most cases, the link between assessment findings and intervention strategies (on PBSPs) was clearly evident and reflected a significant improvement compared to previous reviews. This is discussed in greater detail with regard to Section K.9. It appeared that the Structural and Functional Assessment Self-Monitoring Checklist (discussed in the Monitoring Team's previous report), utilized by behavioral services staff, continued to ensure adherence to the required format and expected content. In addition, LBSSLC appeared to be very responsive to previous recommendations regarding the elimination of raw assessment data in lieu of more summarization and general description of findings. This change appears likely to lead to effective communication of assessment results and facilitate assessment-linked interventions. 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 scales [e.g., Motivation Assessment Scale (MAS), Functional Analysis Screening Tool (FAST)], event recording and permanent product review, and direct observation. At the time of the most recent review, these methods were still evident and were found in all of the SFARs reviewed. As presented, the assessments adhered to a format reflecting: 1) personal attributes and interests; 2) applicable history and review of status, including the current PBSP, medical and psychiatric; 3) assessment procedures, including interviews, behavior rating scales, and direct observation (including observation notes); 5) preferences and potential reinforcers; 6) potential replacement behaviors; 7) conclusions; 8) recommendations; and 9) references. Since the baseline review, progress had been evident 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. One area of improvement included assessments clearly identifying potential underlying functions of each target behavior. However, some assessments overlooked one or more functions of a target behavior(s) (e.g., Individual #70 and #245) when identifying potential replacement behavior(s). Consequently, authors should attempt to identify replacement behaviors for each function identified (unless the target behaviors serve the same function). In addition, all of the SFARs appeared to be updated in parallel with the current ISP meeting. Consequently, it was not clear or evident if any of the SFARs reviewed were revised or updated because an individual did not meet treatment expectations. Lastly, it was not evident that all sampled SFARs included identification of behavioral indices of psychopathology.	

#	Provision	Assessment of Status	Compliance
		Overall, review of the most recent BSC tracking grid of Individuals with SFARs, dated 10/4/11, revealed that 64 SFARs were completed within the last year. However, based on this documentation, it appeared that 26 (15%) were outdated (i.e., recorded completion date exceeded 12 months of current date). This was not an improvement compared with the previously reported estimate. 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.	Limited progress was made in ensuring that psychological assessments were based on current, accurate, and complete clinical and behavioral data. That is, some initial progress was made in completing standardized tests of intelligence and adaptive behavior when, as reported in one of the Monitoring Team's earlier reports, the caseload was removed from a psychologist to facilitate the primary responsibility of conducting these standardized assessments. Consequently, during the months of March through June 2011, the psychological assessments, including the completion of standardized tests of intelligence and/or adaptive behavior, were completed for 10 individuals. Examples provided (i.e., Individual #79 and Individual #202) demonstrated completion of the Slosson Intelligence Test, the Vineland Adaptive Behavior Scales II-Expanded Interview Edition, and the ICAP. However, this progress was halted when staffing vacancies necessitated that the psychometrician return to carrying a caseload. As described earlier with regard to Section K.5, since the Monitoring Team's previous visit, the current LBSSLC Psychological Evaluations policy, requiring that each individual residing at LBSSLC have a current psychological evaluation (i.e., a current psychological evaluation would be completed, updated, and/or reviewed at least annually), had not changed. To determine whether or not psychological assessments were based on current, accurate and complete clinical and behavioral data, a sample of psychological assessments were reviewed. Of those individuals sampled, 24 (100%) had a psychological assessment that, at the time of the Monitoring Team's onsite visit, was updated within the last 12 months. Sampled documentation also indicated that 21 (88%) of those sampled had an ICAP evaluation completed within the last three years. Of those sampled, 23 (96%) contained results of previously completed standardized tests of intelligence. However, only three (13%) had been completed within the last five years.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition, 23 (96%) of the sampled psychological assessments contained results of previously completed standardized tests of adaptive behavior. However, only two (8%) of these assessments were completed within the last five years. Review of sampled psychological assessments continued to evidence considerable diversity in the type of data collected, as well as the format used to display collected data. This included the use of tables, line and/or bar graphs illustrating target behaviors, replacement behaviors, and/or medications and associated dosages. Indeed, the variability ranged from three different displays of data, including bar graphs, line graphs, and tables (e.g., Individual #146 and Individual #23) to no data at all presented in the psychological assessment (e.g., Individual #250, and Individual #309). Variability within the preferred method of display (line graphs) was also noted with some psychological assessments displaying both target and replacement behaviors (e.g., Individual #70, Individual #232, and Individual #233) while others only presented target behaviors (e.g., Individual #245 and Individual #221). 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, of those individuals sampled, 24 (100%) had a psychological assessment that, at the time of the Monitoring Team's onsite visit, was updated within the last 12 months. Sampled documentation also indicated that 21 (88%) of those sampled had an ICAP evaluation completed within the last three years. Of those sampled, 23 (96%) contained results of previously completed standardized tests of intelligence. However, only three (13%) have been completed within the last five years. In addition, 23 (96%) of the sampled psychological assessments contained results of previously completed standardized tests of adaptive behavior. However, only two (8%) of these assessments were completed within the last five years. Overall, since the last review, according to documentation, 80 psychological assessments had been completed. As previously reported, LBSSLC policy stated that a psychological assessment is required to be completed one month from the date of an individual's admittance. According to documentation provided, since the Monitoring Team's last visit four individuals (i.e., Individual #7, Individual #22, Individual #131, and Individual #325) were admitted (Individual #131 was re-admitted) to the Facility. Of these, three individuals had psychological assessments completed. However, only two (67%) of these were completed within one month of the individual's admittance. More specifically, psychological assessments were completed for two individuals (Individual #131 and	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #22) within one month. Although these assessments included a recently completed ICAP, they did not include updated standardized tests of intelligence. The remaining psychological assessment (for Individual #7) was completed over one month after her admittance, and this assessment, similarly, only included the completion of a recent ICAP. A psychological assessment was not yet completed for the fourth individual (Individual #325). However, the one-month criteria had not yet been exceeded.	
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.	Some limited progress was noted in the provision and monitoring of psychological services other than PBSPs. Previous reviews evidenced concerns with the adequacy of counseling services that community-based agencies provided to individuals residing at LBSSLC. Previous recommendations included an emphasis on: 1) defining objective measurable goals that could be monitored weekly or monthly; 2) identifying a level of performance (e.g., lack of progress, failure to attend appointments, etc.) that would trigger review and revision of interventions; 3) identifying attendance at counseling sessions as a specific goal in the ISP, 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 addition, psychological assessments were expected to identify the psychological supports needed, and such supports should be integrated within the ISP. According to the current Plan of Improvement, psychologists had been re-trained on developing and monitoring recommendations regarding psychological services other than PBSPs. Email documentation and meeting minutes from the BSC indicated that psychologists were encouraged to examine the need, and when appropriate, integrate recommendations for psychological supports (e.g., counseling) within psychological assessments and/or SFARs. Verbal reports and summary documentation provided indicated that the Director of Behavioral Services met with outside counselors to review and establish expectations regarding the development of comprehensive treatment plans, ongoing monitoring of progress, and attendance at and continuation of clinic appointments. In addition, reports indicated that increased integration between the counselor and the individual's ISP team was expected in the future. This included, provision of psychological assessments and SFARs to the counselor, as well as his/her active participation in the ISP meeting, Review of documentation revealed that recommendations for (or related to) counseling services were included in psychological assessments for three of the seven individuals receiving counseling (43%) (i.e., Individual #61, Individual #131, and Individual #197). For two of these individuals, the recommendations appeared to be rather general (i.e.,	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #61 and Individual #131). In addition, documentation also indicated that a recommendation for counseling support was only included in the ISP for one of the individuals sampled (14%) (e.g., Individual #197). Overall, variation in the quality of the counseling treatment plans reviewed was also evident. That is, although some plans appeared more comprehensive than others (e.g., Individual #61, Individual #131, and Individual #124), almost all of the plans did not include measureable goals, sufficient specification to determine if supports were evidenced-based, strategies related to supporting generalization, processes related to documentation, monitoring and review of progress, and/or fail criteria. These findings were consistent with observations noted during previous Monitoring visits. As presented within the Monitoring Team's previous reports, 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. Consequently, behavioral services staff should ensure that all psychological supports and services adhere to rigorous, evidenced-based standards. In addition to the counseling services, several other types of therapeutic services were identified and observed during the Monitoring Team's previous visits. As previously noted, 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. The Monitoring Team previously 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. During the Monitoring Team's last review, the Director of Behavioral Services indicated that an effort to discontinue all non-evidenced based interventions was being pursued. At the time of the most recent review, the Monitoring Team continued to observe examples of these non-evidenced based interventions. For example, the IDT recently agreed (PSP Addendum dated 7/14/11) to a recommendation to implement a sensory diet for Individual #4 to assist with problems calming. It was reported that Individual #4 had benefited from this approach in the past. However, it was not clear if any data had been provided and reviewed when making this determination.	
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	Progress appeared to continue in the completion of PBSPs developed to conform to generally accepted practices in applied behavior analysis. That is, direct observation and document review evidenced improvement in the quality of interventions implemented at LBSSLC. To examine the quality of PBSPs, a sample of 14 (10% of the total number) PBSPs, which	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	had been implemented since the Monitoring Team's last review, were selected to assess compliance with the Settlement Agreement. The individuals included in the sample are listed in the documents reviewed section. Of those selected, the most current PBSP (completed since the Monitoring Team's last review) for one individual (Individual #277) was not provided. However, of the remaining plans reviewed, it appeared that they were comprehensive and adhered to a standard format. That is, in general, the PBSPs continued to address the following content areas: 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 and replacement behaviors; 3) treatment outcomes; 4) descriptions of potential functions of behavior; 5) identification of preferences and potential reinforcers; 6) identification of preventative (antecedent) and reactive (consequence) based strategies; 7) display of data and description of data collection procedures; 8) information on psychiatric diagnosis, medications, and potential side effects; and, 9) brief staff instructions. However, some areas within sampled PBSPs still continued to be somewhat limited, insufficient, and/or inconsistent and, consequently, did not meet the requirements of the Settlement Agreement. These included: 1) specification of previously attempted interventions, including descriptions of changes to behavioral programming and explanations regarding why these changes were made (other than medication changes); 2) operational definition of replacement behaviors, especially within staff instructions; 3) complete behavioral objectives that facilitated efficient and accurate determination of progress, especially for identified replacement behaviors; 4) data display, including baseline date, especially for replacement behavior(s); 5) conspicuous integration of reinforcers identified through the SFAR (beyond verbal praise) within antecedent and consequence-based strategies; and 6) plans or considerations to reduce the intensity of identified interventions (i.e., beyond the planned fading of the use of psychotropic medication). These findings are consistent with those identified and described within the Monitoring Team's previous reports. To determine whether or not necessary approvals and consents were obtained prior to the implementation of the sampled PBSPs, during the onsite visit, a small random sample of plans were selected and related approvals (specifically the BSC approval, Guardian consent, and Director approval) were examined. This sample of consents included seven individuals and represented approximately 50% of those PBSPs (N=14) selected for off-site review, and 5% of the total number of PBSPs currently implemented (N=144). The individuals included in this sample are listed above in the documents reviewed section. Onsite documentation review revealed that six (86%) of the seven individuals sampled had all of the necessary consents. Of these, 100% of the PBSPs were implemented only after all the consents had been obtained.	

#	Provision	Assessment of Status	Compliance
		In an attempt to further estimate adherence to the Settlement Agreement, a closer examination of the most current BSP tracking grid, dated 10/4/11, was completed. It should be noted that this indirect examination was limited by the fact that corresponding permanent products were not requested for offsite review. That is, the review consisted of examination of only the dates indicated on the BSC tracking grid. According to listed BSC and HRC approval expiration dates, as well as Consent expiration and Director approval dates, 12 (8%), 15 (10%), three (2%), and 12 (8%), respectively, were outdated. These estimates are similar to those reported at the Monitoring Team's last review. However, one estimate might be somewhat inaccurate, because two Director consents were listed as "not dated." Documentation revealed that using the BSC tracking grid, behavioral services staff now closely monitor the extent to which PBSPs are implemented within 14 days of approval or consent. Data, as of 9/20/11, indicated that 103 (72%) of all active PBSPs met the 14-day criteria, 38 (26%) did not meet the 14-day criteria, and the remainder (2%) were still within the 14-day window.	
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 was observed in the area of data collection and data review. This included use of new data card system to improve the timeliness of data collection, as well as utilization of a standardized graphic display and monthly progress note to facilitate more frequent and effective monitoring. However, since the Monitoring Team's last review, it appeared that only limited progress was made in the collection of inter-observer agreement data. Efforts to collect IOA data were evident during the Monitoring Team's previous review, and documentation provided at that time showed the utilization of standardized instructions and a structured data sheet when collecting IOA on target and replacement behaviors. This included the initial collection of IOA during 15 observations across three residential programs, including Rose (525), Birch (514), and Fir (516). Previously reported IOA estimates ranged from 66 to 100% across these programs, and only one of the fifteen conducted observations targeted a replacement behavior. Since the Monitoring Team's last review, efforts to implement IOA within the other residential programs had been undertaken. According to meeting minutes from the Behavioral Services Meetings, dated 6/8/11 and 7/8/11, and email documentation, system-wide IOA data collection was initially set for 7/1/11. However, it apparently was delayed until 8/1/11 at some sites to ensure accurate implementation. Reports indicated IOA estimates were expected to be collected ten times, including five completed by the psychologist and five completed by the psychological assistant, per month in each residence. According to documentation provided, since the initiation of the system-wide data collection on 7/1/11, a total of approximately 53 IOA probes were	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed across 11 residential sites. No IOA probes were conducted in three residential programs (i.e., Oak, Tulip, and Violet). Given the expectation of 10 completed probes per residence per month, this reflected the completion of approximately 13% of the expected number of probes during this three-month period. It should be noted that this estimate was somewhat challenging to confirm, because inconsistencies in reported data were found across summary documentation, as well as inconsistencies between sampled raw data sheets. Overall, available data indicated that IOA data was collected at least once in 11 (79%) residences. Of the sites where data was collected, however, a high percentage (82%) completed six or less IOA probes. Consequently, the reported IOA estimates, ranging from 77% to 100%, should be interpreted with caution, because they are based on a very small sample of data. Progress did appear to be made in creating a system to track the collection of this data over time and by residence (and collapsed within unit), rater, and shift. As this system is utilized more in the future, it is likely that the "bugs" (as described above) will be worked out. Progress made in utilizing this new system will be examined during the Monitoring team's future visits. As presented within the Monitoring Team's previous reports, considerable variability had been observed in how data was displayed within assessments and plans (e.g., psychological assessments, SFARs, PBSPs, and SPCIs), as well as how data was displayed and reviewed in Monthly PBSP Progress Notes and Safety Plan Progress Notes. As described with regard to Section K.4, the utilization of the new Monthly PBSP progress note facilitated the generation of more effective graphic displays of data in PBSPs compared to those sampled during previous reviews. This finding was consistent with initial progress noted in the Monitoring Team's previous report. Although improvement was noted in this area, inconsistent progress was noted in some sampled PBSPs (as discussed above with regard to Section K.4 of the Settlement Agreement). Variability in the quality of data display was most apparent in the sampled psychological assessments (as is discussed with regard to Section K.6 of the Settlement Agreement), with many displaying redundant information and displaying data in ways that impaired or limited effective visual analysis (e.g., Individual #146). At this time, sampled SFARs and SPCIs did not include any data displays. With regard to monthly data display and review, the new Monthly PBSP Progress Note appeared to effectively display data and other information (e.g., medication changes, changes in placement or programming, etc.) to facilitate more efficient analysis. In addition, this new format prescribed weekly review of target and replacement behaviors. Sampled Safety Plan Progress Notes, however, only displayed and reviewed restraints on a monthly basis, including data on the frequency of restraints, total and average duration of restraints, and injuries related to restraint. In addition, these notes did not utilize the	

#	Provision	Assessment of Status	Compliance
		new graphic formats, and were often difficult to interpret. This finding was similar to those made in Monitoring Team's previous reports. It also was consistent with verbal reports from the Director of Behavioral Services indicating that an emphasis on managing and displaying data in Safety Plan Progress Notes using the new data management and graphing format was planned for the near future. Increasing the frequency of review of restraint data would appear to benefit the individuals served by LBSSLC by ensuring that the most effective supports are in place and, if not, that timely revisions occur. Consideration should be given to prescribing weekly review of restraint data, similar to that currently being completed with PBSP data. Perhaps the integration of the two data sets would allow more regular, as well as more efficient review of both PBSP and SPCI data. In general, improvement was noted in the quality of the Monthly PBSP Progress note and, subsequently, in many of the sampled PBSPs. These improvements were consistent with recommendations offered in the Monitoring Team's previous reports. At the current time, the Facility is encouraged to continue to strive to improve the quality of data display across all documentation to ensure effective and efficient data-based decision-making. In addition, the Facility should continue to consider previous recommendations (included in the Monitoring Team's previous reports) regarding generally accepted graphing conventions. Adherence to these was apparent when reviewing many of the currently sampled PBSPs and monthly PBSPs progress notes, but not necessarily in the other documents. Most importantly, the Facility should continue to closely examine the type of data collected, how and where data is displayed, and the nature and implications of data review.	
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.	Progress continued to be observed in ensuring that PBSPs were written so that they could be understood and implemented by staff. Since the Monitoring Team's last review, one area of progress related to efforts aimed at enhancing direct support professionals' understanding of PBSPs by ensuring that staff instructions (i.e., the last two to four pages of the PBSPs) were written at or below a 7.0 grade reading level. That is, the readability levels of the staff instructions of all PBSPs had been assessed using Microsoft Word and, when necessary, re-written as they were updated to meet this criterion. To assist with reducing reading levels, psychologists were encouraged to spell check the PBSPs, reduce sentence and plan length, and replace more advanced with simpler words. It appeared that these efforts had been successful, because data collected revealed an overall lower average grade level of 8.7 to 7.7, from 5/4/11 to 8/26/11, respectively. At the time of the most recent review, documentation indicated that approximately 74 (52%) PBSPs currently exceeded the 7.0 grade reading level.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted during the Monitoring Team's previous visits, the completion of assessment-guided and observation-guided staff training rubrics was utilized 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 direct observation of staff implementing PBSPs. The completion of these rubrics allowed estimation and monitoring of treatment integrity. At the time of the previous review, assessment- and observation-guided measures had been initiated in only 12 and seven residential programs, respectively. In addition, collected data reflected estimates of overall percentage correct (per week) that ranged from 60.8% to 100%, and 66.7 to 100% for assessment- and observation-guided assessments, respectively. These results were interpreted with caution as estimates were based on a limited number of conducted assessments. Indeed, at the time, the majority of residential programs had collected probe data across five or less weeks. Since the Monitoring Team's last review, changes had been made in the estimation and monitoring of treatment integrity. More specifically, a new rubric entitled the "PBSP Competency/Integrity Training" was implemented to replace the previous Assessment- and Observation-Guided Staff Training forms. This new form appeared to integrate the most salient items on the two previous forms into a more efficient, single document. The new rubric required raters to complete direct observation, as well as interview staff to fully complete the single, comprehensive assessment. Documentation indicated that each psychologist was expected to complete one PBSP Competency/Integrity Training form during the 6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shifts per week, as well one during the 10 a.m. to 6 a.m. shift per month. As described in the Monitoring Team's previous report, a data collection and monitoring system was in place to track the number of assessments completed in each residence, per week, across each psychologist and shift. This system tracked the number of assessments completed each week and, if more than one probe was completed in a week, the data was collapsed to produce an average score for each item, as well as an overall percent correct for items completed that week. It was unclear, however, how "NA" might be derived for an item when multiple assessments were completed. That is, if in a given week, two probes were completed and one of the two assessments had the first item scored "NA," it was unclear if that item would be scored "NA," or if the score (either correct or incorrect) on the first item from the other assessment would be utilized. Further clarification is needed for the Monitoring team to fully understand how "NA" is scored across multiple administrations within a single week. At the time of the review, according to summary documentation provided (i.e., weekly data between 7/1/11 and 9/29/11), new PBSP Competency/Integrity Training assessments were completed a total of 335 times across all programs. This included a	

#	Provision	Assessment of Status	Compliance
		total of 65 (range of four to 45), 113 (range of 13 to 43), and 150 (range of 13 to 47) completed assessments across the residential programs within Unit 1, Unit 2, and Unit 3, respectively. Closer examination revealed that probes were conducted, on average, during a total of seven weeks (range of two to 13) per residence within this time period. Overall, across all residential programs, results indicated that the average weekly score was 89% (range of 45% to 100%). More specifically, the average weekly score was 95% (range of 82% to 100%), 84% (range of 76% to 97%), and 88% (85% to 96%) for Unit 1, Unit 2, and Unit 3, respectively. However, it should be noted that the majority of reported data from 10 (71%) residential programs was based primarily on staff report and not direct observation. That is, data based primarily on direct observation (i.e., the first three items on the assessment) was scored as "NA" for more than 50% of the weeks reported for a majority (10 out of 14) of residential programs. During the onsite visit, direct observation of the completion of one randomly selected PBSP Competency Integrity Training assessment was conducted. Unfortunately, the individual selected (i.e., Individual #274) was not home at the time of the assessment and, consequently, "NA" was scored for the first four items. Indeed, this was consistent with previous observations that a substantial number of assessments included multiple "NA" scores. This limited the usefulness of the assessment, especially given the importance of the first items as direct measures of treatment integrity. In addition, the items related to data cards (i.e., "data cards are present"), and the purpose of replacement behaviors were not scored, and "NA" was indicated when evaluating correct documentation from earlier in the shift. The member of the Monitoring Team viewed this as a limitation, because consistent, timely data collection continued to be of concern, especially for replacement behaviors. Lastly, it was unclear how "competence was demonstrated" when only 56% of the items were scored correct. The current results from the Facility's assessment of staff knowledge of PBSPs reflected continued considerable variability across staff and residential programs, and a substantial number of assessments appeared to lack sufficient direct measurement of staff's actual competent responding. A more robust estimate of staff's actual behavior in implementing PBSPs continued to be a need.	
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	Since the Monitoring Team's last review, progress in the area of competency-based training appeared to continue. It was noted at the previous Monitoring visit that the behavioral services curriculum for New Employee Orientation (NEO) training had been revised and, at that time, was taught by a BCBA. Due to recent changes in behavioral services personnel, it was unclear if this section of NEO was still taught by a BCBA. Other recent changes included an extension of on-the-job-training (OJT) from three to five days. More specifically, new direct support	Noncompliance

#	Provision	Assessment of Status	Compliance
	the specific PBSPs for which they are responsible and on the implementation of those plans.	professionals were now provided five full days of OJT prior to working independently with any individuals. The Director of Residential Services and the Director of Behavioral Services developed a plan to ensure that all new employees would be provided PBSPS training, according to the current CBT Policy, during this five-day period. This was an effort to avoid training all PBSPs within a residence to a new staff all on the same day. Verbal reports from behavioral services staff indicated that this change was helpful, because they now had more time (i.e., two of the five days) to provide the necessary training to new staff. Since the last visit, in addition to the new training policy (i.e., Competency Based Individual Support Plan Training for Direct Support and Program Staff," dated 3/1/11) that was noted in the Monitoring Team's previous report, new monitoring and procedures for tracking staff attendance at scheduled PBSP and safety plan trainings were implemented. Recent efforts included formally informing direct support professionals that their attendance was mandatory, would be tracked over time, and would involve consequences for non-attendance, including performance counseling and a first level reminder for first and second absences, respectively. It was unclear, however, what specific administrative action would occur following a pattern of subsequent absences. These changes were developed in collaboration between the Director of Behavioral Services and the Director of Residential Services. As noted previously, the trainer as well as the staff receiving the training must sign off on training documentation and certify that they received the training and demonstrated competency in performing necessary skills. The Competency Training and Development Department maintained this documentation. At the time of the review, documentation provided reflected recent efforts to inform current staff of expectations related to required training and administrative action following absences. Since the Monitoring Team's last review, efforts to improve competency-based training that behavioral services staff provided had occurred. More specifically, psychologists had been instructed to videotape each competency-based training session (of PBSPs and/or SPCIs) that they completed, and submit their best example for peer review. Peer review would include both written and verbal feedback. At the time of the most recent onsite visit, according to verbal reports, videotapes had been completed and submitted for review. This process appeared to offer considerable benefit to trainers, as well as ensure consistency across residential programs with regard to the use of effective training methods. Documentation indicated that trainers would be required to continue to submit videos until a mastery level had been reached. However, it was unclear what specific criteria peer reviewers were utilizing to determine mastery. As presented earlier with regard to Section K.11 of the Settlement Agreement, additional monitoring and necessary training occurred during PBSP Competency/Integrity Training	

#	Provision	Assessment of Status	Compliance
		assessments conducted in the residential programs. Documentation revealed that these assessments had been implemented across all residential programming. However, the number of completed assessments varied considerably across residential programs in the last six months. The Facility continued to have considerable turnover in staffing. Multiple observations during the previous as well as the current onsite visit suggested that pulled staff were quickly "trained" just prior to providing individualized support to one or more individuals. According to the current Plan of Improvement, a plan had been implemented to address this issue. This included allowing Residential Coordinators and Home Team Leaders who had demonstrated competency on specific PBSPS to provide competency-based training to substitute staff as part of the pulled staff orientation training sheet. However, it was not evident that these staff members had the same training competencies as, for example, behavioral services staff whose training skills had undergone critical evaluation through peer review. This plan appeared to have potential in providing necessary training at unexpected times. However, the Facility should ensure that, if utilized, trainers such as Residential Coordinators and Home Team Leaders have the necessary training competencies that are currently expected of behavioral services staff. That is, just because these staff members are judged to have the competencies to implement behavioral programming, does not necessarily indicate that they have the skills to teach these competencies to other staff. As recommended in the Monitoring Team's previous report, the Facility should ensure that key professional and support staff (e.g., psychological assistants, home team leaders, assistant home team leaders, residence coordinators, QDDPs), 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 should be adequately trained. That is, if they are expected to provide training to pulled or relief staff, the Facility should have confidence that they have been trained and are competent trainers. Given the current nature of turnover and inconsistency in staffing, the Facility might 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. An alternative option might include training a number of permanent "pulled" or on-call staff across residential programs that could be utilized to fill absences in these programs, as necessary.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain	Due to staffing changes within Behavioral Services (as previously described with regard to Section K.2), overall progress was not made in improving the composition of staff providing psychological services. At the time of the recent onsite visit, in addition to the Director of Behavioral Services, LBSSLC employed nine Associate Psychologists, and five	Noncompliance

#	Provision	Assessment of Status	Compliance
	an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	Psychological Assistants. Of these staff, two were BCBAs. At the previous visit, three were BCBAs. In addition, the staff member in a position that was previously created primarily to complete standardized assessments of intelligence and adaptive behavior was temporarily assigned a caseload. At the time of the review, there were three openings, including two vacant psychologist/behavior analyst positions and one vacant psychological assistant position. As of 10/3/11, LBSSLC served 225 individuals. Based on this census, and the recognition that the Director of Behavioral Services did not carry a caseload, an approximate average ratio of 1:25 psychologist-to-individuals served was determined. With five Psychological Assistants currently employed, the Facility exceeded the ratio of one Psychological Assistant for every two Psychologist/Associate Psychologists. The Facility was rated as being in 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.	

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

1. The Facility should examine obstacles that might inhibit current Psychological Assistants from pursuing the educational competencies and supervisory experiences necessary toward BCBA certification. Consideration should be given to offering similar benefits to Psychological Assistants, which might enhance ongoing recruitment and retention of staff within the Behavioral Services Department. (Section K.1)
2. The Facility should ensure adequate attendance by key members (e.g., Psychologists, etc.), in accordance with established expectations (monthly attendance), at BSC meetings. (Section K.3)
3. As previously recommended, to discriminate between zero levels of responding (i.e., reflecting of the actual absence of behavior) and the lack or unavailability of data, clinicians should clearly state in their weekly progress note if data is missing, and/or not graph any value (including "0"). That is, allow a break in line graphs to show lack of data. (Section K.4)
4. Psychologists should ensure that any collected and displayed data is identified and operationally defined. (Section K.4)
5. The Facility should integrate data collection methodology and display within SPCIs and Monthly Safety Plan progress notes. (Section K.4)
6. 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 (e.g., table, graph, and/or summary). Based on current documentation, it appeared that the new graphic format was successfully integrated within PBSPs and Monthly PBSPs notes. Standardization within other documents (e.g., Psychological Assessments, SFARs, SPCIs, and Safety Plan Monthly notes), continues to be necessary. The Facility should consider integrating the Monthly Safety Plan progress note with the Monthly PBSP progress note. (Sections K.4 and K.6)
7. As previously recommended, data collection systems should continue to be trained, evaluated and improved, when necessary to ensure data collection is timely, reliable and valid. This system should be flexible enough to allow individualization, when necessary, and this individualized system should be noted within corresponding documentation (e.g., PBSP). (Section K.4)
8. The Facility should examine alternative strategies to ensure that progress is being made in updating psychological assessments. This might

include asking Psychologists to prioritize individuals on their caseloads and begin to complete necessary standardized assessments. Of course, only professionals with the requisite training and experience should complete these tests. (Sections K.5 and K.6)

9. The Facility should ensure that assessments that are revised due to continued maladaptive responding are conspicuously identified within ISPs and other documentation. (Section K.5)
10. The Facility should examine the challenge of updating SFARs annually. The Facility should examine the necessity of completing the typical SFAR annually, if the current PBSP, according to the data, appears effective. That is, if progress is occurring or maintaining based on reliable data, a simple review of the SFAR might be all that is necessary. In this case, it might be more important to report on the ongoing reliability of data collection and/or treatment integrity of the PBSP. (Section K.5)
11. With regard to counseling sessions, the previous recommendations still apply, including:
    a. Recommendations and/or support for these services should be described and integrated within the ISP, 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 ISP. Psychologists should continue to work closely with community-based therapists to ensure that goals are written so they are objective and measureable.
    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. If not already developed, a system should be in place to monitor attendance at counseling sessions, as well as evaluate 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 (Section K.8)
12. Consistent with strategies utilized within behavioral programming, data should be collected on the use of any intervention (e.g., Sensory Diet) conceptualized, described or utilized as therapeutic or therapy. This data should include goals with measureable objectives and treatment expectations. This would allow teams to determine if the therapies are effective or not, and ensure the more efficient utilization of limited resources. (Section K.8)
13. Emphasis should remain on identifying appropriate replacement behaviors, adequately defining these responses (in the main body of the PBSP as well as within staff instructions), and including measureable objectives in PBSPs to ensure progress toward learning these adaptive skills. (Section K.9)
14. The Facility should improve PBSPs with an emphasis in the following areas:
    a. Specification of previously attempted interventions;
    b. Operational definition of replacement behaviors, especially within staff instructions;
    c. Complete behavioral objectives that facilitate efficient and accurate determination of progress, especially for identified replacement behaviors;
    d. Data display, including baseline date, especially for replacement behavior(s);
    e. Conspicuous integration of reinforcers identified through the SFAR (beyond verbal praise) within antecedent and consequence-based strategies; and,
    f. Plans or considerations to reduce the intensity of identified interventions. (Section K.9)
15. Psychologists should continue to monitor the behavioral services tracking grid to ensure collection of necessary consents and approvals for behavioral programming prior to their expiration and/or implementation, as well as ensure timely implementation once consent has been obtained. (Section K.9)
16. The collection of inter-observer agreement (IOA) data should be expanded. This should include continued use of the tracking system to ensure adequate collection across residence, rater, and shift. (Section K.10)
17. As previously recommended, the Facility should consider the following as it revises its graphing procedures within Safety Plan progress notes:

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. (Section K.10)

18. The Facility should consider prescribing weekly review of restraint data, similar to that currently being completed with PBSP data. Perhaps the integration of the two data sets would allow more regular, as well as more efficient review of both PBSP and SPCI data. (Section K.10)
19. The Facility should continue to examine the readability level of each PBSP (staff instruction section), and revise, as necessary. (Section K.11)
20. The collection of PBSP competency/integrity training assessments should continue. However, further examination should occur related to how items scored as "NA" will be included within summary data. In addition, the Facility should examine how to conduct these assessments in a way that reduces the likelihood scoring items "NA." (Section K.11)
21. In an attempt to improve consistency across scorers, Behavioral Services staff should consider completing a small number of probes where two scorers complete a PBSP competency/integrity training assessment independently at the same time while targeting the same individual, PBSP and staff. (Section K.11)
22. As recommended in the Monitoring Team's previous report, the Facility should ensure that key professional and support staff (e.g., psychological assistants, home team leaders, assistant home team leaders, residence coordinators, QDDPs), 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 demonstrate competence in implementing behavioral programming, as well as competence as trainers. Given the current nature of turnover and inconsistency in staffing, the Facility might 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. An alternative option might include training a number of permanent "pulled" or on-call staff across residential programs that could be utilized to fill absences in these programs, as necessary. (Section K.12)

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

1. The Facility should continue to track and summarize the nature of external peer review. That is, ongoing summaries should be maintained of the reviewers involved and a brief summary of their involvement, including the individuals targeted, associated dates, and the nature of the consultation/review (e.g., conducting functional analysis, participation in BSC, document review, etc.).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List/organizational chart of all staff who work in the Medical Department including names and titles; o Name and CV of Medical Director; o Name of any new provider since the Monitoring Team's last visit; o Number of individuals on each provider's caseload; o Employees listed under Medical Department completing cardiopulmonary resuscitation (CPR) training with certification dates; o Continuing medical education for primary care providers in last six months with course descriptions/topics; o Clinical guidelines developed or implemented since the Monitoring Team's last visit; o Minutes of the infection control committee meetings, dated 4/7/11, 4/28/11, 5/26/11, 6/30/11, and 7/29/11; o Minutes of the skin integrity committee meetings during the prior six months; o Most recent results of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken, including: Compliance by question category (audits for Round 2); questions with multiple "no" answers (audits for Round 2); in-service on 7/14/11 for providers only – preventive care flow sheets; attendance roster for in-service of preventive care flow sheets; in-service on 7/14/11 for providers only - active problem list; attendance roster for in-service of active problem lists; in-service on 7/14/11 for providers only - consultant recommendations; attendance roster for in-service of consultant recommendations; LBSSLC – Health Services: Medical Review System, dated 4/18/11; attendance roster for 4/19/11: medical review system; LBSSLC – Health Services: Submission of timely annual physical assessments, dated 4/18/11; and attendance roster for 4/19/11 for in-service of submission of timely annual medical assessments; o Medical provider morning meeting minutes for the past 30 days; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last visit, including non-facility quality assessment from August 16 to 18, 2011 with notes by Medical Director; o List of individuals who died since the Monitoring Team's last visit with details; o Corrective actions related to mortality reviews, including status reports on previous recommendations; o Notes and orders for any Do Not Resuscitate Orders (DNRs) and rescinding of DNR orders; o Current DNR list; o List of outstanding death reports; o Twenty-two most recent annual medical assessments and physical examinations, and prior annual assessment and examination for the following individuals: Individual #151,

	dated 7/15/10, and 7/13/11; Individual #15, dated 7/7/10, and 7/8/11; Individual #267, dated 7/22/10, and 7/14/11; Individual #175, dated 7/22/10, and 7/21/11; Individual #210, dated 7/6/10, and 7/12/11; Individual #48, dated 8/31/10, and 8/9/11; Individual #291, dated 9/2/10, and 8/11/11; Individual #277, dated 9/3/10, and 8/29/11; Individual #321, dated 7/12/10, and 7/22/11; Individual #79, dated 6/17/10, and 6/29/11; Individual #290, dated 8/5/10, and 8/3/11; Individual #72, dated 6/24/10, and 6/20/11; Individual #265, dated 7/27/10, and 7/26/11; Individual #232, dated 6/8/10, and 7/5/11; Individual #7, dated 6/24/10, and 6/20/11; Individual #196, dated 6/22/10, and 6/23/11; Individual #298, dated 8/24/10, and 8/3/11; Individual #62, dated 7/22/10, and 7/18/11; Individual #149, dated 8/10/10, and 8/2/11; Individual #302, dated 7/15/10, and 7/19/11; Individual #33, dated 7/15/10, and 7/8/11; and Individual #241, dated 8/25/10, and 8/10/11; o Facility specialty clinic schedule per month for past six months; o List of all outside consultations for medical purposes for the past six months, categorized by specialty; o Off-campus weekly medical appointment schedule, dated 8/16/11; o List of individuals with tracheotomies; o List of individuals with Vagal Nerve Stimulators (VNS); o List of individuals with fractures, type, date, and bone fractured; o Individuals with injuries requiring visit to Emergency Room (ER) or hospitalization since the last onsite review; o Individuals with pica or ingesting inedible objects, and taken to ER or hospitalized; o LBSSLC policies/procedures for medical screening and routine evaluations; o Individuals over age 50 with date of colonoscopy; o Women over age 40 with date of mammogram; o List of those with osteopenia/osteoporosis with medications and dosage per person; o For all individuals over age 50, a list of Dual Energy X-ray Absorptiometry (DEXA) scan dates, as well as copies of the most recent DEXA scan reports for each individual in this category, including a list per person over age 50, and any medications with dosages used for osteoporosis or osteoporosis prevention (including Calcium, Vitamin D, etc.); o All individuals with Down syndrome and date of last thyroid test; o For 10 individuals who most recently went to the ER, progress notes from start of signs/symptoms to transfer to ER, and the ER report for the following individuals: Individual #6 on 8/15/11; Individual #199 on 8/5/11; Individual #82 on 8/5/11; Individual #65 on 8/21/11; Individual #161 on 8/9/11; Individual #73 on 8/19/11; Individual #167 on 8/13/11; Individual #139 on 8/20/11, and 8/21/11; Individual #75 on 8/22/11; and Individual #241 on 8/25/11; o For 10 individuals most recently going to the ER and not hospitalized at least 30 days prior to Monitoring Team visit, discharge orders from ER, Facility orders, Integrated Progress Notes, and documentation of follow-up to any recommendations for following individuals: Individual #136 on 7/29/11; Individual #199 on 7/13/11; Individual #184 on 7/31/11; Individual #284 on 5/17/11; Individual #225 on 7/11/11; Individual #103

	on 6/25/11; Individual #290 on 7/14/11; Individual #232 on 6/11/11; Individual #7 on 6/15/11; and Individual #33 on 7/5/11; o For 11 most recent hospitalizations at least 30 days prior to Monitoring Team visit, copy of admission history and physical, discharge summary, hospital discharge orders/ recommendations, Facility orders, Integrated Progress Notes, follow-up to any hospital discharge orders and recommendations for the following individuals: Individual #63 on 5/14/11; Individual #312 on 7/22/11; Individual #136 on 6/9/11, and 7/13/11; Individual #6 on 7/26/11, and 9/4/11; Individual #210 on 8/7/11; and Individual #72 on 7/7/11 and 8/7/11; Individual #308 on 7/19/11; and Individual #221 on 5/20/11; o For 10 most recent hospitalizations, hospital nurse liaison documentation; o Infectious disease data per quarter by category of infection last two quarters; o Summary report/trend analysis of infectious disease last two quarters; o AVATAR pneumonia tracking from 3/1/11 through 8/31/11; o List of individuals with pneumonia in past six months, including diet texture, liquid consistency, and modified barium swallow study (MBS) date; o Antibiotic use per individual for past six months; o Absolute number of new cases by month for: pneumonia, decubiti, Urinary Tract Infections (UTI), and constipation; o Individuals diagnosed with malignancy in the past year; o Individuals newly diagnosed with cardiovascular disease in the past year; o Individuals newly diagnosed with diabetes in the past year; o Individuals diagnosed with sepsis in the past year; o Individuals in past year with bowel perforation or bowel obstruction; o Individuals diagnosed with pneumonia for the past year; o List of individuals with diagnosis of constipation or receiving medications at least weekly; o All policies and procedures related to seizure management, including LBSSLC - Health Services: Seizure management guidelines: nursing protocol, dated 5/16/11(R); o List of individuals being treated for seizure disorders including residence/home, type of seizure, and medication regimen; o For the past six months, for five individuals, documentation of seizure management, including: Individual #76, Individual #164, Individual #171, Individual #120, and Individual #182; o List of individuals seen by neurologist with date and reason seen; o List of individuals with status epilepticus, since the Monitoring Team's last visit; o List of seizure medications per individual; o List of individuals going to the ER for uncontrolled/prolonged/new onset seizures, since the Monitoring Team's last visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder and VNS; o Percentage of individuals on two, three, four, and five antiepileptic drugs; o Percentage of individuals on older antiepileptic drugs; o Tracking data for individuals who have transitioned into the community in past year,

	including hospitalizations, ER visits, and 911 calls; o Resuscitation status/out-of-hospital DNR status; PCP entries in IPNs in past one year; PCP orders past one year; Care-DG-1 form; most recent annual medical summary and physical examination evaluation; most recent quarterly nursing assessment; last 12 months of consult reports, x-ray reports/ultrasound scans/Magnetic Resonance Imaging (MRI)/ Computed tomography (CT)/DEXA scans; most recent PSP and addendums over past year; hospital admission history and physical; hospital discharge summaries past one year; ER reports past one year; any operative/procedure reports over past year; most recent BSP, if applicable; and preventive care flow sheet for following individuals: Individual #70, Individual #7, Individual #41, Individual #34, Individual #17, Individual #279, Individual #72, Individual #8, Individual #112, Individual #118, Individual #3, and Individual #128; o Bowel movement record, physician orders, and Medication Administration Records (MARs) for past six months for Individual #72; o Follow-up information for recommendations made at Administrative Death Reviews; o Morning provider meeting minutes, dated 10/4/11 to 10/6/11; o Most current PCP caseload; o LBSSLC physicals 2009, 2010, 2011, dated 10/5/11; o LBSSLC policy: IDT process – Program Development: Personal Support Plan – At Risk Individuals Process, dated 8/24/11(R); o Home population report/roster: Sparrow, Quail, dated 10/4/11; o May 2011 external audit results, and action plans/follow-up by QA; o Two most recent dates of medical quarterlies, dated 10/6/11; o Emergency room visits from April through June 2011; o Hospital stays from April through June 2011; o List of admissions, deaths, and transitions; o List of individuals who have been seen in the emergency room; o Unusual Incident Report for Individual #23, dated 9/14/11; o Participant roster nursing record review on 10/4/11; o Post Move Monitoring Checklist for Individual #134, and email concerning transition for Individual #134, dated 10/6/10; o List of individuals diagnosed with pica, or an incident of swallowing an inedible object; o Settlement Agreement Monitoring Tool Section L: Medical Care; o Settlement Agreement Monitoring Tool Health Care Guidelines II. Seizures C. Process Criteria, I. Medical Management; o External Audit – Medical Provider QA Audit – Results and Action Plans for Round 2, dated 6/30/11; o Internal Audit – Medical Provider QA Audit – Results and Action Plans for Round 2; and o Presentation Book L: QA/QI Medical Summary - September 2011 (June to August data); SSLC External Medical Quality Assurance Process, dated 8/16/11; and Medical Provider Quality Assurance Audit Using the Database During the Process, dated 8/19/11. ▪ **Interviews with**: o Glenn Shipley, DO, MPH;

	○ Leah Shults, RN, BSN, MPCN; ○ Dr. R. Barranda, and Dr. R. Rodriguez, PCPs; ○ Annette Webster, Post Move Monitor; ○ Dawn Ripley, Quality Assurance Director; and ○ Robin Seale, Assistant Director of Programs. ▪ **Observations of**: ○ Individuals residing in Quail: Individual #136, Individual #6, Individual #195, Individual #293, Individual #181, Individual #281, Individual #211, Individual #225, Individual #176, Individual #283, Individual #196, Individual #263, Individual #29, Individual #215, Individual #78; ○ Individuals residing in Sparrow: Individual #323, Individual #63, Individual #258, Individual #37, Individual #312, Individual #226, Individual #217, Individual #17, Individual #171, Individual #304, Individual #104, Individual #7, Individual #167, Individual #191, Individual #62, Individual #139, Individual #185, Individual #21, and Individual #89; ○ Morning Medical Provider Meetings on 10/4/11, 10/5/11, and 10/6/11; ○ Nursing record review, on 10/4/11.
	Facility Self-Assessment: The Facility determined it was not in compliance with any of the sub-sections of Section L. This was consistent with the Monitoring Team's findings. The QA Department and the medical program compliance nurse's internal monitoring was being implemented. Some limited information based on these internal reviews was included in the Facility's POI. However, in some cases, it appeared that the Facility had used overall scores, and had not included any analysis of the data to support its findings related to compliance, or to assist the Facility in identifying areas requiring focus. For example, the entry for Section L.3 on 7/1/11 provided the inter-rater reliability rates for the internal monitoring, and gave an overall compliance score of 84.47%. This was not helpful in identifying the areas in which the Facility needed to work to attain compliance. However, some better use of data was described in the POI. For example, in Section L.1, descriptions were provided of analysis of data related to individuals at high risk for osteoporosis/osteopenia. This data was then used to improve the completion rate of DEXA scans. In subsequent months, the POI reported the progress being made in addressing the identified issue, and referenced the specific data showing increased compliance levels. Likewise, it appeared the Medical Director had analyzed data produced through the conduct of non-facility physician reviews. The POI identified areas in which systemic issues had been identified. As the Facility expands its self-assessment activities, more of this type of analysis should be included in the POI, as well as descriptions of follow-up activities that the Facility has taken. With regard to corrective action plans, the Facility included two for Section L. One related to the provision and documentation of routine, preventative, and emergency care. The Facility indicated that all of the related action steps were completed. However, based on the Monitoring Team's findings, issues remained in these areas. The second corrective action plan related to the completion non-facility physician reviews

	and related follow-up activities. This was an action plan that will require ongoing implementation.
	Summary of Monitor's Assessment: The Facility continued to make progress with this section of the Settlement Agreement. Many of the essential components of a successful system were in place, but had not been developed to their full potential. The Medical Department had a complex, but user-friendly medical database system. However, little benefit from this system had been realized to date. No periodic reports had been generated to allow analysis of the data, and development and implementation of recommendations. Some of the databases required review to determine how to make them more practical and helpful to the department. The morning provider medical meeting had great potential as a forum for ensuring excellence in integrated care management. There was an interdepartmental presence, and the meeting was often the conduit for reporting health status changes to the QDDP. In turn, once the IDT met, consideration was given to making changes in risk rating and action plans. The morning medical provider meeting also was the forum for succinct in-services by other departments. A need remained for the group to focus on prevention of the recurrence of hospitalizations and adverse events negatively impacting individuals LBSSLC served. The group needed to ask critical questions, make assignments, and follow them until closure. Closure was difficult to track given the lack of structure in the narrative format of the morning meeting minutes. Death review recommendations were implemented in some areas, and remained theoretical for other areas of concern. DNR status was precarious for some individuals, because routine yearly review signatures were not obtained. The external medical peer review and internal peer review continued to make progress. The non-facility medical peer review was currently in place and provided valuable feedback, but the results should be formalized into a written document through the State Office. As noted above, the QA Department and the medical program compliance nurse's internal monitoring was in place. However, the medical program compliance nurse was just beginning to review data. Progress in all areas of this section will require evidence and interpretation of collected data with development and implementation of corrective action plans, as appropriate. According to the POI, all of the routine, emergency and preventive issues were documented in the IPN section of the active record. Despite being tracked through a medical database, a significant percentage of overdue or outdated annuals remained in the records, and quarterly medical progress notes were not identified in the submitted records. Preventive screening was monitored through a database for mammograms, colonoscopies, and DEXA scans. These were valuable tools, but the analysis of this information and meeting with the medical staff to create action plans for performance improvement had not occurred. The tracking of appropriate treatment for those with osteoporosis appeared to be problematic and incomplete. Preventive care flow sheets were incomplete or not available for some of the active records submitted.

#	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 subsections 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, and Do Not Resuscitate Orders. <u>Staffing and Administration</u> Two medical secretaries assisted the Medical Director. Additionally, based on the departmental organizational chart, a new medical program compliance nurse position was filled. Additionally, a long-term PCP had left, and a new staff physician had been hired, effective 9/1/11. This physician had worked at LBSSLC in the past, approximately three years ago. A Registered Nurse (RN) clinic manager, a Licensed Vocational Nurse (LVN) clinic assistant, and a clerk staffed the clinic. There was one laboratory technician, and one position filled by an x-ray technician, which also included lab technician duties. The PCP caseload temporarily changed until the new PCP could be accommodated into the schedule. From the submitted document of 8/26/11, the Medical Director carried a caseload of 19 individuals. The two long-term PCPs each carried caseloads of 101 to 105 individuals. An updated PCP caseload was submitted at the time of the Monitoring Team's visit. The Medical Director was assigned a caseload of 15. The PCPs had caseloads ranging from 67 to 74 individuals. Each of the PCPs who were at LBSSLC during the Monitoring Team's last visit was currently certified in CPR. There was no information concerning the CPR certification status of the new PCP. Information concerning continuing medical education was submitted. Since 3/1/11, the Physician's Assistant (PA) completed 24 hours of continuing medical education, one staff physician completed 18 hours of continuing medical education, and the Medical Director completed 24 hours of continuing medical education. The topics were varied, but all applied to work duties and clinical care of the individuals residing at LBSSLC. <u>Physician Participation In Team Process</u> The morning provider meetings were held each business morning. The group reviewed the Campus Coordinator Log, the daily clinic report/list, physician follow-up list, off-campus weekly medical appointment schedule, consultation reports received, hospital liaison nurse reports, on-call communications to the PCP, and the ER report. Many clinical departments were represented, including the medical staff, psychiatry, dental	Noncompliance

#	Provision	Assessment of Status	Compliance
		staff, pharmacy staff, and PNMT nurse, QA nurse, hospital liaison nurse, nursing administration, nursing staff responsible for infection control, clinic nurse, and the Unit nurse managers. Once weekly, the lab supervisor attended. An attendance roster confirmed interdisciplinary participation, and was an efficient system through which members were prelisted with a check off box to confirm attendance. The subject matter included an important breadth of information, and provided a forum for discussion and in-service education. During three days of the onsite review, a member of the Monitoring Team observed the business of the meeting. The infection control nurse provided a succinct in-service. The lab supervisor provided information concerning individuals with orders for lab testing that did not occur due to refusal, or staff not ensuring that individuals followed the nothing by mouth (NPO) order. This had had a positive impact on campus, because the Unit RN managers took this information back to the IDTs for review. Since this system started, the number of canceled lab draws due to non-NPO status decreased. Individuals with skin integrity issues were discussed weekly. Additionally, the Facility's policy on Personal Support Plan At Risk Individuals Process, dated 8/24/11, specifically required any change in status noted through a consultation or hospital stay to be discussed at the morning medical provider meetings, following which, the unit RN managers were to notify the QDDP/IDT of the change in status. As the next step in the risk tracking process, the QDDP was to schedule an IDT meeting to discuss the change in status. The PST was to review the categories of risk, the risk levels, and current action plans that might have been impacted by the change in status, and to make changes, as appropriate. From the three days of observation during the Monitoring Team's visit, no example was noted of this potentially dynamic process reflecting the new policy revision. However, a similar approach for missed lab draws was utilized, in which the Unit RN managers reported this information to the QDDP/IDT, so that consideration could be given to the need for a meeting to address this concern. A few observations and recommendations might assist in making the meeting more efficient: ▪ An incident occurred on campus for which the campus emergency number was called. No one at the morning meeting had any information concerning this event, which was discussed 36 hours later. Given that a major reason for the morning meeting is to ensure the Medical Director is aware of all ongoing health concerns, the system should be reviewed to ensure information is provided in a timely manner at the morning meeting. There might be a gap in the evening or night shift information being forwarded in a timely manner to the morning meeting, and the Medical Department should review this system. Sufficient information related to campus emergencies should be available at the next	

#	Provision	Assessment of Status	Compliance
		morning meeting to allow discussion of plans and/or closure. ▪ Additionally, an individual had ingested vinyl gloves and was hospitalized. The morning meeting would have been the forum to discuss and ask critical questions related to pre-hospital events, and to begin the process of implementing preventive steps to ensure the environment was safe for the individual's return, but this did not occur. ▪ For the highly medically complex cases, the Medical Director might need to assist the hospital liaison nurse in creating a brief synopsis of the history for those with prolonged or multiple admissions (such as a list of bullets of important information) that can be used as an handout/addendum for those attending the morning provider meeting infrequently. This would allow for less fact-finding questions or confusion, and allow the time to be spent on preparing for the return of the individual and in preventing a repeat acute illness. The minutes of the 10/4/11 to 10/6/11 meetings were reviewed. The intense detail and length of the minutes might detract from the role of the committee and dilute the information logged into the minutes. Brief entries summarizing the status of individuals discussed might suffice. Currently, the lengthy narrative form, did not clearly document closure on any outstanding follow-up items. The minutes could be maintained in a table form, with the final column of the table used for closure. When follow-up information provides closure, a brief entry including the date and the action step completed would allow an understanding of how the closure occurred. Based on the information presented at the three meetings observed, a one- or two-page chart would suffice in providing the Medical Director the needed information. Recording minutes of the meetings and documentation should also not consume significant time out of any one's schedule. The following more specific recommendations are offered: ▪ Questions that are raised might best be translated into a closure item, rather than attempting to quote every question and response in the document. ▪ Addendums should include handouts, such as any in-service provided, or new policy discussed. ▪ For those with prolonged or frequent hospitalizations, the PCP should provide a summary paragraph as an addendum/handout that would allow important facts to be shared and reduce confusion and unnecessary questions. This would streamline the meeting, and prevent the minutes from having to document this information. ▪ Information from the thorough hospital liaison nurse would not need to be repeated in the minutes, but the hospital liaison nurse reports simply could be added as an addendum. ▪ The Medical Director or PCP should be in periodic communication with the attending physician at the hospital, or consultant, to gather important information about the hospitalization not available from the hospital liaison	

#	Provision	Assessment of Status	Compliance
		nurse report, such as areas of ethical concerns, as well as the rationale for tests ordered or medications prescribed. Between the information from the hospital liaison nurse and the physician-to-physician encounter, no confusion should exist as to the clinical course and status of the individual. This is important in order to begin the post-hospital planning at LBSSLC. Without complete and accurate information, a risk exists for one or more important areas of care being overlooked. ▪ The State Office might need to assist in a morning report format that is easy to create, complete, and review, and standardization across the SSLC system might be valuable. The minutes submitted included so much narrative that it was difficult to determine the clinical areas needing closure. It is important to create a format in which closure items are not overlooked, and can be easily tracked. <u>Routine Care</u> The content of annual medical summaries and physical examinations expanded to include an area focusing on a history of tobacco, alcohol, and illicit drug use. After 9/1/11, these annual assessments also included a section commenting on whether the health care needs and supports/services could be provided in the community/less restrictive setting. Areas of supports and services that remained challenges to transition to the community were to be listed with reasons identified. For 22 individuals listed in the documents reviewed section, a copy of the most recent annual medical summary and physical examination evaluation, as well as the prior annual medical summary and physical examination evaluation were submitted for review. The annual evaluations were considered timely if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. For the 22 individuals reviewed, compliance was 15 out of 22 (68%). Separately, a list of the dates of completion for the last two annual medical assessments and physical exams was submitted. Compliance was determined by reviewing timeliness of completion of the most recent annual medical assessment and physical exam within 365 days of the prior assessment and exam. At the time the submitted list was prepared, 226 individuals were listed as residing at LBSSLC. There were 10 who were identified as new admissions during the past year, and would not have had a prior annual evaluation. There were four entries in which the database entry appeared to be an error. Removing these 14 individual names, the denominator was 212. Of these, 115 (54%) had the annual medical assessment completed within 365 days of the prior assessment. The Monitoring Team was informed that the physicians continued to complete a quarterly MD progress note. This endeavor started 10/1/10. A format had been	

#	Provision	Assessment of Status	Compliance
		developed that was to be followed. This included listing allergies, important chronic conditions, any ER visits or hospitalizations, determination of any weight change since the last quarterly review, listing of any consultations with recommendations and follow-up actions, listing non-attendance at any consultations, noting any procedures in that quarter, and a description of any acute care events or additional notes, such as abnormal labs. A review of systems focused on four areas. One of these was neurology for which the MD was prompted to respond to any history of seizures, number of seizure medications, whether a VNS was present, and the number of seizures during the quarter, as well as whether there was a diagnosis of dementia. The Gastrointestinal section reviewed whether a feeding tube (and type) was present, the date it was last changed, and any interventions for constipation. The respiratory section reviewed whether there had been pneumonia, bronchitis, or an upper respiratory infection (URI)/rhinitis. The genitourinary and gynecological section prompted the MD to document the number of urinary tract infections that occurred in the quarter. These quarterly reviews were required as part of the Health Care Guidelines to ensure the PCP reviewed each individual at periodic intervals. The quarterly assessments were designed to review important aspects of health in this population, including weight change, respiratory infections, constipation, etc. A copy of a blank form and several examples were provided in the Presentation Book for Section L. However, in the submitted records, none of these forms could be found either incomplete or complete, in any of the active records. A list of dates of the two most recent physician quarterlies was submitted to determine compliance with timeliness. According to this list, the completion date was identical for each person in the residence. All individuals had a completed physician quarterly note dated the same date in the same home. According to this information, several residences were overdue, including Iris, Zinnia, Violet, Canna, Willow, and Sparrow. The dates of completion of the quarterly PCP progress note was the same date as the "90 day-medication review," which included important non-medication concerns, such as diet, nursing orders, lab orders, adaptive equipment needs, and direct support professional orders. This latter document was considered an order sheet. Compliance will require that these quarterly PCP progress notes be completed in a timely manner every 90 days, and that they are thorough. For a PCP to complete these quarterly progress notes in an entire residence on the same day was concerning, because clinical review takes considerable time and organization. Integrated progress notes continued to be completed using the Subjective, Objective, Assessment, and Plan (SOAP) format for acute care visits (change in health status for which the physician was contacted), for those transferring to the ER/hospital, and for those returning from the ER/hospital. The PCPs dictated SOAP notes, and they were filed into the IPN section of the active record.	

#	Provision	Assessment of Status	Compliance
		A medical database system had been created to track completion of the annual medical assessments, as well as acute care visits for health status change. This provided information that should have been helpful to the Facility in ensuring that appointments and final evaluations were completed in a timely manner. As part of the monitoring review process, the Monitoring Team selected the records of 12 individuals to determine compliance with several requirements of Section L.1. Every nineteenth name listed on a census list was selected, after the first name was chosen by random selection. Documents reviewed included the preventive care flow sheet, resuscitation status/out–of–hospital DNR, PCP entries in integrated progress notes in the past one year, PCP orders for the past one year, the CARE-DG-1 form, the most recent annual medical summary and physical examination evaluation, the most recent quarterly nursing assessment, the last 12 months of consult reports, x-ray reports/ultrasound scans/ MRI/CT/DEXA reports for the past year, the most recent PSP with addendums over the past one year, any hospital admission history and physical, and hospital discharge summaries over the past year, any ER reports over the past one year, any operative/procedure reports over the past one year, and the most recent BSP if applicable. Based on the 12 records reviewed: ▪ Nine (75%) annual medical assessments had been completed within the prior 365 days. There was one active record in which the PCP had documented completion of the annual medical assessment and physical exam, but it was not submitted. Instead the prior outdated report was submitted. Since the updated evaluation was completed a month prior to the Monitoring Team's visit, this suggested the need for a review to be completed to ensure that documents are submitted for filing, and filed in a timely manner. Although the updated documents might have been completed, no evidence was provided to substantiate this claim. ▪ Active problem lists appeared to be thorough in seven (58%) of the records reviewed. ▪ Smoking history was reviewed as part of the annual medical assessment in six (50%). ▪ None (0%) had information discussing requirements for transition. This was a new addition to the annual medical assessment, which was introduced at the 8/18/11 morning medical provider meeting. Due to the recent addition of this requirement, it should begin to appear on any new annual medical assessments completed. ▪ The DG-1 forms were reviewed. Of the 12 DG-1s reviewed, two (17%) had updated diagnoses. The 12 records also were reviewed to determine whether the PCPs had used the SOAP format in the IPN. In 12 (100%), the SOAP format was used, and included date and time	

#	Provision	Assessment of Status	Compliance
		on the IPN. In the 12 records, none (0%) were submitted that had a PCP quarterly medical progress note during the last calendar quarter of the submitted record. This document would have been expected to be part of the IPN section, and copied and submitted as part of the PCP IPN request. <u>Access to Specialists</u> The Facility provided access to a wide range of specialists. The Facility provided an off-campus weekly medical appointment schedule. This information was not sorted by specialty. However, the number of off campus consultant visits indicated that the PCPs used the specialists to assist in providing guidance and care to those with complex medical concerns. The following numbers of off–site visits for consultation or procedures were documented: April 2011 – 93, May 2011 – 68, June 2011 – 78, July 2011 - 63, and August 2011 – 98. On site, several specialty clinics were held to meet the needs of the individuals. These included neurology (i.e., 2/9/11, 2/18/11, 3/16/11, 3/18/11, 3/30/11, 4/6/11, 4/22/11, 4/27/11, 5/11/11, 5/20/11, 6/17/11, 6/22/11, 6/29/11, 7/15/11, 7/27/11, 8/3/11, and 8/17/11), endocrinology (i.e., 2/23/11, 3/31/11, 4/28/11, 5/25/11, 6/30/11, 7/28/11, and 8/31/11), vision (i.e., 2/4/11, 3/4/11, 4/1/11, 5/6/11, 6/3/11, and 7/1/11), podiatry (i.e., 2/16/11, 3/30/11, 4/20/11, 5/18/11, 6/22/11, and 7/20/11), urology (i.e., 4/18/11), gynecology (i.e., 2/16/11, and 8/10/11) and ENT (i.e., 2/25/11, 3/11/11, 4/8/11, 5/6/11, 6/10/11, 7/8/11, and 8/19/11). Although the information did not always appear to be complete, a number of "no shows" were noted. For instance, out of 236 neurology appointments, 31 (13%) were documented as missed appointments. For endocrinology, out of 125 appointments, 18 (14%) were missed appointments. For vision clinic, out of 225 appointments, 87 (39%) were missed appointments and another 17 (8%) had incomplete information. It is recommended that the Medical Department determine the causes of the missed appointments, and begin to implement a plan to reduce these missed appointments. Additionally, the accuracy and completeness of data concerning missed appointments should be improved. <u>Preventive Care</u> Current vision screening was documented in 11 out of 12 of the records reviewed (92%). Audiological screening was current in 10 out of 12 records reviewed (83%). The influenza vaccination had been given to 11 individuals (100%) in a timely manner during 2010. One of the 12 records reviewed was for an individual who was newly admitted, and would not have been at LBSSLC at the time of the influenza vaccination administration.	

#	Provision	Assessment of Status	Compliance
		Whether the individual needed to receive varicella vaccine (depending on birth date and immunity status) and whether it was given if indicated, was recorded in 11 of the 12 active records reviewed (92%). A list was submitted of women over the age of 40, along with the date of the last mammogram. A total of 50 women were identified, and of these, one had recently attained the age of 40 and for another individual, physiological reasons were identified for not completing a mammogram. Additionally, one woman had a contraindication to the procedure (benefit/risk ratio). This resulted in 47 women who should have had a baseline or serial mammogram schedule (according to a DADS SSLC policy #009.1, dated 2/16/11, the American Cancer Society recommendations were to be followed). At the time the data was submitted, 34 had completed a mammogram or acceptable alternative in the past year. This was a compliance rate of 34 out of 47 (72%). Seven mammograms were pending at the time of the submission. There were five identified for which there was no recent mammogram or any information suggesting one had been scheduled. No information about mammogram status was submitted for one individual. From the sample of 12 records reviewed, three females were over the age of 40. Of these, due to physiological reasons, a mammogram was considered beneficial in two of the three. Of these two, two (100%) were up-to-date on mammogram testing. From the sample of 12 records reviewed, four males were age 50 or greater. Of these four, three (75 %) had a PSA test in a timely manner. A list was submitted for those over the age of 50, and the date of the last colonoscopy. Ninety individuals were identified as being over the age of 50. Of these, for three the guardian refused to provide consent, and for three, there were contraindications for the procedure. This left 84 individuals for which a colonoscopy was recommended. A total of 69 individuals successfully completed a colonoscopy. This was a compliance rate of 82%. Two individuals refused the procedure, which suggested the need for further IDT review and guidance from psychology. Attempts were made with nine other individuals, for whom the procedure was incomplete, or attempts were unsuccessful. Three were recently pending at the time the information was submitted. For one individual, no information was submitted. From the sample of 12 records reviewed, five individuals were age 50 or over. Of these five individuals, the guardian refused to provide consent or there was a contraindication to the procedure for none. Of these five individuals, three (60%) had colonoscopies completed within the past 10 years.	

#	Provision	Assessment of Status	Compliance
		A list was submitted of those with a diagnosis of osteopenia and osteoporosis and whether they were on a bisphosphonate. Separately, a list of those on calcium and those on Vitamin D/ergocalciferol/Vitamin D3 were listed. These lists were assimilated and the following is a summary of the treatment of these individuals with osteopenia and osteoporosis: ▪ There were 12 individuals listed with osteopenia. Of these, 12 were on an oral bisphosphonate, one was on a calcium supplement, and nine were on Vitamin D supplementation. ▪ A total of 57 individuals were listed with a diagnosis of osteoporosis. Of these all were on an oral bisphosphonate, 10 were prescribed calcium supplementation, and 18 were prescribed Vitamin D supplementation. The data appeared to be incomplete. There were other individuals that had been prescribed calcium and Vitamin D, but no diagnosis or indication was listed. However, for those with osteopenia and osteoporosis, in most cases, calcium and Vitamin D is commonly prescribed as part of the regimen. It could not be determined if the medication lists were incomplete, or the majority of those with osteoporosis were not receiving calcium and Vitamin D. Treatment was considered incomplete or submitted documents were incomplete, and no conclusion could be drawn. This indicated the need for a more thorough and complete database for this area of care. Additionally, several other families of medication, such as calcitonin, are used to treat osteoporosis, but no other medications were listed. The Facility just had begun utilizing parenteral administration of bisphosphonates. The potential lack of data continued to make it difficult for both the QA department and the Medical Department to determine compliance, and/or create a corrective action plan, because the baseline remained elusive. From the sample of 12 records reviewed, five had a diagnosis of osteoporosis or osteopenia. Of these, five (100%) were prescribed a bisphosphonate or Miacalcin. Four (80%) were on therapeutic doses on calcium/Vitamin D supplements. For one individual, a DEXA scan had been ordered on 6/7/11, but no evidence was provided to show that it had been completed. The preventive care flow sheet was submitted in seven out of 12 records (58%). The notation submitted for five records was that there were no preventive care flow sheets for these records. One of the submitted seven preventive care flow sheets was incomplete. Those individuals with a diagnosis of Down Syndrome are at risk for development of hypothyroidism. Preventive and routine maintenance testing are indicated periodically. The Facility submitted a list of individuals with Down Syndrome, and when the most	

#	Provision	Assessment of Status	Compliance
		recent thyroid test was completed. There were six individuals identified with Down Syndrome, and all six (100%) had thyroid testing completed within the prior 12 months. <u>Acute and Emergency Care</u> The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room and returned. These individuals are listed in the documents reviewed section. The following summarizes the results of this review: ▪ Information was submitted indicating that the ER was verbally notified of the arrival of the individual with appropriate medical background information provided for one out of 10 (10%). This one record indicated that the nurse contacted the ER. There were no records in which there was documentation the PCP contacted the ER, even when the PCP was on site. ▪ Prior to the transfer to the ER, a PCP was on site for four of the 10 transfers. For five of these events, no PCP was on site, due to it being after hours or weekends. For one individual, there was no PCP note, although the transfer to the ER happened on a weekday during business hours. In four active records when the PCP was on site (100%), the PCP had written an IPN that included the date, time, vital signs, and reason for the transfer. In four of the four (100%), the SOAP format was utilized. ▪ Treatment was considered timely in 9/10 (90%) of the active records. ▪ Reasons for transfer to the ER included the following: in five, the chief complaint was trauma, in three there was a gastrointestinal concern, in one there was a seizure, and in one there was hypotension and difficulty breathing. For two of the gastrointestinal concerns, the feeding tube fell out or was pulled out [one with a gastrostomy tube (G-tube) and one with a jejunostomy tube (J-tube)], suggesting the need for further training and monitoring by direct support professionals, nursing, and the PST. ▪ When the individual returned to the Facility after evaluation at the ER, seven of the 10 active records (70%) had an IPN. ▪ Of these seven, seven (100%) utilized a SOAP format. ▪ These post-ER notes included the date, time, and summary of ER information and findings in seven IPN notes (70%). Of the three without follow-up PCP notes, concern was noted in one active record that the J-tube had been pulled out, and replaced with a G-tube, and no PCP note was found to verify this information or to provide evidence that the PCP was aware the J-tube had been replaced with a G-tube. For one active record, the lack of post-ER PCP notes might have been due to lack of record submission, as the submitted information appeared to have been incomplete. ▪ Seven of the 10 records (70%) had additional PCP or consultant notes as follow up on the original concern [four had PCP notes, three had consultant notes (one had both additional PCP and consultant notes), and one had an annual exam	

#	Provision	Assessment of Status	Compliance
		following the ER visit that referenced the ER visit). To ensure completeness of information entered into the database, five individuals on a document listing those with an ER visit due to trauma were compared with a separate list submitted of individuals with injuries that required an ER visit in the prior six months. These five individuals were listed on this document. Based on a different sample of individuals having ER visits, five individuals were seen for trauma. Of these, three were not documented on the list of individuals with injuries that required an ER visit in the prior six months. These included: Individual #241 on 8/25/11; Individual #65 on 8/21/11, and Individual #82 on 8/5/11. It is recommended the Medical Department review the database entry and management to ensure completeness and accuracy of the information, as well as to ensure that document search requests include the dates of the query. Additionally, eight active records were reviewed for those individuals admitted to the hospital. From these eight active records, 11 hospital admissions were reviewed. These individuals and dates of hospitalization are listed in the documents reviewed section. The following summarizes the results of this review: ▪ A PCP wrote a pre-hospital evaluation/transfer note in six of the 11 hospitalizations. For three of these, the transfer occurred after hours or on weekends. For one hospitalization, the time of transfer/occurrence could not be determined from the information submitted. For one hospitalization, the information was not submitted. ▪ All individuals returned to the Facility. When the individuals returned to the Facility, 11 (100%) had IPNs post hospitalization. ▪ Of the 11 post-hospital IPNs submitted, 10 (91%) included vital signs. ▪ Ten of 11 (91%) post-hospital IPN notes included date, time, and an adequate summary of hospital events and findings. ▪ Eleven active records (100%) used the SOAP format. ▪ Documentation of six of 11 (55%) hospitalizations in the active records included a copy of the hospital admission history and physical. One included a copy of a scheduled surgical operative report. ▪ Documentation of six of 11 hospitalizations (55%) included a copy of the hospital discharge summary. ▪ Nine (82%) included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. ▪ For six of the 11 hospitalizations hospital liaison nurse notes were included in the active records. However, for one individual, the hospitalization was at a state psychiatric facility, and hospital liaison nurse notes would not be expected. In an additional case, the hospitalization was brief and occurred over the weekend. Hospital nurse liaison notes would be expected for nine	

#	Provision	Assessment of Status	Compliance
		hospitalizations. Six of these nine (67%) had hospital liaison notes. However, for two of these admissions on one individual, the submitted information was incomplete. ▪ For 10 of the 11 hospital admissions (91%), additional PCP notes/ follow-up testing and recommendations, and consultant notes were included as part of the follow-up. ▪ Reasons for hospitalization included the following: four hospitalizations were for respiratory causes, three were for gastrointestinal concerns, three were for urinary infections and sepsis, and one was for behavioral concerns. The one individual who was admitted for a fecal impaction suggested the need for vigilance in bowel management. Of the total, there were three pneumonias and three urinary tract infections, suggesting the need for review and focus on preventive measures for infectious disease. Several reports were generated that provided information concerning pneumonia. One list was entitled: "LBSSLC Infection Type by Month Report, report date 1/1/2011-7/31/11." Since March 1, 2011, the list included one case of aspiration pneumonia, 19 cases of pneumonia, one case of viral pneumonia, and one case of pneumonitis. However, other data conflicted with this document. In the pneumonia profile report from August 31, 2010 through August 31, 2011, Individual #138 was listed as having aspiration pneumonia on 4/20/11. The AVATAR pneumonia tracking form listed Individual #223 as having had aspiration pneumonia on 3/30/11. Individual #253 died of aspiration pneumonia on 7/23/11, according to the death certificate. These were three documented cases, but the initial list showed only one entry for aspiration pneumonia. Additionally, according to the AVATAR pneumonia tracking form, a total of 16 pneumonias had been diagnosed, and 11 of these individuals had feeding tubes. Pneumonias in those with feeding tubes, especially if recurrent, suggested the need to rule out GERD, and it would have been clinically appropriate to have a recent work-up for GERD in the active record to confirm this was not a concern before labeling a pneumonia non-aspiration. Those with feeding tubes should have a plan of care, including a plan that addressed all of the physical and nutritional management concerns, such as positioning and suction tooth brushing. A third database was entitled "Pneumonia Profile Report, from August 31, 2010 through August 31, 2011." The data in this list was not consistent with the other two databases. From 3/1/11 onward, it listed four cases of pneumonia not listed in the AVATAR pneumonia-tracking database, and it did not include nine cases of pneumonia that were listed in the AVATAR pneumonia-tracking database. Overall, the different databases were too inconsistent to provide accurate information to the Medical Department and QA Department to allow them to establish a baseline from which to determine trends of	

#	Provision	Assessment of Status	Compliance
		progress or not. Additionally, whether labeled as an aspiration pneumonia or not, the individuals were at risk for repeat pneumonias, and preventive steps for pneumonia would be expected as part of the evaluation, plan of care, and ongoing treatment. Information concerning sepsis was submitted. Sepsis was diagnosed four times in individuals at LBSSLC in the past year. One individual had sepsis twice. The current training on health status change for direct support professionals and other departments is an important first step in addressing this diagnosis. Subtle changes that staff in the home would notice might be the only clues to impending sepsis. This also will require improved documentation from the Nursing Department. A retrospective review of the record for an individual with a diagnosis of sepsis might prove instructive in ways to improve monitoring and documentation with the goal of potentially reducing the incidence of sepsis. When an individual was transferred to the ER, a transfer packet accompanied the individual. The content of the packet appeared to be extensive and included a copy of the following documents: the most recent annual medical assessment and physical examination, insurance information, a current medication list, the current medication administration record, current treatment and order records, allergy list, the most recent PNMP plan, the last 24 hours of PCP orders, an identification profile sheet, recent lab results, and contact information for consent for treatment. A new ER/hospital transfer form that State Office distributed was completed (which outlined the essential information with reference to the listed documents). It included such information as the MD on-call phone number, the PCP phone number, the method of transport, phone number of the nurse case manager, phone number of the hospital liaison nurse, reason for transfer/referral, name and title of hospital personnel receiving the report, and name and title of the person providing information to the hospital. Despite the best efforts of facilities, ERs and hospitals at times document a lack of information concerning individuals that are transferred to the ER. It is recommended that there be a sign-off sheet for the receiving Emergency Medical Staff (EMS) or transport personnel, simply listing name and title, with signature, date, and time of transfer of the packet of information. This would provide timely proof of transfer of information. If information is lost or is not available to the ER, this would be the first step in tracking issues related to the transfer of the packet. Of the 12 records reviewed (i.e., Individual #70, Individual #7, Individual #41, Individual #34, Individual #17, Individual #279, Individual #72, Individual #8, Individual #112, Individual #118, Individual #3, and Individual #128), five had visited the ER or been hospitalized in the prior year. Of the 10 ER visits or hospitalizations, seven documented respiratory problems.	

#	Provision	Assessment of Status	Compliance
		A list was submitted indicating those individuals that had sustained a fracture in the prior six months. Eight individuals had had a fracture, and an additional individual had a dislocation of the shoulder. Fractures were listed as fingers, clavicle, wrist, hand, femur, fibula, and facial bones. It is recommended that the Medical Department track fractures to determine if there are preventable medical issues needing more aggressive treatment (e.g., osteoporosis), whether behavioral concerns need further review, whether seizure management is optimal (a seizure was associated with the clavicle fracture), whether the quality of fall assessments and risk plans is adequate, etc. <u>Chronic Conditions and Specific Diagnostic Categories</u> Chronic constipation had been diagnosed in 141 of the individuals residing at LBSSLC. According to data submitted, no individual required admission to the hospital for treatment of bowel obstruction or bowel perforation. However, the record review of hospitalizations included one admission for fecal impaction/ileus. This did not require surgery. It is recommended that the information management system also be able to track ER visits and hospital admissions in which fecal impaction was the diagnosis. As part of the review of 12 records (i.e., Individual #70, Individual #7, Individual #41, Individual #34, Individual #17, Individual #279, Individual #72, Individual #8, Individual #112, Individual #118, Individual #3, and Individual #128), GERD was reviewed. Of the 12, eight were diagnosed with GERD. Of these eight, all eight had appropriate treatment (100%). Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. One individual was newly diagnosed with diabetes mellitus type II. No individuals were newly diagnosed with cardiovascular disease. No cases of a newly diagnosed cancer were reported in the past year. A Skin Integrity Committee reportedly met quarterly. However, minutes were submitted for only two meetings in the past 12 months, including 5/26/11 and 8/23/11. In both these meeting minutes, no active pressure sores were documented. However, the Facility identified eight individuals from March 1, 2011 through August 31, 2011, who had developed a decubitus ulcer at LBSSLC. There was additionally, one individual that developed a decubitus ulcer off-campus. The number of decubiti suggested the need for the skin integrity committee to take a more active role, as well as the PNMT to increase its involvement, and for more intensive monitoring overall. More recently, the morning provider meeting reviewed an individual with a pressure sore. The treatment plan included referral to a wound care specialist. The PCP was fully knowledgeable of the recent history and current status of the pressure sore discussed at	

#	Provision	Assessment of Status	Compliance
		the morning meeting, and had plans in place for aggressive treatment of the individual. A list was submitted indicating that approximately 95 individuals had a diagnosis of a seizure disorder as of 8/25/11. Individuals also were listed with the comment "no seizure disorder," but were on antiepileptic medications prescribed for other diagnoses. The Facility submitted information concerning antiepileptic medication usage. As of September 2011, 101 individuals were prescribed antiepileptic medication. Of these, 43% were prescribed one antiepileptic medication, 33% were prescribed two antiepileptic medications, 15% were prescribed three antiepileptic medications, 5% were prescribed four antiepileptic medications, and 5% were prescribed five antiepileptic medications. Three individuals were considered to have a refractory seizure disorder. All had a VNS implant. In the prior six months, only one individual was sent to the ER for an uncontrolled/prolonged/new onset seizure. That individual subsequently had a six-day hospitalization. A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 38% of individuals with seizures were prescribed Dilantin, 4% were prescribed Primidone, 12% were prescribed Phenobarbital, and 1% was prescribed Felbamate. Additionally, five individuals had a VNS implant. The Facility submitted neurology consultation notes documenting seizure management for five individuals. These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records: ▪ Five of the five individuals (100%) had been seen twice over the past six months. A total of 16 visit reports were submitted for review. ▪ For 16 neurology clinic visits, all 16 (100%) included notes describing the seizure history/frequency and type of seizure. ▪ Sixteen (100%) included a review of current medications for seizures and dosages. ▪ Fifteen (94%) included recent blood levels of antiepileptic medications. ▪ All 16 (100%) included recommendations. ▪ For eight visits (50%), reference was made to the presence or not of side effects, or potential for side effects with increased dosage or additional new medication. When the individual is free of significant side effects, it would be helpful to document that information as part of a brief entry in the routine narrative provided at each neurology visit, or by the PCP that attended the neurology clinic in a subsequent IPN. A roster of individuals on enteral feeding from 9/1/11 through 9/30/11 was submitted. Four individuals were identified as having J-tubes. Included were the drug regimen	

#	Provision	Assessment of Status	Compliance
		review profiles for these four individuals. Based on these profiles, without the benefit of the medical assessment, a number of concerns were noted: ▪ For two of the four, the diagnosis included gastrostomy status. There was no mention of jejunostomy status in either the notes or diagnosis in three of the four. ▪ One stated medication was to be given by J-tube. Two mentioned administration of medication by G-tube. One was listed as having a J-tube, but all medication was ordered through a G-tube or "per tube." If there were both G- and J-tubes in the same individuals, this should be reflected with greater clarity in the notes section or diagnosis section. If there was no longer a G-tube, then the information needed to be updated to reflect use of the J-tube. ▪ Additionally, it was difficult to determine when the J-tube was placed and utilized for medication administration. Even when attempting to align the dates of the various orders, it appeared that the medication routes included J-tube, G-tube, and at times, oral administration in the same time period. ▪ Two individuals were prescribed Levofloxacin when there was continuous feeding via a J-tube. This could be associated with reduced absorption of this antibiotic, unless the administration of the antibiotic was separated in time from formula feeding administration (this information was not available). It was not clear if either had a G-tube in place separately for medication. ▪ In addition, one individual was noted to have a J-tube, but there were orders for Sucralfate through a G-tube. The submitted information did not indicate if two feeding tube ports were present. It is recommended that the PCPs and pharmacy coordinate the orders, and update information available in the database, as well as listed on the drug regimen review profile to ensure accuracy, completeness, and clarity. <u>Do Not Resuscitate Orders</u> From a list dated 6/16/11, 10 individuals had DNR orders. The reasons included end stage renal disease for two individuals, cancer for three individuals, Alzheimer's dementia for two individuals, and restrictive and other terminal lung disease in three individuals. Two of these individuals had been enrolled in hospice. Since the time the list was compiled, an additional individual was made DNR, bringing the total to eleven. On review of the documents for these DNRs, the range of dates that the out-of-hospital DNRs were first signed was from 2005 to 2011. Nine of these were Resuscitation Status II ("conservative therapeutic and supportive measures will be performed to reduce mortality and morbidity, excluding initiation of endotracheal intubation and external cardiac massage"). Two of the eleven were Resuscitation Status III ("no resuscitative measure will be performed. Palliative measures only, directed toward reducing or eliminating pain, if possible, and enhancing the comfort and dignity of the individual will be maintained"). These two individuals were enrolled in hospice services. According to	

#	Provision	Assessment of Status	Compliance
		State Office requirements, the resuscitation status was to be renewed annually, or the resuscitation defaulted to Resuscitation Status I, including full resuscitation measures. The submitted documents indicated that four of the 11 individuals were out of compliance with this aspect of the DNR order, in that the order was not renewed on an annual basis. Two of these four had not been renewed since 2009. The Medical Department should ensure the DNR documents meet compliance standards with the State Office requirements. <u>Individuals Transitioning to the Community</u> The Facility transitioned two individuals into the community in the prior six months, with four to five transitions pending. Discussions with the Post-Move Monitor indicated none of the individuals had had hospitalizations, ER visits, or 911 calls. Follow-up was completed through a combination of periodic site visits and telephone communications. The following concerns were based on discussion with the Post Move Monitor: ▪ Although as discussed with regard to Section T of the Settlement Agreement, individuals' teams were supposed to be available after the individual's transition to the community, a clear plan was not set forth in the Community Living Discharge Plan (CLDP) for resolving potential concerns should they arise. For example, if the individual and his/her new community team required technical support to address medical or behavioral concerns should they arise, the CLDP did not set forth the issues that the community provider needed to report back to LBSSLC or how such technical assistance would be provided. As timely response to the need for technical assistance is essential, a protocol of how the technical assistance would be conducted and areas identified for which this would apply (telephone contact to provider agency administration, professional peer-to-peer telephone contact, team visit by one or more members to the home, etc.) should be included in the plan. ▪ No process was outlined identifying how information would be rapidly collected in order for a technical team to assist in the process. No one was appointed who was responsible for ensuring consent was obtained for release of information from PCP offices, ER visits, hospitalizations, EMS reports, etc. This could be assigned to the provider agency, or consent signed to release information for 90 days to LBSSLC at the day of transition. Without such information, LBSSLC's ability to provide technical assistance would be hindered. ▪ There was no indication that the individuals' teams or the State had identified warning or "red flag" events that would require the increased surveillance and communication between the provider agency and the SSLC. These red flags should then trigger the provision of technical assistance to ensure the individual's safety and success in the transition process. ▪ The routine follow-up communication between the SSLC and the provider agency should be reviewed. The routine scheduled reviews by telephone or	

#	Provision	Assessment of Status	Compliance
		onsite might need to be augmented depending on the individual's behavioral and/or medical challenges. One monitoring schedule does not meet the needs of all individuals. All such communications should be documented.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	The external non-facility medical peer review findings were not provided in a formal report. It is recommended that this be done, because at the time of the review, the Facility staff recorded the findings. Without an objective list of findings, a risk exists for an error of omission or bias when Facility staff are relying on notes taken at the exit meeting. During the prior six months, in May and August 2011, the Facility completed two non-facility physician case reviews. The Medical Department and QA Department maintain copies of the raw data. The QA Department then tabulates the compliance statistics, and gives them to the Medical Director for review with each PCP. It was difficult to determine the dates of the various data submitted, but the following represents a synopsis of the information for the first of the reviews: ▪ From the audit completed in May 2011, a rigorous follow-up system was implemented to ensure 100% compliance/completion of corrective action plans for each PCP's areas of noncompliance. The QA nurse followed this monthly. ▪ For the May 2011 external peer review, PCP compliance in essential areas ranged from 75% to 90%. For areas considered non-essential, compliance ranged from 78% to 92%. ▪ Areas that appeared to need improvement included continual updating of the active problem list, whether the individual had a nicotine habit, ensuring completion of planning care flow sheets, responding to the quarterly drug regimen review (QDRR) recommendations within 15 business days, and ensuring pertinent current and past medical history was included in communication when making a referral to a consultant. For the second non-facility medical peer review, it appeared the sets of data for the two visits were combined to provide composite scores, because compliance per PCP included both entries from the May and August visit. Providing data for each visit separately might allow tracking of progress and improvement in practice patterns. Separate tabulations might have been distributed to the medical staff, but the Monitoring Team was not provided copies for review. From the August composite data submitted, PCP compliance in essential areas ranged from 69% to 90%. The PCP compliance in non-essential areas ranged from 75% to 88%. In response to areas needing improvement, several in-service sessions were provided to the PCPs, including "Preventive Care Flow Sheets" on 7/15/11, "Active Problem Lists" on 7/15/11, consultant recommendations on 7/15/11, "Medical review system" on 4/19/11, and "Submission of Timely Annual Medical Assessments" on 4/19/11. These should assist in improved compliance in the	Noncompliance

#	Provision	Assessment of Status	Compliance
		non-facility medical peer reviews. A copy of the flow diagram for "SSLC External Medical Quality Assurance Process," dated 8/6/11, was submitted. It documented the steps and flow of information from the external review findings to implementation of corrective action plans. A series of instruction steps for this process was entitled "Medical Provider Quality Assurance Audit Using the Database During the Process," dated 8/19/11, and provided more precise guidance regarding the audit tool and process. At the time of the review, the Facility had no outstanding clinical death reviews. Since the start of the Monitoring Team's last visit, three deaths had occurred: ▪ The average age was 61 (varied from 52 to 70). ▪ The cause of death was respiratory failure in two cases, from presumed aspiration of emesis or feeding tube contents. Sepsis from a urinary tract infection was the cause of death in the third individual. ▪ An autopsy was only performed in one of the three. ▪ DNR status was ordered while residing at LBSSLC for two of the three, and ordered for the third while in the hospital. ▪ All three died in a hospital setting. ▪ All had multiple or prolonged hospitalizations prior to death (from two to four hospitalizations in the months leading up to death). ▪ Two had J-tube placements and one had a G-tube with a tracheal-esophageal separation. ▪ All were aggressively treated. Since the Monitoring Team's last visit, three death review investigations were completed. Of these, each had follow up recommendations. The death reviews included from two to five recommendations, for a total of 11 recommendations for the three death reviews. Of these, each had an initial response to request follow-up on the recommendations. The Facility submitted follow-up documentation for these recommendations. Information was submitted for three of the recommendations providing evidence of follow-through in the form of in-service training rosters for nurses or QDDPs, as appropriate, on topics/concerns included in the recommendations. For a recommendation that the request for information from the hospital specifically include nursing notes, the Facility form "Authorization and Consent for the Disclosure of Clinical Record Information" was expanded to include this information. However, for the other eight recommendations, the Facility did not submit practical follow-up steps, timeline for completion of these steps, and/or documentation until closure, indicating they might not have been addressed. For instance, a recommendation	

#	Provision	Assessment of Status	Compliance
		was included that the Facility ethics committee should assist families in working with the hospital when the family desired the individual's status to be changed to DNR. However, no information was provided to suggest an interdisciplinary committee had discussed the recommendation to determine next steps, such as who would notify the Facility ethics committee, the expected time interval during which the Facility ethics committee should meet or contact the family member, who would discuss this option with the family, the steps to identify the legal representative from the family (appointed guardian, health care representative, etc.), how the process would be initiated, the role of Facility staff in the ethics committee meeting or conversation, etc. There appeared to be no strategy for the implementation of a protocol to ensure the recommendation would be efficiently and effectively carried out the next time an applicable situation arose. Further, no information was provided as to how this recommendation would be communicated with the members of the various PSTs, especially the QDDPs or other team members who would be appointed to initiate the process. Similarly, a recommendation was made that with the assistance of the Medical Director or Facility Director, a communication problem with an outside provider should be resolved. No information was provided to show that the other PCPs or PSTs were aware of this recommendation, and/or that the Medical Director or Facility Director would be expected to be involved. Further, additional guidance was needed regarding whether the Medical Director of the Facility Director would be involved, because both did not need to approach the outside consultant. Development of a protocol regarding where to route such issues would be important. For instance, discussion at the morning medical meeting could result in the decision that the Medical Director proceed in communicating with the consultant. An additional step would be documentation of closure, which could be written into the morning medical meeting minutes.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	<u>Facility's QA Department and Medical Department Review System</u> Starting in June 2011, the Facility monitoring took place monthly. The sample size for the audit was seven individuals per month, which totaled 3% per month or 12% per quarter. The external review audited a 5% sample at each visit. The medical compliance nurse completed the monthly audit, with inter-rater reliability measured by having the Medical Director complete one record audit per month from the same sample. Additionally, the QA nurse monitored two of the audited records per month to determine inter-rater reliability. Common deficits related to medical supports were noted with the internal and external reviews, indicating validity to both reviews. These common findings included incomplete active problem lists, and a lack of information concerning nicotine habit in the annual assessments. However, according to a QA/QI medical summary of September 2011, the internal audit only identified approximately 50% of the findings discovered by the external audit. Twenty problems were identified by the external audit, and 11 problems were identified by the internal audit. Given that the internal audit reviewed 12% in three months versus the external audit of 5%, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		sampling was much greater with the internal audit. From the larger sample size, one would have anticipated finding more rather than less numbers of concerns compared to the external review process. In response to the external medical peer review findings, the QA Department followed up monthly on corrective action plans for each PCP until completion. For the findings of the May 2011 visit, documentation of completion of the corrective action plans was available. The September 2011 QA/QI report also identified other concerns. The corrective action plans following the internal and external audits needed more focused attention by the Medical Department. The need for a timeframe to accomplish corrective action plans would be indicated. Serial meetings then should be held with the PCPs, and intradepartmental monitoring of the corrective action plan should occur independent of the QA department. This would be important to ensure progress has been made when the QA Department completes its monthly reviews. Additionally, it was noted the Medical Department had not begun to gather monthly data for analysis, and no monthly reports were available analyzing current information. There was need for formal intradepartmental monitoring for all of the 20 areas of concern identified by the external peer review process, including, for example, monitoring of active problem lists to ensure ongoing completeness and accuracy, completion of the preventive care flow sheets, improvement in the information provided on the consultant referral forms, etc. <u>Medical Department Initiatives and Improvement Projects</u> The Medical Department was tracking consultation reports. When available, consultations were discussed in the morning medical provider meeting, including recommendations. Pre-treatment sedation information received in the medical office for medical and dental visits was entered into the AVATAR system for trend analysis. Preventive screenings, such as colonoscopies, mammograms and DEXA scans, were tracked through both an Excel spreadsheet process, as well as a separate medical database. The medical database system was able to track many aspects of medical services. Reports could be provided that would provide future guidance to the Medical Department if the entries into database were complete and accurate. Areas for which reports were available included: diagnosis frequency, individual history, visits by type, daily clinic report, progress notes, diagnosis codes, off-campus appointments, risk level report, procedure visits, x-ray log, active problems, and clinics due by date, among others. However, there was little to no analysis of this data, nor were reports summarizing such analysis presented to the morning provider meetings for discussion. Such review and analysis is necessary in order to identify and implement corrective actions or new programs for systems improvement in the department.	

#	Provision	Assessment of Status	Compliance
		Information could be obtained concerning ER visits and hospital admissions (April to June 2011), in part due to the ability of the medical database to provide the needed information. It was noted for emergency room visits that contusions represented the highest rate of ER use (12.3% of visits). However, when combining abdominal diagnoses (e.g., abdominal pain, gastrointestinal bleed, vomiting, and feeding tube complications), GI concerns represented the most common reason for an ER visit at 24.5% of all ER visits. For hospitalizations, 20.8% of the individuals had the cause listed as pneumonia. Seizures were the second most common reason for a hospitalization. This is an important area for analysis and should lead to discussions amongst the medical staff. In order to reduce the ER visit usage and hospitalization rate, the Facility should track the reasons for the transfers. This first step of analysis provides important information that should guide the Medical Department in areas needing focus and review. However, no information was provided to suggest a written plan of action had been developed based on this information. As part of the improvement in data collection in order to create a complete and accurate database, from the Infection Control Committee meeting minutes of 4/7/11, 4/28/11, and 5/26/11, the QA department met with the infection control nurse to improve the database for infection control. The goal was to reduce and remove the category "other" in order to improve the clarity and completeness of the data. However, this was an ongoing challenge. A quality enhancement initiative had been undertaken to improve the legibility of the PCP entries, as well as the turnaround time in which the documents were available for filing in the record. On 9/1/11, the Facility began using a dictation system which allowed online viewing of notes within three to four hours for editing prior to filing in the record. The PCPs also were allowed the option of signing the documents electronically. In addition to the important monitoring/auditing of records, it also will be important for the Facility to develop a set of clinical indicators and outcomes through which to identify areas of strength, as well as areas of concern.	
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	A number of policies/procedures/protocols were developed and implemented. Training also had been provided to the Medical Department staff on a variety of these policies and procedures. An in-service for "Adverse Drug Reaction Reporting – PCPs" was held on 8/26/11. Content included a review of the new Facility policy on adverse drug reaction reporting (LBSSLC - Health Services: Adverse Drug Reaction Reporting, dated 7/22/11),	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	completion of the adverse drug reaction (ADR) reporting form, detection and assessment of potential adverse drug reactions, and a written test at the end of the in-service training. A draft was submitted, entitled Administration Protocol – Reclast that provided the pre-infusion instructions, instructions for use, and monitoring information post-infusion. Importantly, to reduce post infusion symptoms, prescribing of Acetaminophen was included in the post-infusion recommendations/suggestions. Additionally, the Nurse Educator provided direct support professional staff with an in-service entitled "Observing and Reporting Clinical Indicators of Health Status Change." A policy entitled LBSSLC – Health Services: Seizure management guidelines: nursing protocol, dated 5/16/11, was a revision. A policy entitled LBSSLC – Health Services: Vagal Nerve Stimulator: Nursing Protocol, was dated 5/16/11. The Facility submitted a policy: LBSSLC – Health Services: Medical Review System, dated 4/18/11, which outlined the steps in the non-facility medical review process. Additionally, LBSSLC – Health Services: Submission of Timely Annual Physical Assessments was dated 4/18/11. As the State Office develops and issues clinical guidelines, LBSSLC will need to be prepared to implement them, and modify its policies and procedures to be consistent with the guidelines.	

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

1. The Medical Department should ensure all PCPs remain currently certified in CPR, including those newly hired. (Section L.1)
2. The Medical Director should ensure information is provided in a timely manner at the morning meeting, including the shifts up to the time of the meeting. Campus emergencies should be discussed at the next morning medical provider meeting, with sufficient clinical details to provide a thorough discussion. (Section L.1)
3. Critical questions should be asked, especially concerning ways to prevent a reoccurrence of an acute illness or event. (Section L.1)
4. The Medical Director should assist, or designate the attending PCP, to assist in creating a synopsis of events (such as a bullet format), including important clinical facts for those with prolonged hospitalization or frequent hospitalizations, to be added as an addendum to the morning report. (Section L.1)
5. The morning medical provider meeting minutes should be reduced to chart form (rather than narrative). A column should document closure of items that are derived from critical questions and tasks that the Medical Director assigns. The format of the minutes should be conducive to quickly identify outstanding areas needing closure. Minutes should not repeat information in the various reports submitted, which can be appended to the daily report. (Section L.1)

6. The Medical Director or attending PCP should be in periodic communication with their medical counterpart at the hospital to gather important information not available through the hospital liaison nurse reports, especially concerning ethical decisions or rationales for testing or treatment. (Section L.1)
7. The Medical Department should be thoroughly familiar with the clinical course of hospitalized individuals, in order to ensure a smooth transfer back to LBSSLC. (Section L.1)
8. The Medical Department should monitor the timely completion and quality of the quarterly PCP progress notes, and take action as necessary to improve them. (Section L.1)
9. The process for the timely filing of documents, such as the annual medical evaluation, should be improved. (Section L.1)
10. The Medical Department should determine the cause of the missed medical appointments for both off-campus and onsite specialty clinics. (Section L.1)
11. The accuracy and completeness of the data concerning missed medical appointments should be improved. (Section L.1)
12. The Medical Department should ensure that each woman receives a mammogram according to the standards set forth in the HealthCare Guidelines or updated State Office policies. (Section L.1)
13. For individuals that refuse preventive procedures, the IDT should become involved in resolving the concern, including maintaining a documentation trail. (Section L.1)
14. A method for maintaining and analyzing information related to osteopenia/osteoporosis should be developed/improved, including date of last DEXA, T score of most recent DEXA, and current treatment, including dosage and frequency of all classes of medication used in the treatment of the diagnosis (including dosage of calcium and Vitamin D). Dietitian calculations for supplement needs of calcium and Vitamin D should also be included if appropriate. (Section L.1)
15. Given the number of incidences of dislodged feeding tubes, this area should be reviewed and training on preventive steps should be provided to the direct support professionals and the Nursing Department. (Section L.1)
16. The Medical Department should ensure the quality of the data entry for its medical database. (Section L.1)
17. The Medical Department and QA Department should resolve the differing databases and statistics available for determining the incidence of pneumonia. (Section L.1)
18. The medical information management system should include tracking of ER visits due to fecal impaction. (Section L.1)
19. Given the number of decubiti, the skin integrity committee should take a more active role, the PNMT should increase its involvement, and more intensive monitoring should occur overall. (Section L.1)
20. A sign off sheet should be completed with the receiving Emergency Medical Staff or transport personnel, simply listing name and title, with signature, date, and time of transfer of the packet of information. (Section L.1)
21. The Medical Department should track fractures to determine if there are preventable medical issues needing more aggressive treatment (e.g., osteoporosis), whether behavioral concerns need further review, whether seizure management is optimal (a seizure was associated with the clavicle fracture), whether the quality of fall assessments and risk plans is adequate, etc. (Section L.1)
22. The PCPs and pharmacy should ensure that the drug regimen review profiles are current, especially determining route and rate of formula feeding, as well as type of feeding tube. (Section L.1)
23. Neurology consultations and/or related IPNs should document the individual's status regarding medication side effects. Even when an individual is free of significant side effects, it would be helpful to document this information as part of a brief entry in the routine narrative provided at each neurology visit, or by the PCP that attended the neurology clinic in a subsequent IPN. (Section L.1)
24. When individuals have a history of recurrent vomiting, as well as a history of bronchospasm, a current GERD evaluation is recommended, and evaluation included in the record. Additionally, when there is continued aspiration despite placement of a G-tube (or recurrent pneumonia not identified as due to aspiration), a thorough GERD work up is recommended, with results available in the record. (Section L.1)
25. The Medical Director should consider creating a tracking system to ensure "Resuscitative Status" forms are reviewed and updated annually. (Section L.1)

26. The Medical Department should ensure the DNR documents meet the standards that the State Office set forth. (Section L.1)
27. Prior to an individual's transition to the community, a release of information should be obtained for any hospitalization, ER visit, PCP visit, etc. (either through the SSLC or through the provider agency). (Section L.1)
28. Based on the requirement in Section T, periodic communication with and monitoring of the community provider agency concerning an individual should occur within the agreed upon timeframes. However, in the Facility's attempts to correct any deficiencies using "its best efforts," some individuals might require more frequent routine telephone contact or site visitation, and this should be provided as appropriate. (Section L.1)
29. The transition process should identify warning signals within the CLDP that indicate the need for increased intensity of surveillance and/or need for technical support, and community providers should be responsible for reporting these triggers to LBSSLC. For individuals identified as needing technical assistance in the community to achieve success, the team should agree in advance how and when technical assistance will be accessed. If provider agencies do not agree to accept the technical assistance, the SSLC should determine whether the provider agency is assuring health and safety of the individual. (Section L.1)
30. The external non-facility peer review process should be documented in a formal report authored by a member of the team in collaboration with the State Office. (Section L.2)
31. Separate results should be available for each of the external non-facility peer reviews as opposed to being presented as aggregate or cumulative results. This would allow comparisons to be made to determine if progress had been made in the provision of care. (Section L.2)
32. The State Office 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. (Section L.2)
33. For closure of recommendations included in the administrative death reviews, the Facility should detail the practical follow-up steps, and timelines for the completion of those steps. Documentation should be maintained of their completion. Documentation also should be maintained of discussions and strategies developed in implementing the recommendations. (Section L.2)
34. 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 (e.g., 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, hospitalizations, and poor quality of life. (Section L.3)

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's Monitoring Tools for Nursing; o LBSSLC-Health Services Management of Acute Illness and Injury; o Nursing Protocol: Seizure Management Guidelines; o State Office's curriculum addressing Documentation; o Laminated cards for nursing protocols addressing head injuries, antibiotic therapy, diarrhea, temperature elevations, respiratory distress/aspiration, constipation, and vomiting; o LBSSLC's nursing staffing information for turnover and overtime; o Resumes and job descriptions for Quality Assurance Nurse, and Physical Nutritional Management Team Nurse; o LBSSLC Nursing Monitoring tools with instructions; o Nursing QA data, from April through August 2011; o LBSSLC's training rosters; o QA and Nursing summary data for Nursing Department's monitoring data, from April through August 2011; o LBSSLC's lists of individuals who were seen in the emergency room, and hospital; o Monthly Infection Control Reports; o Discrepancy Reports for Infection Control, for June and July 2011; o Curriculum for Infection Control Training; o Infection Control Committee meeting minutes, dated 4/28/11, 5/26/11, 6/30/11, 7/29/11, and 8/30/11; o Infection Control Monitoring data from April through August 2011; o LBSSLC's Medical Emergency Response Drill Quarterly Reports, for May and August 2011; o LBSSLC raw data for Mock Drills; o List of 3733 calls (medical emergencies), since April 2011; o Medical records for the following individuals: Individual #323, Individual #63, Individual #312, Individual #136, Individual #6, Individual #181, Individual #193, Individual #281, Individual #210, Individual #147, Individual #138, Individual #300, Individual #72, Individual #175, Individual #239, Individual #315, Individual #304, Individual #13, Individual #254, Individual #73, Individual #131, Individual #127, Individual #109, Individual #134, Individual #313, Individual #257, Individual #166, Individual #240, Individual #322, Individual #213, Individual #171, Individual #19, Individual #146, Individual #121, Individual #94, Individual #100, Individual #199, Individual #237, Individual #115, Individual #205, Individual #298, Individual #10, Individual #48, Individual #43, Individual #313, Individual #245, and Individual #55;

	○ 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); ○ LBSSLC's Risk lists for health indicators; ○ Lists of Nursing In-Services, from April through August 2011; ○ LBSSLB - Risk Management - Infection Control: Data Collection and Analysis Process for Infection Control; ○ LBSSLC Standard Precautions Monitoring Tool; ○ DADS Weekly Infection Report; ○ Medication Administration Observation tracking data; ○ Minutes of the Medication Error Committee meetings, dated 3/9/11, 4/28/11, and 6/9/11; ○ Medication Safety and Systems Committee meeting minutes, dated 7/10/11, and 8/17/11; ○ Nursing Leadership/Pharmacy meeting minutes, dated 8/3/11; ○ LBSSLC Health Services: Protocol for the disposition of medication errors; ○ LBSSLC Protocol for weekly Medication Administration (MAR) checks; ○ Medication Error Reports (actual) for March, April, June, and July 2011; ○ LBSSLC Medication Error data; ○ LBSSLC - Health Services Medication Administration Guidelines, dated 7/15/11; ○ Quality Assurance/Quality Improvement Council meeting minutes, dated 7/27/11; ○ Quality Assurance/Quality Improvement Quarterly Section Review of Settlement Agreement Process Section M meeting minutes, dated 5/10/11, and 7/27/11; ○ QA Monitoring of Nursing Services Section M summary report, undated; ○ RN IV Meeting minutes, dated 4/20/11; ○ RN Meeting minutes, dated 4/12/11, and 6/22/11; ○ RN Unit Manager Meeting minutes, dated 7/6/11; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 3/29/11, and 6/23/11; ○ Brainstorming Work Session Returned Medications meeting minutes, dated 3/9/11; ○ Medication Administration Observation audit data, from April through August 2011; ○ Emergency Competency Checklists and training roster; and ○ Emergency Medical Equipment Checklists for October 2011. ▪ **Interviews with**: ○ Don Minnis, RN, BSN, Chief Nurse Executive; ○ Jeremy Ellis, RN, QE Nurse; ○ Eddie McFadden, RN, QE Nurse; ○ Michelle McElroy, RN, Infection Control; ○ Connie Horton, FNP, State Consultant; ○ Mary Ortiz, Competency Training Department (CTD); ○ Sally Schultz, Ph.D., State Consultant; ○ John Todd, R.Ph., Clinical Pharmacist; ○ Dawn Ripley, QA Director;

	○ Bob Robbins, QA Program Compliance Monitor; ○ George Schock, State Incident Management Coordinator; ○ Robin Seale, Assistant Director of Programs; ○ Latrell Castanon, RN, Physical Nutritional Management Team; ○ Debbie Ellison-Jones, SLP; ○ Corey Verett, Dietitian; ○ Missy Olive, PTA; ○ Linda Thomas, OTR, Habilitation Therapies Director; ○ Donna Jesse, State Office SSLC Operations Director; and ○ Jim Todd, Attorney, State Attorney General's Office. ▪ **Observations of**: ○ Medication Administration in Residence 504 East; ○ Infection Control Committee meeting, on 10/6/11; and ○ Use of emergency equipment at Birch, Elm, Quail, and Sparrow
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section M of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings. Although the Facility self-assessment of noncompliance was in alignment with the findings of the Monitoring Team, no indication was provided regarding what information, observations, or data the Facility had based its findings. For some areas in Section M, the POI included a single compliance percentage score without explanation of how the score determined or what it actually reflected. Since none of the items included on the Health Monitoring Tools were weighted according to the importance of the item, a single compliance score had virtually no meaning. Consequently, no relevant data was presented to substantiate its findings of noncompliance, or to assist the Facility in identifying areas requiring attention. Although the Facility had developed and implemented Action Steps/Plans addressing Emergency Equipment, alternative scenarios for Mock Code Drills, nursing assessments for changes in status, quarterly and annual nursing assessments, and Case Manager training for the ISP process, few Action Steps were included in the Action Plans to address deficient priority clinical issues found during the past reviews. For example, the Action Steps addressing Nursing Assessments essentially consisted of training that was already provided in July 2011, and had no impact on improving the assessments. In addition, no indication was given regarding what actions and interventions the Facility planned to implement and accomplish by the next review.
	Summary of Monitor's Assessment: Since July 2011**,** LBSSLC had stopped using agency nurses. This was significant, since at the time of the baseline review, they were using the services of seven agencies to cover vacant nursing positions. Since the last review, LBSSLC's allotted positions for Nurses decreased from 100 to 96. This was due to one position being allotted to QA, one position being converted to a program compliance nurse for the Medical Department, one nursing position being moved to the Physical Nutritional Management Team, and one Licensed Vocational Nurse (LVN) III position being closed. Overall,

	the total nursing vacancies included two Registered Nurse positions, and five LVN positions. In addition, the Facility had 92% of the nursing positions filled, which was an increase from the previous review when 89% of nursing positions had been filled. These positive staffing advancements should assist the Facility in achieving positive clinical outcomes for the individuals residing at LBSSLC. Since the last review, LBSSLC's QA Nurses, and the Nursing Department made progress in the following areas: initial instructions were developed for the monitoring tools for nursing; the Facility implemented the use of the Statewide Medication Administration Observation tool; the State Office Nurse Practitioner Consultant provided in-service training on documentation to the Facility RNs and LVNs; Facility training was provided entitled "Observing and Reporting Clinical Indicators for Nursing and Direct Care Professionals;" different emergency scenarios had been developed, approved, and were currently being added to the Mock Code Drills; and Infection Control (IC) had developed a method to ensure data reliability regarding infectious and contagious disease processes data. In the area of Infection Control, the Facility had made progress in building some of the necessary infrastructure. Some of the progress noted specifically included: the IC Nurse outlined a procedure addressing data reliability, and implemented the use of Discrepancy Reports to track data reliability issues; the Facility was currently working on the development of a database for immunizations, which should be completed and implemented by the next review; competency-based training was provided to the Residential Coordinators regarding the Standard Precautions Monitoring Tool; and a structured format was implemented to organize and document actions taken in response to outbreaks that should increase the Facility's ability to analyze the events more clearly. Also, some progress was made regarding the Medical Emergency Response system, such as the recent implementation of different scenarios for the Mock Drills. However, consistent with the findings from the past reviews, no progress was made in the critical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in status, and the quality and timeliness of the quarterly and annual nursing assessments.

#	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	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 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 Settlement Agreement. Information and recommendations addressing nursing documentation regarding restraints is included above with regard to Section C.	Noncompliance

#	Provision	Assessment of Status	Compliance
	changes in status.	In assessing its progress, LBSSLC indicated in the Facility's POI that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ *"04/12/2011: Texas Tech nursing presented Bipolar Disorders in the Developmentally Delayed to all unit managers and case managers.* ▪ *04/15/2011: All nurses retrained on responsibilities for checking emergency equipment (EME) on each shift. Procedure to check compliance of EME checks by the Nurse Educator was implemented.* ▪ *04/21/2011: All nursing staff was in-serviced on the importance of using sunscreen in the population we serve.* ▪ *04/26/2011: During the RN Meeting presented Care Plan Development policy and discussed proper preparation of HMP'S (sic), Acute Care plans and the new statewide Infection Control manual.* ▪ *04/21/2011: The Director of Psychological Services provided training on the nurse's role in Intervention and Restraints for nursing staff.* ▪ *05/01/2011: Implemented weekly tracking by shift of the EME by assigned nurses and Shift Supervisors. Actions for noncompliance will be completed on an individual basis.* ▪ *05/11/2011: Texas Tech nursing presented Dual Diagnosis in People with Intellectual or Developmental Disability for nurses assigned.* ▪ *05/17/2011: New seizure Management Guidelines presented to all nurses.* ▪ *06/21/2011: Texas Tech nursing presented; Exploring Evidence Based Practice for all Unit Managers, Case Managers and interested LVN'S (sic).* ▪ *07/12/2011: Texas Tech nursing presented Problems in Cognition as Related to Developmental Disorders for all Unit Managers, Case Managers and interested LVNs.* ▪ *07/29/2011: Nurse Educators completed new emergency scenarios and presented those to CNE.* ▪ *07/31/2011: During the monthly meeting between QA and nursing we discussed how the area of seizure management has a 40% compliance rate, Acute Illness and Injury shows a 75% compliance rate and Urgent Care/ ER visits and hospitalizations shows 52% compliance. These areas have been designated as priority for improvement. QA and nursing will work together on developing an action plan during future monthly meetings.* ▪ *08/05/2011: New emergency scenarios draft form was completed and presented to facility director for review.* ▪ *08/08/2011: Presented new emergency scenarios to Medical Director for review.* ▪ *08/16/2011: Began training on the new Clinical Indicators class to all non-medical staff. Training includes signs and symptoms of illness and injury, familiarizes staff with frequently used medical terminology and instructs when and how to report problems and changes that might occur with the persons we serve. This has also*	

#	Provision	Assessment of Status	Compliance
		been incorporated into New Employee Orientation with annual refresher training required. ▪ *08/18/2011: Received approval for the emergency scenarios from The Medical Director.* ▪ *08/19/2011: Presented new emergency scenarios to nursing staff.* ▪ *08/22/2011: Met with CTD staff and discussed the scenarios and how they will be accomplished. The scenarios will be implemented in September.* ▪ *08/29/2011: Went to South Plains College Associate degree of Nursing program to meet with students and faculty to raise awareness of positions available in nursing at the LbSSLC. I met with the instructors of the Mental Health section of the program. We agreed to meet and discuss the possibility of RN Nursing Students to do a mental health clinical rotation at the LbSSLC ."* <u>Staffing</u> At the time of the review, LBSSLC had a census of 225 individuals. Since the last review, LBSSLC's allotted positions for Nurses decreased from 100 to 96. This was due to one position being allotted to QA, one position being converted to a program compliance nurse for the Medical Department, one nursing position being moved to the Physical Nutritional Management Team, and one Licensed Vocational Nurse III position being closed. Overall, the total nursing vacancies included two Registered Nurse positions, and five LVN positions. The Chief Nurse Executive reported that since 7/10/11, the Facility had not used the services of any agencies to cover nursing positions, and had used overtime for situations when the Facility needed to augment nursing coverage. This was a very positive step for LBSSLC, since at the time of the baseline review, the Facility used the services of seven agencies to cover vacant nursing positions and shifts. In addition, at the time of the review, the Facility had 92% of the nursing positions filled, which was an increase from the previous review when 89% of nursing positions had been filled. These positive staffing advancements should assist the Facility in achieving positive clinical outcomes for the individuals residing at LBSSLC. As noted above, the Facility had lost one nursing position and reallocated three positions from the Nursing Department, including a Program Compliance Nurse was assigned to the Medical Department, an RN was assigned fulltime to the Physical Nutritional Management Team, and an additional RN was assigned to the QA Department in April 2011. Also, since the last review, all/only RNs were assigned to the Quail building, which supported a population of the individuals with the most medical complexities in the Facility. These positive staffing reallocations should assist the Facility in its efforts at moving toward achieving compliance with the requirements of the Settlement Agreement. Overall, LBSSLC continued to maintain an adequate number of nursing staff. From	

#	Provision	Assessment of Status	Compliance
		discussions with the CNE and from the Facility's POI, the Facility had continued to communicate with some of the Nursing Schools in the area regarding available nursing positions at the Facility, as well as the possibility of having RN Nursing Students complete a mental health clinical rotation at the LBSSLC. As recommended previously, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Also, as LBSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures and/or protocols address the integration of these new positions. <u>Quality Enhancement Efforts</u> With the addition of another QA Nurse in April 2011, the completion of the nursing auditing tools had been divided between the QA Nurses. From discussions with the CNE and the QA Nurses, and review of the raw data generated from the QA and Nursing Departments, there was no question that LBSSLC was committed to moving forward in meeting the requirements of the Settlement Agreement. From these interviews and review of the documentation included in the Presentation Book for Section M, progress made since the last review included the following: ▪ Initial instructions were developed for the monitoring tools for nursing; ▪ The Facility implemented the use of the Statewide Medication Administration Observation tool; ▪ The State Office Nurse Practitioner Consultant provided in-service training sessions on documentation to the Facility RNs and LVNs; ▪ Facility training was provided entitled: "Observing and Reporting Clinical Indicators for Nursing and Direct Care Professionals;" ▪ The auditing of specific areas within nursing was divided among the QA Nurses, Nursing Education, and Case Manager/Campus Nurses with some purposeful overlapping of auditing; ▪ The Facility's QA database for auditing data was operational in September 2011; ▪ The Facility continued to generate monitoring data from the Nursing Monitoring tools. This data was being entered into the Facility's QA database; ▪ The Facility's QA database generated a data summary report of the audit data for each of the Nursing Health Monitoring tools. Specifically, the data was presented by item for the specific monitoring tool. This method of presentation gave the data meaning, in that trends could be identified easily and outcomes of corrective actions could be evaluated easily; ▪ Attempts at establishing inter-rater reliability were being implemented; ▪ Different emergency scenarios had been developed, approved, and were currently being added to the Mock Code Drills; and ▪ Infection Control had developed a method to ensure data reliability regarding infectious and contagious disease processes data.	

#	Provision	Assessment of Status	Compliance
		Building on the commitment and positive steps forward noted above, in order for the Facility to move into a position of sustainable substantial compliance, a number of foundational systems should be constructed first before additional systems are implemented. The integrity of the foundational framework will affect the determination of substantial compliance in most, if not all clinical and nonclinical areas. To adequately and consistently monitor all of the areas of the Settlement Agreement, the Facility should ensure the following systems are adequately implemented: ▪ Although the Facility had developed initial instructions for the Nursing Health Monitoring tools, overall, the instructions were not clear and specific. They did not outline where exactly the required documentation should be found, and what specifically should be included to meet compliance. In addition, items addressing the quality of nursing documentation should be compared to quality standards, such as nursing protocols in determining compliance. Without clear and specific instructions, compliance will be determined according to each auditor's judgment, which should not be the case and produces unreliable data. The Facility and the State should collaborate on developing specific instructions for the Health Monitoring tools. ▪ The auditors scoring the Health Monitoring tools must be clinically competent in the areas they are reviewing in order for the data generated to be an accurate reflection of the current practices. For example, a discussion with the QA Director and QA Auditor for the nursing section regarding restraints found that the QA Auditor, not being a nurse, was not auditing the section in alignment with Nursing Standards of Practice for documentation. Thus, the auditing results only reflected the completion of the section, rather than the quality of the documentation from nursing. As a result, the monitoring yielded inaccurate results. ▪ Inter-rater reliability should be established for each of the Health Monitoring tools to ensure that all auditors are consistently determining compliance using the same process and criteria. The lack of clear and specific instructions for the monitoring tools will negatively affect inter-rater reliability. Based on discussions with the QA Nurses, and the CNE, no consistent and adequate method was used to establish inter-rater reliability. The Facility and the State should collaborate on developing a specific procedure regarding the establishment of inter-rater reliability to ensure consistency of the process throughout the SSLCs. ▪ Regarding the presentation of data, as noted in previous reports, it should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample, indicating the relevance of the compliance scores. A review of the QA Nurses and Nursing Department's audits for the Nursing Health	

#	Provision	Assessment of Status	Compliance
		Monitoring tools showed that they appeared to have generated some relevant data in different areas. However, due to the problematic issues listed above, the data generated were unreliable. Implementing the structures listed above should facilitate the accuracy and reliability of the data, as well as bring the Facility's findings more into alignment with the findings of the Monitoring Team. The Facility should consider decreasing the number of Health Monitoring audits conducted, and implement the remaining essential pieces of the monitoring system listed above to generate credible data going forward. In addition, the Facility should give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring audit tools based on the significant problematic areas that affect the health and safely of the individuals at LBSSLC. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility' POI indicated that training had been provided regarding Documentation and Clinical Indicators, including the signs and symptoms of acute illness or injury. However, from interviews with the CNE, the Facility had not implemented any overall system modifications that would have resulted in any measurable changes regarding the documentation of nursing assessments, identification of health care problems, the timely notification physicians/practitioners of health care problems, and/or the on-going monitoring of individuals with nursing reassessments and interventions addressing changes in health/mental health status. In addition, the Facility's POI indicated that regarding Acute Illness and Injury, their data reflected a 75% compliance rate, and Urgent Care/ER visits and hospitalizations reflected 52% compliance. However, information was not included as to how, and from what these percentages were determined, or exactly what they represented. Also, they did not comport with the findings of the Monitoring Team. Consequently, no progress had been made since the past reviews with regard to this requirement of the Settlement Agreement. A review of 13 individuals' medical records (i.e., Individual #323, Individual #63, Individual #312, Individual #136, Individual #6, Individual #181, Individual #193, Individual #281, Individual #210, Individual #147, Individual #138, Individual #300, and Individual #72) who had been transferred to a community hospital or emergency room found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in none (0%). ▪ Licensed nursing staff timely informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. ▪ Appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse performed appropriate and complete assessments as dictated by the	

#	Provision	Assessment of Status	Compliance
		symptoms in none (0%) of the cases. ▪ The nurse conducted frequent assessments of the individual's clinical condition in none (0%) of the cases. ▪ A plan of care was developed including instructions for implementation and follow-up assessments in none (0%) of the cases. ▪ The documentation indicated that acute illness/injuries were followed through to resolution in none (0%) of the cases. A review of these 13 individuals found the same significant problematic clinical issues regarding nursing assessments and documentation that were identified during the past three reviews. The overall problematic issues that were found in all 13 records included specifically: ▪ The chronic lack of nursing documentation rendered it impossible to accurately determine when changes in status were initially occurring. Gaps in nursing documentation were found for up to 24 hours for individuals with significant health issues; ▪ There was a consistent lack of recognition that the symptoms the individuals experienced were signs of changes in status, and warranted nursing assessments and documentation of the findings from assessments; ▪ A consistent lack of complete and appropriate nursing assessments was noted in response to status changes in vital signs, and oxygen saturations; ▪ There was a chronic lack of follow-up from health issues noted in previous nurses' progress notes; ▪ The nursing notes consistently lacked specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There was consistent inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of PRN medications (as needed medications); ▪ There was consistent inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ There was a chronic lack of documentation of individuals' activities and tolerance for activities during the day, evening, and night to indicate any changes in mental status; ▪ There were essentially no mental status assessments documented during status changes; ▪ Significant gaps in nursing documentation were noted when nurses' notes indicated that they were "closely monitoring" the individual's status; ▪ There was a consistent lack of documentation indicating that lung sounds were regularly assessed and documented for significant respiratory issues; ▪ There was a consistent lack of assessment of bowel sounds, and abdomen exams documented for individuals with constipation or receiving PRN laxatives;	

#	Provision	Assessment of Status	Compliance
		▪ Physicians/Practitioners were consistently not timely notified of changes in status, due to nurses' inadequate follow-up; ▪ The type of temperatures taken were not consistently documented; ▪ There was consistently no documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ A consistent lack of communication was noted between shifts regarding status changes, and the need for regular assessments and follow up; ▪ There was a consistent lack of specific descriptions of the individuals' behaviors, assuming that all staff reading the progress notes were familiar with the individuals; ▪ There was a consistent lack of analysis of contributing problematic issues affecting changes in status documented in the nursing notes; ▪ A number of inappropriate abbreviations were used that could not be interpreted; ▪ A consistent lack of documentation was noted regarding the individual's status and assessment at the time of transfer to the hospital or emergency room; ▪ There was inconsistent documentation indicating that an information packet was sent to the receiving hospital at the time the individual was transferred; ▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ In the progress notes, there was inconsistent documentation of the time, date, and/or method of transfer to the receiving facility; ▪ There was a consistent lack of a complete nursing assessment upon return to the Facility, especially addressing the same symptoms that precipitated the transfer to a community hospital; ▪ There was a consistent lack of regular follow-up days after the transfer occurred for symptoms related to the initial reason for the hospitalization; ▪ Heath Management Plans addressing health issues were consistently inadequate with regard to the goals and nursing interventions, and were not effectively modified after hospitalizations; ▪ Dates and times were not consistently documented for progress notes; ▪ A significant number of nursing progress notes and signatures were illegible; and ▪ There was a consistent lack of systematic documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. The above findings were consistent with the findings from each of the previous reviews at LBSSLC. Although the Facility had received the nursing competency-based training that the State Office Nurse Practitioner group provided, and training regarding documentation, these interventions had not yet resulted in any improvements regarding	

#	Provision	Assessment of Status	Compliance
		nursing assessments and documentation. To facilitate progress in addressing this requirement, the Facility should implement the use of nursing protocols to guide nursing practices in conjunction with the competency-based nursing skills training. The Facility's POI indicated that it was not in compliance with the elements of this requirement, which was consistent with the findings of the Monitoring Team. Based on the number of individuals with medical complexities at LBSSLC, this area should be considered a priority for implementation of plans of actions addressing the significant deficits in nursing care. <u>Availability of Pertinent Medical Records</u> From a limited review of records while on site, it was noted that very few documents were missing from the active records. The Nursing Operations Officer indicated that most of the missing documents, such as a few of the Hospital Liaison Nurse's notes, Health Management Plans, and Nursing Quarterlies, had probably not been printed off the computers rather than not timely filed in the active records. This was a considerable improvement from the last review. The Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Infection Control</u> Since the last review, LBSSLC continued to have one full-time RN as the IC Nurse, who was responsible for the Infection Control duties for the Facility. However, the full-time IC assistant position, which was filled with an LVN in August 2010, was no longer working with the IC nurse. From discussions with the IC Nurse, and the CNE, the assistant IC position would not continue to exist. Interviews with the IC Nurse, review of the documentation, and information gathered during the review, indicated that the area of Infection Control had made significant movement forward in the process of building an infrastructure to meet the requirements of the Settlement Agreement. Some of the progress noted specifically included; ▪ The IC Nurse outlined a procedure addressing data reliability, and implemented the use of Discrepancy Reports to track data reliability issues; ▪ Training was completed for RNs regarding administering and reading PPDs; ▪ The Facility was currently working on the development of a database for immunizations, which should be completed and implemented by the next review; ▪ Competency-based training was provided to the Residential Coordinators regarding the Standard Precautions Monitoring Tool; ▪ A structured format was implemented to organize and document actions taken in response to outbreaks that should improve the Facility's ability to analyze the	

#	Provision	Assessment of Status	Compliance
		events more clearly; and ▪ The minutes of the Infection Control Committee contained significantly more information and analyses of the Facility's infection control data, and actions initiated to address problematic issues. Since the last review, the Facility and IC Nurse had reviewed many of its systems regarding infection control, and began developing and implementing formal systems to build the infrastructure for the Facility's IC program. The positive steps outlined above demonstrated a significant increase in the understanding of the structure needed in order to attain and maintain compliance with the requirements of the Settlement Agreement. However, systems that address clinical issues and outcomes were in need of further attention, including; ▪ A formalized immunization schedule and system to track immunization information should be developed, and implemented to ensure all individuals have received all the required current immunizations as outlined in the Health Care Guidelines; ▪ The Facility should develop and implement a system to ensure the adequacy and implementation of Health Management Plans addressing infectious and communicable diseases. The same problematic issues were found during this review as were found during the previous three reviews. Specifically, of 18 individuals reviewed that were identified as having an infectious communicable disease, all (100%) had HMPs addressing the infectious issue. However, of the 18 Health Management Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. This is discussed in more detail with regard to Section M.3. The Facility should develop and implement a system to ensure the HMPs for individuals with infectious/communicable disease are clinically appropriate. ▪ The Facility should continue to focus its efforts on the implementation of the clinical auditing tools assessing the clinical practices and treatments of infectious and communicable diseases. ▪ IC should initiate the auditing of all individuals who are suspected and/or diagnosed with an acute infectious/communicable disease. These should be real-time audits that do not fall under the randomized sampling procedures of the Facility. Due to the acute nature of infectious diseases and the potential for spread, auditing for this area needs to be conducted while the acute infection is active. Conducting retroactive auditing (conducting an audit after the event) would not be clinically appropriate, nor would choosing only a percentage of these cases to audit. ▪ The Facility should develop a list of individuals who have had and those who still	

#	Provision	Assessment of Status	Compliance
		need immunizations to render them current, which the Facility had not yet developed at the time of the review. ▪ The Facility should expand its pool of staff that conducts environmental monitoring auditing. Including different staff members would prevent auditors from becoming desensitized, and not accurately and adequately assessing the environment. ▪ The Facility should continue to conduct analyses of the IC data, implement plans of action addressing problematic issues, and document the interventions implemented, and the resulting outcomes. Since the last review, the Facility and the IC Nurse had implemented a number of positive steps to move forward in meeting the requirements of the Settlement Agreement. In addition, since the last review, the Statewide Infection Control Manual was approved, and in September 2011, the Facility implemented it. Although some progress had been made regarding LBSSLC's infection control issues, consideration should be given to having additional expertise in Infection Control provided to the Facility to assist in effectively operationalizing the Infection Control Systems in alignment with IC standards of practice, as well as providing professional feedback regarding the quality and completeness of the finalized Infection Control Manual. <u>Mock Code Drills and Emergency Response Systems</u> Since the last review, the Facility had made some progress in its efforts toward addressing issues regarding emergency response, including the following: ▪ The Facility had continued to conduct Mock Drills in alignment with the Facility policy. ▪ CDT recently implemented a Medical Mock Emergency Drill Summary spreadsheet to track Mock Drills. ▪ Since the last review, Emergency Equipment training was provided to all LBSSLC staff. ▪ Risk Management recently had initiated doing monthly checks to ensure that the emergency equipment was available in each residence. ▪ By the next review, the Facility planed to replace all the current Automated External Defibrillators (AEDs) with newer models. ▪ The Facility had just begun to implement additional emergency scenarios, other than those requiring CPR. The data from the drills conducted since the last review were as follows: ▪ 19 drills conducted in March 2011 – 19 passed (100%); ▪ 18 drills conducted in April 2011 – 18 passed (100%); ▪ 20 drills conducted in May 2011 – 19 passed (95%); ▪ 18 drills conducted in June 2011 – 17 passed (94%);	

#	Provision	Assessment of Status	Compliance
		▪ 19 drills conducted in July 2011 – 18 passed (95%); and ▪ 24 drills conducted in August 2011 – 23 passed (95%). Although the pass rate of the Mock Code Drills was consistently high, and the CNE reported that training regarding emergency equipment was conducted for the staff, the few issues found on the Mock Code Drills indicated that nurses were still not consistently responding to the Mock Drills. In addition, the observations of the Monitoring Team of nurses demonstrating the emergency equipment at Birch, Elm, Quail, and Sparrow indicated that the nurses were unfamiliar with using the emergency equipment at the residences due to: ▪ Being unfamiliar with where to plug in the suction machines; ▪ The suction machines were tightly wrapped in plastic indicating that they were not being checked at each shift; ▪ Staff needing a number of prompts regarding how to use the emergency equipment; ▪ One nurse did not know which key was for the AED; and ▪ The alarms on the AEDs for Quail and Sparrow were barely audible when the AED was removed. From discussions with the Nurse Educator, the training regarding emergency equipment was conducted off the units, and no training was conducted at each residence where the actual equipment would be used in the event of an emergency. These findings were troubling in light of the fact that the Facility had a number of individuals who had medical complexities, and that the training provided and the high compliance rates for Mock Code Drills was not reflected in the Monitoring Team's observations of emergency equipment usage. The Facility should review all data related to its emergency systems to ensure that Mock Drills include the actual use of the emergency of equipment, and ensure that any training provided translates into improved practices in the residences. In addition, trends from the actual codes (3733 calls) should be identified and analyzed, so that appropriate corrective actions can be timely implemented. Since the last review, the Facility had implemented some positive steps addressing the emergency response systems. However, the Facility continued to have much work to do in adequately developing and implementing systems addressing it emergency response systems.	
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	In assessing its progress, LBSSLC indicated in the Facility's POI that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ *"04/12/2011: Texas Tech Nursing staff provide training on Bipolar Disorders in people with Intellectual and developmental disorders for all Unit Managers, Case*	Noncompliance

#	Provision	Assessment of Status	Compliance
	care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	*Managers and other interested staff.* ▪ *05/25/2011: The Nurse Educators attended a three day training session at Denton SSLC covering Dysphagia, and physical assessment. In addition received and discussed the new nurse orientation books. These books will assist in standardization of orientation for new nurses throughout the state. The new program is scheduled for a September roll-out. As of 06/15/2011: The State Office nursing coordinator announced implementation of identified portions of this manual.* ▪ *06/01/2011: As of this date all assigned RN'S have attended the Physical Assessment refresher training.* ▪ *08/17/2011: Conducted refresher training on the quarterly/Annual Assessment form. Discussed individual sections and need for summaries of significant items in each section. A template was provided to use when completing the summary section. The nurses were given the charge to include professional opinion statements in the annual assessment.* ▪ *08/26/2011: Received a directive from state office nursing coordinator to incorporate and begin use of the provided template for quarterly and annual nursing assessments beginning September 1, 2011."* From review of the information contained in the Section M Presentation Book addressing this requirement, training rosters were included that indicated nurses had been trained on the Comprehensive Nursing Assessments, the Quarterly/Annual Assessments Template, and Community Integration. However, no structured curriculum was found indicating exactly what was included in the training. Including the curricula for these trainings would have been important, since based on the following findings of the Monitoring Team, no progress had been made in this area. The Quarterly/Annual Nursing Assessments for 23 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #193, Individual #175, Individual #239, and Individual #315 for aspiration; Individual #304, Individual #13, and Individual #147 for cardiac; Individual #254, Individual #73, and Individual #131 for behavior; Individual #127, Individual #109, Individual #134, and Individual #313 for constipation; Individual #257, Individual #166, and Individual #240 for dental issues; Individual #322, Individual #213, and Individual #171 for fractures; and Individual #19, Individual #146, and Individual #63 for weight issues. ▪ Of the 23 individuals' nursing quarterly assessments reviewed, 12 (52%) were timely completed. Assessments that were not timely completed, or were not included in the documentation provided were for Individual #175, Individual #147, Individual #254, Individual #73, Individual #134, Individual #313, Individual #166, Individual #322, Individual #171, Individual #146, and	

#	Provision	Assessment of Status	Compliance
		Individual #63. ▪ There was an adequate analysis of the health/mental health data between the previous and current quarters in none (0%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues. ▪ There was an adequate assessment of the high-risk health indicators included in none (0%) of the Comprehensive Nursing Assessments. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. Despite the interventions provided by the Facility since the last review, no observable difference was noted in the quality of the documentation in the Comprehensive Nursing Assessment summaries since the last review. Although several different formats were found among the nursing summaries, such as including the Health Management Plan objectives in the Summary Section, no associated analysis of the health issues was included in the summaries. Similar to the last review, the summaries contained in the assessments were essentially a listing of sequential dates of events, such as hospital admissions, or the dates an individual received a PRN ("as needed") medication for constipation, with no associated analysis of the data indicating if the health issue was improving or getting worse. Based on the consistent and ongoing problematic findings regarding Comprehensive Nursing Assessments, it was evident that nursing at all levels lacked the understanding of how to analyze, summarize, and document health/mental health issues of the individuals to determine whether or not there was progress with their health and behavioral status. The Facility should provide competency-based training to ensure nursing assessments include adequate clinical analysis, resulting in an appropriate summary of the individuals' progress. Without adequate and appropriate competency-based training regarding the documentation of a clinical analysis that should be included in the Summary Section of the Comprehensive Nursing Assessments, the quality of the Comprehensive Nursing Assessments will not improve. Regarding Nursing discharge documentation, from discussions with the CNE, no changes had been made regarding the process and content of Nursing Discharge Summaries. However, the State Nurse Practitioner Consultant reported that the State was working on a form addressing the nursing documentation regarding discharges that should be completed and implemented by the next review. Since the last review, the Facility continued to use the Comprehensive Nursing Assessment form for discharges. As was noted in the last report, this was inadequate. These assessments were actually the most recent quarterly Comprehensive Nursing Assessment, and not an updated and comprehensive assessment for someone who was being discharged from the Facility	

#	Provision	Assessment of Status	Compliance
		where they had possibly resided for a number of years. It is essential that LBSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that documentation addressing transition planning and implementation is specific enough to maintain continuity of care in the community. Overall, similar problematic issues were found in all the Comprehensive Nursing Assessments reviewed as noted from all previous reviews. These issues included: ▪ 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 health issues; and ▪ A lack of critical thinking. The Facility's POI indicated that it was not in compliance with the elements of this requirement, which was consistent with the findings of the Monitoring Team.	
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.	In assessing its progress, LBSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ *"04/14/2011: Personal Support Plan Process: Supporting Visions training was provided to all Unit Managers, Case Managers, the NOO and CNE.* ▪ *05/09/2011: Case Managers received training on meal time monitoring.* ▪ *05/20/2011: Implemented Clearing Clogged Enteral Feeding tubes protocol.* ▪ *05/20/2011: Tracheotomy tube insertion training was completed for all assigned nurses.* ▪ *05/25/2011: Reviewed protocol on proper sanitation of medication spoons with all nurses assigned.* ▪ *05/10/2011: New Seizure management guidelines were reviewed and approved by OPM.* ▪ *05/17/2011: All assigned nurses received in-servicing on the Seizure Management Guidelines.* ▪ *06/23/2011: Implemented Administration of IV fluids and antibiotics protocol with training provided to all nurses who work at 504 E. Mesquite and Case Managers for 504 East and West Mesquite.* ▪ *06/30/2011: First Infection control Discrepancy report completed. The report compares data from the weekly infection control report and the Medical data base to ensure all reported infections have been addressed and ensures the credibility of data in the monthly infection control report.* ▪ *06/30/2011: Performed competency training for all RN's who will be starting peripheral IV cannulation.* ▪ *07/08/2011: A dedicated nursing classroom was established to conduct new nurse orientation and to provide an area to conduct competency training.* ▪ *07/26/2011: In-service on cleaning and disinfecting glucometers was provided for*	Noncompliance

#	Provision	Assessment of Status	Compliance
		all assigned nurses. ▪ *07/31/2011: Current monitoring using the prevention tool shows an 85% compliance rate. This dovetails into the fact that the overall general health of the individuals we serve is improving. Nursing QA and nursing has decided to make this a priority area and will work together to develop an action plan.* ▪ *07/31/2011: Monthly monitoring shows a 65% compliance rate. During the monthly meeting with nursing QA, this area has been selected as a high priority and QA and Nursing will collaborate to develop and action plan during future monthly meetings.* ▪ *08/23/2011- 08/24/2011: All Nurse Managers, Case Managers, NOO, and CNE attended State office training on new PSP process."* From discussions with the CNE, since the last review, the Facility had not implemented any interventions directly addressing Health Management Plans (HMPs). Consequently, no progress had been made in this area as illustrated by the following findings of the Monitoring Team. In addition, the Facility's POI indicated an overall compliance score of 85% for the preventative tool and 65% for monthly monitoring, but did not include how, and from what this percentage was determined or exactly what it represented. Thus, the percentages provided by the Facility were meaningless. The records of 23 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #193, Individual #175, Individual #239, and Individual #315 for aspiration; Individual #304, Individual #13, and Individual #147 for cardiac; Individual #254, Individual #73, and Individual #131 for behavior; Individual #127, Individual #109, Individual #134, and Individual #313 for constipation; Individual #257, Individual #166, and Individual #240 for dental issues; Individual #322, Individual #213, and Individual #171 for fractures; and Individual #19, Individual #146, and Individual #63 for weight issues. Of the 23 individuals' Health Management Plans reviewed: ▪ Three (13%) were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have a related HMP included: Individual #193, Individual #175, Individual #239, Individual #304, Individual #13, Individual #147, Individual #254, Individual #73, Individual #131, Individual #127, Individual #109, Individual #134, Individual #313, Individual #257, Individual #166, Individual #240, Individual #322, Individual #213, Individual #19, and Individual #63. ▪ None (0%) of the goals listed in the three HMPs were clinically appropriate. ▪ None (0%) of the nursing interventions contained in the three 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	

#	Provision	Assessment of Status	Compliance
		when they should be considered for modification. ▪ None (0%) of the three HMPs were found to be clinically adequate. ▪ None (0%) of the three HMPs included proactive interventions addressing the health indicator. ▪ None (0%) of the three HMPs were adequately individualized. As noted during the three previous reviews, LBSSLC's Nursing HMPs continued to lack: ▪ The interventions addressing risk indicators; ▪ Clinically appropriate goals/objectives related to the etiology of the identified health/mental health problems; ▪ Individual-specific interventions based on the individuals' needs; ▪ Adequate specific directions for caring for individuals who were identified as being at high risk related to their health/mental health issues; and ▪ Proactive interventions directed at preventing or minimizing the specific health risks. Overall, the Health Management Plans reviewed were essentially the same basic protocol templates for individuals who had specific health issues, such as constipation, seizures, falls, and pneumonia, with only minimal modifications made to the template. While on site, a review of Individual #136's medical record was conducted with some members of the nursing staff, the Facility ADOP, the CNE, the State Office Nurse Practitioner Consultant, the QA Nurses, as well as members of the Facility's Physical and Nutritional Management Team. The documentation indicated that the individual was at high risk for aspiration, was enterally nourished by a gastrostomy feeding tube (G-tube), and had several past hospitalizations and a recent hospital admissions related to aspiration pneumonias and respiratory issues. In addition, the PNMT was following this individual. The Integrated Progress Notes reviewed indicated that a number of changes in the individual's status, such as decreased oxygen saturations, and variability in vital signs were occurring. In reviewing the documentation, specifically the IPNs, a number of significant problematic issues were found regarding the recent care of this individual. Some of these problems included: ▪ Lack of recognition by nursing of changes in status; ▪ No nursing assessments conducted in response to changes in status; ▪ No consistent and regular nursing documentation to establish baselines and promptly identify changes in baselines regarding physical assessments, mental status, daily activities, positioning, treatments provided, pain assessments, vital signs, oxygen saturations, functioning of G-tube, site inspections for G-tube, and bowel and urinary output; ▪ Significant gaps in the nursing documentation (i.e., up to 24-hours without an IPN) for an individual with several health risks and changes in status;	

#	Provision	Assessment of Status	Compliance
		▪ No indication that the physician was notified of changes in status; ▪ No indication that the PNMT was notified of changes in status; ▪ No IPNs indicating that Individual #136 was being followed, assessed, or monitored by the PNMT, even after a recent hospitalization; and ▪ No Nursing HMPs adequately addressing the individual's current health risks that provided specific nursing interventions to guide nursing care. Due to these critical deficits found regarding the care of this individual, the Monitoring Team requested that a HMP be developed and implemented during the onsite review to address the significant health risks identified. To LBSSLC's credit, the Facility promptly scheduled a meeting with the appropriate disciplines to address this issue, along with the State Nurse Practitioner Consultant and one of the State's ISP Consultants. LBSSLC's first attempt at developing what was actually an interdisciplinary-integrated HMP for Individual #136 was very promising. Some problematic issues were noted related to specifying the frequency of some of the interventions, the timeliness of notification of the PNMT, the consistency of the assessment criteria to be regularly documented, and the lack of a clinically appropriate overall goal. However, given the short time frame in which the team had to meet to develop the plan, and the fact that this was the first time the Facility had taken on such a task, the team did an impressive job. It was obvious that after this meeting of the disciplines, each participant viewed the care of Individual #136 very differently than before the meeting. The team participants were able to speak to the clinical needs of the individual based on supporting clinical data provided by the medical record, as well as from all other disciplines involved, including the direct support professionals. From a professional and clinical perspective, it is not acceptable for the Facility to continue to allow disciplines to not to develop HMPs, or to develop HMPs that are clinically inadequate for the individuals under their care. Now that the disciplines have had the experience of developing an integrated HMP, albeit under some pressure from the Monitoring Team to do so during the onsite review week, the Facility should continue to develop and implement appropriate HMPs based on priority and risk for all individuals at LBSSLC The critical deficits that were found regarding the care of this individual were directly related to the fact the LBSSLC did not have nursing protocols in place, and no clinically adequate HMPs guiding the care for this individual. Prompt discussions should occur between the Facility's Nursing Department and the State Office to evaluate whether or not what the Facility believed to be adopted templates for HMPs are a barrier, rather than a functional and usable outline for the development of clinically appropriate and adequate HMPs. This discussion likely should include other SSLCs' Nursing Departments, and immediate actions should be taken based on this evaluation.	

#	Provision	Assessment of Status	Compliance
		An additional sample of individuals' records was requested for review to determine if individuals with infectious diseases had appropriate care plans to address their needs. The HMPs for 18 individuals (Individual #323, Individual #121, Individual #94, Individual #100, Individual #199, Individual #237, Individual #115, Individual #205, Individual #312, Individual #298, Individual #10, Individual #48, Individual #43, Individual #313, Individual #245, Individual #281, Individual #55, and Individual #72) that had a variety of infections since the last review period. ▪ Of the 18 individuals reviewed, all (100%) had HMPs addressing the infectious issue. ▪ Of the 18 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 HMP template; o The lack of criteria for documentation, including 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 Inappropriate goals that did not address the prevention of the spread of the infectious illness, but rather indicated that the individual would remain free from the infection, when the individual already had the infection; o The lack of specific 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. Consistent with the findings of the previous reviews, no system was in place to ensure that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. As noted in all the past reports, due to the clinical ramifications of not having HMPs adequately addressing infectious and communicable diseases, it is imperative that this requirement of the Settlement Agreement be addressed. Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the HMPs addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. In order for progress to be made regarding this section of the Settlement Agreement, the Health Management Plans should be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the interventions will	

#	Provision	Assessment of Status	Compliance
		be reviewed and by whom. Regardless of the HMP format or template, as required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should continue to occur so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all Health Management Plans. Thoughtful and serious consideration should be given to the use of an integrated Health Management Plan that would incorporate all clinical disciplines' goals and interventions regarding an individual's health risk into one plan. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement, which was in alignment with the findings of the Monitoring Team.	
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.	In response to this requirement, LBSSLC's POI indicated the following actions were implemented: ▪ *"05/21/2011: The Lippincott Nursing Manual was reviewed with nurses as the source for nursing procedures. Anything not covered in Lippincott will have a separate nursing procedure contained in a manual on every home.* ▪ *05/31/2011: Seizure Management guidelines implemented.* ▪ *05/31/2011: Reviewed Lippincott Nursing Manual as procedure manual with all nurses assigned.* ▪ *06/20/2011: The policy on hospital transfer record and the Hospital Verification record list was reviewed and approved.* ▪ *07/08/2011: In-service on transporting individuals in nonemergency conditions provided for all nurses assigned.* ▪ *07/11/2011: Reviewed Record checks and new orders policy.* ▪ *07/13/2011: Refresher In-service on responding to restraints provided to all nurses assigned."* In addition, the Presentation Book for Section M included the curriculum and training rosters for each of the above listed in-service training sessions completed during the review period. Also, from discussions with the State's Nurse Practitioner Consultant during the onsite review, initial training recently had been provided regarding nursing documentation that included some basic nursing protocols. To guide nursing assessments and documentation, the training addressed issues including head injuries, antibiotic therapy, diarrhea, temperature elevations, respiratory distress/aspiration, constipation, and vomiting. Also, these protocols were placed on small laminated cards for portability and accessibility for all nursing staff. Although at the time of the review, no positive outcomes had yet been seen from this training, it was a promising step in the introduction of the use of nursing protocols for the assessment and documentation of health issues and should be continued. In addition, as has been recommended previously, adequate modifications should be made to the procedures and protocols contained in the resource books that were obtained after the	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team's initial review in order to bring them into alignment with the Facility's structure and systems. These modifications should include identification of 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 and PNMT, if indicated. Based on the Monitoring Team's findings, the Facility's interventions thus far had had no positive impact on the nursing practices, or reporting protocols that the Settlement Agreement required. The significant and consistent problematic findings regarding nursing assessments, Health Management Plans, and the nursing care and documentation for individuals, especially individuals with high-risk health indicators and/or changes in status warranting hospital admissions, indicted a continued lack of comprehension regarding the importance of nursing protocols and how they structure nursing practice and documentation to ensure it is in alignment with quality standards of practice. Due to the lack of appropriate nursing protocols, no structured system was in place guiding nursing practice and documentation at LBSSLC to ensure that: ▪ Clinically appropriate nursing assessments were conducted for significant health issues and documented at the appropriate clinical frequency; ▪ Timely communication occurred with practitioners/physicians or other disciplines regarding changes in status; ▪ Appropriate and clinically adequate HMPs were developed that outlined specific nursing interventions for specific health issues; and ▪ Audits addressing nursing practice included quality standards by which to accurately measure the nursing care, and documentation resulting in accurate compliance data. The findings from this review and the previous three reviews indicated that LBSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. Consequently, the Facility had not met the Settlement Agreement requirements for this section. Although some initial training regarding nursing protocols was initiated shortly prior to the review, little progress had been made towards compliance. The Facility indicated that it was not in compliance with this requirement, which comported with the findings of the Monitoring Team.	
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	In response to this requirement, LBSSLC's POI indicated that since the last review, progress made included the following: ▪ *"07/21/2011: CNE and QA nurse met to discuss monthly monitoring.* ▪ *07/29/2011: Case Managers and Unit Managers received nurse specific training from Robin Seale, ADOP and Kathleen McCutchan, Qualified Developmental Disability Professional (QDDP) on their role in the PSP process.*	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	▪ *07/31/2011: Monitoring of documentation through the end of July shows a 58% compliance rating. Representatives from state office will be conducting a documentation class in September.* ▪ *This should raise awareness of the importance of credible charting by all nurses.* ▪ *08/18/2011: CNE and QA nurse met to determine priority tools in which corrective action plans would be addressed for issues identified."* Since the last review, the Facility had implemented a number of steps addressing the At Risk system. These are specifically outlined with regard to Section I.1. At the time of the review, most of the steps were found to be in various stages of implementation. However, the Facility's systemic interventions addressing the timely notification of disciplines, and implementation of the At Risk process for individuals experiencing changes in health status were not yet reflected in the documentation reviewed for the At Risk Individuals who had been hospitalized, as noted with regard to Section M.1. Also, the Facility's POI indicated an overall compliance score of 58% at the end of July 2011, but did not include how, and from what this percentage was determined, or exactly what it represented. The information contained in the Facility's Presentation Book for Section M indicated that the Facility had provided training specifically to nursing staff regarding the ISP process and the nurses' role in the ISP, which was a positive step. However, regarding the nursing assessments for risk indicators, basically no progress was noted. The CNE reported that for individuals who were designated as being at high or medium risk for aspiration, nursing was using the Aspiration Pneumonia Enteral Nutrition Evaluation to conduct the required nursing assessment for risk. However, a review of the APEN indicated that nursing's role was to complete the areas of the APEN that addressed the history of aspiration pneumonias, and other respiratory infections/conditions, and related hospitalizations. This did not constitute a nursing assessment. In addition, for those individuals who were designated as having high or medium risk indicators in areas other than aspiration, nursing was using the last quarterly or annual Comprehensive Nursing Assessment to meet the nursing assessment of risk requirement. These assessments were used even if they had been completed months prior to the meeting at which risk levels were determine, and included little to no information or assessment of the specific risk indicator(s). Consequently, neither the APENs nor Comprehensive Nursing Assessments were adequate or representative of a focused assessment addressing health risk indicators. A review of 23 individuals' APENS and/or Comprehensive Nursing Assessments (Individual #193, Individual #175, Individual #239, Individual #315, Individual #304, Individual #13, Individual #147, Individual #254, Individual #73, Individual #131, Individual #127, Individual #109, Individual #134, Individual #313, Individual #257,	

#	Provision	Assessment of Status	Compliance
		Individual #166, Individual #240, Individual #322, Individual #213, Individual #171, Individual #19, Individual #146, and Individual #63) found that none (0%) were adequate nursing risk assessments due to: ▪ None specifically addressed the high-risk health indicators; ▪ None had been updated regarding health issues related to the high-risk health indicators; and ▪ None included a nursing assessment as opposed to just a narrative summary of health information. A review of these 23 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. The review found that none (0%) consistently contained specific clinical information to enable the IDTs to adequately evaluate and designate risk levels. Some of the problematic issues included: ▪ Lack of specific data indicating regular bowel medication regimens, frequency of needed bowel pro re nata (PRN, or "as needed") medications, and additional factors such as medications, fluid intake, and positioning affecting risk of constipation; ▪ Lack of DEXA Scan scores, date(s) obtained, and treatment regimens for osteoporosis; ▪ Lack of results of cultures and sensitivities for urinary tract infections to evaluate hygiene practices by staff; ▪ Lack of data regarding the number of seizures during the past year compared to previous years, needed medications changes to stabilize the seizure disorder, and the date of the last seizure activity; ▪ Lack of specific dates and locations of past fall and/or fractures; ▪ Lack of specific information, such as dates, locations, and organisms of infections; and ▪ Lack of Braden Scores, frequency of specific skin issues, responses to treatments, and additional factors, such as immobility, nutritional status, or incontinence affecting risk related to skin integrity. A review of the same 23 individuals records conducted to assess nursing staff's role in the development and implementation of Action Plans related to the high and medium risk indicators found that nursing: ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the (0%) cases. ▪ Implemented a plan that met the needs identified by the IDT in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%).	

#	Provision	Assessment of Status	Compliance
		▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in none of the cases (0%). ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ For none of the plans (0%) were appropriate, functional, and measurable objectives incorporated into the ISP 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%). During the onsite review, the State Office Nurse Practitioner Consultant reported that the State was in the process of reviewing and redefining the "assessment" requirement noted in the At Risk Individuals policy in an effort to clarify the expectations regarding risk indicators and nursing assessments. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. The ongoing significant deficits regarding aggressive and timely recognition of risks, and lack of implementation of clinical interventions for individuals who were designated to be at risk due to their health/mental health issues demonstrated the significant lack of progress that has been made regarding this requirement. At the time of the review, LBSSLC's POI indicated that they were not in compliance with this requirement of the Settlement Agreement, which was consistent with the findings of the Monitoring Team.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in	In response to this requirement, LBSSLC's POI indicated that since the last review, progress made included the following: ▪ *"05/31/2011: Training provided for Direct Support Professionals on their role in medication administration implemented.* ▪ *06/02/2011: New Medication Observation tool implemented* ▪ *06/13/2011: Medication systems and safety committee recommended that the Director of Residential Services should be added to the committee.* ▪ *06/21/2011: The 90-day medication review process was reviewed by the case managers.* ▪ *07/13/2011: Adverse Drug Review policy was presented to OPM [Operating Procedures Manual Committee] and approved.* ▪ *07/18/2011: Provided New Medication Administration Guidelines training to all nurses.* ▪ *07/20/2011: New Telephone orders protocol was implemented.* ▪ *07/20/2011: Medication Safety and systems committee meeting held. Medication errors, outcomes, need to analyze reported errors, and returned medications were discussed. The committee concurred on a pilot project to count all refill*	Noncompliance

#	Provision	Assessment of Status	Compliance
	a separate monitoring plan.	*medications prior to leaving the pharmacy. Pilot to begin on the next refill cycle and continue for a month with an analysis to be conducted to determine if counting on refill day should continue.* ▪ *07/26/2011: Workgroup consisting of the Clinical Pharmacist, the CNE, NOO and the RN Unit Managers met to review new protocols for medication error process and returned medication. All agreed to the process. The Clinical Pharmacist will review and recommend a final version.* ▪ *07/28/2011: A one month pilot program was initiated to have the nurse and pharmacy count refills prior to delivery to the home.* ▪ *07/31/2011: Monitoring of medication and documentation currently shows an overall Compliance score of 95%.* ▪ *08/02/2011: Nursing leadership and Pharmacy met to Standardized returned medication error and returned medication protocols.* ▪ *08/03/2011: RN Case Managers received training on Medication Administration Observations and checking MAR'S (sic) weekly for medications not signed for.* ▪ *08/10/2011: Implemented weekly process of checking MAR'S (sic) for medications not signed for.* ▪ *08/17/2011: Monthly Medication safety and systems meeting conducted. The medication error protocol, medication error steps and timelines along with the MAR weekly check protocol were finalized and approved. Discussed the need to develop a methodology to track percentage of persons being reviewed for Medication Administration. The Clinical Pharmacist outlined the expansion of error reporting errors to include: ordering, transcribing, dispensing, administering and monitoring functions across the entire medication use system. Discussed medication errors with a severity score of D or above as listed on the Medication error form".* Since the previous review, the Nursing Department in conjunction with the Pharmacy had implemented a number of very positive and promising interventions addressing the overall medication administration system. Along with the above noted interventions, other interventions included the following: ▪ The Medication Error Committee was renamed in July 2011 to the Medication Safety and Systems Committee. This was representative of the expanded scope of the committee, including analyses of current practices, procedures, and identification of educational needs to improve systems and processes that promote safety and reduce the opportunity for errors; ▪ Committee meeting minutes contained more information regarding the subjects of discussion during the meetings. As data become available, trends of variances, including the category of errors, severity, shift, unit, and home are expected to be included in the minutes;	

#	Provision	Assessment of Status	Compliance
		▪ The Returned Medication Committee was integrated into the Medication Safety and Systems Committee in July 2011; ▪ The Medication Safety and Systems Committee noted a need for additional teaching regarding medication error reporting process to encourage the reporting of errors; ▪ The Facility's policy regarding medication error reporting was reviewed and found to lack timelines for the reporting process; ▪ The Medication Safety and Systems Committee set timeframes for variance data to be available for committee review; ▪ Since the last review, the Medication Safety and Systems Committee was aggressively reviewing the issue of medications returned to the pharmacy, and had implemented a pilot project that included counting the medications before they left the pharmacy to ensure the number of medications sent to a residence was accurate; and ▪ LBSSLC had developed protocols for the disposition of medication errors and weekly Medication Administration Records (MAR) checks. Significant discrepancies were noted with regard to the numbers of medication variances per month. This included discrepancies between documents provided prior to the review, and the information provided during the review. However, based on a compilation of this information, and the State's comments to the draft report, the following summarizes the numbers per month: ▪ March - 134 reported variances; ▪ April - four reported variances; ▪ May - 11 reported variances; ▪ June - 19 reported variances; ▪ July – 17 reported variance; and ▪ August - 359 reported variances. In addition, the Facility had been tracking the number of unexplained returned medication doses since October 2010. From March through June, the numbers of unexplained returned medications ranged from 940 to 1047 per month. However, the numbers of unexplained returned medications as listed in the Unexplained Returned Medication Doses, Fiscal Year 2010-2011 report were not the same as reported in the Medication Safety and Systems Committee meeting minutes, dated 7/20/11. Other concerns related to the reliability of the data also were noted. For example, while on site, the Monitoring Team noted during a medication observation that LBSSLC nursing staff did not report pre-signing a MAR before administering medications as a medication variance despite the fact that this clearly was a breach in procedure. Also, MAR blanks	

#	Provision	Assessment of Status	Compliance
		had not been reported as medication variances, and were not included in the variance data. However, the Facility recently had begun to track these occurrences. During an interview with the Clinical Pharmacist, he had reported that 612 MAR blanks were discovered in August 2011, with 206 of these found to be medications that were not administered. Consequently, the medication error/variance data provided by the Facility was not reliable, which the CNE candidly agreed was an ongoing issue. Although the Facility had much work to do to address the requirements of this section of the Settlement Agreement, interviews with the CNE and Clinical Pharmacist indicated that the Facility was in the early stages of systematically reviewing all of the elements of the medication administration system in an organized and thoughtful manner. The Facility, through its Medication Safety and Systems Committee should continue to critically review, and modify the medication administration system, and expand its analysis of the medication variance data. Also, as additional reliable variance data is collected, it should be thoroughly analyzed to identify problematic trends from which plans of correction are generated. From discussion with the CNE, due to staffing, and other various issues, the Facility had not been able to conduct the required medication administration observations for each nurse each quarter. From a review of the available Medication Administration Observations audit data from April through August 2011, very few observations were not scored 100% in compliance. This did not comport with Facility's medication administration data regarding MAR blanks, and unexplained returned medications. In addition, no comments were found on the audits addressing whether or not the nurse checked the PNMP for the correct position, or for other specific medication administration instructions prior to administering the medications. From the lack of comments found on these audits, one would surmise that nurses at LBSSL were consistently implementing appropriate medication administration practices. However, this finding did not comport with the Monitoring Team's findings, based on observations of medication administration at Residence 504 East. The following significant issues were found while observing medication administration. Specifically, the nurse did not: ▪ Ensure individuals were in the proper positioning prior to and after medication administration. A chain that indicated the correct position and height of the bed for medication administration was missing. Neither the nurse nor the Nurse Educator conducting a Medication Administration Observation reviewed the PNMP to verify correct positioning prior to medication administration; ▪ Consistently utilize the PNMP when administering medications; ▪ Initial the MAR after administering the medication to the individual verifying that the medications had been given. The nurse observed was noted to initial the MAR before the medications were administered, and when asked about this	

#	Provision	Assessment of Status	Compliance
		procedure, indicated that it was something she commonly did while passing medications. Neither the nurse nor Nurse Educator recognized this inappropriate procedure as a medication error/variance; ▪ Listen to lungs sounds both before and after administering medications via G-Tube to assess for possible aspiration; and ▪ Receive competency-based training on the PNMPs for individuals for whom she was responsible for administering medications. Given the consistent problematic issues noted from this review and the previous reviews regarding medication administration, little progress was noted this area, and individuals continued to be placed at risk during medication administration, especially those individuals at risk for aspiration. Based on these consistent problematic issues observed during medication administration at LBSSLC, the current auditing process for this area was inadequately capturing the lack of compliance regarding positioning and interventions for medication administration in alignment with the PNMPs. From observations, and discussions with nursing staff, a critical lack of understanding continued to exist within the Nursing Department regarding the clinical importance of consistently implementing the PNMPs. The Facility should develop and implement a system to ensure that prior to nurses providing care to individuals with a PNMP, they are provided competency-based training regarding the PNMPs. In addition, training should be provided to nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and other medication administration interventions, including following the instructions in the PNMPs. Also, as mentioned with regard to Section M.1, a procedure should be developed and implemented to establish inter-rater reliability and assist in generating reliable data regarding medication administration observations. Although the Facility was in the very early stages of reviewing its overall medication monitoring systems, the initiation of regular MAR reviews, medication counts by the pharmacy, further reviews and analyses of medication error/variance trends, and expansion of the scope of the Medication Safety and Systems Committee were all positive steps forward. The Facility was in the process of developing some of the basic yet essential infrastructures and implementing some very promising systematic processes regarding the medication administration system. The increase in collaboration between the Pharmacy, Nursing, and Medical Departments was evident during the review, as well as in the minutes of the Medication Safety and Systems Committee meetings. The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the	

#	Provision	Assessment of Status	Compliance
		Medication Administration Records (MARs), and documenting these as audits. At the time of the review, problematic issues regarding the administration of medications practices continued to exist that were in need of aggressive corrective actions. Although the Facility had taken some very positive steps forward regarding this requirement of the Settlement Agreement, the Facility indicated that it was not in compliance with the elements of this requirement, which comported with the Monitoring Team's findings.	

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. (Section M.1)
2. The Facility should ensure that all newly created or reallocated positions are appropriately integrated into the Facility's policies, procedures or protocols. (Section M.1)
3. The Facility should ensure that each monitoring tool has appropriate instructions identifying the specific criteria that constitute compliance with each item being monitored. (Section M.1)
4. The Facility in conjunction with the State should develop and implement a procedure for establishing inter-rater reliability to ensure it is executed appropriately and consistently. (Section M.1)
5. Data and data graphs 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. (Section M.1)
6. The Facility should consider decreasing the number of Health Monitoring audits conducted, and implement the remaining critical pieces of the monitoring system listed above with regard to Section M.1. This is necessary to generate credible data going forward. Once these systems are put in place, the Facility should give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring tools, based on the problematic areas that affect the health and safely of the individuals at LBSSLC. (Section M.1)
7. The QA Nurses, and the Nursing Department should ensure that all auditors are clinically competent, critically auditing clinical issues, and focusing on the quality of the nursing services provided, not the just completion of required documentation. (Section M.1)
8. The Facility should address aggressively the lack of the implementation of nursing protocols to guide nursing care, as well as the lack of development of appropriate Health Management Plans, and the associated documentation. (Section M.1)
9. A formalized immunization schedule and system to track immunizations should be developed, and implemented to ensure all individuals have received all the required current immunizations as outlined in the Health Care Guidelines. (Section M.1)
10. The Facility should continue and expand its efforts in the implementation of the clinical tools assessing the clinical practices and treatments of infectious and communicable diseases since these issues affect clinical outcomes. (Section M.1)
11. The Facility should initiate the auditing of all individuals who are suspected and/or diagnosed with an acute infectious/communicable disease. These should be real-time audits that do not fall under the randomized sampling procedures of the Facility. 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. Conducting retroactive auditing (conducting an audit after the event) would not be clinically appropriate, nor would choosing only a percentage of these cases to audit. (Section M.1)
12. The Facility should develop a list of individuals who have had and those who still need immunizations to render them current. (Section M.1)
13. The Facility should expand its pool of staff that conducts environmental monitoring auditing. Including different staff members, such as residential services staff, including unit directors, and home supervisors, would prevent auditors from becoming desensitized, and not

accurately and adequately assessing the environment. (Section M.1)

14. The Facility should continue to conduct analyses on the Infection Control data, implement plans of action addressing problematic issues, and document when the interventions were actually implemented. (Section M.1)
15. As recommended in past 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. Such expertise also should be used to obtain professional feedback regarding the quality and completeness of the finalized Infection Control Manual. (Section M.1)
16. The Facility should review all data related to its emergency systems to ensure that Mock Drills include the actual use of the emergency of equipment, and ensure that any training provided translates into improvement in the actual practices in the residences. (Section M.1)
17. Trends from the Mock Code Drills and 3733 calls (actual emergencies) should be identified, so that appropriate corrective actions can be implemented timely, and included in the Mock Code Drills Committee minutes. (Section M.1)
18. The Facility should provide competency-based training to ensure nursing assessments include adequate clinical analysis, resulting in an appropriate summary of the individual's progress regarding his/her health/mental health issues. (Section M.2)
19. Competency-based training should be provided to the nursing staff regarding the criteria and structure of the development of adequate Health Management Plans. (Section M.3)
20. As required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should occur so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated into all Health Management Plans. Thoughtful and serious consideration should be given to the use of an integrated Health Management Plan that would incorporate all clinical disciplines' goals and interventions regarding a health risk into one plan. (Section M.3)
21. Prompt discussions should occur between the Facility's Nursing Department and the State Office to evaluate whether or not the adopted templates are a barrier, rather than a functional and usable outline for the development of clinically appropriate and adequate HMPs. This discussion likely should include other SSLCs' Nursing Departments, and immediate actions should be taken based on this evaluation. (Section M.3)
22. Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the Health Management Plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. (Section M.3)
23. It is critical that the Facility develops and implements adequate nursing protocols. Modifications to the available resource materials should include identification of 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 and PNMT, if indicated. (Section M.4)
24. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. (Section M.5)
25. The Facility should continue to expand its analysis of the medication variance data in conjunction with the Pharmacy and Therapeutics Committee. As additional reliable variance data is collected, it should be thoroughly analyzed to identify trends and plans of correction generated. (Section M.6)
26. The Facility should develop and implement a system to ensure that prior to any nurse providing care to individuals transferred to the units that serve the individuals with the most challenging medical issues, nurses are provided competency-based training regarding the PNMPs. (Section M.6)
27. Training should be provided to nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and medication administration, including following the instructions in the PNMPs. (Section M.6)
28. The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, such as conducting

regular reviews and spot checks of the MARs, and documenting these as audits. (Section M.6)

29. Further collaboration should occur between the Pharmacy, Nursing, and Medical Departments in constructing a solid process that lends to a critical review of the overall medication system. (Section M.6)

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 Policies addressing provision of pharmacy services: LBSSLC-Health Services: Adverse Drug Reaction Reporting, dated 7/22/11; o Drug Utilization Evaluation (DUE) reports completed since last visit, including: DUE calendar 2011-12; Lacosamide DUE and worksheet; Lacosamide DUE 3/29/11 P&T review; HMG-COA Reductase inhibitors (statins) DUE and worksheet/DUE evaluation report, dated 6/23/11; and Simvastatin DUE secondary to Federal Drug Administration (FDA) advisory report, dated 6/15/11; o Minutes of Pharmacy and Therapeutics Committee, dated 3/29/11, and 6/23/11 with handouts, including: Administration protocol - Reclast (draft), polypharmacy and psychoactive medications through May 2011; Summary of Chemical Restraints September 2010 to May 2011; chemical restraints by individual Total FY 2011 for three quarters; all chemical restraints LSSLC 9/1/10 to 6/14/11; pharmacy monitoring summation FY 2011 3rd Quarter, dated 6/23/11; Medication error summary by home September 2010 to May 2011; Medication error summary by type September 2010 to May 2011; unexplained returned medication doses October 2010 to May 2011 (Units II, III); and enteral feeding list; o Minutes of Medication error/variances committee, dated 3/9/11, 4/28/11, 6/9/11 with handouts, including: Medication error report April 2011/May 2011; medication error summary by home September 2010 to April 2011; medication error summary by type September 2010 to February 2011; and excess medication form report May 2011 (Units I, II); Unexplained returned medications doses FY October 2010 to April 2011; o Medication Safety and Systems Committee (MSSC) minutes, dated 7/20/11 with handouts, including: Modification and expansion of the role of the med error committee; unexplained returned medication doses FY October 2010 to June 2011; medication error report June 2011 (Unit I, II); medication error summary by home September 2010 to June 2011; medication error summary by type September 2010 to June 2011; and medication observation tracking, dated 3/11, 4/11, 5/11, and 6/11; o Medication Safety and Systems Committee minutes, dated 8/17/11 with handouts, including: Revised Agenda for called meeting of unit nursing leadership/pharmacy, dated 8/3/11; minutes of called meeting of nursing/pharmacy leadership, dated 8/3/11; Excess medication review process steps; training roster for in-service/meeting entitled: medication administration observations, dated 8/3/11; handout for record checks and new orders; training roster for in-service/meeting entitled: record checks and new orders, dated 7/11/11 to 7/20/11; medication error report for July 2011 for Unit I, II, III; Medication error summary by home for September 2010 through July 2011; Medication error summary by type for September 2010 through July 2011; excess medication report for July 2011 (Unit I, II, III); and Unexplained returned medication doses FY 2010 to 2011

	through July 2011; o Drug Utilization Calendar for next 12 months; o Quarterly Drug Regimen Reviews for the following individuals: Individual #52, dated 7/7/11; Individual #154, dated 7/14/11; Individual #258, dated 8/4/11; Individual #76, dated 7/6/11; Individual #204, dated 8/1011; Individual #250, dated 7/7/11; Individual #226, dated 8/4/11; Individual #136, dated 8/4/11; Individual #7, dated 8/15/11; Individual #293, dated 8/4/11; Individual #181, dated 8/4/11; Individual #193, dated 6/3/11; Individual #74, dated 6/3/11; Individual #59, dated 7/7/11; Individual #210, dated 7/7/11; Individual #314, dated 7/1/11; Individual #17, dated 8/4/11; Individual #291, dated 7/7/11; Individual #321, dated 8/10/11; Individual #238, dated 8/10/11; Individual #176, dated 8/4/11; Individual #171, dated 8/4/11; Individual #72, dated 8/4/11; Individual #283, dated 8/4/11; Individual #304, dated 8/4/11; Individual #68, dated 7/7/11; Individual #7, dated 8/4/11; Individual #251, dated 7/14/11; Individual #191, dated 8/4/11; Individual #182, dated 8/10/11; Individual #139, dated 8/4/11; Individual #324, dated 8/4/11; Individual #223, dated 7/7/11; Individual #259, dated 8/10/11; Individual #185, dated 8/4/11; Individual #80, dated 8/10/11; Individual #98, dated 7/14/11; Individual #168, dated 8/10/11; Individual #29, dated 8/4/11; and Individual #215, dated 8/4/11; o Ten QDRRs where recommendations were followed with verification by MD orders for: Individual #146, dated 5/16/11; Individual #154, dated 7/14/11; Individual #6, dated 8/4/11; Individual #203, dated 5/16/11; Individual #184, dated 6/8/11; Individual #35, dated 5/12/11; Individual #245, dated 5/12/11; Individual #111, dated 8/10/11; Individual #266, dated 5/12/11; and Individual #259, dated 5/12/11; o Ten QDRRs where recommendations were not accepted for: Individual #126, dated 6/8/11; Individual #321, dated 5/12/11; Individual #270, dated 5/12/11; Individual #79, dated 6/8/11; and Individual #283, dated 5/9/11; o Single Patient Intervention Reports April through August 2011; o Note extracts associated with single interventions April through August 2011; o Adverse drug reaction reports; o Medication error report for past six months by error type, nurse, home shift, unit, individual, category of severity, and error made; o Medication variances per month per home and Facility aggregate September 2010 through July 2011; o Case analysis of medication error and plan of correction; o Data summaries for medication variances and QA activities; o Last 10 medication errors; o Communication between pharmacy and nursing concerning medication errors/variances (e-mails); o Prior two months reports/summaries of medication observations conducted; o Policies and Procedures addressing Medication Administration, including: LBSSLC – Health Services: Medication Administration Guidelines, dated 7/15/11; and LBSSLC – Health Services: Administration of IV fluids and IV Antibiotics, dated 5/23/11;

	o Drug Regimen Review Profiles from 9/1/10 to 9/12/11 for individuals with J- and G-tubes; o Quarterly drug regimen review schedule (homes per month); o Documentation for each chemical restraint (i.e., restraint checklist, face-to-face assessment, debriefing, and reviews for crisis intervention restraint) for the following: Individual #126, dated 4/20/11, and 5/28/11; Individual #220, dated 6/10/11, and 6/11/11; Individual #124, dated 7/29/11; Individual #221, dated 4/2/11, 5/15/11 at 2:53 p.m., 5/15/11 at 9:39 p.m., 5/16/11 at 5:08 p.m., 5/16/11 at 5:53 p.m., 5/17/11 at 4:52 p.m., 5/18/11 at 3:38 p.m., and 5/18/11 at 8:24 p.m.; Individual #288, dated 5/9/11; Individual #4, dated 3/5/11 at 8:55 a.m., 3/5/11 at 3:25 a.m., 3/11/11 at 3:27 p.m., 3/11/11 at 12:30 p.m., 6/9/11, 6/11/11, 6/13/11, 6/16/11 at 8:02 p.m., 6/21/11, 6/22/11, 6/23/11, and 6/26/11; Individual #33 at 3/2/11, 3/10/11, 3/14/11, 3/24/11, 4/2/11, and 5/22/11; o Trend analysis of chemical restraints; o Emergency Chemical checklist, dated 9/8/11; o Quarterly Drug Regimen Review Completion Date Comparison past 12 months; o Agenda and handouts for Pharmacy and Therapeutics Committee Meeting on 10/5/11, including: Polypharmacy and Psychoactive medications (through 8/11); Drug Utilization Evaluation: Metformin, dated 9/26/11; summary of chemical restraints FY 2011; all chemical restraints LSSLC, report date 9/1/10 to 8/31/11; chemical restraints by individual for fiscal year 2011; adverse drug reaction reporting form for incident on 7/29/11; pharmacy monitoring summation, FY 2011 4th Quarter, dated September 14, 2011; QDRR Follow up Monitoring Study, dated July 1, 2011; Medication Error Summary by Home from 9/10 to 8/11; expanded reporting format for FY 2012; unexplained returned medication doses FY 2010-11; Pharmacy/Nursing Medication Count Study; Medication Administration Observations Inter-rater Reliability Update for 7/11, and 8/11; LBSSLC Health Services: Protocol for the disposition of medication errors, dated 7/26/11; flow chart of medication error reporting and timelines for nursing; protocol for weekly MAR checks, dated 7/26/11; flow chart of weekly MAR checks; MAR observations report/update; DADS SSLC statewide policy and procedure: Medication Variances Policy #053, effective 9/23/11; and DADS SSLC statewide policy and procedure: Pharmacy Services, policy number #001, effective 9/26/11; o Laboratory interventions for July and August 2011; o ADR policy and training rosters: PCPs on 8/26/11, registered pharmacists/certified pharmacy technicians on 8/25/11, nurses on 8/2/11 to 8/16/11, and 9/19/11 to 9/23/11, and summary of training status for PCPs, pharmacy staff, nursing, and direct support professionals; o Presentation Book for Section N; o Settlement Agreement Monitoring Tool for Section N - Pharmacy Services and Safe Medication Practices; and o Medication Safety and Systems Committee agenda, dated 10/3/11 with handouts, including: training roster of in-service/meeting entitled: weekly MAR checks, dated

	9/21/11; training roster of in-service/meeting entitled: medication error disposition, dated 9/21/11; adverse drug reaction reporting in-service training roster, dated 9/19/11 to 9/23/11; Competency Assessment Tools for Health System Pharmacies: adverse drug reaction reporting post-test; MSSC suggested actions, based upon activities and findings FY 2011 and focus of activities for FY 2012; Medication Error report for 8/11 (Units I through III); Excess Medication Report for 8/11 (Unit I through III), and Medication observation tracking for 7/11 and 8/11. ▪ **Interviews with**: o John Todd, Clinical Pharmacist; and o Billy Bob Beck, Director of Pharmacy. ▪ **Observations of**: o Medication Safety and Systems Committee, on 10/3/11; and o Pharmacy and Therapeutics Committee Meeting, on 10/5/11.
	Facility Self-Assessment: The Facility's self-assessment showed compliance with Sections N.1, N.2, N.3, N.4, and N.7, and indicated the Facility was in noncompliance with Sections N.5, N.6, and N.8. Based on the Monitoring Team's review, for each subsection, progress was made, and the Facility attained compliance for some areas, including Sections N.1, N.2, N.4, and N.7. Although the Facility's findings related to compliance were similar to the Monitoring Team's findings, the POI did not include adequate data to substantiate findings. The POI often provided helpful information regarding the steps the Facility had taken to achieve compliance. However, audit data was not consistently used, and, when it was used, it was not completed. Such data is necessary to support the Facility's findings of compliance or noncompliance, and the Facility should use such data to identify areas requiring focused attention. The following provides a couple of examples of where analysis of data was missing and/or incomplete: ▪ The Facility identified itself as being in compliance with Section N.1. However, no data or data analysis was offered to support this finding. ▪ For Section N.3, the Facility found itself to be in compliance, and provided some minimal data regarding the use of polypharmacy. However, this provision addresses a number of other issues, such as the use of chemical restraint; monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications. In the POI, the Facility made no mention of these other components of the provision, and provided no audit data to substantiate that it was in compliance. As noted elsewhere, the Monitoring Team did not find the Facility in compliance with this provision. As the Facility expands its self-assessment process, it will be essential for internal audit data to be used in addition to the important narrative section to substantiate the Facility's findings. More importantly, the Facility should regularly review and analyze the data to identify areas of strength as well as weakness, and use this information to improve the system. Descriptions of such analyses and activities should be described briefly in the POI as well.

	The Facility had developed and was implementing three action plans for this section. They addressed the following: ▪ The Pharmacy Department was able to include an assessment of state lab data into the initial processing of new orders. Combined with the software abilities of the WORx program, new orders included a review of allergies, drug interactions, side effects, and dosage appropriateness. Communication with the PCP on significant drug interactions and lab concerns were documented through the software program. ▪ The adverse drug reaction policy was implemented, and training currently focused on the direct support professionals. ▪ As first steps in resolving the medication error/variance challenge, the pharmacy had methodically created systems to begin tracking documentation errors in Medication Administration Records (MARS). Efforts also were underway to address the high numbers of unexplained returned medications.
	Summary of Monitor's Assessment: The Pharmacy Department continued to make strides towards achieving compliance with this section. Based on review of submitted documents, the pharmacy appeared to be processing new orders in accordance with the requirements of the Settlement Agreement. For the Quarterly Drug Regimen Reviews, the revision of the reviews over time made them a valuable tool in clinical care. The drugs for which blood levels were drawn were monitored through the QDRR process, to determine whether the level was within the therapeutic range. Lab values were reviewed, as well as monitoring of benzodiazepines, anticholinergics, polypharmacy, and new generation antipsychotic medication risks (endocrine and metabolic). The PCPs reviewed the QDRRs and signed off indicating agreement with recommendation, or providing justification if they did not agree. Section N.3 includes requirements related to the Pharmacy Department's role with chemical restraints. Monitoring of stat use of psychotropic medications as chemical restraints had improved, and all such use was communicated to the pharmacy. However, the documentation of pharmacy information on the chemical restraint form was incomplete. The pharmacy did not appear to be answering the concerns noted on the chemical restraint forms. This was an area that needed further review and documentation support. At the time of the review, Facility staff were undergoing training on the adverse drug reaction policy. It will take considerable effort to provide adequate training to the large numbers of staff that would need the training. The drug utilization evaluation process was a mature system, and the results provided a measurement of quality of care that the PCPs provided. The process also was having a positive impact on practice patterns. The task of determining the true medication error rate and the cause of the many returned medications will require continued diligence and attention. Obtaining complete data remained a challenge, as did accurate analysis of data.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the 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 included a Pharmacy Director, a Pharm D, two pharmacists, and two pharmacy technicians. The Pharmacy Department was able to use two software programs (the state lab software and WORx) to achieve compliance with this section. Based on a document entitled: "Procedure for Laboratory Monitoring of Targeted Drugs (6/15/11)," an in-service training was completed in the Pharmacy Department. An undated flow diagram was submitted for the "Lab Review Process." These documented the training and implementation of the Pharmacy Department's lab tracking for new orders. For each new prescription, a review was completed of drug-drug interactions with the current drug regimen prescribed, allergies, significant side effects, and current laboratory results and potential need for further testing or review. Consideration was given to dosage adjustments. The PCP was contacted to review any concerns, and this was documented in the pharmacy software in two areas, including under patient interventions, and separately under a notes section. Under the patient intervention entries, for adverse drug reactions, the PCP was contacted for review. In each entry, the drug was identified, and the PCP response was recorded. The log documented frequent communication between the Pharmacy Department and the PCPs. The following was the number of entries for patient interventions with PCP contact and response per month: April 2011 - 45, May 2011 – 33, June 2011 – 36, July 2011 – 29, August 2011 – 32. In addition, another subcategory was entitled "drug information." This focused on additional communications between the Pharmacy Department and the PCPs concerning lab values or labs to be drawn. For July 2011, 12 entries were submitted, and for August 2011, 21 entries were made. The detailed entries included lab results, labs ordered, ranges of normal values, and consultant clinics. The PCPs had signed off on the majority of these intervention reports with lab values, indicating their review (26/27 of lab notes reviewed). It provided an important assurance of timely review of lab data, as well as other information relevant to the new prescription order. Under the "Notes" section of the pharmacy software, additional comments were listed. These were sorted by topic (administrative most of which involved diet and positioning orders), drug, allergy alert, and drug alert. Of these sorted entries in the "Notes" section, the administrative category had the most entries (i.e., May 2011 – 91, June 2011 – 80, July – none recorded, and August - 60). The other categories had small numbers varying from none to eight entries per category per month.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		To ensure compliance within the Pharmacy Department, the clinical pharmacist completed an ongoing monthly review of the patient intervention logs to ensure appropriate communication between the pharmacy staff and the PCPs, and appropriate action was taken, if indicated.	
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.	A quarterly drug regimen review schedule was submitted for the residences on campus. Each residence was seen every third month. Four to five residences were seen every month. The changes in the residences that took place on campus also were reflected on the schedule. Separately, a schedule of completed QDRRs was submitted for 2011. Each of the prior QDRRs was reviewed for date of completion and compared to the current QDRR's date of completion. For 100% of the campus, all current QDRRs were completed within 90 days of the prior QDRR. A system for timely completion and tracking of QDRRs was in place. A sample of 40 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 40 QDRRs (100%). ▪ The lab results included exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hgb A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (most commonly noted were antiepileptic drug levels with therapeutic ranges). ▪ All labs (100%) had the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab. ▪ There were few recommendations noted on the QDRRs, and especially from the laboratory results section. Most recommendations simply stated to continue monitoring for a particular lab. ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. Of the sample reviewed, five QDDRs were identified for which some of the laboratory information and comments provided needed further review. These included the following: ▪ For Individual #29's QDDR, dated 8/4/11, the Phenytoin level was elevated at 54.3 (therapeutic range 10 to 20). No recommendation or comment was made. The drug regimen review profile of 8/1/11 did not list Phenytoin, indicating it	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		had been reduced and discontinued, or simply discontinued. It would have been helpful for the pharmacy to respond to the elevated level of Phenytoin on the line item for that lab value. ▪ For Individual #226's QDRR, dated 8/4/11, the thyroid function was documented as within normal limits [WNL]," but the notes/comments line item stated "elevated free t3, t4 and TSH WNL." From this entry it could not be determined if the t4 was elevated or normal, as it could be interpreted in either direction. It is recommended that clear phrases be listed in the notes to prevent confusion. ▪ For Individual #304's QDRR, dated 8/4/11, the entry under lipid panel level indicated "notes," which was not helpful. A "WNL" entry might have been appropriate and consistent with the notes section that stated: "except low HDL and elev triglycerides (400)," or the notes section could have started with "WNL, except…" ▪ For Individual #98's QDRR, dated 7/14/11, the glucose level was elevated, but no recommendation was made regarding this abnormality. No recommendation to monitor glucose was made. The only recommendation was to continue to monitor the lipid panel and hepatic functions. ▪ For Individual #250, the phenytoin level was 110.5 (10 to 20 therapeutic), but no comment was included in the lab line item or recommendation. According to the 6/29/11 Drug Regimen Review Profile, this individual was still on phenytoin. If the dosage had been lowered, it would have been important information to include on the document, and whether a subsequent lab value was ordered with the date to be completed. If it was a typographical error, the PCP should have corrected this before signing it. However, these represented a minor fraction of the entire lab data review for each QDRR and the QDRR process. As a result, the Facility was found to be in substantial compliance.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for 32 chemical restraints used from 3/2/11 to 7/29/11. A separate listing of chemical restraint use was provided from 9/1/10 to 8/31/11. One of the restraints on this list was not included in the copied completed forms, for Individual #4 dated 6/16/11 at 5:45 p.m. Additionally,	Noncompliance

#	Provision	Assessment of Status	Compliance
	benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	the two most recent events on the list, from 8/4/11 and 8/5/11, were not included. The chemical restraint documentation indicated that seven individuals had the 32 chemical restraints. One individual had 13 restraints, one individual had eight restraints, and one individual had six restraints. No information was provided on these forms indicating how the maintenance medication, and/or BSP/environmental factors were being changed in order to reduce the use of chemical restraints. Information on these forms should reflect recommendations, and changes in the maintenance routine medication. It was not indicated if these individuals with frequent repeat need for chemical restraints were hospitalized. Pertaining to the pharmacy, one section was to be completed, with focus on three areas: "whether the medication was used in a clinically justified manner, the potential medication-related risks that should be considered, and actions/recommendations, if any." A determination of whether the medication was justified, with brief reference to the history, was to be included. Justification included two parts, with documentation that the behaviors were difficult and unresponsive to all BSP action steps, and whether the continued use of chemical restraints was justified based on whether routine medication regimens have been changed and adapted to meet the needs of the individual. The potential medication-related risks would be expected to include any drug-drug interactions with current medications being prescribed, potentiation of side effects when used with other medications, a review of any medical diagnoses that would change the dosage prescribed or the side effect profile (e.g., renal failure, heart failure, etc.), as well as a statement whether any adverse effects occurred. Actions and recommendations were to clarify if the individual had an effective dosage and whether the pharmacy recommended this same medication and dosage for any future chemical restraints. Recommendations should be clearly stated and guide the IDT in choosing medications and dosages for any future events. Information as to whether a change had occurred in routine medication to reduce chemical restraint use would be part of the discussion of whether the chemical restraint was justifiable, as well as any actions being undertaken (e.g., blood levels drawn, etc.). Based on this information, the pharmacy sections were reviewed for adequacy of completion and compliance. Of the 32 submitted chemical restraint documents, one document did not have the page that the pharmacist and psychiatrist would complete. The following summarizes the review of the remaining 31 documents: ▪ Of the 31 chemical restraint forms, nine forms (29%) included information concerning the justification of use due to the behavior. ▪ None (0%) included information concerning whether the maintenance medication or the BSP had been changed to reduce chemical restraint use, especially for the three individuals that had multiple chemical restraint events.	

#	Provision	Assessment of Status	Compliance
		▪ Effectiveness of the chemical restraint was documented in 29 out of the 31 chemical restraint forms completed (94%). ▪ Side effects and adverse effects were noted in 27 of the completed chemical restraint forms (87%). ▪ Risk analysis of use of the medication was documented on one of these forms (3%). ▪ There were four statements that were considered recommendations. The psychiatrist also had a designated space for completion on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. Review of these documented showed: ▪ Of the 31 completed, there were 22 forms (71%) on which the psychiatry comment section was completed. ▪ For 22 of the chemical restraints used (71%), by describing the behaviors and steps taken, clinical justification was provided. ▪ For none of those who required frequent chemical restraints (0%) was comment made regarding whether maintenance medication had been changed, the BSP had been amended, or other environmental changes were completed. ▪ Side effects were mentioned in 18 of the reviews (58%). ▪ Effectiveness was documented in 19 of the cases (62%). ▪ However, there was no information discussing the risks of drug-drug interactions, or other risks except for side effects. ▪ There were five recommendations documented. Considerable variation in the time period from the date the chemical restraint was used to completion by the pharmacist was noted. The range of time varied from being completed the same day to greater than two months. The value of the pharmacist's section is to provide guidance to the IDT in determining if the chemical restraint was optimal in type of medication, dosage, and route for the individual. This information should be reviewed with recommendations made to the IDT quickly. In addition, information concerning side effect profiles, drug-drug interactions, and use in those with certain diagnoses would be valuable in guiding the team to the appropriate choice. The Facility should create a tracking system to document the completion of the chemical restraint forms, and a timeframe should be established for their completion. A graph of restraint use was submitted from January 2009 through July 2011. This included both physical and chemical restraints. The two were not necessarily parallel in each month, according to the graph. More recently, restraint use appeared to peak in March, May, and June 2011. No trend could be determined. A summary of chemical restraint data was presented at each P&T Committee. At the	

#	Provision	Assessment of Status	Compliance
		6/23/11 P&T Committee meeting, the pharmacist summarized the information as of May 2011. For three quarters of data, 32 restraints had been used on 11 individuals. According to the minutes, the pharmacist reviewed all chemical restraints. No allergies or adverse outcomes were noted, and there was no indication that the restraints had been used as a substitute for long-term treatment. At the 10/05/11 P&T Committee meeting, from September 2010 through August 2011, agreement was found in the two databases: "Events from chemical restraint database," and "restraint checklist and debriefing report reviewed by RPh and filed in pharmacy." Each listed 46 chemical restraints during that time period. The conclusions of the report documented that each event was a one-time intervention and not as a substitute for long-term treatment. However, as noted above, it was not clear how these conclusions were drawn if adequate analysis had not occurred of each event, and/or the series of chemical restraint used with some individuals. <u>Polypharmacy</u> Of the 40 QDRRs reviewed, polypharmacy was noted in 16 reviews. Justification by diagnosis was documented in 16 (100%). Side effect risk was reviewed in 12 (75%) of those with polypharmacy. Polypharmacy also was reviewed through the Psychotherapeutic Polypharmacy Committee. At the 6/23/11 meeting, the psychiatrist reviewed the results of the May 2011 data. Of 123 individuals on psychoactive medications, 24 individuals with greater than one year of residence at LBSSLC had polypharmacy prescribed, and four individuals with residence of less than one year at LBSSLC had polypharmacy. At the 10/5/11 meeting, the psychiatrist reviewed the results of the August 2011 data. There were 126 individuals on psychoactive medications. Of these, 25 individuals with greater than one year of residence at LBSSLC had polypharmacy prescribed, and five individuals with residence of less than one year at LBSSLC had polypharmacy. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in 13 of the 40 QDRRs. ▪ Of these, 13 (100%)documented justification with appropriate diagnoses; and ▪ All 13 QDRRs (100%) indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 40 QDRRs, 39 (98%) were screened for medications associated with potential significant anticholinergic side effects. Eight QDRRs identified anticholinergic medications. Of these, seven (88%) documented clinical justification. Seven (88%) QDRRs addressed side effects/significant risks. However, one additional QDRR did not address anticholinergic medication (the space was blank), and had a medication with	

#	Provision	Assessment of Status	Compliance
		potential anticholinergic activity (imipramine) listed in the individual's drug regimen review profile. It was later listed under the observation section and included justification and review of side effects. However, the form needed to be completed as intended for clarity and completeness. Additionally, one QDRR, which stated there was no anticholinergic medication of significance, listed cyproheptadine in the drug regimen review profile, and in other QDRRs this medication was listed as one with significant anticholinergic side effects. Under the observations section of the QDRR, the indication/justification of the medication was documented. Hence, 10 drug regimens included anticholinergic activity, not eight as the Facility had reported. Based on the 10 drug regimen profiles with potential anticholinergic activity, nine (90%) documented clinical justification, and nine (90%) addressed side effects and significant risks. However, the anticholinergic section of the QDRR was completed in only seven (70%) of cases with this medication prescribed. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 40 QDRRs reviewed, seven listed atypical antipsychotic medication. Of these, seven (100%) included lab values that reviewed endocrine and metabolic risks (i.e., basic metabolic profile, glucose level, Hgb A1C, and/or lipid panel as appropriate). Additionally, the pharmacy completed an audit of QDRRs in July 2011. Ten QDRRs were randomly selected. Four areas were reviewed, including: the documentation of a psychiatric diagnosis to justify the psychoactive drug administration, presence of laboratory results for medications requiring periodic serum levels, laboratory monitoring of individuals with atypical antipsychotic therapy, and whether the new format for the QDRR was utilized. In all four areas, the Facility reported 100% compliance.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Review of 40 QDRRs showed the following: ▪ Of the 40, 39 QDRRs (98%) had the PCP signature. ▪ Of the 40, 39 QDRRs (98%) had the date the PCP reviewed the document. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 39 out of 40 (98%). o Agreement was documented in 38 out of 40. For one out of 40, the box indicating agreement was not checked, but the recommendations were followed for that one QDRR. o There was disagreement by the PCP for one QDRR. For that one (100%), a note of justification/plan was recorded on the QDRR. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed 12 QDRRs, and agreement or disagreement with justification and plan was documented in 11 out of 12 (92%). However, for the one on which no documentation was found indicating	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		agreement or disagreement, no action was required, suggesting there was agreement with the recommendation. To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted 10 active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of 10, all 10 (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. These examples indicated the QDRR was an important clinical tool that impacted the PCPs' ordering practices and monitoring. The Facility submitted five active records in which recommendations from the QDRR were not followed, which are listed in the documents reviewed section. In all cases (100%), the response, rationale, and plan were written on the QDRR. Although 10 active records were requested in which recommendations from the QDRR were not followed, only five examples could be found in the past six months. This suggested agreement between the pharmacy findings and the PCPs.	
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 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 sample of 20 individual records was conducted. A current DISCUS (within the last three months), and evidence of quarterly evaluations over the past year were identified in 16 of the 20 records reviewed (80%). Those individuals for whom there was not a DISCUS within the last three months (and the most recent DISCUS date) were as follows: Individual #162 (5/25/11); Individual #254 (5/24/11); Individual #111 (5/24/11); and Individual #300 (5/23/11). This documentation also was analyzed with regard to whether or not the prescribing physician had reviewed the DISCUS instrument within seven to 10 days following the completion of the evaluation. This review indicated that the DISCUS had been reviewed in a timely manner for 18 of the 20 individuals (90%). The DISCUS also was performed on those individuals who received Reglan for gastroesophageal reflux disease (GERD), 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 9/8/11, was obtained which listed all individuals who were prescribed Reglan. This list was then compared and cross-referenced with the list of individuals who received psychotropic medication. Those individuals who received both Reglan and psychotropic medications were then deleted. The compilation of names that resulted from this process of elimination contained only individuals who received Reglan for GERD. A	Noncompliance

#	Provision	Assessment of Status	Compliance
		random sample of this list (20%) produced the following seven individuals: Individual #226, Individual #181, Individual #74, Individual #225, Individual #191, Individual #139, and Individual #29. 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 six of the seven individuals (86%) within the most recent three months, and quarterly for the prior year. The only exception was Individual #74, whose most recent evaluation was on 6/19/11. These records also were reviewed for documentation that the prescribing physician had reviewed these evaluations within seven to 10 days of completion. This analysis indicated that for three of the seven individuals (43%), documentation had been reviewed in a timely manner. The delay for the other four individuals was approximately two weeks. The review of the sample of 20 records also indicated that the MOSES was completed as specified in the Settlement Agreement for 18 of the 20 individuals (90%). The two individuals for whom this documentation was not present were Individual #131 for whom no MOSES forms were found in the record, and Individual #22. Although Individual #22 only recently had been admitted to the Facility, a baseline examination should have been performed. The MOSES forms also were examined for the timeliness with which the prescribing physician had reviewed and signed the documents. This analysis indicated that the prescribing physician reviewed the clinical information contained in the MOSES regarding side effects within seven to 10 days of completion for only six of the individuals in the sample of 20 (30%). The delay for the other individuals ranged from two to three weeks. The greater delay in the review of the MOSES, as compared to the DISCUS, might have been due to the fact that the Psychiatry Assistant performed the DISCUS evaluations. This staff member's office was contiguous to that of the Psychiatrist, who reviewed the documentation. The primary Nurse performed the MOSES evaluations, and thus, the processing of the forms for the physicians' review was logistically more complicated. Nevertheless, the Facility will need to develop strategies to ensure that the prescribing physician reviews these important side effect monitoring tools in a timely manner. 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 seven individuals: Individual #226, Individual #181, Individual #74, Individual #225, Individual #191, Individual #139, and Individual #29. This review indicated that the MOSES was current and had been completed as specified for 100 percent of this sample. These records also were reviewed to determine if the prescribing physician had reviewed the evaluations within seven to 10 days of completion. This	

#	Provision	Assessment of Status	Compliance
		analysis indicated that this documentation had been reviewed in a timely manner for only one of the seven individuals (14%). The duration of the latency before the remaining forms were reviewed was in the range of two to three weeks. The Facility should develop systems to ensure that the prescribing physician reviews side effect monitoring forms in a timely manner.	
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.	A new policy was implemented entitled: LBSSLC – Health Services: Adverse Drug Reaction Reporting, dated 7/22/11. As part of this policy, an "Adverse drug reaction reporting form" was implemented that included sections the RN/LVN (symptoms suggesting an ADR and suspected medication), the pharmacist (the Naranjo Probability Score), and the PCP (Criteria for Assessment of Severity of ADR) had to complete. One ADR was reported in the past six months, and this ADR report was completed using the new policy/process. The ADR was a dystonic reaction to Seroquel that required treatment with Benadryl for resolution. This ADR was discussed at the P&T meeting in October 2011 during the Monitoring Team's visit. The ADR reporting process appeared to represent an effective and efficient system. Training on the ADR process is an important task, and requires training in identification and reporting of ADRs at all levels of health care. Training was completed for PCPs on 8/26/11, Pharmacy Department staff on 8/25/11, and Nursing Department between 8/2/11 and 8/16/11, and 9/19/11 and 9/23/11. The documents submitted indicated that training for PCPs was 100%, for pharmacy staff 100%, and for nursing (100% excluding those on leave of absences). The direct support professionals had had no training, but training was to begin October 2011. There were 492 full-time equivalent direct support professionals to train. In order for an effective ADR identification, reporting, and follow-up system to be fully implemented, it is essential that direct support professionals, who have significant contact with the individuals, be fully trained, and participating in the process. Hopefully, by the next review, training will have been completed, and the Facility will be able to demonstrate that it has a fully operational ADR system.	Noncompliance
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally	A calendar was for the fiscal year 2011-2012 that documented the medications to be included in drug utilization reviews. These included Metformin (September 2011), December 2011 (anticholinergic utilization in residents treated with psychoactive or seizure medications), March 2012 (Topiramate), and June 2012 (Memantine and Donepezil in residents with dementia). During the past six months, several DUE initiatives were undertaken. On 3/29/11, a	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	Lacosamide DUE was completed and presented to the P&T Committee. Seven individuals were prescribed this medication and all were reviewed in this DUE. Criteria reviewed included indication (i.e., partial-onset seizures), disease related concerns (i.e., hepatic impairment, renal impairment, cardiac problems), whether a recent electrocardiogram (EKG) had been completed, signs or symptoms of side effects (e.g., dizziness, ataxia, nausea/vomiting/diarrhea related to the medication), and lowering of Lacosamide drug level due to drug interactions with other anti-epileptic medications. No concerns were noted in the seven records reviewed. According to the P&T Committee minutes, no recommendations were made based on this information and no actions were required. The June 2011 DUE related to HMG-CoA Reductase Inhibitors (i.e., "statins" prescribed for lipid control) was reported at the P&T Committee of 6/23/11. A total of 42 individuals had been prescribed this medication. A 20% sample was reviewed. Four "statin" drugs had been prescribed, and the sampling reflected the proportional use of each of the four medications. Criteria included indications for use, contraindications for use, and clinical monitoring. All had indications documented, and no contraindications were noted. Clinical monitoring also occurred in all cases reviewed. Because the Federal Drug Administration issued an advisory for high dose Simvastatin, the pharmacy completed a review of all individuals on this medication, with focus on contraindications and dose limitations. This DUE included documentation that no individual was on the high dose regimen of Simvastatin. Each record was reviewed based on the changes in the package insert from the pharmaceutical company. No individual simultaneously had been prescribed a contraindicated medication or a medication that required reduction of maximum dosage. A DUE was completed on September 26, 2011, which reviewed Metformin utilization. There was 100% review of nine individuals. Indications for use, contraindications for use, and clinical monitoring were included in the review. No findings were made that required action.	
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.	<u>Policies and Procedures regarding Medication Variances</u> There was creation and/or revision of several policies concerning medication administration. The following were submitted: ▪ DADS: SSLC Policy and Procedure #053, Medication Variances, effective 9/23/11; ▪ DADS: SSLC Policy and Procedure #011, Pharmacy Services, effective 9/26/11; ▪ LBSSLC – Health Services: Medication Administration Guidelines, dated 7/15/11; ▪ LBSSLC – Health Services: Administration of IV fluids and IV antibiotics, dated	Noncompliance

#	Provision	Assessment of Status	Compliance
		5/23/11; ▪ LBSSLC Health Services: Protocol for the Disposition of Medication Errors, dated 7/26/11, revision 8/3/11; and ▪ LBSSLC: Protocol for Weekly MAR Checks, dated 7/26/11, revision 8/15/11. To assist in preventing medication errors, a draft policy was written providing guidance for processing medication errors, entitled: LBSSLC Health Services – Protocol for the Disposition of Medication Errors. It included detailed process steps, including timeframes for completion of those process steps. A flow diagram paralleling these process steps also was created to support understanding of the process. As part of this process, the Pharmacy Department was to receive a copy of the completed medication error form and staff follow-up form to allow data entry and eventual presentation at the following Medication Safety and Systems Committee. As part of this process, the Facility adopted the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index for categorizing the medication errors. One of the significant differences from prior categorization definitions was the determination that an error of omission was an error that did reach the individual, and would no longer be categorized as Category B, but a Category C error. Additionally, the prior policy for medication error reporting did not provide required timeframes for the various steps involved. Implementation of the Protocol for Weekly MAR Checks began in July 2011. Each individual's MAR was reviewed weekly to determine if recording of medications was correct, and to determine if blanks in the MAR represented errors of omission or errors of documentation. <u>Pharmacy Review of Categorization of Errors</u> Additionally, the Pharmacy Department was active in verifying that the categorization of medication errors was consistent with the pharmacy's interpretation of the medication error categorization. A report dated 8/18/11 that the Pharmacy Department generated indicated that the Pharmacy reviewed 17 reports and agreed with all of the Nursing Department's categorization of the variances. This was to be repeated in six months time. <u>Committee Monitoring of Medication Errors/Variances</u> The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Error Committee meetings, which the clinical pharmacist chaired. The following describes some of the findings of this committee:	

#	Provision	Assessment of Status	Compliance
		▪ The April 28, 2011 Medication Error Meeting documented 112 medication errors in Unit I during March 2011 (107 were considered omissions). Unit II reported 34 medication errors. Unit III reported two errors. ▪ The June 9, 2011 minutes documented that Unit I had 28 unexplained returned medications, and Unit II had 716 returned medications. The report from Unit 3 was not available. However, a submitted table indicated Unit III had 28 returned medications for this time period. A need was identified to improve the reporting of medication errors and to overcome the stigma associated with self-reporting of errors. Of concern, the QA department indicated several errors had occurred in the administration of seizure medication. No information was provided regarding tracking to determine whether or not the frequency or severity of seizures increased, or toxicity of medications increased following errors involving anti-epileptic medication administration. Various charts were submitted as part of these minutes. A chart entitled "Unexplained returned medication doses, fiscal year 2010-2011" recorded the variation per month for each unit from October 2010 through April 2011. During this time period, for Unit I, the unexplained returned medications varied from 51 to 393 per month. For Unit II, the unexplained returned medications varied from 374 to 750 per month. For Unit 3, the unexplained returned medications varied from 68 to 1194 per month. This clearly demonstrated significant and ongoing need for investigating each step of the process, and confirmed the need for the Pharmacy and Nursing Departments to review in detail the process of tracking medication errors as a first step in defining the problems causing the medications to be returned. Separately, for the time period of September 2010 through February 2011, information was submitted tabulating the types of medication errors which occurred during nursing's administration of medication. A total of 45 errors were reported during this time period. The majority of errors were due to the medication not being given (16 errors), an incorrect dose/rate/frequency (12 errors), and incorrect patient (seven errors). ▪ The July 20, 2011 meeting minutes reflected the change in the name of the committee from Medication Error Committee to Medication Safety and Systems Committee. The minutes documented "minimal improvement" in reducing the number of returned medications. June data indicated the following: Unit I: 82 unexplained returns, Unit II: 346 unexplained returns, and Unit III: 512 unexplained returns. The Committee determined that the unit manager responsible for reviewing and reporting raw data to the Pharmacy needed written guidance to ensure a uniform approach was used in investigating the reason for the returned medication.	

#	Provision	Assessment of Status	Compliance
		The data continued to note that several homes reported no medication errors, which was interpreted as under reporting of medication errors. Updated fiscal year information documented that through June 2011, the largest category of medication administration error continued to be "medication not given." This type of error was responsible for 79% of the total errors that had been reported (i.e., 169 out of 215 medication administration errors reported from September 2010 through June 2011). As part of the process to decrease medication errors, Nursing Administration continued to complete medication administration observations each month (e.g., March 2011 - 17 reviews, April 2011 – 15 reviews, May 2011 - 21 reviews, and June 2011 – nine reviews.) Given the observations of the Monitoring Team, it was problematic that the scores were often 100%. Additionally, there was discussion that the RN case managers would be checking MARS for all individuals and recording results. The pharmacy indicated the need to develop a format to include medication errors due to PCP orders, as well as subsequent monitoring. As part of this, a revised reporting format was drafted for fiscal year 2012 that expanded the categories of error from preparation/distribution and administration to prescribing, transcribing, dispensing, administering, and monitoring. In the July 2011 meeting, documentation was included of a plan of correction and implementation of that plan. An order written on 4/28/11 was discovered during a 6/7/11 record review as not having been processed by the clinical pharmacist. The error was corrected immediately. The pharmacy had not received the order, and was missed on the record check. In response to this, from 7/1/11 to 7/20/11, the Nursing Department conducted re-training on "Chart Checks and New Orders". A total of 91.5% of nurses on duty (not on leave) completed the training. The training roster confirmed that there were 87 nurses responsible for medication administration, and that five were on leave. The submitted roster indicated signatures for all 82 nurses, indicating training was completed with 100%. ▪ The minutes of the August 17, 2011 Medication Safety and Systems Committee reflected the continued diligence in creating a systems approach to determining the cause of the identified errors, discussion of ways to resolve underreporting of medication errors, and determining the cause of returned medications. As part of the process to ensure each step of medication administration was reviewed, a pilot program was created in which a nurse and pharmacist counted pharmacy filled carts before releasing them to the homes. This would assist in	

#	Provision	Assessment of Status	Compliance
		determine the role of the Pharmacy in medication errors related to dispensing. Although the four-week pilot had not been completed at the time of the meeting, the third round of counts had been completed and nurses noted no discrepancies. At this meeting, it was determined that omissions of medications should be categorized as "C" rather than "B" to be consistent with the NCC-MERP index. Omissions of medications continued to be the major source of reported medication errors. The minutes also noted that the new process for medication error reporting included treating unexplained blanks on the MAR as medication errors of omission. Several additional undated documents (protocols and forms) were submitted that reflected the ongoing progress toward developing a system to reduce medication errors and medication returns. These included: LBSSLC Health Services: Protocol for the disposition of medication errors; Protocol for weekly MAR checks, Weekly Random MAR checks, and Excess Medication Review Process Steps. At the August 17, 2011 meeting, from the data as of 7/31/11, 233 medication errors had been reported, of which 182 (78%) were omissions. No change was noted with regard to this trend. As blanks in the MAR were now considered errors, the reported error rate was expected to increase. For returned medications, large numbers of medications continued to be returned for unexplained reasons (Unit I – 73 doses, Unit II - 374 doses, Unit III – 268 doses). ▪ At the Oct 3, 2011 (scheduled date September 21, 2011), the medication error data was reviewed from September 2010 through August 2011. Of 612 medication errors reported, 348 were medications that were not administered (omission) and 206 medications that were given, but not recorded. More specific data was available for the "Excess Medication Report" for the month of August 2011. For Unit I, 112 tablets were returned for between 11 and 13 individuals. For Unit II, 421 medications were returned for 34 individuals. For Unit III, 354 medications were returned for 43 individuals. Although the Facility was making efforts to ensure accurate reporting, and address medication variance, underreporting remained an issue, and efforts thus far to address large numbers of reported omissions, as well an unexplained returned medications largely had been unsuccessful. <u>Medication Error Reports</u> The recently completed medication error report forms were submitted for review. There were four Category B errors (an error occurred but the medication did not reach the	

#	Provision	Assessment of Status	Compliance
		individual), four Category C errors (an error occurred that reached the individual, but did not cause harm), and two Category D errors (an error occurred that reached the individual and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm.) Of the 10 medication errors, three involved agency nursing. It was noted in the June 9, 2011 Medication Error Committee minutes that as of July 2011, no further utilization of agency nurses would occur at LBSSLC. <u>Medication Observation Monitoring</u> Medication observations continued on campus. Data was submitted for observations completed in July 2011 and August 2011. In July, five observations were conducted with a score of 97 to 100%. In August 2011, 16 observations were conducted with a score of 93 to 100%. From a separate document submitted with the 10/3/11 Medication Safety and Systems Committee, an additional eight observations were completed in August 2001 with a score ranging from 79 to 100%. Inter-rater reliability scores in July 2011 were 96 to 97% and in August 2011 were 87 to 91%. As noted above, the consistently high scores were not consistent with the Monitoring Team's findings. This is discussed in further detail with regard to Section M.6. To be in substantial compliance, the Facility should track pharmacy errors/variances internal to the pharmacy to prevent final dispensing errors from the pharmacy, as well develop criteria for physician orders that could be considered a medication error/variance. This latter category of errors/variances should be developed with guidance from the Medical Director. Additionally, the Pharmacy Department should assist the Nursing Department in root cause analysis and innovative approaches to resolving the number of medication errors.	

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

1. For elevated drug levels, a response should be included in the comment section. (Section N.2)
2. The chemical restraint documentation should include information indicating recommendations for changes in maintenance medication or changes in the BSP or environmental factors, etc. (Section N.3)
3. The Pharmacy Department should answer three questions in the chemical restraint document, including whether it was clinically justified (i.e., behavior plan followed and behavior justifies medication, and whether prior chemical restraint use resulted in a change in ordering of maintenance medication), whether or not medication related risks exist (i.e., especially drug interactions, and potential serious side effects, and a review of diagnoses that would change the dosage prescribed or alter the side effect profile, etc.), and whether any adverse effects occurred. Recommendations should be made to continue the medication if effective, change the medication or increase the dosage, if needed, or reduce the dosage. (Section N.3)
4. The Facility should create a tracking system to document the completion of the chemical restraint forms, and a timeframe should be established for their completion. (Section N.3)
5. LBSSLC should develop a mechanism to ensure that the prescribing physician reviews the MOSES and DISCUS side effects monitoring forms on

a timely basis. (Section J.12 and N.5)

6. The pharmacy should continue to provide training to all direct support professionals on the identification and reporting of ADRs. Additionally, yearly refresher training should be provided to all staff. New hires should be provided training as they enter the system in order. (Section N.6)
7. With regard to the significant number of returned medications, the Pharmacy and Nursing Departments should review in detail the process of tracking medication errors as a first step in defining the problems causing the medications to be returned. Once causes are identified, aggressive action should be taken to correct the deficiencies noted. (Section N.8)
8. The Pharmacy Department should track and analyze pharmacy-dispensing errors internally (as well as externally), as well as physician prescribing practices that would be considered errors/variances by the Medical Department. (Section N.8)
9. The Facility should further analyze the medication data, and use the information gained from the analysis to develop next steps. The same is true for the data being collected in relation to medication pass observations. (Section N.8)
10. As the Facility expands its self-assessment process, it will be essential for internal audit data to be used in addition to the important narrative section to substantiate the Facility's findings. More importantly, the Facility should regularly review and analyze the data to identify areas of strength as well as weakness, and use this information to improve the system. Descriptions of such analyses and activities should be described briefly in the POI as well. (Facility Self-Assessment)

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 Presentation for Section O for the LBSSLC Monitor's Compliance Visit October 2011; o The following documents: Occupational Therapy/Physical Therapy/Speech Language Pathology and Registered Dietician evaluations, Aspiration Pneumonia/Enteral Nutrition evaluation, OT/PT/SLP consultations for the last year, Individual Support Plan and ISP Addendums for the last year, including ISPAs for Integrated Risk Rating Form and risk action plan, Physical and Nutritional Management Plan with pictures, Interdisciplinary Team Integrated Risk Rating Form, IDT action plan for risk assessment, person-specific monitoring for past six months, competency-based training for staff, supporting documentation for implementation of IDT risk evaluation and action plan, Nursing Care Plan, Aspiration Trigger sheets for past six months, and Daily Schedule for 10 individuals (Sample O.1), including: Individual #193, Individual #109, Individual #118, Individual #66, Individual #6, Individual #211, Individual #263, Individual #267, Individual #315, and Individual #175; o The following documents: APEN evaluation, Head of Bed Elevation evaluation, Physical and Nutritional Management Team evaluation, PNMT action plan, ISP and ISP Addendums including integration of PNMT evaluation and action pan, PNMP with pictures, Integrated Risk Rating Form, competency-based staff training for staff related to PNMT action plan, individual-specific monitoring for PNMT action plan for the past six months, supporting documentation for implementation of PNMT evaluation and action pan, PNMT Discharge Plan/Summary, Daily Schedule, Aspiration Trigger sheets for past six months, and Nursing Care Plans for nine individuals (Sample O.2), including: Individual #258, Individual #89, Individual #72, Individual #283, Individual #323, Individual #63, Individual #196, Individual #29, and Individual #62; o The following documents: OT/PT/SLP/RD evaluations, APEN evaluation, HOBE evaluation, ISP and ISPAs for past year, PNMP with pictures, pleasure/therapeutic feeding program/plan, therapy (OT and/or SLP) progress notes for pleasure/therapeutic feeding program, individual-specific monitoring for past six months, staff competency-based training, and OT/PT/SLP/RD Consultations for the past year, dining plan and daily schedule for 10 individuals (Sample O.3), including: Individual #128, Individual #109, Individual #161, Individual #293, Individual #281, Individual #114, Individual #68, Individual #97, Individual #324, and Individual #78; o The following documents: PNMPs and dining plans for 21 individuals (Sample O.4), including: Individual #196, Individual #181, Individual #199, Individual #277, Individual#192, Individual #308, Individual #77, Individual #205, Individual #12, Individual #162, Individual #226, Individual #258, Individual #6, Individual #176,

	Individual #164, Individual #298, Individual #149, Individual #52, Individual #97, Individual #223, and Individual #100; o Home population report/roster, revised 9/30/11; o Competency-based training checklist (templates), undated; o On-the-job training packets (templates), undated; o List of PNMT members and curriculum vitae, various dates; o PNMT guidelines, undated; o Continuing education sessions for PNMT members, from 3/11 through 8/11; o PNMT core training session sign-in sheets and certificates of completion, from 3/11 through 8/11; o List of individuals with hospital visits, dated 8/24/11; o List of individuals at risk and corresponding level of risk-by home, dated 8/16/11; o ISPs, in-service training, and active treatment program development, various dates; o List of individuals at risk for aspiration and/or pneumonia, dated 8/16/11; o List of individuals at risk for chronic respiratory infections, GI concerns, choking, falls, weight loss/gain, skin breakdown/decubitus, challenging behavior, constipation, or dehydration, dated 8/24/11; o List of individuals at risk for ingesting inedible items, seizures, dental issues, or osteoporosis, dated 8/25/11; o List of individuals who are non-ambulatory or require assisted ambulation, undated; o List of individuals who require mealtime assistance, undated; o List of individuals who have had an emergency room visit or admitted to the hospital, dated 8/24/11; o List of individuals who have been diagnosed with pneumonia, dated 8/24/11; o List of individuals who have had a swallowing incident, dated 8/25/11; o PNMT evaluations/assessments on multiple individuals, from 3/11 through 9/11; o PNMT guidelines and ISP policies/procedures, dated 8/11; o PNMT tools (templates), undated; o List of individuals with Physical Nutritional Management (PNM) needs - by home, undated; o List of individuals without PNM needs - by home, undated; o Screening documents for wheelchair assessments, various dates; o PNMPs for multiple individuals, from 2/10 through 8/11; o PNM-related spreadsheets, from 10/10 through 10/11; o List of individuals on modified diets/thickened liquids, dated 8/24/11; o List of individuals who require mealtime assistance, undated; o List of individuals on enteral feeding, from 8/1/11 through 8/31/11; o List of individuals with diet texture downgrades, from 8/25/10 through 8/25/11; o List of individuals with Body Mass Index (BMI) greater than or equal to 30, with BMI less than 20, with unplanned weight loss greater than 10% during past six months, or who have had a choking incident during past 12 months, undated; o List of individuals who have had an aspiration and/or pneumonia incident, chronic

respiratory infections, chronic dehydration, skin breakdown and/or active pressure ulcer, a fall, or a fracture, from 8/10 through 8/11;
    - List of individuals who are non-ambulatory or require assisted ambulation, undated;
    - List of individuals with poor oral hygiene, undated;
    - List of individuals who have received a Modified Barium Study (MBS) study, from 9/10 through 6/11;
    - Schedule of meals – by home, undated;
    - Schedule of PNM-related meetings, dated 10/6/11; and
    - Quarterly report for Quality Assurance/Quality Improvement data (Sections O, P, and R), from 2/11 through 4/11.
- **Interviews with**:
    - Linda Thomas OT, Director of Habilitation Therapy, PNMT Chairperson;
    - Robin Seale, Assistant Director of Programs;
    - Francie Shaw, PT, PNMT member;
    - Corey Verett, Chief Dietician, PNMT member;
    - Debbie Jones, SLP, PNMT member; and
    - Latrell Castanon, Nurse, PNMT member.
- **Observations of**:
    - In residences and dining rooms in 504 E. Mesquite Drive, 504 W. Mesquite Drive, 525 North Cedar Avenue, 527 North Cedar Avenue, and 528 North Cedar Avenue.

Facility Self-Evaluation: Based on a review of the Facility's POI, with regard to Section O of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings.

Section O of the Facility's POI/Self-Assessment indicated that the Program Compliance Monitor (PCM) met with the Habilitation Therapy (HT) Director to review the completed monitoring, findings and analysis of information for a sample of three individuals. The following chart presents reported findings:

Sample of Three Individuals	Inter-Rater Reliability	Overall Compliance	Overall QA Compliance
May	89%	98%	-
June	94%	94%	-
July	89%	99%	-
August	94%	94%	99%

The Monitoring Team was unclear how these scores were obtained. An overall compliance percentage was not useful. The monitoring tools were not designed to provide an overall compliance rating. In addition, in order for the data to be useful to the Facility in identifying areas in which strengths or needs exist, data should be reviewed per indicator. This will allow the Facility to identify and broaden best practices, and

	identify and address specific areas requiring correction. The absence of adequate instructions for the monitoring tool and distinct trials to achieve inter-rater reliability between therapists and the PCM will result in audit findings that will not be reliable and/or valid. Focus should be placed defining the sample for Section O and the development of adequate instructions for the audit tools. Standardized procedures should be implemented to determine inter-rater agreement. The Facility had four action plans developed for Section O. The action plan for O.1 addressed the hiring of the PNMT Nurse and Clerk, and included action steps for the PNMT Nurse to attend Medical Morning meetings and to review information for individuals on the PNMT caseload discussed during the meeting. All action steps were documented as having been completed. In addition to the existing action plan steps, the Monitoring Team recommends that the PNMT Nurse formalize standardized documentation procedures to notify PNMT members and therapists about individuals discussed during the meetings. The action plan for Section O.2 documented the completion of the implementation of seven HOBE evaluations for individuals on the PNMT caseload, updating of assessments/risks/PNMPs as appropriate, review of PNMT and IDT action plans, revision of PNMP action plans, scheduling of ISPAs to review action plans, and development of PNMT monthly meetings. The Monitoring Team's review of individual records did not support these action steps had been completed. This is discussed in further detail with regard to Section O.2. The Section O.5 action plan set forth a the review process for HT New Employee Orientation (NEO) training for PNM to ensure objectives were present, and competencies and staff return demonstration were defined and completed. All action steps were documented as having been completed. However, the Monitoring Team's review of NEO competency check-offs showed that they did not meet the standard for competency-based performance check-offs. The Section O.3 and O.8 action plan focused on the Facility Mealtime Improvement Committee (MIC). The MIC had developed a policy that the Monitoring Team reviewed and a recommendation has been made related to the policy in the narrative below related to Section O.6.
	Summary of Monitor's Evaluation: The Facility hired a full-time PNMT Nurse and Clerk. The Chief Dietician had become a dedicated PNMT member. The PNMT Nurse made hospital visits. This provided the opportunity to interface with the Hospital Liaison Nurse and provide updates to PNMT members. The PNMT Nurse attended morning medical meetings, and provided updates to PNMT members and Habilitation Therapists on individuals' medical status. LBSSLC PNMT Guidelines were finalized in August 2011. However, individuals had inadequate risk action plans and/or no action plans, but had not been referred to the PNMT. Furthermore, individuals who experienced a health change status had not been referred to the PNMT in a timely manner. The Facility criteria for PNMT referral should be further defined for IDT members.

	The PNMT did not consistently review an individual's Integrated Risk Rating Form at the beginning of the evaluation to determine if rated risk factors were accurate. As a result, PNMT evaluations and action plans did not provide strategies to identify and/or address high and medium risk factors. The Monitoring Team has provided recommendations regarding improvement of the PNMT process related to the referral process, review of the Integrated Risk Rating Form, and the PNMT evaluation and action plan. The Monitoring Team conducted an onsite review of the Integrated Progress Notes for Individuals #136, who presented with an overall high-risk rating. His Integrated Progress Notes did not demonstrate an effective approach to addressing his multiple health concerns. At the conclusion of the onsite review that involved a number of his team members, State Consultants worked with Individual #136's IDT and PNMT members to review his Integrated Risk Rating Form and re-evaluate his risk ratings, develop an Integrated Health Care Plan for respiratory compromise/pneumonia, and revise his risk action plan. The IDT and PNMT members enthusiastically presented these work products to the Monitoring Team. These work products showed the potential for a strong interdisciplinary problem-solving approach to address Individual #136's health risk for respiratory compromise and pneumonia. The Monitoring Team commended Individual #136's IDT, PNMT, and the State Consultants for this approach that produced integrated interdisciplinary interventions. The Facility should expand this approach to other individuals with an overall high-risk rating and/or individuals that the PNMT supports. No Facility policies memorialized the development and implementation of PNMPs. The Monitoring Team reviewed multiple PNMPs that did not provide adequate staff instructions to support safety for individuals at high risk, which reinforced the need for PNMP policy/procedures. Based on interview, the PNMT was in the process of revising PNMPs to incorporate triggers, risk factors, and outcomes. The incorporation of these components would result in positive additions to the PNMPs. However, at the time of the review, no formal plans and/or individual-specific prioritization list had been developed for integration of triggers, risk factors, and outcomes. The LBSSLC Mealtime Improvement Committee (MIC) had four individual work groups that met on a monthly basis, including the Mealtime Coordinator, Environmental, Active Engagement, and Enteral Feeding workgroups. The Monitoring Team continued to support the interdisciplinary approach of the MIC to identify issues/concerns occurring during meal times, and proactively work towards systemic solutions. Unfortunately, the MIC had not made significant progress in completing competency-based training and testing of mealtime coordinators' competency in providing oversight in dining rooms. The MIC should formalize the mealtime curriculum for MTCs, develop and implement competency-based performance check-off forms to support compliance with the MTC mealtime curriculum, and establish a MTC validation process that therapists with mealtime expertise would implement. The HT Department had developed written tests and/or competency check-offs for completion with new employees, which was a positive development. However, many of the new employee core competency check-offs did not incorporate a demonstration component, which did not meet the standard for competency-based training.

	The Mealtime Improvement Committee was to be commended for developing a monitoring policy, and initiating mealtime monitoring. However, additional foundational work was needed to ensure MTCs were competent, and MTC monitors produced valid and reliable mealtime monitoring data. Individuals who received enteral nutrition were to receive an APEN evaluation, the purpose of which was to determine if receiving nutrition by tube was medically necessary, and, where appropriate, to implement a plan to return the individual to a less restrictive form of receiving enteral nutrition and/or to oral feeding. It was concerning that only 50% of the individuals in the Monitoring Team's sample had received an APEN evaluation. In addition, the APEN evaluations that were completed were not adequate to address the intention of the Settlement Agreement requirements.

#	Provision	Evaluation of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility	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, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. The evaluation and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the Settlement Agreement. The Monitoring Team's record sample for Section O is as follows: ▪ Sample O.1 – 10 of 30 individuals (33%) who were identified at high risk of aspiration and had experienced a change in status, including: Individual #193, Individual #109, Individual #118, Individual #66, Individual #6, Individual #211, Individual #263, Individual #267, Individual #315, and Individual #175; ▪ Sample O.2 – nine of the 16 individuals (56%) who the PNMT supported, including: Individual #258, Individual #89, Individual #72, Individual #283, Individual #323, Individual #63, Individual #196, Individual #29, and Individual #62; ▪ Sample O.3 – 10 of the 48 individuals (21%) who received nutrition through non-oral methods, including: Individual #128, Individual #109, Individual #161, Individual #293, Individual #281, Individual #114, Individual #68, Individual #97, Individual #324, and Individual #78; and ▪ Sample O.4 – Observations of staff compliance with PNMPs and dining plans in five residences for 21 individuals, including: Individual #196, Individual #181, Individual #199, Individual #277, Individual#192, Individual #308, Individual #77, Individual #205, Individual #12, Individual #162, Individual #226, Individual #258, Individual #6, Individual #176, Individual #164, Individual	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Evaluation of Status</th><th>Compliance</th></tr>
<tr><td></td><td>shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, Physical Therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.</td><td>#298, Individual #149, Individual #52, Individual #97, Individual #223, and Individual #100.

<u>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].</u>
Positive developments included:
▪ The Facility hired a full-time PNMT Nurse and Clerk.
▪ The Chief Dietician became a dedicated PNMT member.
▪ The PNMT Nurse made hospital visits to individuals on the PNMT caseload. These visits provided the opportunity to collaborate with the Hospital Liaison Nurse, and provide updates to PNMT members.
▪ The PNMT Nurse was the PNMT designee to attend daily morning medical meetings. Written feedback was provided to update PNMT members and Habilitation Therapists on individuals' medical status.

The PNMT core members were an OT, PT, RD, SLP, Nurse, and Clerk. The following chart identifies the current caseloads and/or responsibilities of PNMT members:

<table><tr><th>Core PNMT Member</th><th>Current Caseloads and Responsibilities</th></tr><tr><td>OT</td><td>Director of Habilitation Therapy, and PNMT Chairperson with PNMT caseload of 16 individuals</td></tr><tr><td>SLP</td><td>PNMT caseload of 16 individuals, and 20 individuals in Quail and Sparrow</td></tr><tr><td>PT</td><td>Caseload of 16 PNMT individuals, and 20 individuals in Quail and Sparrow</td></tr><tr><td>RN</td><td>Dedicated Nurse with PNMT caseload of 16 individuals</td></tr><tr><td>RD</td><td>PNMT Caseload of 16 individuals, and 20 individuals in Quail and Sparrow</td></tr></table>
PNMT core members attended multiple state-sponsored webinars, such as Introduction to PNMT, Seating and Positioning for Eating and Management of Dysphagia, Clinical Assessment Technologies, and Skill Acquisition Programs. Additional continuing education courses related to PNM issues were completed. Attendance rosters, course certificates of completion, and agendas were submitted. The State-sponsored webinars and continuing education courses attended provided relevant and appropriate clinical instruction for PNMT members. Based on interview, the Director of Habilitation Therapy was developing a continuing education tracking system for PNMT members, therapists and dieticians.</td><td></td></tr>
</table>

#	Provision	Evaluation of Status	Compliance
		PNMT meets regularly to address change in status, evaluations, clinical data, and monitoring results. PNMT Guideline – LBSSLC, dated August 2011, documented the PNMT would "meet at least weekly to review active cases and begin assessments for new referrals," and "meet as scheduled to review inactive cases to insure continued stability and avoid adverse outcomes." The PNMT was meeting weekly. However, there was a significant lag of time between the completion of the HOBE evaluations and initiation of ISPA meetings to address the HOBE evaluation results and integrate them into the plans. The PNMT schedule documented the completion of 13 individual HOBE evaluations from April to August 2011. These evaluations were a positive addition to the PNMT evaluation process, and provided valuable information to support safety in multiple positions. PNMT evaluation sign-in sheets for HOBE evaluations showed attendance by the PNMT OT, PT, RD, and/or SLP. In some cases, a licensed nurse and/or a registered nurse case manager was present, but their attendance was not consistent according to the sign-in sheets for the HOBE evaluations. One HOBE evaluation was completed in April, five in May, four in June, and one each in July, August and September. Also, the PNMT began requesting and participating in ISPA meetings beginning in July 2011. Although, these were positive steps forward, the documentation did not support that the PNMT met within a reasonable time frame with IDT members to discuss and integrate the HOBE evaluation results into individuals' plans. Consequently, individual plans were not updated to incorporate HOBE evaluation results. The extensive time period between the completion of an individual HOBE evaluation and a scheduled ISPA meeting is documented in the chart below: **Individual** / **HOBE Evaluation Date** / **PNMT/IDT Meeting Date** Individual #29 / 4/25/11 / 7/6/11 Individual #283 / 5/2/11 / 7/20/11 Individual #176 / 5/9/11 / 8/22/11 Individual #226 / 5/16/11 / 8/18/11 Individual #258 / 5/23/11 / 8/22/11 Individual #323 / 5/31/11 / 7/12/11 Individual #312 / 6/6/11 / 8/26/11 Individual #89 / 6/13/11 / 7/12/11 Individual #196 / 6/20/11 / 8/24/11 Individual #191 / 6/27/11 / 8/7/11 Individual #62 / 7/5/11 / 8/7/11 Individual #136 / 8/11/11 / 7/20/11	

#	Provision	Evaluation of Status	Compliance
		The preceding chart illustrates that the PNMT did not meet in a timely manner to integrate HOBE evaluation results into PNMT action plans and discuss these results with the individuals' IDTs. However, from July through September, the PNMT began meeting weekly with IDT members to present PNMT evaluations and action plans. LBSSLC was not yet in compliance with this provision of the Settlement Agreement, because the PNMT did not meet regularly to integrate evaluation results and action plans into individuals' ISPs. In addition, as is illustrated in the sections that follow, the Facility remained out of compliance with other provisions of Section O, which also were encompassed in Section O.1.	
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.	Positive developments included: ▪ During the onsite review, a review was conducted with members of Individual #136's IDT and members of the PMNT to analyze the content of his Integrated Progress Notes. Individual #136 was chosen for this review due to his overall high-risk status, six hospitalizations from April to September 2011 related to respiratory distress and hypothermia, and being on the PNMT caseload. The review identified inadequate documentation for Individual #136 to address his significant health concerns. Upon completion of the review, State Consultants worked with Individual #136's IDT and PNMT members to review his Integrated Risk Rating Form and re-evaluate his risk ratings, develop an Integrated Health Care Plan for respiratory compromise/pneumonia, and revise his risk action plan. The IDT and PNMT members enthusiastically presented these work products to the Monitoring Team. These work products showed the potential for a strong interdisciplinary problem-solving approach to address Individual #136's health risk for respiratory compromise and pneumonia. The Monitoring Team commended Individual #136's IDT, PNMT, and the State Consultants for this approach that produced integrated interdisciplinary interventions. The Facility should expand this approach to other individuals with an overall high-risk rating and/or individuals that the PNMT supports. <u>A process is in place that identifies individuals with PNM concerns.</u> LBSSLC PNMT Guidelines were finalized in August 2011. According to the guidelines, IDTs were to refer an individual to the PNMT if action plans were not effective in reducing risks, or the IDT needed assistance in developing a plan. However, IDTs had not referred individuals with inadequate risk action plans and/or no action plans to the PNMT. Furthermore, individuals who experienced a health change status had not been referred to the PNMT in a timely manner. In addition, the guidelines indicated that the PNMT addressed "primarily physical risk issues." This was not an adequate description of the scope of the PNMT. The Facility criteria for PNMT referral should be further	Noncompliance

#	Provision	Evaluation of Status	Compliance
		defined for IDT members. The Integrated Risk Rating Form for individuals in Sample O.1 identified a high risk rating for aspiration pneumonia, which was a significant PNM concern, but the IDT had not developed plans and/or the plans were inadequate to address aspiration pneumonia. Based on a review of Sample O.1: ▪ Only four of these 10 individuals (40%) had Risk Action Plans. ▪ IDTs referred none of these 10 individuals (0%) in Sample O.1 to the PNMT even though they had experienced a health status change, were identified at high risk of aspiration pneumonia, and/or had identified PNM concerns. ▪ Six individuals (Individual #193 – diagnosis of respiratory distress, Individual #118 – diagnosis of pneumonia, Individual #66 – diagnosis respiratory distress, Individual #6 – diagnosis pneumonia, Individual #211 – diagnosis respiratory distress, and Individual #263 – diagnosis pneumonia) had experienced a health status change and been hospitalized. ▪ Individual #263 was at high risk for aspiration and respiratory compromise. Her risk action plan, dated 3/16/11, was developed post hospitalization, but she did not have any nursing care plans to address multiple action steps. Her PNMP had not been revised to provide staff strategies for bathing, which had the potential to place her at risk. Her risk action plan was not adequate nor had it been implemented, which placed her at continued risk. ▪ Six individuals (Individual #211, Individual #267, Individual #315, Individual #175, Individual #109, and Individual #6) did not have risk action plans. <u>The PNM Team provides individuals identified as being at an increased risk level with a comprehensive evaluation and strategies that focus on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day, and during nutritional intake.</u> The PNMT's current caseload was 16 individuals (i.e., Individual #210, Individual #312, Individual #89, Individual #196, Individual #191, Individual #62, Individual #258, Individual #63, Individual #29, Individual #283, Individual #176, Individual #226, Individual #136, Individual #323, Individual #122, and Individual #72). Two individuals previously on the PNMT caseload were deceased (Individual #301 and Individual #138). The LBSSLC At Risk List by Home, dated 8/16/11, indicated 15 of these 16 individuals were given an overall rating of high risk. Nine of these 16 individuals were rated at high risk for aspiration (i.e., Individual #312, Individual #89, Individual #196, Individual #258, Individual #29, Individual #283, Individual #176, Individual #122, and Individual #72). The Monitoring Team reviewed Integrated Risk Rating Forms, PNMT evaluations, and	

#	Provision	Evaluation of Status	Compliance
		action plans for individuals in Sample O.2. The following concerns were noted: ▪ In none of the nine records reviewed (0%) had the PNMT reviewed the individuals' risk levels during the comprehensive evaluation process, and accurately updated them, as appropriate. Integrated Risk Rating forms had been updated prior to the PNMT assessment for Individual #283, and one day after the PNMT assessment for Individual #72. However, the Integrated Risk Rating forms for Individual #283 and Individual #72 did not accurately reflect the PNMT assessment risk ratings. For example, Individual #72's PNMT assessment, dated 8/25/11, documented he was at high risk for aspiration, respiratory compromise, gastrointestinal problems, and fluid imbalance. His Integrated Risk Rating Form, updated 8/26/11, did not include a high-risk rating for fluid imbalance. Individual #283's Integrated Risk Rating form, dated 3/22/11, identified her at high risk for choking, aspiration, and respiratory compromise. In addition to these high-risk areas, her PNMT assessment also identified her as being at high risk for infections, and dental. For other individuals, there were significant time gaps between a completed Integrated Risk Rating form and a PNMT assessment (e.g., Individual #196, Individual #29, Individual #323, Individual #63, Individual #89, Individual #72, and Individual #258). The expectation would be that the date of the Integrated Risk Rating form would coincide closely with the PNMT assessment date. For example, Individual #196's Integrated Risk Rating form, dated 3/8/11, was not updated during the PNMT assessment, dated 9/8/11. This practice could result in PNMT evaluations not evaluating an individual's current risk status, and as a result, adequate PNMT action plans might not be developed. The PNMT should ensure an updated Integrated Risk Rating form closely aligns with the PNMT evaluation date. The Integrated Risk Rating form with revised risk ratings, if appropriate, should accompany the PNMT evaluation to substantiate valid risk ratings." ▪ In none of nine records (0%) was there documentation of a comprehensive evaluation. ▪ In none of the nine records reviewed (0%) did the comprehensive evaluation reflect a comprehensive review/evaluation of identified risk levels. ▪ In none of the nine records (0%) did the PNMT evaluation include an analysis 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(s). ▪ In none of the nine records reviewed (0%) was a PNMT action plan found that addressed all high and medium risk factors identified on the Integrated Risk Action Form. ▪ For none of the nine individuals (0%) was a PNMT/ISPA meeting conducted within established timeframes to discuss the Integrated Risk Rating Form, PNMT evaluation, and action plan.	

#	Provision	Evaluation of Status	Compliance
		The Monitoring Team's review of the nine individuals in Sample O.2, as well as Individual #49, and Individual #136 did not support compliance with the Settlement Agreement, State and/or Facility PNMT process. The review revealed the PNMT did not consistently review and update the Integrated Risk Rating form, an extended time period lapsed (e.g., several months or longer) between the completion of an HOBE evaluation and the scheduling of an ISPA to discuss and integrate the PNMT action plan steps into the ISP, PNMT evaluations did not consistently address high and medium risk factors, PNMT action plans did not address a schedule for review and updating, and PNMT action plans were not updated within an appropriate time frame. Concerns noted were as follows: **Referral to the PNMT** ▪ Individuals had multiple hospitalizations and experienced a change in status before the IDT initiated a PNMT referral (e.g., Individual #72, Individual #48, and Individual #136). For example: o In its response to the draft report, the State indicated: "[Individual #48] was addressed by the IDT with appropriate plans/interventions, she was stable, and there was no need that she should be referred to the PNMT." Based on review of documents provided, Individual #48's IDT was not appropriately supporting her. For example, Individual #48's PT consultation, dated 4/18/11, indicated: "[Individual #48] has recently been in the hospital multiple times secondary to seizure activity. During her last hospitalization a feeding tube was placed." The IDT had not developed a risk action plan to reduce the severity of her high risk status for weight, seizures, and/or polypharmacy/side effects, and/or medium risk status for choking, aspiration, respiratory compromise, constipation, osteoporosis, falls, fractures, fluid imbalance, dental, and allergic rhinitis. Consequently, the IDT had not developed appropriate plans/interventions to address her change in status. The available documentation did not support that she was stable, or that she should not have been referred to the PNMT. ▪ IDTs did not appear to understand the PNMT referral criteria. The Facility should further define the PNMT referral criteria and provide training to the IDTs. **Integrated Risk Rating Form** ▪ The PNMT was not consistently reviewing individuals' Integrated Risk Rating Form to determine if risk ratings continued to be accurate as a result of a change in health status. The first step of the PNMT evaluation, in partnership with the individual's IDT, should be the review the Integrated Risk Rating Form to determine if an individual's current risk ratings continued to reflect an accurate	

#	Provision	Evaluation of Status	Compliance
		portrayal of the individual's risk for illness and/or injury. In the absence of the PNMT completing an updated Integrated Risk Rating Form, incomplete PNMT evaluation(s) and action plan(s) were developed, because they did not reflect an individual's current high and medium risk factors. **HOBE Evaluations** ▪ ISPAs were convened months after the completion of a HOBE evaluation. **PNMT Comprehensive Evaluation** ▪ Based on comments the State provided in response to the draft report, individuals referred to the PNMT were primarily PNMT self-referrals. However, it was unclear if the PNMT assessment date also indicated the date of the PNMT self-referral. The PNMT evaluation should document the IDT referral and/or the PNMT self-referral date. ▪ PNMT evaluations did not consistently evaluate high and medium risk factors. ▪ The PNMT was not consistently addressing the APEN evaluation and action plan. The PNMT should review the APEN evaluation to determine if recommended strategies support transitioning an individual to a less restrictive approach to enteral nutrition, and/or implementation of therapeutic/pleasure feedings, potentially leading to a return to oral eating. The APEN action plan should be integrated and/or revised, if appropriate, into the PNMT action plan. ▪ During the evaluation process, the PNMT was not consistently identifying individual-specific triggers related to an individual's identified high and medium risk indicators for PNMT, nursing staff, and direct support professionals to observe, document, and alert identified staff. ▪ PNMT evaluation(s) did not consistently provide an analysis of evaluation data related to high and medium risk factors. The PNMT evaluations should encompass a detailed analysis of clinical evaluation data to support the development of recommendations and measurable outcomes to minimize and/or reduce identified risk indicators. **PNMT Action Plan** ▪ Individual PNMT action plans steps recommended integration with nursing care plan, but individuals reviewed did not have nursing care plans developed and/or plans did not integrate PNMT action plan steps. This did not support an integrated interdisciplinary approach to assessing, tracking, and resolving/minimizing identified health risk indicators. ▪ Individual PNMT action plans did not consistently identify objective clinical data for clinical staff to monitor, and individual triggers for direct support professionals to monitor that communicated an individual's wellness and/or the onset of illness. The action plans should identify appropriate staff to be alerted if an individual exhibits the defined individual-specific clinical data and/or triggers. These clinical indicators and triggers should be integrated into the nursing/health care plan(s), PNMPs, Trigger sheets, etc.	

#	Provision	Evaluation of Status	Compliance
		▪ Action plan steps did not consistently provide sufficient information to successfully determine whether or no an action step had been implemented. Frequently, action plans were included such as: "PNMP techniques for bathing will be followed" with the person responsible listed as "staff" and the timeline listed as "in-service completed" with a date. Such an action step did not identify who would receive competency-based training and complete performance check-offs, when the training and performance check-offs would occur, the schedule for PNMT monitoring of staff compliance with bathing strategies, and/or where documentation would be maintained to support action step completion (e.g., IPNs). ▪ PNMT action plans were not specific in identifying how often the PNMT would conduct a hands-on evaluation of an individual's current status. ▪ PNMT action plan action step timelines did not support a sense of urgency for the initiation and completion of action steps to minimize high risk factors. ▪ PNMT action plans were not updated within a structured timeframe. A review of individual action plans revealed no updates, and/or updates that occurred months later. The PNMT action plan steps should identify how often action plan steps will be reviewed and updated. Additionally, Facility policy should identify the timeframe for action plan updates. ▪ Eight of the nine individuals in Sample O.2 had been hospitalized. The PNMT had not consistently reviewed action plans post hospitalization to analyze the efficacy of action steps, and make revisions to action steps, if appropriate. ▪ The PNMT Nurse had developed two transition plans for individuals who were hospitalized (Individual #136 and Individual #89). This was a positive step to provide necessary supports for an individual post-hospitalization, but additional work needed to be completed. A PNMT/ISPA meeting should be convened to discuss the transition plan prior to the individual returning to the Facility. PNMT action plans should be revised to integrate the transition plan. **ISP Addendum** ▪ Eight of the nine individual's record in Sample O.2 stated "no ISP." ISPAs were not consistently held within an acceptable timeframe to discuss the Integrated Risk Rating Form, PNMT evaluation, and action plan. ISPAs should have been initiated at the conclusion of the PNMT evaluation (including the HOBE evaluation), as well as the action plan process to collaborate with the IDT and integrate the PNMT action plan into the ISP and related plans (e.g., nursing care plans). Efforts should be made to ensure that this is standard practice and supported through Facility policy. LBSSLC was not yet in compliance with this provision of the Settlement Agreement. Individuals with significant physical and nutritional needs were not being provided with adequate and effective interventions and supports sufficient to meet the individuals'	

#	Provision	Evaluation of Status	Compliance
		needs. The PNMT process was not being adequately performed, because individuals were not afforded a comprehensive PNMT evaluation and action plan.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> No Facility policies memorialized the development and implementation of PNMPs. Based on interview, the PNMT was in the process of revising PNMPs to incorporate risk factors, triggers, and risk-related outcomes. These changes eventually would be integrated into all PNMPs, but no timelines had been developed related to the PNMP revision process. The Monitoring Team recommends PNMP revisions be formalized in Facility policy. The PNMPs for individuals in Sample O.1 were reviewed, but essential components were missing: ▪ In two of 10 records (20%), adequate positioning instructions for wheelchair and alternate positioning were included, including instructions for elevation range (i.e., Individual #6 and Individual #267). The remaining individuals' PNMPs had some form of instructions for wheelchair positioning and alternate positions, but these instructions were not adequate to ensure correct positioning and elevation in wheelchairs and/or alternate positions. For example, PNMPs and/or written and pictorial instructions stated: "elevate head of bed," but did not indicate how staff were to determine placement to ensure an individual's head of bed was elevated to the correct position. Recliner positioning instructions did not provide degree of elevation and/or position. Wheelchair positioning instructions stated: "wheelchair reclines and elevates feet," but did not provide staff instruction for tilt of wheelchair during medication administration and/or oral care. ▪ In nine of 10 records (90%), adequate transfer instructions were included. The transfer instructions for Individual #66's PNMP stated: "mechanical lift-Green Sling (see pictures)." However, no pictures were provided for review. ▪ In 10 of 10 records (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks, and/or addressed receiving nutrition through a feeding tube. ▪ In 10 of 10 records (100%), the mealtime/dining plan included food/fluid textures, and/or addressed receiving nutrition through a feeding tube. ▪ In five of 10 records (50%) the time an individual needed to remain upright after eating and/or receiving enteral nutrition was identified (i.e., Individual #263, Individual #193, Individual #66, Individual #6, and Individual #109). ▪ In 10 of 10 records (100%), the mealtime/dining plan included behavioral concerns related to intake, and/or addressed receiving nutrition through a feeding tube. ▪ In four of 10 records (40%), adequate strategies for medication administration	Noncompliance

#	Provision	Evaluation of Status	Compliance
		were included (i.e., Individual #6, Individual #175, Individual #267, and Individual #109). The remaining individuals' PNMPs did not have adequate instructions for nursing staff. For example, the PNMP positioning sections stated: "instructions for oral intake, medication administration and oral/dental care are included with PNMP pictures/instructions," but no instructions were included for positions in which the individuals should receive medication. In addition, wheelchair position and/or alternate positions for medication administration did not identify the position to be used during presentation of medication. ▪ In two of 10 records (20%), adequate strategies for oral hygiene were included (i.e., Individual #267, and Individual #109). The remaining individuals' PNMPs did not provide staff instructions for oral care; recommended that oral care be performed in bed, which had the potential to place an individual at risk; and/or the pictures of the individual in the wheelchair included the most upright and most reclined position, but did not indicate which position was to be used for oral care. ▪ In 10 of 10 records (100%) individual adaptive equipment was included. ▪ In one of 10 records (10%), adequate bathing/showering positioning and related instructions were included (i.e., Individual #66). The remaining PNMPs did not provide staff instructions for bathing/showering; the shower chair was identified under assistive equipment, but no written and/or pictorial instructions were provided; and/or bathing wedge/bolster was listed under assistive equipment, but no instructions were provided. ▪ In none of 10 records (0%) were adequate personal care instructions for elevation during checking and changing included. Multiple individuals' PNMPs stated: "encourage to never lay flat," but there was no reference to personal care for checking/changing adult briefs. No staff strategies were included for personal care, such as placement of the bed and/or on a changing table to achieve the prescribed degree of elevation. ▪ In 10 of 10 records (100%) communication strategies were included. The absence of adequate PNMT staff instructions had the potential to place individuals at a heightened risk of aspiration pneumonia. The following describes in greater detail concerns with PNMPs: ▪ As noted above, the Facility did not have a PNMP policy and/or procedures. The Facility should develop procedures which, at a minimum, define the purpose, content and outcome(s) of the PNMP, outline the evaluation process used to provide justification for PNMP strategies (e.g., HOBE evaluation to identify safe elevation ranges), define the therapists' responsibility for development and implementation of the PNMP sections, describe the PNMP revision process,	

#	Provision	Evaluation of Status	Compliance
		process to integrate PNMPs into the ISP, set forth requirements regarding competency-based training and performance check-offs, and describe PNMP compliance monitoring. ▪ PNMPs for the individuals identified at high risk for aspiration and/or those who received enteral nutrition within this sample did not include adequate staff strategies to support safety in daily activities. Current strategies in PNMPs should be re-evaluated using HOBE evaluation results to identify safe elevation ranges. PNMPs should present safe elevation range strategies for wheelchairs, alternate and nighttime positioning, bathing/showering, mealtime, medication administration, personal care, and oral hygiene. Staff strategies to achieve a safe degree of elevation should be clearly defined through photographic and written instructions. ▪ Multiple PNMPs supported receiving oral care in bed. The Facility should address the appropriateness of receiving oral care in bed, which has the potential to place an individual at risk. ▪ PNMPs for individuals identified at high risk for aspiration did not consistently identify a recommended time to remain upright after a meal. Recommended time for an individual to remain upright after a meal for those who eat orally and/or are enterally nourished should be an essential PNMP staff instruction. ▪ PNMP positioning instructions did not consistently present optimal alignment and support in seating systems. Therapists should review photographic instructions for wheelchair and alternate positioning to validate that these photographs promote optimal alignment and support. ▪ PNMPs did not present adequate instructions for nursing staff for medication administration and oral care. PNMPs were not integrated in nursing/health care plans. Medication administration instructions should include the position of nurse (e.g., eye level with individual); individual-specific positioning instructions, including elevation range in wheelchair and/or alternate position; use of adaptive equipment; presentation techniques; and medication presentation that is consistent with the prescribed diet texture (e.g., crushed pills for a pureed diet) and fluid consistency (e.g., nectar-thick fluids). ▪ PNMPs did not consistently identify the position of staff and an individual during tooth brushing. Positioning for the individual and staff during oral care should be clearly defined by photographic and written instructions. The absence of these PNMP components reinforces the need for policy/procedures to standardize PNMP development. <u>PNM plans were incorporated into individual's ISPs.</u> Five of the 10 individuals in Sample O.1 had ISPs (Individual #267, Individual #175, Individual #6, Individual #211, and Individual #263), and five individual's records	

#	Provision	Evaluation of Status	Compliance
		stated: "no ISP" (Individual #109, Individual #193, Individual #66, Individual #118, and Individual #315). Review of the five individuals with ISPs found that none of the PNMPs (0%) were incorporated and/or integrated into individuals' ISPs. Information from the PNMP should be integrated within the ISP and other supporting documents (e.g., nursing care plans), not simply referenced and/or listed. Eight of the nine individual's records in Sample O.2 stated: "no ISPs." The Monitoring Team could not determine if PNMPs had been integrated into ISPs. The PNMT did not consistently document an individual's status and/or progress with PNM plan action steps in Integrated Progress Notes. The absence of PNMT documentation in IPNs did not allow interdisciplinary integration of the PNM process with other disciplines, or provide adequate documentation regarding the implementation of PNM activities, which should be integral to the monitoring of an individual's ISP implementation. When the PNMT discharges an individual, an ISPA meeting should be held to present and discuss the PNMT discharge plan. This plan should continue to support the implementation of action steps (e.g., nursing, therapy and direct support professionals) to minimize identified health risk indicators. <u>PNMPs are developed with input from the PST, home staff, medical and nursing staff.</u> For the five individuals in Sample O.1, it could not be determined if the PNMPs were developed with input from the IDT, with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Although the Monitoring Team requested the ISPs and ISPAs for this sample of individuals, the five ISPs and/or ISPAs submitted in the document request were not complete, because only the ISP and/or ISPA action plans were submitted. The absence of a complete ISP resulted in a lack of documentation to substantiate an interdisciplinary approach to PNMP development. In addition, therapists had revised PNMPs (i.e., for Individual #263 and Individual #6), but these revisions were not discussed and/or documented in the ISP and/or ISPA documentation. <u>PNMPs are reviewed annually at the ISP meetings, and updated as needed.</u> As noted above, it could not be determined if the PNMPs were reviewed annually at ISP meetings. <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 the records for Sample O.1 (0%) were PNMPs reviewed and updated as necessary based on a revised Integrated Risk Rating Form, a change in the individual's	

#	Provision	Evaluation of Status	Compliance
		status, a transition (change in setting), and/or as dictated by monitoring results. The PNMT Guidelines indicated that one of the nurse's responsibilities was to collaborate with the hospital liaison nurse to integrate PNMT services for individuals who were hospitalized. This was a constructive approach to ensuring PNMT strategies continued to be implemented during hospital stays. In addition, the PNMT Nurse's responsibility was to develop transition plans for individuals returning to LBSSLC from the hospital. A PNMT Tentative Transition/Action Plan had been developed for Individual #89, but had not been implemented. Eight of the nine individuals in Sample O.2 had been hospitalized in 2011. Individual record review for individuals in Sample O.2 did not document the integration of a transition plan into the PNMT action plan post hospitalization. LBSSLC was not yet in compliance with this provision of the Settlement Agreement. Individuals with physical and nutritional needs were not being provided with adequate PNMPs, and the PNMPs were not integrated into ISPs, nursing/health care plans, etc.	
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.	Positive developments: ▪ Pharmacy staff integrated individual's diet texture and fluid consistency with the Medication Administration Records (MAR). <u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> The Monitoring Team observed implementation of PNMPs and dining plans in the Quail, Sparrow, Zinnia, Iris, and Rose residences. The Monitoring Team observed numerous issues related to compliance with PNMP and/or dining plan strategies. Staff engaged in unsafe mealtime practices, transfers, and positioning during medication administration, which posed undue risk of harm for individuals. The following summarizes the results of Sample O.4 individual observations: ▪ In five of 18 observations (27%), staff were following dining plans that referred to positioning, use of adaptive equipment, and/or presentation techniques. ▪ In none of one observation (0%) were staff following wheelchair-positioning instructions. ▪ In none of two observations (0%) were staff following alternate positioning instructions. ▪ In none of two observations (0%) were staff completing a pivot transfer correctly. ▪ In none of one observation (0%) were staff completing a mechanical lift transfer correctly. ▪ In none of two observations for medication administration (0%) were nursing staff following the PNMP instructions for individuals who received enteral	Noncompliance

#	Provision	Evaluation of Status	Compliance
		nutrition. The LBSSLC Mealtime Improvement Committee (MIC) had four individual work groups that met on a monthly basis, including the Mealtime Coordinator, Environmental, Active Engagement, and Enteral Feeding workgroups. Two workgroups, including the Policy/Procedure and Workshop Meal Service workgroups, had been disbanded. The Monitoring Team continued to support the interdisciplinary approach of the MIC to identify issues/concerns occurring during meal times, and proactively work towards systemic solutions. Unfortunately, the MIC had not made significant progress in relation to the provision of competency-based training, and testing Mealtime Coordinator's competency in providing oversight in the dining rooms to encourage staff compliance with prescribed mealtime practices. The LBSSLC Mealtime Coordinator workgroup appointed 60 Mealtime Coordinators. Two Mealtime Coordinators were assigned per home to first and second shift. Two attendance rosters (i.e., 9/14/11 and 9/23/11) documented that an OT provided training to six Mealtime Coordinators in the following areas: oral-motor development, diet textures, thickened fluids, diet cards/dining plans, adaptive feeding equipment, aspiration/choking, positioning during oral intake, and safe feeding guidelines. The length of the class was one hour, which did not provide adequate time to provide competency-based training in the preceding eight mealtime content areas. No performance check-offs had been completed for the six MTCs to test their competency with instructional content. The Monitoring Team's mealtime monitoring continued to identify staff non-compliance with dining plans. The MIC, in collaboration with the Director of Habilitation Therapy should define the content and timeframe for mealtime competency-based training curriculum for MTCs. The Environmental work group completed surveillance of appropriate table heights in dining rooms. Staff training was recommended on table height adjustment. The Monitoring Team concurred with this recommendation, because multiple individuals were observed during mealtime with table heights that were too high and/or low. MTCs should be tested for their proficiency in recognizing and adjusting appropriate table heights. The Active Engagement work group completed hand-washing monitoring. The work group was implementing a plan to address issues related to hand washing in coordination with the Infection Control Nurse. Again, MTCs should be provided training for mealtime infection control procedures. The Enteral Feeding (EF) work group was investigating alternate feeding pumps to provide individuals with more mobility on campus and in the community, which was a	

#	Provision	Evaluation of Status	Compliance
		positive project. The EF workgroup had not developed a monitoring system for individuals who received enteral nutrition. The Monitoring Team recommends the MIC develop MTC mealtime procedures to incorporate the following: ▪ Formalization of instructional content for mealtime competency-based training for MTCs. The curriculum should support the attainment of mealtime foundational knowledge and skills, including: o Mealtime position and alignment for individuals who eat orally and/or receive enteral nutrition; o Mealtime environment; o Mealtime staffing ratios; o Staff compliance with the dining plan; o Purpose of prescribed diet texture and fluid consistency; o Presentation techniques to enhance nutritional intake and hydration; o Care and use of adaptive equipment; o Strategies to minimize/reduce high risk indicators during mealtime; o Aspiration and choking precautions and rationale; o Understanding a swallow study; o Risk indicators and problem solving; o Mealtime infection control; o Techniques to promote optimal levels of independence and skill acquisition during mealtimes; and o Mealtime skill acquisition programs. ▪ Development and implementation of competency performance check-off forms to ensure MTCs are able to demonstrate the skills the mealtime curriculum is designed to teach; and ▪ Establishment of a process through which Facility mealtime therapy experts validate the skills of MTCs. In summary, LBSSLC was not yet in compliance with this provision of the Settlement Agreement. Staff were not consistently competent and/or compliant with implementing PNMPs and dining plan strategies that were prescribed to support health and safety for individuals with identified health and PNM risk factors. A process also was not in place to ensure the competency of Mealtime Coordinators.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> No Facility policies and/or procedures were submitted related to the provision of competency-based training for foundational physical and nutritional supports, training on individual-specific strategies/programs, and/or performance competency check-offs.	Noncompliance

#	Provision	Evaluation of Status	Compliance
	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.	The Monitoring Team reviewed the New Employee Orientation schedule, dated 9/1/11 to 9/22/11. Training for approximately nine instructional hours included: ▪ Alternative/Augmentative Communication - duration of one hour and 30 minutes; ▪ Orientation and Mobility - duration of one hour and 45 minutes; ▪ Feeding/Mealtime Management - duration of one hour; ▪ PNMP/Assistive Equipment - duration of one hour; ▪ Positioning - duration of one hour and 15 minutes; ▪ Nutrition Services - duration of one hour; and ▪ Lifting - duration of two hours. The NEO schedule did not provide adequate instructional time to present competency-based training for foundational physical and nutritional supports. The HT Department had developed written tests and/or competency check-offs to be completed by new employees, which was a positive development. The Monitoring Team reviewed the new employee core competency check-offs, but many did not incorporate a demonstration component. For example: ▪ New Employee alternative and augmentative communication (AAC) Competency Test, included a written test with no staff performance check-off component; ▪ Audio, Hearing and Orientation Mobility, included a12-question written true/false test; ▪ Feeding and Meal Time Management, included a 10-question written true/false test; ▪ Dining Chair Feeding Competency, Wheelchair Feeding Competency, and Enteral Feeding Competency indicated that staff were to choose the incorrect positioning picture and identify three errors; ▪ PNMP, Handling and Positioning Quiz, included a10-question written test; ▪ Positioning Competency form for wheelchair, left and right sidelying and supine had identified 10 steps identified, but the steps did not accurately reflect what staff would have to demonstrate for each of these positions; ▪ Mealtime Assistance Test, included an 11-question written test; ▪ Stand-Pivot Transfer Assessment Checklist, included a task analysis of steps for preparation, positioning and transfer; ▪ Two-Person Manual Lift, included a task analysis of required steps for preparation, positioning and transfer for transfer leader and second lifter; and ▪ Mechanical Lift, included a task analysis of required steps for preparation, positioning and transfer. New employees completed written tests, but they did not have to demonstrate their competency in the use of generic and individual-specific AAC systems; audio, hearing,	

#	Provision	Evaluation of Status	Compliance
		and orientation mobility; mealtime positioning before, during and after the meal; safe mealtime presentation techniques; identification of prescribed diet textures and fluid consistency; or how to correct food consistency. Written tests did not meet the accepted standard of competency-based training. Competency-based training should define specific skills staff should demonstrate to test their competency. The HT Department should define competencies that new employees need to demonstrate to show that they have mastered the core competencies presented in NEO. New employees did have to demonstrate competencies related to positioning, the stand-pivot transfer, and the two-person manual lift. The Positioning Competency form should be reviewed to further define specific tasks that staff should demonstrate for wheelchair and alternate positioning. The testing of the defined PNM competencies should be incorporated into the Facility's On-the-Job Training (OJT) for new employees. Therapists should complete a detailed task analysis for each of the defined performance competencies. The task analysis then should be translated into a competency check-off form, which should provide specific, defined tasks that staff must demonstrate to test their competency. The completion of performance check-offs for new employees will be labor intensive. In addition, current LBSSLC staff will need to complete performance check-offs to demonstrate their mastery of the PNM core competencies. The completion of PNM competency performance check-offs for current LBSSLC employees and new employees will demand staff hours that exceed the HT Department's capabilities. The Facility should appoint core leadership staff to participate in a train-the-trainer process. The therapists should complete competency-based training and performance check-offs with the core leadership staff. The core leadership staff then should be responsible for completing training and check-offs with current LBSSLC staff, as well as performance check-offs with new employees. This approach would enhance the PNM foundational skill level of core leadership staff. In addition, by increasing leadership's skills in this area, additional oversight could be provided to staff to ensure consistent implementation of prescribed PNMP and dining plan strategies. Physical and Nutritional Management Plan Coordinators (PNMPCs) completed competency check-offs for mechanical lifting, two person manual transfer, stand pivot, gait belt, walking program/walking, bed positioning, positioner and wheelchair positioning, rolling shower-toilet chair/stationary shower chair, mealtime/adaptive dining equipment, Simply Thick/pre-thickened fluids, heel protector/soft shoes, hosiery/compressions stocking, elbow pad/splints, palm protectors, and wrist-hand splint/ankle foot orthotic. The Monitoring Team observed a PNMPC in the Zinnia dining room who did not intervene to model and/or coach multiple staff who were not following individuals' prescribed dining plan instructions. As a result, the Monitoring	

#	Provision	Evaluation of Status	Compliance
		Team questioned the PNMPC's competency to provide mealtime coaching and mentoring. Therapists should conduct regularly scheduled reviews of PNMPCs to validate their skills for PNM core competencies. <u>All foundational trainings are updated annually</u>. The Facility provided annual refresher training for lifting. No additional annual refresher courses for physical and nutritional supports were provided. <u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u> In reviewing the samples of individuals' records: ▪ None of the 10 individuals' staff in Sample O.1 (0%) had received adequate individual-specific PNMP training. ▪ In Sample O.2, two individuals' staff (Individual #62 and Individual #72) had not received any competency-based training. Seven of the nine individuals had limited individual-specific training. Examples in which appropriate competency check-offs were seen included: for Individual #63 staff completed Handling, Techniques for Brief Changes, Mechanical Lift Transfers, Positioning and Repositioning; for Individual #63, Switch-Activated Radio Competencies check-off required staff to demonstrate the set-up for the radio; and for Individual #89, Bathing Technique Competencies check-off provided appropriate steps for staff demonstration. Although staff assigned to some of the individuals in the samples had completed what the Facility indicated was competency-based training, the training was not considered adequate. Reasons included some already listed above, including the lack of identification of specific tasks in task analyses, staff who needed to complete the competency-based training not being identified by position, and tests that included written questions, but did not require demonstration of skills. Additional concerns noted included steps in sequences on competency checklists that were not in the correct order, and training forms that did not identify the trainer's credentials. The PNMT should complete a review of action plans to identify which action steps require individual-specific staff competency-based training and performance check-offs (e.g., nursing, supervisors, etc.). As stated above, the identification of core leadership staff to provide competency-based training and check-offs will provide needed support to the PNMT. <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>	

#	Provision	Evaluation of Status	Compliance
		In none of the 10 individual-specific staff training records in Sample O.1 (0%), for staff providing assistance to individuals determined to be at high risk for aspiration, had staff successfully and fully completed individual-specific competency-based training and performance check-offs to address PNMP strategies. To support this conclusion, the following examples are provided: ▪ Although these individuals had multiple PNMP strategies recommended, staff for the following six individuals had not completed any competency-based performance check-offs for PNMP strategies: Individual #66, Individual #118, Individual #193, Individual #211, Individual #175, and Individual #263. ▪ Individual #267's staff had only completed performance check-offs for her alternative and augmentative (AAC) Step-by-Step voice output communication aide (VOCA) Competencies. ▪ Staff for Individual #6, Individual #109, and Individual #315 had completed some PNMP competency-based performance check-offs, but it was not adequate. For example, Individual #6's staff had completed a two-question written test related to the use of his lap tray while he was in his wheelchair. This test did not meet the standard for competency-based performance check-offs. Individual #6 also had written and pictorial instructions for left and right sidelying, recliner left side sitting, recliner right side sitting, recliner supine sitting side, supine, wheelchair, day bed with wedge, white heelbos, and hospital bed with chain/mat at bedside. Staff had not completed performance check-offs on these individual-specific PNMP strategies. None of the nine individuals' staff in Sample O.2 (0%) participated in the provision of competency-based training and performance check-offs for all recommended action steps to ensure staff was competent to implement the PNMT plan, including revised PNMPs. The PNMT action plan should describe the purpose and content of the training related to identified risk indicators, identify the staff responsible for conducting the training and performance check-offs, state the timeline for completion of training and performance check-offs, and identify which specific staff across shifts are to complete the training and performance check-offs (i.e., nursing, direct support professionals, supervisory staff, etc.). <u>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.</u> As noted above, for Sample O.1 and O.2 inadequate individual-specific competency-based training and performance check-offs completed were documented, and/or no competency-based training and/or performance check-offs had been completed. Multiple individuals in Sample O.1 and O.2 had PNMP revisions, but no competency-	

#	Provision	Evaluation of Status	Compliance
		based training and/or performance check-offs had been completed. In summary, LBSSLC was not yet in compliance with this provision of the Settlement Agreement. Staff responsible for individuals with physical and nutritional management problems had not successfully completed competency-based training and performance check-offs to ensure adequate implementation of PNMPs and dining plans.	
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 MIC had adopted a new monitoring form that the State Coordinator for Specialized Services provided. The form could be used to monitor nine different programs, including: mobility, transfer, communication, dining, oral care, medication administration, positioning, bathing, and toileting. The MIC used the form for mealtime monitoring. The form monitored the presence and accessibility of the PNMP and/or dining plan, whether or not the equipment was present and working, if staff performed the plan as written, if staff explained the rationale and risks associated with not implementing program, if there was an acknowledgement of training, whether or not data was recorded in the appropriate location, and if staff knew who to contact if there was a problem. If a staff member had to be retrained on site for deficient areas observed, the monitor would document this and sign the form. The form had a section to address corrective action that documented the person responsible, due date, action taken, and completion date with staff signatures. The bottom of the form documented receipt of the form and corrective action notification, receipt, and review. The monitoring form indicators were appropriate to monitor staff compliance with an identified program. The Mock Survey Team began utilizing this form in August 2011. The goal was to monitor each meal one time per month in all 15 homes. The monitoring form was designed to provide data by individual, staff person, and home. All follow-up action was to be documented on the monitoring form. The monitors were instructed to immediately correct any serious issues, and follow up on all other issues with an email to a supervisor. The Monitoring Team reviewed 13 monitoring forms. The monitoring indicators were appropriate to document compliance with prescribed dining plans. The nine indicators had been scored on all forms. In 12 of the 13 forms, the monitor did not complete the corrective action and/or the delivery of the form sections. The following issues were noted: ▪ Monitoring form documented staff were not following the plan as written, but the corrective action section was blank. ▪ Forms scored materials/equipment were present (Indicator #2) and equipment is working properly (Indicator #3) as "N/A." These indicators should have been	Noncompliance

#	Provision	Evaluation of Status	Compliance
		scored "yes" or "no." ▪ A monitoring form indicated the dining plan was being performed as written, but the comment section acknowledged staff was doing a better job of following the dining plan. It was not clear from the comment whether or not the staff was performing the dining plan correctly. ▪ Monitor documented staff "had very long fingernails with raised decorations. I asked her about the risk of scratches. She had no comment." The corrective action plan section was blank. The MIC should, in collaboration with the infection control nurse, define fingernail length for staff. ▪ The form documented staff member was not able to explain the risks associated with not implementing the program and/or explain the rationale, goals(s) desired outcome(s) of the program, but no corrective action was recommended. ▪ Seven of the 13 forms achieved 100% compliance with the indicators. The Facility should complete competency-based training, performance check-offs and initiate inter-rater reliability trials with therapy experts with mealtime monitors in order to have confidence in mealtime monitoring results. The purpose of Mealtime Coordinator Monitoring policy, dated 5/9/11, was to define the mealtime monitoring process. The policy presented seven criteria for mealtime monitoring, but policy components were missing, including: ▪ Identification of curriculum for competency-based training and performance check-off forms to define mealtime competency for MTCs and MTC monitors; ▪ Development of detailed scoring instructions for the MTC monitoring tool indicators and corrective action section; ▪ Definition and implementation of a validation process involving Facility therapists to achieve inter-rater agreement with MTC monitors for mealtime monitoring; ▪ Development of a schedule to ensure individuals at highest risk (e.g., those with issues related to aspiration pneumonia, respiratory concerns, choking, weight, dehydration, and fluid imbalance) are monitored on a more frequent basis; ▪ Definition of an auditing process to ensure resolution of individual-specific concerns and systemic issues; ▪ Formalization of a schedule to review the MTC monthly summary of the monitoring tool checklists to make recommendations for retraining and/or action to be taken for systemic issues; ▪ Integration of the MTC monitoring tool checklist monthly summary into the QA/QI system; and ▪ Definition of what re-training will be required if the score falls below 80%. The MIC was to be commended for developing a monitoring policy and initiating	

#	Provision	Evaluation of Status	Compliance
		mealtime monitoring. However, additional foundational work was needed to ensure MTCs were competent and MTC monitors produced valid and reliable mealtime monitoring data. The Habilitation Therapy Department did not have policies and/or protocols for implementation of the following monitoring forms, nor were there procedures identified for the integration of the following forms into an interdisciplinary monitoring system or integration into the QA/QI system. ▪ HT PNMP Observation; and ▪ HT Meal Observation. <u>All members of the PNM team conduct monitoring.</u> Based on a review of PNMT action plans and supporting documentation for individuals in Sample O.2, none of these records (0%) showed that the PNMT consistently conducted individual-specific monitoring to document the efficacy of their interventions and/or staff compliance with the PNMT action plans. <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> As discussed with regard to Section O.1, the PNMT nurse attended the morning medical meeting to secure "information pertinent to an individual's health status, hospitalization or risk change." The PNMT nurse would send an email providing updates to PNMT members and therapists for individuals on their caseloads. The PNMT nurse should develop a system to document what action was taken by the PNMT. The Director of Habilitation Therapy should ensure therapists who are not PNMT members document the action taken for individuals on their caseloads. The Director of Habilitation Therapy attended the daily Incident Management Meeting and provided updates to the PNMT and therapists. The Incident Management Meeting minutes provided documentation of resolution. The PNMT should review the monthly trending of ER/Hospital visits. The PNMT should analyze this information to determine if any significant patterns emerge. The PNMT was not represented in the group that conducted internal mortality reviews. A representative of the PNMT attending internal mortality reviews would be beneficial. At a minimum, a PNMT representative should be present for mortality reviews for individuals on their caseload who have died to gain knowledge from the individual's death, including identifying specific barriers or system issues related to significant health risk factors, and/or ways in which supports for individuals could be provided differently.	

#	Provision	Evaluation of Status	Compliance
		Immediate intervention is provided if the person is determined to be at risk of harm. Individuals who were identified at high risk for aspiration in Sample O.1 did not have action plans developed, and/or action plans did not recommend individual-specific monitoring to alert staff to a change in status. In addition, the PNMT did not complete individual-specific monitoring for the individuals in Sample O.2. The absence of individual-specific monitoring for these individuals had the potential to place them at risk of harm. In summary, LBSSLC was not yet in compliance with this provision of the Settlement Agreement. Policies and procedures were not in place for monitoring, and monitoring was not being completed on an individual or systemic level.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. For none the 10 individuals in Sample O.1 (0%), at high risk for aspiration, did the IDTs include measurable objectives designed to determine the efficacy of plans. The IDTs did not document progress related to individual strategies on a monthly basis, or determine the efficacy of those strategies in minimizing and/or reducing PNM risk indicators. In none of the 10 records (0%) reviewed was documentation found describing whether or not strategies were effective. As a result, changes could not be made to potentially ineffective plans. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators. The PNMT did not consistently provide recommendations for PNMT individual-specific monitoring, nor was there consistent evidence provided to support implementation of PNMT monitoring of staff's compliance with the PNMT action plan recommendations and measurable outcomes. None of records of the nine individuals in Sample O.2 provided evidence of individual-specific monitoring by the PNMT. LBSSLC was not yet in compliance with this provision of the Settlement Agreement, and no progress had been made with regard to Section O.7.	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by	All individuals receiving enteral nutrition receive annual evaluations that address the medical necessity of the tube and potential pathways to by mouth (PO) status. According to State policy, all individuals who received enteral nutrition would receive an annual APEN evaluation. Evaluation information was to be obtained from the PCP, RN, Habilitation Therapies, Dietary, and IDT members. The Nurse Case Manager would compile the APEN evaluation document. The Monitoring Team's previous report	Noncompliance

#	Provision	Evaluation of Status	Compliance
	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.	identified the major elements of the APEN evaluation. Five of the 10 individuals (50%) (Individual #68, Individual #293, Individual #128, Individual #324, and Individual #97) in Sample O.3 had received an APEN evaluation, but the purpose of the APEN evaluation had not been achieved. The APEN evaluation should assess the appropriateness of receiving enteral nutrition, leading to the development of strategies to transition to a less restrictive approach to enteral nutrition and/or development of a plan to return to oral intake, if appropriate. The following concerns were identified: ▪ APEN evaluations did not document the evaluation authors. APEN evaluations should document who collaborated in the completion of the evaluation. ▪ APEN evaluations did not recommend strategies to transition an individual to a less restrictive approach to receiving enteral nutrition and/or recommend a plan to return the individual to oral eating (e.g., Individual #97, or Individual #324). ▪ Individual #128 was receiving pleasure/therapeutic feeding, but this was not an APEN recommendation. The Facility should ensure that justification is provided in APENs for individuals with pleasure/therapeutic feeding programs, supported in recommendations, and implemented through action plan steps. ▪ Individual #68's APEN evaluation, dated 1/28/11, recommended a transition to intermittent feeding during the day. There was no documentation to address the implementation of this recommendation. The action plan did not incorporate this recommendation. Training should be provided to IDTs to explain the desired outcome of an APEN evaluation. These evaluations should be audited to confirm the intent of the APEN evaluation has been achieved. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the Settlement Agreement components.</u> Facility PNMPs identified prescribed assistive equipment, as well as non-negotiable staff strategies for communication, mobility, transfers, movement, dining instructions, positioning, and skin care. Additional attachments to the PNMPs included pictorial and written instructions for wheelchair and alternate positioning (e.g., right/left sidelying, supine). These instructions identified adaptive positioning equipment, and stated if a position was appropriate for enteral feeding, medication administration and/or oral care. As stated above in Section O.3, the PNMT was in the process of completing HOBE evaluations to determine the safe elevation range for an individual in their wheelchair, alternate positioning, bathing, tooth brushing and medication administration. None of the individuals in Sample O.3 had received a HOBE evaluation. Alternate and wheelchair positioning instructions stated clearly the correct method of elevation for an individual, but in some cases the photograph did not show where the chain was to be placed for	

#	Provision	Evaluation of Status	Compliance
		proper elevation. Based on interview, all individuals who require their head of bed to be elevated will receive the placement of red/green chain on their bed. Individuals in Sample O.3 were provided with a PNMP, but required components were absent as documented below: ▪ In four of 10 records (40%), positioning instructions were included with identified safe elevation range for wheelchair and alternate positions (i.e., Individual #109, Individual #161, Individual #114 and Individual #68). ▪ In 10 of 10 records (100%), transfer instructions were included. ▪ In nine of 10 records (90%), staff instructions were provided to identify the prescribed time an individual was to remain upright after receiving enteral nutrition (Individual #114's PNMP did not provide the time to remain upright after meals). ▪ In four of 10 records (40%), strategies for medication administration were included (i.e., Individual #109, Individual #161, Individual #114, and Individual #68). ▪ In four of 10 records (40%), strategies for oral hygiene were included (i.e., Individual #109, Individual #161, Individual #114, and Individual #68). ▪ In 10 of 10 records (100%), individual adaptive equipment was included. ▪ In none of 10 records reviewed (0%), bathing/showering positioning instructions were included. ▪ In none of 10 records (0%), personal care instructions for elevation during checking and changing were included. ▪ In 10 of 10 records reviewed (100%), communication strategies were included. The following concerns were noted: ▪ Multiple PNMPs indicated individuals could receive oral care in bed, which had the potential to place an individual at risk for aspiration. The Facility should assess the safety of individuals receiving oral care in bed. ▪ Individual #128's wheelchair pictorial instructions showed two options: most upright and most reclined. Both of these wheelchair positions were approved for enteral feeding, medication administration, and oral care/dental care. Her dining plan instructions were to "ensure upright position for all meals and 1 hour after meal." It was unclear why it was appropriate for her to receive enteral nutrition in the most reclined position in her wheelchair. Wheelchair positioning instructions were not consistent, which could lead to staff confusion. Staff should not have to make the decision for the most optimal position to receive enteral nutrition. Positioning instructions should be reviewed to ensure staff instructions were consistent.	

#	Provision	Evaluation of Status	Compliance
		As discussed above in further detail with regard to Section O.3, the HT Department should develop PNMP procedures that define an audit system to ensure compliance with PNMPs. <u>The need for continued enteral nutrition is integrated into the PSP.</u> Based on a review of individuals in Sample O.3, none (0%) of the individuals' ISPs 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 component of the DADS At-Risk Individuals policy (Policy Number 006, dated 11/02/10) required "a comprehensive integrated evaluation 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. However, the Facility had not followed this policy. LBSSLC was not in compliance with this provision of the Settlement Agreement as individuals had not received an APEN evaluation and/or the APEN evaluation was not adequate to support the Settlement Agreement requirements.	

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

1. The Facility Administration, in collaboration with the Habilitation Therapy Director, should continue to recruit therapists. (Section O.1)
2. The Facility should provide IDTs with training so that teams understand and implement the Facility's PNMT Guidelines, with an emphasis on PNMT referrals. (Section O.1)
3. To support successful implementation of the PNMT process leading to an adequate and effective comprehensive PNMT evaluation and action plan, the following is recommended:
    a. PNMT review and revision of individual Integrated Risk Rating Forms during the evaluation should be standard practice at LBSSLC.
    b. Once an individual is referred due to an IDT's identification of a high-risk indicator, the PNMT should initiate a timely evaluation per the At Risk Individuals policy "as soon as possible, or within five working days."
    c. Individual PNMT evaluation(s) should document when and why an individual was referred to the PNMT, including the concerns and risks that the IDT has identified.
    d. For individuals with tubes, the PNMT evaluation should review the results of an APEN evaluation to determine if recommended strategies support transitioning an individual to a less restrictive approach to enteral nutrition, and/or implementation of therapeutic/pleasure feedings, potentially leading to a return to oral eating.
    e. The PNMT evaluation(s) should reflect an evaluation of the identified high-risk and medium-risk areas.
    f. The PNMT evaluation(s) should document a comprehensive review of an individual's PNMP to determine if staff strategies continue to be adequate to minimize risk factors.
    g. The PNMT evaluations should encompass a detailed analysis of clinical evaluation data, which supports the development of

recommendations and measurable outcomes to minimize and/or reduce identified risk indicators.

h. Individual PNMT action plans should be integrated, as appropriate, into Nursing Care Plans, ISPs, PNMPs, Trigger Data Sheets, Dining Plans, and/or Behavior Support Plans.
i. Individual PNMT evaluations and action plans should identify individual-specific objective clinical data through which an individual communicates wellness and/or the onset of illness for clinical staff. The action plan should identify appropriate staff to monitor, document, and report on the clinical data. The clinical indicators should be integrated into nursing/health care plans.
j. In addition, the action plan should incorporate individual-specific behavior triggers for which direct support professionals are responsible for observing. The plan should identify how staff will monitor, document, and report on the triggers.
k. PNMT action plans should document how often action plan steps will be reviewed and updated.
l. PNMT action plans should identify how often the PNMT will conduct a hands-on evaluation to assess an individual's current status and provide data to support the efficacy of action plan interventions.
m. PNMT action plans should provide comprehensive steps to address high-risk indicators.
n. PNMT action plans should support proactive interventions to eliminate and/or minimize Infirmary, emergency room, and/or hospital admissions.
o. PNMT action plans should be reviewed post hospitalization to determine the efficacy of action steps and make revisions as appropriate.
p. PNMT action plans should incorporate transition plans for individuals who have been hospitalized.
q. PNMT action plans should be implemented with urgency.
r. ISPAs should be initiated to integrate the updated Integrated Risk Rating Form, PNMT evaluation, and action plan. This should be standard practice and supported through Facility policy. (Section O.2)

4. The Facility should develop PNMP procedures that should, at a minimum:
    a. Define the purpose, content and outcome(s) of the PNMP; outline the evaluation process to be used to provide justification for PNMP strategies (e.g., HOBE evaluation to identify safe elevation range); identify the responsibility of various disciplines for development and implementation of the PNMP sections; define the process to integrate PNMPs into the ISP; identify reason(s) for PNMP revision, and describe expectations for competency-based training and performance check-offs, as well as PNMP monitoring.
    b. Require the inclusion of non-negotiable staff strategies for individuals at high risk, such as time for an individual to remain upright after a meal, range of safe elevations for wheelchair and alternate positioning, personal care, oral care, bathing/showering, medication administration, etc. (Section O.3)
5. The PNMT should document an individual's status via Integrated Progress Notes to communicate with IDT members and provide evidence of the implementation of the PNMT action plan. PNMT members also should review Integrated Progress Notes to determine an individual's current wellness status and/or identification of the onset of illness, and document their review. (Section O.3)
6. When the PNMT discharges an individual, an ISPA meeting should be held to present and discuss the PNMT Discharge Plan. This plan should continue to support the implementation of staff strategies (e.g., nursing, therapy, and direct support professionals) to minimize identified health risk indicators. (Section O.3)
7. The MIC should develop MTC mealtime procedures to incorporate the following:
    a. Formalization of instructional content for mealtime competency-based training for MTCs. The curriculum should support the attainment of mealtime foundational knowledge and skills, including:
        - Mealtime position and alignment for individuals who eat orally and/or receive enteral nutrition;
        - Mealtime environment;
        - Mealtime staffing ratio;
        - Staff compliance with the dining plan;
        - Purpose of prescribed diet texture and fluid consistency;

- Presentation techniques to enhance nutritional intake and hydration;
- Care and use of adaptive equipment;
- Strategies to minimize/reduce high risk indicators during mealtime;
- Aspiration and choking precautions and rationale;
- Understanding a swallow study;
- Risk indicators and problem solving;
- Mealtime infection control;
- Techniques to promote optimal levels of independence and skill acquisition during mealtimes; and
- Mealtime skill acquisition programs.

b. Development and implementation of competency performance check-off forms to ensure MTCs are able to demonstrate the skills the mealtime curriculum is designed to teach; and
c. Establishment of a process through which Facility mealtime therapy experts validate the skills of MTCs. (Section O.4)

8. The Facility should review the NEO core competencies to ensure the competency check-offs include a detailed task analysis for each of the specific foundational/core competencies related to physical and nutritional supports. The competency check-offs should incorporate a demonstration component. (Section O.5)
9. Given that the completion of PNM competency performance check-offs for current LBSSLC employees and new employees will demand staff hours which exceed the HT Department's capabilities, the Facility should appoint core leadership staff to participate in a train-the-trainer process. The therapists should complete competency-based training and performance check-offs with the core leadership staff, who in turn would do so with existing and new employees. (Section O.5)
10. The PNMT should provide individual-specific competency-based training and performance check-offs to document staff competency in implementing PNMT action plans. The PNMT action plan should describe the purpose and content of the training related to identified risk indicators, identify the staff responsible for conducting the training and performance check offs, state the timeline for completion of training and performance check-offs, and identify which specific staff across shifts are to complete the training and performance check-offs (i.e., nursing, direct support professionals, supervisory staff, etc.). (Section O.5)
11. The MIC monitoring policy should incorporate the following:
    a. Identification of curriculum for competency-based training and performance check-off forms to define mealtime competency for MTCs and MTC monitors;
    b. Development of detailed scoring instructions for the MTC monitoring tool indicators and corrective action section;
    c. Definition and implementation of a validation process involving Facility therapists to achieve inter-rater agreement with MTC monitors for mealtime monitoring;
    d. Development of a schedule to ensure individuals at highest risk (e.g., those with issues related to aspiration pneumonia, respiratory concerns, choking, weight, dehydration, and fluid imbalance) are monitored on a more frequent basis;
    e. Definition of an auditing process to ensure resolution of individual-specific concerns and systemic issues;
    f. Formalization of a schedule to review the MTC monthly summary of the monitoring tool checklists to make recommendations for retraining and/or action to be taken for systemic issues; and
    g. Integration of the MTC monitoring tool checklist monthly summary into the QA/QI system; and
    h. Definition of what re-training will be required if the score falls below 80%. (Section O.6)
12. The HT Department should develop a system to document what action was taken with information provided by the PNMT Nurse to PNMT members and therapists from the morning medical meetings. (Section O.6)
13. The PNMT should analyze the monthly trending of ER/Hospital visits to determine if any significant patterns emerge. (Section O.6)
14. A PNMT representative should be present for mortality reviews for individuals on their caseload who have died to gain knowledge from the

individual's death. (Section O.6)

15. The PNMT should conduct individual-specific monitoring to document staff compliance with PNMT action plans. (Section O.6 and O.7)
16. IDTs that support individuals with high-risk physical and nutritional management difficulties should provide tracking and analysis of action steps to determine the efficacy of their interventions to minimize and/or reduce identified risk indicators. (Section O.7)
17. The Facility should ensure APEN evaluations are completed thoroughly, and that resulting recommendations are integrated as appropriate into individuals' ISPs. (Section O.8)
18. Focus should be placed on defining the sample for Section O, expansion of instructions for the audit tools, and the development of standardized procedures to achieve inter-rater agreement. (Facility Self-Assessment)

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 for Settlement Agreement Monitoring Team Compliance Visit, October 2011; o The following documents: OT/PT Evaluation and Update, HOBE Evaluation, Wheelchair Evaluation, supporting documentation for implementation of direct/indirect therapy programs; OT/PT Consultations for the past year, ISP and ISPAs for the past year, PNMP with pictures, Dining and Diet Card, PNMP Clinic documentation for the past year, PNMP and individual-specific monitoring for the past six months, staff competency-based training, daily schedule, Community Living Discharge Plan, Integrated Risk Rating Form, Risk Action Plan and Modified Barium Swallow Study for 11 individuals, including: Individual #213, Individual #48, Individual #167, Individual #147, Individual #199, Individual #210, Individual #34, Individual #128, Individual #203, Individual #14, and Individual #159; o OT/PT evaluations for new admissions for four individuals, including: Individual #131, Individual #92, Individual #273, and Individual #7; o Organizational chart of Habilitation Therapy Department, undated; o List of current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff with corresponding caseloads, undated; o Continuing education completed by OTs and PTs, various dates; o Lists of individuals who use wheelchair as primary mobility, use ambulation/assistive devices, or have had decubitus/pressure ulcers during past 12 months, undated; o List of individuals using transport wheelchairs, orthotics and/or braces, undated; o PNM maintenance log utilized to track modifications made to adaptive/assistive equipment, from 3/11 through 8/11; o OT/PT evaluation schedule, from 4/11 through 9/11; o Wheelchair seating and PNM clinic assessment (templates) with instructions, undated; o OT/PT-related spreadsheets, dated 9/1/11; o HT PNMP observation and HT meal observation forms, revised 1/26/11; o OT/PT competency-based training materials, various dates; o QA/QI data for sections O, P, and R, from 10/10 through 8/11; and o List of individuals receiving direct OT and PT services and focus of intervention, undated. ▪ **Interviews with**: o Linda Thomas, OT, Director of Habilitation Therapy; o Jon Olive, PT; o Megan Copeland, OT; o Jennifer Cunningham, PT;

- Francis Shaw, PT;
- Missy Olive, PTA; and
- Lillie Loggins, COTA.

- **Observations of**:
  - In residences and dining rooms in 504 E. Mesquite Drive, 504 W. Mesquite Drive, 525 North Cedar Avenue, 527 North Cedar Avenue, and 528 North Cedar Avenue.

Facility Self-Evaluation: Based on a review of the Facility's POI, with regard to Section P of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings.

Section P of the Facility's POI/Self-Assessment indicated that the Program Compliance Monitor (PCM) met with the Director of Habilitation Therapy to review the completed monitoring, including the findings and analysis of the information. The following chart presents reported findings:

Sample of Three Individuals	Inter-Rater Reliability	Overall Compliance	Overall QA Compliance
May	59%	94%	-
June	66%	94%	-
July	75%	96%	-
August	92%	92%	97%

The Monitoring Team was unclear how the overall compliance percentage was calculated, and questioned its validity. The monitoring tools were not designed to provide an overall compliance rating, because individual items were not weighted. In addition, in order for the data to be useful to the Facility in identifying areas in which strengths or needs exist, data should be reviewed per indicator. This will allow the Facility to identify and broaden best practices, and identify and address specific areas requiring correction.

Monthly Analysis of data for Section P from May to August was provided in the Presentation Book for Section P. It documented systemic problems that were, in most cases, repeated from month to month. The monthly form did not present strategies and/or initiatives to ameliorate problems identified. Summary of this data, as well as actions taken to correct problematic trends should be described in the Facility's POI.

The absence of adequate instructions for the monitoring tool and distinct trials to achieve inter-rater reliability between therapists and the PCM will result in audit findings that will not be reliable and/or valid. Focus should be placed defining the sample for Section O and the development of adequate instructions for the audit tools. Standardized procedures should be implemented to determine inter-rater agreement.

The Facility had two Action Plans for Section P. The Action Plan for P.2 related to improving therapists'

	participation in the IDT and individual planning process, including their role in the development and implementation of relevant skill acquisition programs. The Action Plan for P.3 involved improving new employee orientation, and particularly defining the parameters of competency-based training for direct support professionals. The Facility indicated that all action steps for these plans had been completed. Based on interview and document review these action steps had been completed. However, additional work will need to be completed to ensure therapy recommendations are supported through the development and implementation of skill acquisition programs. In addition, multiple competency check-off forms needed to be revised to include performance components.
	Summary of Monitor's Evaluation: The Director of Habitation Therapy, OTs, and PTs continued to revise the OT/PT evaluation template. In addition, a Therapy Consultant presented an evaluation modification to the State OT/PT evaluation template, which the OTs/PTs were using. The revised OT/PT evaluation format incorporated discussion of health risk indicators and recommendations for therapeutic interventions to improve health status, which was a constructive development. The Monitoring Team supported continued revisions to the OT/PT template. However, a review of multiple OT/PT evaluations showed they continued to include recommendations that were primarily service objectives. An absence was noted of individual-specific recommendations to enhance quality of life and function through skill acquisition and learned skill application. The OT/PT evaluation template should provide guidelines to identify an individual's preferences and strengths. An individual's potentials should be based on identified strengths, personal preferences, and desired outcomes that the individual and the team have identified. The evaluation should identify how to minimize an individual's impairments and functional limitations that are barriers to achieving desired outcomes. The current evaluation format did not incorporate these components, and/or provide adequate information to assist the individual and IDT members to develop and implement functional outcomes to achieve an individual's goals, preferences, and needs. Thirteen (13) of the 225 individuals (6%) living at LBSSLC were receiving direct OT and/or PT services. Based on a review of a sample of these individuals, numerous issues were noted with regard to absence of functional, measurable outcomes; integration of the plan into the ISP; absence of skill acquisition programs; and plan implementation and documentation. Individuals' daily activities and/or schedules did not include opportunities to practice skills acquired or provide diverse opportunities for practice of new skills. The HT Department was to be commended for the development of multiple written and pictorial staff instructions for prescribed PNMP strategies, which reflected a significant investment of time. Competency-based training and performance check-offs had been completed for some of these PNMP strategies, but not all. Additional competency-based training and performance check-offs will need to be completed for PNM core competencies and individual-specific PNMP strategies.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days	Minimal progress had been made with regard to Section P.1, which requires the Facility to identify individuals with therapy needs and complete a comprehensive integrated	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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 evaluation, within 30 days of the need's identification, including wheelchair mobility evaluation as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.</td><td>occupational and physical therapy evaluation, as well as to assess individuals newly admitted to the Facility within 30 days. The OT/PT evaluation should consider significant medical issues and health risk indicators, and identify therapeutic interventions to support individuals' health.

The Monitoring Team's record sample for Section P was as follows:
▪ Sample P.1 – four individuals who experienced a health status, including: Individual #34, Individual #128, Individual #203, and Individual #14;
▪ Sample P.2 – five of 30 (17%) individuals with a diagnosis of aspiration pneumonia who had been hospitalized within the past year, including: Individual #193, Individual #118, Individual #66, Individual #211, and Individual #263;
▪ Sample P.3 – one of one individual (100%) who had transitioned to the community: Individual #159;
▪ Sample P.4 – four of four individuals (100%) newly admitted to LBSSLC, including: Individual #131, Individual #92, Individual #273, and Individual #7;
▪ Sample P.5 – seven of 13 individuals (54%), who were receiving direct OT/PT services, including: Individual #213, Individual #48, Individual #167, Individual #147, Individual #199, Individual #283, and Individual #74; and
▪ Sample P.6 – four individuals assessed with new OT/PT format, including: Individual #274; Individual #209; Individual #199, and Individual #128.

<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, 225 individuals were living at LBSSLC. The Facility had budget authority for five OT positions, and three PT positions. The following chart represents the reported current caseload of OTs, and PTs:

<table>
<tr><th>OTs</th><th>Current Caseload and Responsibilities</th></tr>
<tr><td>OT #1</td><td>Supported 154 individuals</td></tr>
<tr><td>OT #2</td><td>Vacant</td></tr>
<tr><td>OT #3</td><td>Vacant</td></tr>
<tr><td>OT #4</td><td>Vacant</td></tr>
<tr><td>OT #5</td><td>Vacant</td></tr>
<tr><th>PTs</th><th>Current Caseload and Responsibilities</th></tr>
<tr><td>PT #1</td><td>PNMT member, caseload of 16 PNMT individuals and 20 individuals in Quail and Sparrow</td></tr>
<tr><td>PT #2</td><td>Supported 82 individuals</td></tr>
<tr><td>PT #3</td><td>Supported 95 individuals</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Four vacant OT positions will have a significant impact on individuals receiving adequate OT supports. Documented throughout this section of the report, individuals were not receiving needed therapy supports. In addition, the HT Department had implemented procedures to ensure that one therapist attended the ISP meetings, which was an improvement over not having any therapists present for the annual meetings. Unfortunately, the preceding procedure provided therapy representation for one discipline, but individuals for whom therapy's involvement was necessary continued to not have therapy representation for the two remaining disciplines during annual ISPs and ISPAs. Therapy vacancies and current caseloads will continue to have a negative impact on the HT Department's ability to achieve compliance with Section P. Facility OTs, COTAs, PTs, and PTAs had attended State-sponsored webinars, including: Assessment of Technologies, and GI/Dysphagia Issues in Individuals with Developmental Disabilities. Documentation submitted included attendance rosters and certificates of completion. The attendance by therapists and assistants who were not PNMT members was important to build capacity within the Department for future PNMT membership, and to assist therapy staff in working with IDTs to develop effective risk action plans. Additional community continuing education completed by OTs and PTs included Enteral Nutrition in the Neurologically Impaired Child, and Aging Body and Aging Mind, which were appropriate continuing education courses. <u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u> Individuals in Sample P.1, P.2. P.3, P.5, and P.6 had received an OT/PT assessment. The HT Department did not complete screenings, because they completed full assessments of newly-admitted individuals. Since the last on-site review, four individuals had been admitted to LBSSLC. The HT Department completed an OT/PT assessment not a screening. The OT/PT assessment was more extensive than a screening. Four individuals' OT/PT assessments were submitted for new admissions to LBSSLC. Individual OT/PT evaluations for Sample P.4 confirmed the evaluations had been completed within 30 days of admission. However, these evaluations did not identify preferences and strengths, which would lead to the discovery of potentials for learning and skill acquisition. A review of these individuals' evaluations showed they did not include individual-specific recommendations for functional skill acquisition programs, nor did they set forth the outcomes expected from the implementation of plans or programs. The recommendations were more reflective of service objectives. For example: "continue and/or implement PNMP," "continue assistive equipment," "use communication strategies," "reassess in one year," or "skilled	

#	Provision	Assessment of Status	Compliance
		OT/PT not indicated," etc. As a result, specific supports were not designated, nor could the implementation of supports be measured to determine their efficacy. Within 30 days of admission, IDT members were responsible for completing a risk assessment to determine areas of risk. None of the OT/PT evaluations (0%) in Sample P.4 discussed an individual's risk assessment. For example, Individual #7's OT/PT Evaluation, dated 7/26/11, stated: "[Individual #7] has not had an initial risk assessment as she is newly admitted to the living center." The OT/PT evaluation for newly admitted individuals should address an individual's high and medium risk indicators related to therapeutic interventions. <u>All people identified with therapy needs have received a comprehensive OT and PT evaluation within 30 days of identification.</u> An Evaluation schedule tracked individual ISP dates, as well as evaluation and re-evaluation dates for OT, PT, and audiology. The Director of Habilitation Therapy reported priority criteria would be created in the future to assist in the development of a schedule for OT and PT evaluations. The LBSSLC OT/PT evaluation template, 9/30/11, was revised and included the following sections: general information, diagnosis/medical history, medications, method of communication, behavioral considerations, OT/PT consults, identified risks, HT assessments, nutritional/oral motor/eating ability, medication administration/oral care, assistive/supportive devices, PNMP, and summary/analysis of findings. This final section was to include strengths; OT analysis related to adaptive living skills (ADLs); oral motor, sensory and nutritional risks; and PT analysis related to functional mobility, transfers, and physical risks. Other sections were included for additional recommendations, reassessment schedule, and supports needed for community placement. The revisions were positive, but the Monitoring Team's review of multiple OT/PT evaluations did not reflect the development of individual-specific recommendations for functional skill acquisition programs, nor did they set forth the outcomes expected from the implementation of plans or programs. The HT Department should continue to revise the OT/PT evaluation template to provide adequate evaluation data consistent with the revised ISP process. The Evaluation Instructions that provided guidelines for the OT/PT evaluation had been revised. The instructions required an analysis of findings and rationale for recommendations. The recommendations were to be stated clearly and include responsible person(s) for implementation. The recommendations were to include criteria to monitor and assess their efficacy. Recommendations for supports/activities, other than direct therapy were to be incorporated into the ISP and integrated into an individual's daily routine. Additions to the evaluation instructions included an analysis	

#	Provision	Assessment of Status	Compliance
		of findings/rationale for recommendations at the conclusion of each evaluation section, and incorporation of bathing and toileting under ADLs, medication administration, and oral care. The Evaluation Instructions did not mirror the format of the revised OT/PT evaluation template. To avoid confusion, the evaluation template and instructions should be compatible. Additional concerns regarding the content of the instructions are provided below. For individuals in Sample P.6, OT/PT evaluations using the new format were reviewed. The following observations describe weaknesses in these evaluations and offer recommendations to ameliorate these deficiencies: ▪ Three of these individuals (i.e., Individual #209, Individual #199, and Individual #128) had been seen in the emergency room. Although hospitalizations were to be addressed in the PNMP review portion of the OT/PT assessment, it was unclear if emergency room visits were to be reported in this section. The PNMP review section for these individuals did not discuss emergency room visits within the past year, which might have an impact on therapeutic interventions and PNMPs. Evaluation instructions should prompt therapists to report emergency rooms visits within the past year. ▪ OT and PT analyses related to risks did not discuss the status of IDT Risk Action Plans and/or the efficacy of therapy interventions. Evaluation instructions should provide guiding questions in the risk level section to assist therapists in addressing current and/or future strategies to minimize high and medium risk levels to achieve improved health status. The evaluation guidelines should prompt therapists to talk about the individual's risk action plan, current status, and efficacy of therapeutic interventions, and to make recommendations for change, if appropriate. ▪ Individuals at high risk of aspiration did not receive a HOBE evaluation to assess safe elevation levels for wheelchair and alternate positioning, bathing, tooth brushing, personal care, medication administration, and mealtime. ▪ OT/PT evaluations did not provide a description of an individual's preferences, interests, and potentials. Hands-on collaborative evaluation (OT and PT) data should be sufficiently discrete to identity an individual's preferences and interests, leading to the discovery of potentials for learning and skill acquisition. The evaluation data should lead to the development of functional outcomes that are meaningful for the individual in the context of everyday living at home, work, and during leisure activities. Functional outcomes should identify an integrated series of behaviors that allow an individual to achieve important everyday goals. ▪ Evaluation recommendations primarily focused on providing services (e.g., "continue with PNMP and assistive equipment"). Recommendations should reflect opportunities for individuals to learn. Recommendations should lead to	

#	Provision	Assessment of Status	Compliance
		the development of skill acquisition programs. The OT/PT evaluation template should provide guidelines to identify an individual's preferences and strengths. The evaluation should identify how to minimize an individual's impairments and functional limitations that are barriers to achieving desired outcomes. The current evaluation format did not incorporate the preceding strategies and/or provide adequate information to assist the individual and IDT members to develop and implement functional outcomes to achieve the individual's goals, preferences, and needs. ▪ Individuals who experienced a loss of function and had received direct therapy supports did not have specific recommendations for skill acquisition programs (e.g., Individual #199). ▪ OT/PT assessments did not recommend individual-specific competency-based training for staff and check-offs for PNMPs and/or OT/PT programs. ▪ OT/PT recommendations did not consistently support the attainment of a functional outcome. The analysis of evaluation findings should provide a rationale for functional outcomes and recommendations. The analysis should discuss possibilities for the development of formal programs and informal activities that would support the achievement of ISP action plan training objectives. The revision of the OT/PT evaluation template to incorporate risk levels was a constructive addition. Additional template instructions should require an evaluation of an individual's preferences, interests, and potentials to form the foundation for potential learning and skill acquisition. The evaluation data also should lead to the discovery of an individual's potentials for an improved health status. The HT Department should develop and implement audit protocols to ensure OT/PT evaluations follow evaluation instructions. <u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT evaluation every three years, with annual interim updates or as indicated by a change in status.</u> Individuals in Sample P.5, who received direct therapy, had received an OT/PT evaluation within the past three years. These evaluations did not consistently include individual-specific recommendations for functional skill acquisition programs, nor did they set forth the outcomes expected from the implementation of the plans or programs. HT Department utilized individual-specific consultations to address a change in health status. Monitoring results were utilized to identify an individual change in status. Health status changes were communicated to therapists through therapist representation at the Incident Management Review Team morning meetings, and the	

#	Provision	Assessment of Status	Compliance
		PNMT nurse's attendance at the morning medical meetings. However, the HT Department should formalize therapists' responsibilities to evaluate and document an individual's change in status. An ISPA meeting should be initiated to discuss and integrate the results of the evaluation. Records were reviewed for individuals in Sample P.2 who experienced a change in status, such as diagnosis of aspiration pneumonia and who had been hospitalized (i.e., Individual #193, Individual #118, Individual #66, Individual #211, and Individual #263), and individuals in Sample P.1 who experienced falls (e.g., Individual #203), weight gain and/or loss (e.g., Individual #34 and Individual #128), unexplained weight loss (Individual #213), received a MBSS (Individual #14), received a feeding tube (Individual #48). The following issues were noted with regard to OT/PT evaluations and updates: ▪ HOBE evaluations had not completed for individuals who were at high risk for aspiration and had been hospitalized. ▪ It was positive that the Facility had updated PNMPs after individuals had been hospitalized. However, individuals' PNMPs in Sample P.2 were not adequate to address their high-risk status for aspiration pneumonia. PNMPs had been updated, but essential components were missing to ensure safety. For example, the PNMPs did not consistently address bathing/shower instructions. On a positive note, Individual #66 had written and pictorial instructions for her shower chair position. These instructions included notch positions for shower chair seat back and leg elevation. Of additional concern, PNMPs stated: "never lay flat," but no staff instructions were provided for degree of elevation in bed and/or a changing table for personal care. In addition, none of the staff for these individuals had received competency-based training and performance check-offs for revised PNMP strategies. ▪ OT/PT updates did not discuss high risk factors for weight, or provide individual-specific recommendations to support weight loss and/or gain. ▪ Current OT evaluations and/or updates were not completed to discuss the need for changes, and/or justify the need for changes made. ▪ For individuals with significant histories of falls (e.g., Individual #203), OT/PT updates did not provide individual-specific recommendations for skill acquisition program(s) or integration of walking activities into individuals' daily schedule to minimize his high risk for falls. ▪ OT/PT evaluations and updates did not address integration with nursing/health management care plans. ▪ Individuals with skin breakdown were at serious risk for infection and ongoing compromised health status. The OT/PT evaluations and updates did not include a comprehensive evaluation of the reasons for the skin breakdown, which should lead to collaboration with nursing and medical staff on the	

#	Provision	Assessment of Status	Compliance
		development of an integrated care plan with aggressive strategies to address skin breakdown. ▪ OT/PT evaluations did not address preferences. Sample P.3 included one individual who had transitioned to the community. An OT/PT evaluation and/or update that comprehensively evaluated her future change in status (e.g., community transition) had not been completed: ▪ Individual #159 transitioned to the community on 4/4/11. Her OT evaluation, dated 8/1/08 and PT evaluation, dated 7/14/10, did not provide current essential information to her community provider prior to community placement. OT/PT evaluations should be completed within an established timeframe prior to community transition. In addition, the evaluations should address risk factors and the strategies employed to minimize these risks. <u>Medical issues and health risk indicators are included in the evaluation process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.</u> Recent revisions of the OT/PT evaluation format had integrated an analysis of risk factors by the OT and PT. Although this was a positive change, its impact had not yet been seen in the evaluations or updates completed for individual in the samples reviewed. In fact, none of OT/PT evaluations and/or updates for individuals in Samples P.1 and P.2 (0%) addressed high and medium health risk indicators, discussed the efficacy of therapy interventions in IDT Risk Action Plans, and/or made additional recommendations, if therapy interventions had not been effective. <u>Evidence of communication and/or collaboration is present in the OT/PT evaluations.</u> Based on review of the records of individuals in Sample P.1 and P.2, all OT/PT evaluations (100%) included signatures of the OT and PT, as well as the date. LBSSLC was not yet in compliance with this provision of the Settlement Agreement. The Facility should continue to recruit OTs, update the Evaluation Instructions to ensure alignment with the most current OT/PT evaluation template, continue to improve the instructions provided to OTs and PTs on the completion of evaluations, and develop and implement policies to define the OT/PT comprehensive functional evaluation process.	
P2	Within 30 days of the integrated occupational and physical therapy evaluation the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and	Minimal progress had been made with regard to Section P.2 that requires the Facility to develop plans to address the recommendations in the integrated OT/PT Evaluations through the incorporation of plans into individuals' ISPs. <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>	Noncompliance

#	Provision	Assessment of Status	Compliance
	physical therapy evaluation and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Based on a review of individuals in Sample P.1 and P.2, none of these individuals (0%) had a plan that had been developed based on OT/PT recommendations, and integrated into the ISP. The following concerns were noted: ▪ OT/PT evaluations identified individual potentials, but no skill acquisition programs had been recommended and/or developed. ▪ OT/PT evaluations acknowledged individuals were dependent on staff for activities of daily living, but no plans were developed to provide opportunities for skill acquisition and practice to support an individual's ability to increase independence in dressing, bathing, toileting, personal hygiene, grooming, etc. ▪ OT/PT evaluations were not current, and as a result, did not reflect an individual's current preferences and potentials for learning, leading to the development of plans to support learning new skills. ▪ Individuals had been identified as significantly overweight, but no plans had been developed to address their overweight status to minimize health risk concerns. ▪ OT/PT recommendations mainly addressed the implementation of service objectives and not individual-specific recommendations that resulted in the development of plans to promote active learning at home, in activity centers and work sites, and during leisure pursuits. Thirteen (13) of the 225 individuals (6%) living at LBSSLC were receiving direct OT and/or PT services. Based on review of individuals in Sample P.5, none of the six HT Therapy Plans (0%) recommended ISP integration of the therapy plan's outcome measures, or development and implementation of related skill acquisition programs, and/or other opportunities for practice of the new skills throughout the 24-hour day. Numerous issues were noted with regard to the implementation of the plans, and integration of the plans into the ISPs. Generally, direct therapy plans were not reinforced through skill acquisition programs and/or during daily activities. These issues included: ▪ Activity plans did not have measurable outcomes. Objectives such as: "to improve his abilities with transfers and ambulation and to possibly decrease his left lower extremity and lower back pain" were not measurable. ▪ Multiple plans stated: "will be seen 1 to 5 times per week in the designated area." Activity plans should identify a scheduled time and location to allow adequate integration of the HT activity plan into an individual's daily schedule. ▪ A review of HT data sheets revealed multiple sessions were cancelled due to an individual's enteral feeding schedule, individuals not being present when the therapist arrived, individuals already being engaged in another activity, multiple refusals to participate; etc. The initiation of an HT Activity Plan should be discussed and approved during an ISPA meeting to establish an	

#	Provision	Assessment of Status	Compliance
		implementation schedule. Team members then should support the implementation of the plan. The therapist should recommend strategies to reinforce therapy treatment through a variety of experiences, practice, and repetition. ▪ An activity plan was not present for an individual receiving HT services (i.e., Individual #199). ▪ Completion of monthly progress/summary note documentation was inconsistent. ▪ Direct therapy was discontinued due to lack of progress without adequate justification and/or approval of the IDT (e.g., Individual #167, and Individual #48). ▪ Progress Notes documented discharge from therapy services, but no ISPA meeting was recommended to discuss what strategies would be employed to reinforce therapy goals that had been achieved. ▪ No IPNs documented the initiation of HT therapy services, individual therapy sessions, and/or discontinuation of therapy services. ▪ HT Activity Plans recommended therapy services for a specific time span (e.g., two months), but HT data sheets entries stopped before the identified timeframe without explanation. <u>Within 30 days of development of the plan, it is implemented.</u> The HT Activity Plans for five of the seven individuals within Sample P.5 (86%) (Individual #213, Individual #48, Individual #167, Individual #283, and Individual #74) had been implemented within 30 days of an HT Consultation. As discussed above, concerns were noted with the development and implementation of the HT Activity Plan, as well as the absence of integration in the ISP. Facility policy should define therapists' responsibility for an HT activity plan. This should include ensuring the components of the direct therapy action plan define a formal schedule, developing therapy outcomes that are functional and measurable, requesting an ISPA meeting to integrate the therapy plan into the ISP, and reinforcing the therapy plan through formal skill acquisition programs and multiple opportunities to practice new skills within an individual's daily routine. <u>Appropriate intervention plans are: integrated into the ISP, individualized, based on objective findings of the comprehensive evaluation with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.</u> In Sample P.5, none of individual's (0%) HT activity plans were integrated into the ISP. <u>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</u>	

#	Provision	Assessment of Status	Compliance
		(change in setting), or as dictated by monitoring results. Individuals in Samples P.1, P.2, P.3, P.4, and P.5 did not have an individual-specific monthly review of their status, or review as a result of a change in status, and/or completion of individual-specific monitoring. LBSSLC was not yet in compliance with this provision of the Settlement Agreement. As discussed above, individual HT therapy plans had not been implemented into individuals' ISPS, did not have functional measurable outcomes, and were not consistently implemented and/or documented.	
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.	Progress had been made with regard to Section P.3 in the development and implementation of competency check-offs for some individual-specific PNMP instructions. However, staff demonstration was absent from multiple check-off forms. Staff implements recommendations identified by OT/PT. As noted above with regard to Section O.4 of the Settlement Agreement, the Monitoring Team observed multiple instances of staff not following prescribed PNMP strategies. Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. The HT Department was to be commended for the development of written and pictorial staff instructions for prescribed PNMP strategies, which reflected a significant investment of time. A review of the individuals' records for Sample P.5 revealed multiple individual-specific instructions for gait belts, recliner positioning, beds with blocks, wedge and chain elevation, wheelchair positioning, bedrails, alternate positioning (e.g., left and right sidelying, supine), assisted ambulation, right ankle brace, hands-on assistance of two for standing, transfers, and walking one to two steps. Staff competency check-off sheets were developed and implemented for some individual-specific PNMP strategies for individuals in Sample P.5. The following forms were good examples of competency check-offs with sequential steps required for staff demonstration: ▪ Mechanical Lift Assessment Checklist; and ▪ Transfer/Walk With Assist of One. None of the individuals' staff (0%) had completed competency-based training and performance check-offs to address implementation of PNM core competencies and/or all individual-specific PNMP instructions. The following issues were noted: ▪ Competency check off forms did not identify the instructor's credentials or the staff's position title. ▪ Multiple competency check-off forms did not require staff demonstration, such	Noncompliance

#	Provision	Assessment of Status	Compliance
		as Meal Time Competencies, and the PNMP Update Competency-Based Written Test. ▪ Competency check-offs forms were not congruent with PNMP written instructions. LBSSLC had not yet achieved compliance with this provision. The Facility had implemented competency check-offs for some PNMP strategies, but these check-offs did not always incorporate staff demonstration. The Facility had not established a policy and procedures for the development and implementation of competency-based training and performance check-offs for core competencies of PNM foundational skill training, individual-specific PNMP strategies, and strategies to reinforce skill acquisition related to direct therapy plans.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	Minimal progress had been made with regard to Section P.4 that requires the Facility to develop and implement a system to monitor and address individual's adaptive/assistive equipment, the OT/PT and PNMP treatment interventions, and direct support professionals' implementation of the interventions. <u>System exists to routinely evaluate: fit; availability; function; condition and effectiveness of all adaptive equipment/assistive technology.</u> The OT/PT evaluation instructions for assistive/supportive devices required therapists to identify equipment, describe the function, present the schedule for use, as well as the rationale for selection of equipment, and document the efficacy of all assistive equipment. The Monitoring Team did not find OT/PT assessments and/or PNMP Clinic documentation to adequately provide a comprehensive review of prescribed equipment. None of the individuals from Sample P.1 (0%) had a comprehensive evaluation/review during the PNMP Clinic and/or OT/PT evaluation to evaluate the fit, availability, function, condition, and effectiveness of all prescribed PNMP adaptive/assistive equipment. The following concerns were noted: ▪ The PNMP Clinic documentation format did not require documentation of medium and high risk indicators that would impact PNMP adaptive/assistive equipment; ▪ No comprehensive list was documented of individual-specific prescribed PNMP adaptive equipment, mealtime equipment, and communication/hearing equipment; ▪ The PNMP Clinic format did not document appropriate therapist evaluation/review of prescribed equipment for fit, availability, function, condition, and effectiveness of all prescribed equipment; ▪ The PNMP Clinic form did not have signatures for therapists in attendance; ▪ Recommendations did not, but should identify the responsible therapist, date of delivery, staff to receive competency-based training and performance check-off,	Noncompliance

#	Provision	Assessment of Status	Compliance
		identified staff to conduct training, how often the equipment will be monitored, and staff to conduct monitoring. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. 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 Settlement Agreement). Systemic and individual-specific issues related to training staff are discussed above with regard to Section O.5 of the Settlement Agreement. 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 Settlement Agreement). Systemic and individual-specific issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. As discussed above, adequate safeguards were not in place to ensure each individual had appropriate adaptive and assistive technology supports. 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 Settlement Agreement). As is discussed above with regard to Section O.5 of the Settlement Agreement, adequate training and monitoring of staff compliance with individual-specific plans was not being completed. Data collection method is validated by the program's author(s). For none of the six individuals (0%) receiving direct OT/PT services was the data collection method validated by the program's author.	

#	Provision	Assessment of Status	Compliance
		LBSSLC had not yet achieved compliance with this provision. The Facility had defined procedures for the PNMP and Wheelchair Clinic, but they did not address the Settlement Agreement requirements. The procedures should be expanded to monitor the status of individuals with identified occupational and physical therapy needs; the fit, availability, function, condition and effectiveness of prescribed equipment; 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.	

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

1. The Facility should continue to recruit and fill vacant therapy positions. (Section P.1)
2. The Facility should incorporate the following recommendations into the OT/PT evaluation template and instructions:
    a. The evaluation medical history section should include discussion of hospitalizations and/or emergency room visits within the past year that might have an impact on therapeutic interventions and PNMPs. Evaluation instructions should prompt therapists to report hospitalizations and emergency rooms visits within the past year.
    b. The evaluations of individuals at high risk of aspiration and respiratory concerns should incorporate a HOBE evaluation to assess safe elevation levels for wheelchair and alternate positioning, bathing, tooth brushing, personal care, medication administration, and mealtime.
    c. Hands-on collaborative evaluation (OT and PT) data should be sufficiently discrete to identity an individual's preferences, interests, current skills, and discovery of potentials for learning and skill acquisition. This should be accomplished through observation, staff interview, record review and clinical evaluation. It should lead to the development of functional outcomes that are meaningful for the individual in the context of everyday living at home and work, and during leisure activities. Functional outcomes should identify an integrated series of behaviors that allow an individual to achieve important everyday goals.
    d. Instructions for the Health Risk Indicator(s) section should be revised to reflect the current risk evaluation process, including the individual's risk ratings, and therapists' responsibility within risk action plan(s), including determining the efficacy of interventions.
    e. Individual-specific recommendations should be based on an individual's preferences, goals, preferences, and needs, and should support learning to achieve these goals within the home, work, and leisure environments, and in the community.
    f. Recommendations should include criteria that would enable the team to assess and monitor implementation to ensure efficacy of formal program(s).
    g. Recommendations should be integrated into an individual's ISP, not only through formal skill acquisition programs, but also informally through multiple informal activities that reinforce and generalize the learning of new skill(s) in multiple environments throughout the 24-hour day. (Section P.1)
3. The Facility should develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines. (Section P.1)
4. With regard to the provision of direct and indirect therapy services:
    a. Direct and indirect therapy interventions should be analyzed, during the evaluation 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;
    b. 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;

c. As appropriate, 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 ISP;
d. Monthly documentation should justify the initiation, continuation or discontinuation of evaluation recommendations, and reflect the status of measurable outcomes;
e. Quarterly documentation should be provided for the provision of indirect supports; and
f. There should be a formal process for 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. (Section P.2)

5. Facility policy should define the process that should occur across the 30 days post development of the plan. This should include, but not be limited to ensuring the components of the direct therapy action plan identify and support outcomes that are functional and measurable, and integrating the plan(s) within the ISP, including the plans' outcomes and objectives, as well as, as appropriate, formal skill acquisition programs and informal activities for implementation during the individual's daily routine. (Section P.2)
6. The Facility should establish a policy and procedures for the development and implementation of competency-based training and performance check-offs for PNM core competencies, individual-specific PNMP strategies, and strategies to reinforce skill acquisition related to direct therapy plans. The implementation of competency-based training and performance check-offs should receive be a priority, with individuals identified at high risk for choking, aspiration, respiratory concerns, falls, fractures, and skin integrity being highest priority. (Section P.3)
7. The Facility should expand the defined process for the PNMP and Wheelchair Clinics to ensure individuals' adaptive/assistive equipment is reviewed for fit, availability, function, condition, and effectiveness. (Section P.4)
8. The Facility should focus on the identification of a relevant sample, and development of adequate instructions and criteria for the audit tools for Section P. In addition, procedures should be developed and implemented to ensure inter-rater reliability. (Facility Self-Assessment)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o LBSSLC Policies and Procedures, including: LBSSLC – Health Services: Dental/Medical Sedation and Restraint, dated 9/8/11; LBSSLC – Dental Services: Dental Prophylaxis, dated 9/8/11; LBSSLC - Dental Services: Oral Care for Enterally Fed Individuals, dated 9/8/11; LBSSLC-Dental Services: Suction Toothbrush, dated 9/8/11; LBSSLC – Dental Services: Oral Care, dated 9/9/11; o Drafts of following policies and procedures: LBSSLC-Health Services: Dental Anesthesiologist; General Anesthesia Medical Clearance; Criteria for General Anesthesia; General Anesthesia Recovery; General Anesthesia Surgery; General Anesthesiology Personnel; Instructions for Individuals following the General Anesthesia Clinic; Instructions for Individuals Prior to General Anesthesia Clinic; General Anesthesia Policy; and Pre-operative Sedation prior to General Sedation; o Newly admitted individuals and date of initial dental exam; o List of individuals seen for dental services in past six months, other than annual dental exam, with date of visit, and reason for visit; o List of individuals that refused dental services in the past six months; o List of individuals with missed appointments, other than refusals, with appointment dates of completed follow-up visits; o List of individuals that had tooth/teeth extractions in the past six months; o List of individuals seen for dental emergencies in the past six months; o List of individuals completing preventive dental care visits; o List of individuals completing restorative dental care in the past six months; o List of individuals with date of last completed dental exam; o Most recent comprehensive exams for one individual from each residence, including: Individual #276, Individual #36, Individual #217, Individual #61, Individual #73, and Individual #215; o List of abbreviations used in Dental Department; o QA/QI Dental Services – July 2011 - Section Q report; o Attendance tracking sheet for dental appointments for the past six months; o List of refusals for the past six months per date of refusal (list reason for appointment); o List of individuals that have not seen dentist in one year with reason listed; o List of those individuals that have an outstanding need for dental x-ray according to standard, with type of x-ray listed; o List of individuals who were edentulous at time of last onsite visit, and those who have become edentulous since that time; o List of other reasons for missed appointments per date for past six months (include reason for appointment); o List of no show/missed appointments per building per month since Monitoring Team's last visit;

	o List of refusals per building per month for last six months; o List of interventions per individual for missed appointments (correspondence); o QMRP, IDT minutes; o For five most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment, including for the following individuals: Individual #217 on 6/30/11, Individual #181 on 5/4/11, Individual #184 on 8/8/11, Individual #34 on 4/4/11, and Individual #73 on 5/12/11; o Appointments schedule for those undergoing general anesthesia/conscious sedation 3/4/11-8/1/11; o For six individuals using general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of operative report, monitoring tapes, consents, second opinions consult reports, preoperative anesthesia record/anesthesia pre-op evaluation, and postoperative discharge score/recovery note for: Individual #77 on 7/20/11, Individual #217 on 6/3/11, Individual #199 on 7/29/11, Individual #245 on 1/14/11, Individual #170 on 7/29/11, and Individual #132 on 1/7/11, and 8/1/11; o For the past six months, copies of any correspondence concerning restraint and sedation use for dental office visit; o Copy of complete dental records for prior five years at SSLC for the one individual most recently seen from each residential unit, including: Individual #312, Individual #112, and Individual #132; o For sample of individuals given dental pre-treatment sedation, copies of progress notes and dental office notes from start of sedation in residence to release, including: Individual #276 on 3/23/11, Individual #1 on 4/14/11, Individual #238 on 4/7/11, Individual #143 on 4/5/11, Individual #198 on 4/15/11, and Individual #215 on 4/12/11; o Current list of HRC-approved dental/medical restraints with sedation, undated; o Percentage of individuals utilizing general anesthesia/IV sedation for past six months; o Percentage of individuals utilizing oral sedation for past six months; o Percentage of individuals utilizing mechanical restraints for past six months; o For any extractions in the past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure for following individuals: Individual #151, Individual #10, Individual #190, and Individual #84; o Oral hygiene rating in each exam listed per individual and date of exam, from 3/3/11 to 8/4/11; o Quarterly oral hygiene rating; o List of individuals who receive suction tooth brushing; o Copy of annual dental assessments completed in the last 30 days and prior year for same individuals, including: Individual #146, Individual #38, Individual #154, Individual #36, Individual #318, Individual #213, Individual #183, Individual #26, Individual #222, Individual #173, Individual #317, Individual #299, Individual #203, Individual #41, Individual #267, Individual #184, Individual #164, Individual #10, Individual #108, Individual #48, Individual #99, Individual #172, Individual #103, Individual #220,

	Individual #79, Individual #178, Individual #190, Individual #47, Individual #86, Individual #124, Individual #13, Individual #251, Individual #298, Individual #320, Individual #149, Individual #134, Individual #58, Individual #98, Individual #242, Individual #214, Individual #316, Individual #75, Individual #84, and Individual #156; o List of annual assessments and date of previous annual; o Copies of 10 most recent annual dental summaries provided for the PSP for the following: Individual #313, Individual #312, Individual #293, Individual #260, Individual #291, Individual #211, Individual #140, Individual #308, Individual #112, and Individual #274; o Recent/current Facility oral hygiene data; o New monitoring tool for Section Q: Settlement Agreement Cross Referenced with ICF-MR Standards, revised August 2011; o Copy of oral hygiene index; o New blank Annual Dental Summary and six completed ones for: Individual #313, Individual #258, Individual #140, Individual #22, Individual #308, and Individual #269; o Settlement Agreement Monitoring Tool for Section Q; o Dental Emergency Log: Monthly Dental Emergency Log for September 2011; and o Presentation Book for Section Q. ▪ **Interviews with**: o Russell Reddell, DDS, MBA.
	Facility Self-Assessment: The Facility self-assessed itself as being in non-compliance with both sub-sections of Section Q. This was consistent with the Monitoring Team's findings. The Facility's POI included detailed narrative information describing activities undertaken to address compliance issues. In addition, the Facility had used some data from monitoring conducted to identify particular areas in need of improvement. The notation in the POI for 9/8/11 indicated that the Dental Director had reviewed the data for the year and quarter, and based on this analysis two areas requiring attention were identified, including missed appointments and desensitization plans. This was an example of good use of data to assist the Facility in substantiating its findings with regard to compliance, as well as determining where focused efforts were needed to achieve compliance and improve the supports provided to individuals at LBSSLC. The Facility had developed three important action plans as part of the POI. They included: ▪ The Dental Department began to develop a database that would be helpful in providing efficient care to the individuals at LBSSLC. The "no show" appointments database was expanded to include the reasons for the missed appointment. However, the current data reflected continued gaps in information. This remained a hindrance in resolving some of the causes of missed appointments. The POI indicated that the missed appointments were rescheduled at the next available opportunity, but the submitted data did not reflect the rescheduling initiative. ▪ The dental desensitization program was restructured to include PSTs' early participation and decision-making. The decision was made that skill acquisition plans would be developed for dental desensitization. Pilot homes were chosen, and a number of desensitization programs were

	implemented. ▪ In addition, the dental hygienist retrained nursing staff on implementation of tooth brushing programs. This included ensuring that individuals were in the appropriate position during these activities.
	Summary of Monitor's Assessment: The Dental Department made considerable strides toward compliance. The creation of a practical information management system to meet the needs of the department had not been finalized. Consequently, such areas as determining the many reasons for a missed appointment remained difficult to analyze. Only a few months of data had been collected, and according to the Dental Department, sufficient data was not available to provide a trend analysis. The missed appointment rate in the Dental Department remained high. There was continued focus on oral hygiene, with the dental hygienist visiting each home and providing instruction in tooth brushing and positioning to the individuals and the staff. The oral hygiene index was considered fair to good for a majority of individuals. Desensitization plans or other strategies to reduce the need for pre-treatment sedation remained in the beginning stages of development. A new process was created providing the PSTs with more opportunities for input and more responsibility for decision-making. It was noted that 45 individuals were prioritized to receive dental desensitization plans, and 15 had completed plans. However, the degree of implementation was not clear. The structure that had been developed appeared to support the successful completion of quality desensitization plans. Under the guidance of the Dental Department, pre-treatment sedation assessment became a more rigorous process, with increased surveillance before the dental visit after the medication was dispensed. The annual dental summary also was further amended to include a comments section. As many of the action steps were in process, the Facility remained noncompliant with this section.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this	The Dental Department consisted of a staff dentist, two dental assistants, and a dental hygienist. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from 3/3/11 through 7/6/11. Of these, 90 were listed with a prior annual examination dates. Of these, 65 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 72%. It was noted that nine individuals had one or more missed appointments for the annual examination. One individual (Individual #166) had not had an examination completed	Noncompliance

#	Provision	Assessment of Status	Compliance
	Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	between 6/3/08 and 5/18/11. Separately, copies of the annual dental assessment that were completed in the prior 30 days to the Monitoring Team visit along with the prior year's completed assessment were submitted. For September 2011, a total of 44 annual assessments were submitted. One individual was a new admission in 2011, and had no 2010 dental annual assessment. This left 43 individuals for which a 2010 annual assessment was reviewed. However, 24 out of the 43 (56%) had a 2011 annual assessment (either in September 2011 or an earlier month in 2011, because some had more than one 2011 annual assessment recorded), which was within 365 days of the annual assessment in 2010. For five out of 43 (12%), no annual dental assessment had been completed in 2010, and the prior evaluation was in 2009. Copies of the completed annual assessments for six individuals were submitted. Each included the annual assessment from the IPN entry, and the dental progress note (DPN) entry. Both included identical stamped templates allowing entries to be made. Each of the six submitted assessments had an entry in both the IPN and DPN (100%). For one individual, lack of cooperation did not allow completion of the oral exam, and this information was entered in the IPN, but the same entry was not written in the DPN. That individual had IV sedation, and a repeat exam two days later. That entry was written in the DPN, but not the IPN (or the IPN was not submitted). Additionally, for one individual, copies were written on the same date, but the IPN lacked an oral hygiene rating, and lacked a behavior rating. This information was completed in the DPN. The other four individual annual assessments had identical information in the IPN and DPN, resulting in a compliance rate of four out of six (67%). Oral cancer screening was documented in five out of six IPNs (83%). The plan was documented in both the IPN and DPN in 100% of the cases. From a separate data list submitted, for dental exams completed from 3/3/11 through 8/3/11, there were 110 appointments listed. Of these, 62 had documentation as having been completed (56% completion rate). Fourteen were documented as an incomplete dental examination (13%). There were 22 missed appointments (no shows and refusals), which was 20% of the appointments scheduled, and nine for which there was no information provided. It was noted that a few individuals had repeat missed appointments (four individuals were responsible for 16 of the 22 missed appointments). Additionally, during this time period there were three new admissions. All three had completed an initial dental exam in the first month (from two to 30 days). <u>Oral Hygiene</u>	

#	Provision	Assessment of Status	Compliance
		An oral hygiene index was completed on each individual at the time of the annual exam. The most recent oral hygiene scores were submitted. Although the document was undated, it was scanned 9/9/11. According to this document, for a census of 232 individuals (which included individuals not living at the Facility at the time of the review, given that the census at the time was 225), 37% had a good oral hygiene score, 56.5% had a fair oral hygiene score, and 6.5% had a poor oral hygiene score. From a separate list, which was undated, appointments from 3/3/11 through 8/6/11 were listed. Of these, 86 individuals completed the appointment and allowed an oral hygiene rating to be completed. Of these, 40 out of 86 (47%) had an oral hygiene rating of good, 40 out of 86 (47%) had an oral hygiene rating of fair, and three (4%) had a score of poor. Three others had scores of 1.5 and 2.5 that were not included in these calculations. As part of the oral hygiene program, the dental hygienist had begun to visit each home one morning per month. This was to assist the staff with oral care in the residence, by demonstrating tooth brushing and educating the direct support professionals and individuals concerning tooth brushing. Preliminary schedules were submitted for most of the residences for the month of May. No information was provided regarding whether visits were conducted in subsequent months. It is recommended that a formal list per building be created in order to determine the frequency of visits to each of the homes. As part of preventive oral care, suction tooth brushing was provided to those with dysphagia and other indications for this procedure. A list submitted indicated 55 individuals received suction tooth brushing, which was 55 out of 232 (24%) of the population. As part of the oral hygiene program, the Dental Department assisted in re-training the nursing staff on the use of suction toothbrushes, Spinbrushes, and positioning during tooth brushing. According to training rosters submitted, this training occurred over a period of time, from 3/18/11 through 7/21/11. <u>Preventive, Restorative, Emergency Dental Services</u> According to the Dental Department, no individuals were overdue for recommended dental x-rays. In addition, each individual at the Facility had seen the dentist in the past year. Information submitted indicated 19 individuals residing at LBSSLC were edentulous, for a rate of 19 out of 225 (8%). As noted in other of the Monitoring Team's reports, the dental peer review should determine an average percentage across the state and determine a future goal for edentulousness. With more attention to dental hygiene, as	

#	Provision	Assessment of Status	Compliance
		well as access to conscious sedation/general anesthesia and restorative care, individuals newly admitted should have an increased opportunity to preserve the teeth that remain. The Dental Department provided the breadth of services required to care for the individuals at LBSSLC. In the prior six months, 38 individuals were seen for prophylactic care. Eighteen individuals underwent restorative care (the period of time was not listed). Fourteen individuals were seen and treated for dental emergencies. Four individuals underwent dental extractions (the submitted information did not include the number of teeth extracted per individual). In a separate document, over a four-month time period (March to June 2011), 82 appointments were completed other than for annual dental exams. This included 28 appointments for prophylactic care, five additional appointments in which prophylactic care was "attempted," and 44 appointments in which general anesthesia/IV sedation was used. The difference between the data in the previous paragraph was due in part to the difference in time period, one being six months and one four months. However, there was also no mention of those undergoing oral sedation, and if those were included in these numbers it could not be determined based on the submitted information. Monitoring and evaluation of use of oral sedation was reviewed. Six active records were submitted for individuals who underwent oral sedation (a sample of 10 records was requested, but the Facility provided six). The purpose of the oral sedation was for prophylactic treatment or tooth brushing. The following summarizes the results of this review: ▪ Three out of the six (50%) recorded nothing by mouth (NPO) status. ▪ All six (100%) listed the medication administered, the dose, and the route. ▪ Six (100%) listed pre-procedure vital signs. In all cases, at least two sets of pre-procedure vital signs were documented, and most had three to nine sets of pre-procedure vital signs. This indicated serial monitoring once the medication was administered until the individual was seen in the dental office. ▪ Five (83%) had intra-procedure and post procedure vital signs. One individual refused vital sign monitoring after the initial four readings. There was no further information submitted with this document indicating a reason for lack of completion of the intra or post procedure monitoring form. A separate document indicated the procedure was cancelled. ▪ For two of six, a notation was made that the sedation was effective. For one individual, a notation was made that there was need for better sedation. For one individual, the notation was made that the sedation was not effective. For one individual, conflicting information was included. There was documentation that there was the "intended level of sedation/analgesia obtained," but the procedure note indicated the individual clenched lips and put hands in front of	

#	Provision	Assessment of Status	Compliance
		the face, and that the individual would need more medication or possibly IV sedation. For the individual that refused to attend the dental clinic after being given sedation, no comment was made regarding effectiveness. Adequate documentation of effectiveness was found in four of the six (67%) of the active records. The active record was submitted for six individuals who had undergone general anesthesia in 2011. One individual had undergone two dental procedures under general anesthesia. The date range of these procedures was from 1/7/11 through 8/1/11. The procedures under general anesthesia included more than one aspect of dental care. The list varied in each case, and included two or more of the following: prophylactic exam, restorative care, radiographs, and annual exam. Review of these records revealed the following: ▪ Consent for the dental procedures/anesthesia was up-to-date in seven (100%). ▪ The operative anesthesia record was completed in seven (100%). ▪ A pre-operative anesthesia record was completed and submitted in six (86%). ▪ A recovery note was submitted for seven (100%). However, the recovery note was only dated for five (71%). For four individuals that underwent extractions, the dental record was submitted. From the handwritten entries, the number of extractions and the actual tooth extracted was difficult to determine. The Dental Director also dictated notes concerning his visits/procedures, but these were not submitted. The following findings were made: ▪ For three of the four cases, IV sedation was used. One had one tooth extracted using a local anesthetic. ▪ Pain medication was provided in three cases. No documentation was included regarding pain management or whether the individual had pain post procedure in the fourth case. Pain management should be documented for each procedure and dental emergency. If the individual did not have pain, this should be clearly stated. Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: one for a dislodged filling, two for lip lesions, one individual who had general agitation was referred to determine if dental discomfort was the source of the pain, and one had a fractured tooth. The following findings are made based on this review: ▪ Four records (80%) documented the presence or not of pain. For only one was pain present, and this was treated with pain medication. ▪ Follow-up occurred for three individuals (60%). ▪ It would be helpful if the dental note and IPN entry included the term “dental emergency visit” for those visits fitting this category.	

#	Provision	Assessment of Status	Compliance
		A monthly dental emergency log was created to assist in tracking emergency cases to closure. A column indicated when the case had been resolved. The dental progress notes were submitted for three individuals, one from each residential unit, for the past five years. ▪ Of these, only one (33%) had a current annual dental exam on the record, dated 8/1/11. For one record, the last annual dental exam was 6/1/10, and for a third record, it was 7/14/10. ▪ All three individuals (100%) had a prophylactic treatment recorded in 2011. However, for two of these individuals, the prophylactic exam was over 12 months apart. The dates of the two most recent prophylactic exams were as follows: 6/11/10 and 1/7/11, 6/11/09 and 5/3/11, and 3/11/10 and 5/5/11. ▪ All three had appointments that were missed in the past year. Two records indicated one missed appointment in the past year, and one record indicated three missed appointments. ▪ Restorative care appointments were documented in two of the records. One record indicated one restorative visit, and one record indicated eight restorative visits since 9/1/11. ▪ One of the three individuals had an emergency visit on 4/22/10 for a chipped tooth.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review,	This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to PSTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> A number of dental policies and procedures were completed and implemented during the past six months. These included: ▪ LBSSLC – Health Services: Dental/Medical Sedation and Restraint, dated 9/8/11; ▪ LBSSLC – Dental Services: Dental Prophylaxis, dated 9/8/11; ▪ LBSSLC – Dental Services: Oral Care for Enterally Fed Individuals, dated 9/8/11; ▪ LBSSLC-Dental Services: Suction Toothbrush, dated 9/8/11; ▪ LBSSLC – Dental Services: Policy for Crest Spinbrush ®, dated 9/8/11; ▪ LBSSLC – Dental Services: Policy for Positioning During Dental Treatment, dated 9/8/11; and ▪ LBSSLC – Dental Services: Oral Care, dated 9/9/11.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Additionally, other policies and procedures that were submitted were in draft form. These included: ▪ LBSSLC – Health Services: Dental Anesthesiologist; ▪ LBSSLC – Health Services: General Anesthesia Medical Clearance; ▪ LBSSLC – Health Services: Criteria for General Anesthesia; ▪ LBSSLC – Health Services: General Anesthesia Recovery; ▪ LBSSLC – Health Services: General Anesthesia Surgery; ▪ LBSSLC – Health Services: General Anesthesia Personnel; ▪ LBSSLC – Health Services: Instructions for Individuals Following the General Anesthesia Clinic; ▪ LBSSLC – Health Services: Instructions for Individuals prior to General Anesthesia Clinic; ▪ LBSSLC – Health Services: General Anesthesia Policy; and ▪ LBSSC – Health Services: Pre-operative Sedation prior to General Sedation. Other forms developed by or for the Dental Department included: ▪ Pre-sedation assessment, revised 5/5/11; ▪ Dental Desensitization Assessment Form; ▪ Dental Desensitization Skill Acquisition Program Strategy Sheet; and ▪ Four Stages of Desensitization. <u>Provision of Dental Records to PSTs</u> A new Annual Dental Summary form was submitted, along with five completed forms, all dated in September 2011. This was a computerized form that was user-friendly for the PST members. It included the number of refusals and broken appointments (however, the time period of these was not indicated); the prior attempts at office visits, and the degree of behavior; the date of the last annual exam and the last prophylaxis form; the oral hygiene rating; condition of tissues; behavior at the most recent exam; whether sedation was indicated and the type of sedation, along with a comment on the effectiveness of the sedation; whether restraints were indicated and the type, along with a comment on effectiveness; information concerning desensitization; risk of caries or periodontal disease; the present condition of the teeth, including a comment if bruxism was present; the prior work completed; and the recommended plan for the next visit. There was a diagram of the teeth. There was no key to indicate the lines and "Xs" placed on the diagram. It also was not clear which marks represented caries and which represented prior fillings. Of the five submitted completed Annual Dental Summary forms, two out of five did not have completed attempts with dates and behaviors listed. There was one individual listed as having caries, but no recommendation was included for restoration. The present condition section was completed for an individual on the same date as a comment that the cleaning appointment was missed. It was not clear the	

#	Provision	Assessment of Status	Compliance
		circumstances of the visit, and if the individual actually completed the exam, or if the information was carried over from a prior visit. However, if a cleaning and annual exam were scheduled on the same date, and only one completed, the form should have been sufficiently clear to reflect this information. The Dental Department also should include an entry on the form indicating the dental needs and requirements for the individual's successful transition to the community. <u>Refusals/Missed Appointments</u> In order to reduce the missed appointment rate, the dental clinic needed to track these missed appointments, and determine which were due to refusals by the individual, and which were due to other causes. For each etiology, a strategy then would need to be developed to reduce the missed appointment rate. The Dental Department submitted numerous emails showing efforts to obtain information from the various residences concerning missed appointments. Information for refusals was submitted. For the time period between 3/3/11 and 7/11/11, of the 28 refused appointments listed, 24 were for annual exams. In order to comply with timely annual assessments, the Dental Department should consider scheduling those known to miss appointments approximately two months ahead of the due date. Additionally, for those with repeat refusals, the Dental Department should work closely with the IDT and the Psychology Department to incorporate strategies into the BSP/PSP. Of the 28 refused appointments listed, one refusal was for an appointment with general anesthesia, and one refusal was for an appointment scheduled for restorative care. For two refusals, the reason for the appointment was not identified. A separate list that was not dated for the time period involved indicated that 30 individuals had refused appointments. The reason for the discrepancies between the two lists was unclear. A breakdown of refusals per building was submitted. In April 2011, the Zinnia building had a number of refusals. Otherwise, based on the information submitted per residence, no trend could be determined. The Dental Department was asked to submit background information for the visits that were refused, including any QDDP discussions or IDT minutes that reviewed, assessed, developed, or implemented strategies to reduce repeat refusals. The Dental Department indicated it "does not keep this information." For individuals refusing more than one appointment, a file of such information should be available to the dental team for review to allow strategies to be discussed within the department. This information and options discussed then should be shared at the PST/IDT meetings.	

#	Provision	Assessment of Status	Compliance
		A list of missed appointments was provided with the reason for the appointment that was missed. A total of 47 missed appointments were identified during the months of March through July 2011. For the 47 missed appointments identified, 10 were for procedures under general anesthesia, and 37 were for prophylaxis. The reasons identified for the missed appointments were that five did not follow the dental order to not allow anything by mouth for a period of time before the appointment, five were considered missed due to time constraints in the dental office, two individuals had outdated consents from the human rights committee, and other reasons were identified for three other missed appointments. However, for 29, no information was provided. It is important to determine the many different causes of the missed appointments, in order to reduce the total percentage of missed appointments in the system. From a report "monitoring tool data," the Dental Department had created categories of "no show" appointments. However, implementation of this system remained a challenge. Additionally, one of the POI action steps was to ensure that the PST met to discuss any second "no show" appointment by the individual. However, no information was provided to determine if this process had been implemented. If the process were in place, it would be important to have PSPA documentation available in the dental office. One of the causes of "no show" appointments was identified as the staff being unaware of the appointment. This was despite the dental office forwarding a schedule, and making calls to the residence the day prior to and the morning of the appointment. The Dental Department suggested placing the schedule on the "M" or shared drive to allow each residence access. However, no information was provided to determine if this was piloted, and, if so, the impact of this endeavor. Lack of staffing in the residence also was identified as a concern, and at times, staff reportedly were not available to accompany the individual to the dental office. At times, the individual was not kept NPO the morning of the appointment. The residential services department had responded to this concern by creating a card system for morning meals, presumably to alert staff of the NPO status of the individual. No information was provided regarding the degree of implementation, or if this strategy was successful. In the past six months, the dental office tracked cancellations of appointments due to dental office reasons to determine trends. In the prior six months, 12 days were rescheduled due to dental clinic needs. A list of internal causes was submitted for 11 of these days. Ten of the days were for reasons outside the scope of the Dental Department's influence. Three of these days were due to lack of funding for the	

#	Provision	Assessment of Status	Compliance
		anesthesiologist. The budget for this service had been depleted for the month of August. The funding should be tracked so that appointments do not need to be cancelled. The dental office also should review the impact of dental office cancellations, such as for anesthesiology services, on the individuals to determine whether such delays had any clinical impact on the care of the individuals. Another list was submitted that included the weekly schedule update for those appointments requiring general anesthesia. Dates included: 3/4/11, 3/7/11, 3/11/11, 4/8/11, 4/11/11, 5/6/11, 5/13/11, 5/16/11, 6/3/11, 6/10/11, 6/13/11, and 8/1/11. For these dates, 60 appointments were scheduled. A total of 45 individuals completed the appointments (75%). Of the 25% for which the appointment did not occur, one was rescheduled due to the time constraints in the dental clinic, two refused, two were not kept NPO, one was reviewed and considered too high risk and placed on the hospital list (not a candidate for IV sedation), one had documentation that insufficient staff were available in the home to bring the individual to the dental clinic, and seven had no information regarding the reason entered into the database submitted. Although the database had a box to be checked indicating if the individual had been rescheduled, for none of the missed appointments was this box checked. A separate document submitted indicated how many of the missed appointments subsequently had a follow-up appointment not only scheduled, but also completed. From March through July, this list documented 46 missed appointments (similar to the number above). Of these, only 12 (26%) had a follow-up appointment scheduled and completed. No follow-up information was available for the remaining 34. It is recommended that missed appointments be tracked to completion, to ensure follow-up appointments are kept. Further, a need existed for a tracking system related to the causes of all the missed appointments. As noted above, without further information, success will not be achieved in reducing the high missed appointment rate, or recurrent missed appointments. Other submitted data from approximately the same time period suggested problems with the data. A review of information from the attendance-tracking sheet for dental appointments for the prior six months indicated gaps in information. From this database, 158 appointments were kept, and 251 appointments were not kept, resulting in a 39% show rate. Additionally, according to the data on these tracking sheets, at the time of the missed appointment, none were offered a date to reschedule. It was noted that there were eight refusals among the missed appointments. The other 150 missed appointments then would have been due to other reasons. However, these numbers did not agree with the data provided above that was obtained through other sources. That the eight appointments due to refusals increased to 28 appointments suggested that the	

#	Provision	Assessment of Status	Compliance
		dental office later determined there were 20 other appointments that fit this category. However, the data was not updated. In order for the Facility to have data that is useful in identifying areas requiring attention, it is essential that data be accurate and consistent across data sources and resulting reports. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> Information was submitted concerning use of restraints for dental procedures. For the prior six months, the dental office did not use mechanical restraints. For oral sedation, from March through August 2011, according to the data provided, 144 appointments were kept. Of these, there were seven appointments in which oral sedation was given (5%). The data for IV sedation indicated a discrepancy in the kept appointments. For those completing IV sedation, the baseline kept appointments was similar to the oral sedation in March, April, May, and August, but varied greatly in June (the oral sedation list indicated 17 appointments were kept, but the IV sedation list indicated 51 were kept), and in July (the oral sedation list indicated five were kept, and the IV sedation list indicated 24 were kept.) Using the IV sedation list, of 197 completed appointments, there were 53 appointments in which IV sedation was used (27%). Combined, for 32% of the appointments, the individuals were given chemical sedation. This percentage indicates the need to review each case to determine which individuals would benefit from desensitization or other programs to reduce the need for sedation. Additionally, in order to provide evidence the sedation administered was the appropriate choice, thorough attempts should be documented of trials with lesser doses of medication as well as use of less restrictive methods or programs with a description of the effect. Separately, a list of HRC-approved dental and medical restraints was submitted, including the use of sedation. However, this list might not have been updated, but listed consents with dates of expiration as of the 9/9/11 submission date (the document did not list the date it was created). A total of 129 individuals were listed that required dental sedation. Of these, 42 had current consents (33%), and 86 consents had expired (67%). For one individual, the data field was blank. Additionally, two individuals who were deceased were listed. Although the data appeared outdated and required updating, according to this document, a significant number of individuals had expired consents. This might have indicated the future use was not anticipated, or that the process for renewal had not been completed. Desensitization remained a challenge. A process change had been implemented. Now, the Dental Department, in cooperation with the Psychology Department, discussed desensitization with the IDT/PST to determine whether the individual would benefit from a desensitization plan. If the team agreed, then a plan was created. Although the report that provided the information was undated ("Monitoring Tool Data"), it	

#	Provision	Assessment of Status	Compliance
		documented that 15 new desensitization plans were in place following this procedure. Additionally, 46 individuals from five pilot homes were identified on a "desensitization priority" list for the skill acquisition program/pilot. Meeting minutes from 7/20/11 (the Section S monthly meeting) indicated interest in visiting a sister facility with a successful skill acquisition plan for desensitization to determine if it could be adapted to LBSSLC. Two documents for desensitization were created, including a "Dental Desensitization Assessment Form," which was a checklist of the individual's skill level, and a document entitled "Four Stages of Desensitization," outlining the various steps within each stage. A sample of the completed "Dental Desensitization Skill Acquisition Program Strategy Sheets" was submitted, which were specific to the individual. Comments related to the quality of this endeavor are discussed in relation to Section C.4 of the Settlement Agreement. However, these initial steps appeared to be essential to a successful program. Eleven of these desensitization plans were submitted. As these were all new programs, no data was available to determine success or need to revise the program. The Dental Department should develop a database system to monitor each of the components outlined in these desensitization plans. The successful components could then be adapted to desensitization plans for other individuals, and, at the same time, components that were not proven to be helpful could be revised. <u>Quality Assurance/Improvement Initiatives</u> The QA/QI Department provided a report "Dental Services – July 2011." It showed that the Dental Department reviewed eight dental records internally per month. The sample was randomly selected. The dentist monitored one of those eight records for inter-rater reliability. Additionally, a QA nurse monitored two of the eight records each month. The report was written in three sections, including trending problems, strengths, and weaknesses. For trending problems, the monitoring tool's question related to "physical health's impact on dental service" was not found to have been addressed specifically. Additionally, the required review of medications and allergies for each individual was not completed at each visit. Challenges existed in identifying which appointments were completed. The suggestion from QA Department was that the dental office should complete an IPN entry for each missed/rescheduled appointment that would clarify this concern. In addition, the QA Department recommended that desensitization programs should be recommended for all those that receive general anesthesia. It was also recommended that information should be analyzed and presented at the individual's PSTs. Most of these recommendations were not new, but were carried over from the prior quarter.	

#	Provision	Assessment of Status	Compliance
		From the QA review, the strengths included timely provision of dental services, continued improvement in the documentation in both the IPN and the dental tab section of the active record. The monitoring tool was being revised, and the Dental Department was meeting monthly with the QA nurses. Weaknesses included the lack of review and analysis of data that the department collected. A copy of the Settlement Agreement Cross Referenced with ICF-MR Standards Section Q, Dental Services Guidelines, revised August 2011, was submitted. It incorporated many of the areas of the Settlement Agreement, including instructions on completion of the form to optimize inter-rater reliability.	

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

1. A tracking system should be used to provide notification of annual assessments that have an upcoming due date to allow sufficient time to schedule and complete the required appointment. (Section Q.1)
2. All sections, as appropriate, should be completed in the annual dental summary. (Sections Q.1 and Q.2)
3. The dental hygienist's visits to the homes should be documented to ensure all homes receive instruction and monitoring, and as evidence of this approach to improve dental hygiene. (Section Q.1)
4. Pain management should be documented for each procedure and dental emergency. If the individual did not have pain, this should be clearly stated. (Section Q.1)
5. The IPN dental entries for dental emergencies should be documented as such. (Section Q.1)
6. A key should be created for the symbols and marks used in the dentition diagram included in the annual dental summary. (Section Q.2)
7. The annual dental summary should include comments about the individual's needs related to successful transition to the community. (Section Q.2)
8. For those individuals known to miss appointments, the Dental Department should consider scheduling approximately two months ahead of the due date. (Section Q.2)
9. For those with repeat refusals, the Dental Department should work closely with the IDT and the Psychology Department to include strategies into the BSP/ISP. (Section Q.2)
10. For those that refuse dental appointments repeatedly, the Dental Department should keep a copy of communication with the QDDP, and psychologist, as well as the section of the BSP/ISP that addressed the refusal. This information should be analyzed, and the Dental Department should provide teams with recommendations to address any continuing concerns. (Section Q.2)
11. The Dental Department should maintain documentation when the IDT addresses an individual's second "no show" appointment. (Section Q.2)
12. The Dental Department should continue focusing on identifying the causes for "no show" appointments with the goal of determining all causes., and offering recommendations to teams and/or Facility Administration to resolve the issues. (Section Q.2)
13. The funding of the dental anesthesiologist should be tracked to prevent future cancellation of appointments due to lack of funds. (Section Q.2)
14. When a dental appointment is cancelled, the dental office should track the individual until the rescheduled appointment, and determine if the delay had any clinical impact on the care of the individual. (Section Q.2)
15. Rescheduling for a missed appointment should be completed promptly and documented. (Section Q.2)
16. Each individual needing oral or IV sedation should be reviewed to determine the potential benefit of a desensitization program. (Section Q.2)

17. For those individuals requiring sedation for a dental appointment, documentation should be maintained of attempts at lesser doses of medication or other less restrictive alternatives with a description of the effect. (Section Q.2)
18. The Dental Director should review the database for any trends at periodic intervals, and identify areas needing improvement. This should result in a written document developed 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. (Facility Self-Assessment and Sections Q1 and Q2)

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 for Monitors' Compliance Visit October 2011; o The following documents: SLP evaluation and updates, SLP progress notes, supporting documentation for implementation of direct/indirect SLP communication program, therapy progress notes for communication program, ISP and ISPAs for past year, Positive Behavior Support Plan, SLP consultations for the last year, competency-based training documentation, individual-specific monitoring for the past six months for communication programs, Communication Dictionary, individual-specific monitoring for past three months for communication equipment, daily schedule, and PNMP for the following 12 individuals: Individual #100, Individual #33, Individual #131, Individual #277, Individual #77, Individual #312, Individual #99, Individual #190, Individual #283, Individual #185, Individual #201, and Individual #63; o Speech evaluations for new admissions for the following four individuals: Individual #92, Individual #131, Individual #273, and Individual #7; o Continuing education completed by SLP, various dates; o List of SLP and Audiology staff with corresponding caseloads, undated; o List of individuals with augmentative/alternative communication (AAC) devices, undated; o Communication Master List, undated; o AAC screening forms (template), undated; o Speech-Language assessments/updates (template), undated; o Completed Speech-Language evaluations for multiple individuals, various dates; o Speech evaluation schedule and tracking log, from 3/11 through 8/11; o Monitoring forms used by SLPs, Speech Language Assistants (SLPAs), and PNMP coordinators, various dates; o SLP competency-based performance checklist (template), undated; o QA/QI data sheets for sections O, P, and R, from 11/10 through 8/11; o AAC-related spreadsheets, undated; o List of individuals with behavioral issues and coexisting severe language deficits, dated 8/23/11; and o List of individuals with Positive Behavior Support Plans (PBSP) and replacement behaviors related to communication, undated. ▪ **Interviews with**: o Linda Thomas, Director of Habilitation Therapy. ▪ **Observations of**: o In residences and dining rooms in 504 E. Mesquite Drive, 504 W. Mesquite Drive, 525 North Cedar Avenue, 527 North Cedar Avenue, and 528 North Cedar Avenue.
	Facility Self-Evaluation: Based on a review of the Facility's POI, with regard to Section R of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was

consistent with the Monitoring Team's findings.

Section R of the Facility's POI/Self-Assessment documented that the Program Compliance Monitor met with the Habilitation Therapy (HT) Director to review the completed monitoring, findings, and analysis of information. The following chart presents reported findings:

Sample of Three Individuals	Inter-Rater Reliability	Overall Compliance	Overall QA Compliance
May	33%	92%	-
June	100%	97%	-
July	61%	92%	-
August	100%	89%	93%

The Monitoring Team was unclear how the overall compliance percentage was calculated and questioned the validity of the score. The indicators on the monitoring tools were not weighted, so an overall compliance score did not have any meaning. The POI did not provide any information about particular indicators for which low scores had been noted. As a result, no indication was provided that the Facility had been successful in identifying areas requiring particular attention, and/or developing plans to address such areas. Other data, such as the numbers of PBSPs that included communication-related replacement behaviors, were used as evidence of compliance with specific aspects of the Settlement Agreement. However, no qualitative analysis was noted as having been completed to confirm, for instance, that because PBSPs included such goals, Psychologists and SLPs had collaborated, and this had resulted in integrated, adequate, and appropriate goals.

Monthly Analysis of monitoring data for Section R from May to August was provided in the Presentation Book for Section R. It documented systemic problems that were, in most cases, repeated from month to month. The POI did not present strategies and/or initiatives to ameliorate problems identified. As the Facility expands its self-assessment processes, the POI should summarize this data and analyses completed, as well as any actions to correct problematic trends identified.

Focus should be placed on defining a relevant sample for Section R. The development of adequate instructions for the audit tools and standardized procedures for reviews should be implemented to achieve inter-rater agreement. The absence of adequate instructions for the monitoring tool and distinct trials to achieve inter-rater reliability between therapists and the PCM will result in audit data that will not be reliable and/or valid.

One action plan was developed for Section R. The action plan for R.3 included steps for the Director of Habilitation Therapies to meet with the SLPs to review the therapy role and expectations for an IDT meeting, schedule training for skill acquisition programs (SAP) with therapists and psychologists, audit ISPs to check integration of HT assessments into SAPs and ISPs, and develop a process for therapists to attend annual ISP meetings and share meeting information with other therapists. These action plan steps were relevant, but additional steps needed to be developed and implemented to address multiple

	indicators with which the Facility was not in compliance. No other action plans were included to address noncompliance with the four sections in Section R. No additional action plans addressed future strategies the HT Department planned to implement prior to the next review to achieve compliance.
	Summary of Monitor's Evaluation: LBSSLC had five approved SLP positions. Three positions were filled and two positions were vacant. During the past six months, no SLP had been hired. Vacant SLP positions will continue to challenge the HT Department to achieve compliance with Section R. The Facility and the HT Department should critically review concerns related to SLPs provision of necessary supports and services to individuals and IDT members, and the impact on compliance with the Settlement Agreement. Vacant SLP positions cannot be a justification for not providing needed therapy supports to individuals that are of adequate quality. For example, multiple Priority 1 individuals had received SL evaluations (i.e., 94%), but none of these individuals had been recommended to receive direct therapy supports. Furthermore, individual AAC systems had not been integrated into their ISPs, and/or supported through skill acquisition programs and incorporation into their daily schedules. The Facility was to be commended for providing therapists with opportunities to attend relevant community continuing education courses. Eighty individuals had prescribed AAC systems, but none of these individuals received direct therapy supports. Review of samples of individuals' records substantiated that these individuals would have benefitted from receiving direct SL services to facilitate learning and practice opportunities for functional communication systems. Individuals had prescribed AAC systems, but no individual-specific functional, measurable outcome measures/objectives had been developed to provide formal learning opportunities to facilitate the use of individual-specific AAC systems. AAC systems were not integrated into daily schedules. Competency-based training and performance check-offs were not consistently implemented for prescribed AAC systems.

#	Provision	Evaluation of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative	The Monitoring Team's record sample for Section R was as follows: ▪ Sample R.1 – five of 10 individuals (50%) reported to be receiving supports from SLP and psychologist, including: Individual #100, Individual #33, Individual #131, Individual #277, and Individual #77; ▪ Sample R.2 – seven of 80 individuals (9%) who had AAC systems, including: Individual #312, Individual #99, Individual #190, Individual #283, Individual #185, Individual #201, and Individual #63; ▪ Sample R.3 - four of four individuals (100%) newly admitted to LBSSLC, including: Individual #92, Individual #131, Individual #7, and Individual #273; and	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Evaluation of Status</th><th>Compliance</th></tr>
<tr><td></td><td>communication, to conduct evaluations, develop and implement programs, provide staff training, and monitor the implementation of programs.</td><td>
Sample R.4 – six of 137 (4%) individuals with PBSPs: Individual #99, Individual #190, Individual #63, Individual #100, Individual #33, and Individual #131.
<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>
LBSSLC had five approved SLP positions. Three positions were filled and two positions were vacant. Based on the documentation provided, the following chart illustrates the caseloads and responsibilities of SLPs for 227 individuals, which exceeded the current census of 225:
<table>
<tr><th>SLPs</th><th>Current Caseloads and Responsibilities</th></tr>
<tr><td>SLP #1</td><td>PNMT caseload of 16 individuals, and 20 individuals in Quail and Sparrow</td></tr>
<tr><td>SLP #2</td><td>Supported 105 individuals</td></tr>
<tr><td>SLP #3</td><td>Supported 86 individuals</td></tr>
<tr><td>SLP #4</td><td>Vacancy</td></tr>
<tr><td>SLP #5</td><td>Vacancy</td></tr>
</table>
During the past six months, no SLP had been hired. From 7/1/11 to 8/20/11, a commercial was aired on local television for recruitment purposes. Vacant SLP positions will continue to challenge the HT Department to achieve compliance with Section R.

Seven of 12 ISPs (58%) reviewed documented SLP attendance. Based on interview, the Director of Habilitation Therapy implemented a schedule to ensure one therapist (i.e., PT, OT, or SLP) was in attendance during an annual ISP. This was an improvement from not having any therapy representation during an ISP meeting. However, the absence of SLP representation during the annual ISP meeting for individuals who required input from a SLP did not meet Settlement Agreement requirements. Of further concern, even when SLPs were in attendance during an annual ISP meeting, AAC systems were not adequately integrated within individuals' ISPs.

As stated in the previous report, therapists were not present during IDT meetings for individuals with identified communication needs, individuals with communication needs were not receiving SL direct therapy, therapy recommendations were not integrated into formal skill acquisition programs, and informal activities to provide opportunities for utilization of prescribed AAC systems were not present in daily schedules. The Facility and the HT Department should critically review concerns related to SLPs provision of necessary supports and services to individuals and IDT members, and the impact on compliance with the Settlement Agreement. Vacant SLP positions cannot be a</td><td></td></tr>
</table>

#	Provision	Evaluation of Status	Compliance
		justification for not providing needed therapy supports to individuals that are of adequate quality. For example, multiple Priority 1 individuals had received SL evaluations (i.e., 94%), but none of these individuals had been recommended to receive direct therapy supports. Furthermore, individual AAC systems had not been integrated into their ISPs or PBSPs, and/or supported through skill acquisition programs and incorporation into their daily schedules. SLPs attended the following state-sponsored webinars: ▪ Introduction to PNMT (one SLP); ▪ GI Issues in Individuals with Developmental Disabilities (three SLPs); and ▪ Assessment of Technologies (two SLPs). Community continuing education courses attended included: ▪ Region 17 Educational Service Center 2011 Autism Conference, involving a two-day Conference on Autism Spectrum Disorders that featured Peer Reviewed Research based on strategies for use in the home and school environments (one SLP); ▪ Texas Statewide Assistive Technology Conference (two SLPs); and ▪ Problems in Cognition as Related to Developmental Disorders (one SLP). The Facility was to be commended for providing therapists with opportunities to attend relevant community continuing education courses. The Director of Habilitation Therapy understood the importance of having SLPs attend state-sponsored webinars to build future capacity for the PNMT, as well as to enhance their ability to provide supports to individuals on their caseloads with high and medium risk factors. Certificates of Completion, attendance rosters, and conference itineraries were presented as documentation of completion of these courses. <u>Communicative Aides 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> Based on documentation provided, 80 of the 225 individuals at LBSSLC (36%) had an augmentative/alternative communication or assistive technology (AT) device(s). However, SLPs were not providing direct supports to any of these individuals. Individual AAC devices were labeled high tech (requires a power source and extensive training to competently program and maintain the device), low tech (requires a power source and is very easy to program), or no tech (any communication system that does not require a power source). No individuals had a mid tech system (requires a power source and some level of training to adequately program and maintain the device). None of the SL evaluations of the seven individuals with AAC systems in Sample R.2 (0%)	

#	Provision	Evaluation of Status	Compliance
		recommended direct SL supports, and/or included individual-specific recommendations to facilitate the use of the prescribed AAC system. Based on review of Sample R.2 the following observations are made: ▪ Section R.2 of the Facility's Presentation Book indicated that SLPs had started to include an analysis and rationale as part of the SL evaluation. However, SL Evaluations reviewed did not include an analysis of findings. Evaluation data should be analyzed to identify an individual's strengths, abilities, and potentials for learning and skill acquisition. The analysis of evaluation findings should provide a rationale for functional outcomes and recommendations. The analysis should discuss possibilities for the development of formal programs, as well as informal activities that would support the achievement of functional outcomes and recommendations. ▪ Recommendations did not reflect measurable outcomes. Recommendations should include criteria that would enable the team to assess and monitor implementation to ensure efficacy of formal program(s). ▪ Recommendations, in many cases, were not individual-specific. Recommendations should be based on an individual's preferences, goals, wants and needs. The recommendations should support learning within the home, work and leisure environments, including the community. ▪ Evaluation recommendations for multiple individuals encompassed recommendations for a communication system, communication/programming instructions, and home programming. The recommendations for communication/programming instructions and home programming were, in many cases, generic and not individual-specific. In many of the evaluations reviewed, the following recommendations were included: "use Communication Dictionary Page as a guide for ALL SERVED ACC equipment," "use communication system for ALL SERVED in conjunction with routine activities to inform him/her of the activity and thereby attach meaning to the object and provide a means to request that activity utilizing the object," and "build routines and sequences which may allow recognition of certain activities and anticipating upcoming events." There were no recommendations for direct SL supports or skill acquisition programs to promote utilization of a prescribed communication system within multiple environments. ▪ Even when an SL consultation(s) recommended initiating a skill acquisition program, neither the ISP nor an ISPA integrated such programs into the ISP, nor were there any SLP progress notes (e.g., Individual #99). ▪ Multiple evaluations stated the SLP "will be available to provide in-service and assist in planning appropriate communicative programming," but no recommendations were included for direct SL supports and/or skill acquisition programs. ▪ SL evaluations did not discuss risk action plans and/or risk factors that might	

#	Provision	Evaluation of Status	Compliance
		impact functional communication. ▪ Even when an SL evaluation recommended clinical trails with an AAC system, no ISPA meetings were held to discuss the initiation of these trials. No Facility policy and/or evaluation instructions existed to define therapist's role and responsibilities in the SL evaluation process. Based on staff report, none of the 225 individuals residing at LBSSLC (0%) were receiving direct SLP services. Review of individuals in Sample R.1, R.2, and R.4 substantiated that these individuals would have benefitted from receiving some form of direct SL services. The following concerns were noted: ▪ Individuals had prescribed AAC systems, but no individual-specific functional, measurable objectives/outcome measures had been developed to provide formal learning opportunities to facilitate the use of individual-specific AAC systems. ▪ AAC systems were not integrated into daily schedules. ▪ Competency-based training and performance check-offs were not consistently implemented for prescribed AAC systems. LBSSLC was not in compliance with this provision of the Settlement Agreement, and minimal progress had been made. Multiple individuals' SL evaluations did not provide individual-specific recommendations to facilitate AAC systems. Individuals with identified communication deficits who would have benefitted from SL services did not receive direct SL supports. There was an absence of the development and implementation of formal programs to provide opportunities to promote learning and use of AAC systems within multiple environments.	
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 evaluation 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> Since the Monitoring Team's last review, the LBSSLC Protocol for Communication had not been revised. These protocols included criteria for provision of communication assessments and communication dictionaries, as well as collaboration with Behavioral Services. The following progress was documented: ▪ 94% of Priority 1 individuals, which included individuals with BSP and/or Autism who did not speak, had received a SLP evaluation; ▪ 68% of Priority 2 individuals, including individuals with BSP and/or Autism who spoke, had received a SLP evaluation; ▪ 73% of Priority 3 individuals without a BSP and/or Autism who did not speak had received a SLP evaluation; ▪ 86% of Priority 4 individuals, including individuals without a BSP and/or Autism who spoke, had received a SLP evaluation.	Noncompliance

#	Provision	Evaluation of Status	Compliance
		The following individuals' evaluations recommended AAC systems: four of five individuals in Sample R.1 (80%); seven of seven individuals (100%) in Sample R.2, and five of six individuals in Sample R.4 (83%). Unfortunately, AAC systems had not been successfully integrated into individuals' ISPs through direct therapy supports, development and implementation of formal programs, and/or integration of informal strategies for implementation throughout the day. This did not provide the foundation for an individual and/or their staff's successful utilization of an AAC system. <u>All people have received a communication screening or evaluation within 30 days of admission, readmission or change in status.</u> Since the last review, four individuals had been admitted to LBSSLC. Based on a review of Sample R.3, these individuals had received a SLP evaluation. However, the SL evaluations for three of four newly admitted individuals (Individual #92, Individual #131, and Individual #273) identified communication deficits, but no direct speech therapy/supports were recommended. The evaluations documented communication needs could best be addressed in the context of daily living activities. Individual #7's SLP evaluation, dated 7/20/11, identified her potential for skill acquisition as "fair to good" based on observation and evaluation data. In addition, she was recommended for direct SL therapy, but was not receiving direct therapy. <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> None of the individuals in Sample R.1, R.2, and R.4 had formal plans and/or programs developed and implemented by SLPs. <u>For persons receiving behavioral supports or interventions, the Facility has a screening and evaluation designed to identify who would benefit from AAC. Note: this may be included in the PBSP.</u> SLPs were attending Behavior Support Peer Review Committee meetings. Therapists' roles and responsibilities with psychologists in the development of PBSPs and skill acquisition programs should be formalized in policy and/or procedures. A review of individuals in Sample R.4 documented the following: ▪ PBSPs were co-signed by the SLP but the body of the PBSP did not document how the SLP and psychologist collaborated in the development of the PBSP. ▪ Communication equipment and strategies were not consistently integrated into PBSPs and ISPs. ▪ Even when clinical trials were conducted, and recommendations were made, documentation did not show follow-through with PBSP revisions or competency-based training for staff (i.e., Individual #100).	

#	Provision	Evaluation of Status	Compliance
		▪ There were no procedures to define the collaboration process between SLPs and psychologists for the development and implementation of PBSPs and skill acquisition programs. <u>Policy exits that outlines evaluation schedule and staff responsibilities.</u> The Facility did not have a policy to address therapists' responsibilities for completion of an SL evaluation, define evaluation instructions and direct therapy procedures, and/or integrate AAC systems into ISPs.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> None of the individuals in Samples R.1, R.2, and R.4 (0%) who would benefit from AAC systems or had an AAC system received direct support and/or indirect support from a SLP. Such services were necessary to develop and implement formal communication programs to integrate the use of these devices into their ISPs and daily schedule, as well as to identify strategies for inclusion into informal activities to support the use of AAC systems. <u>Rationales and description of interventions regarding use and benefit from AAC are clearly integrated into the PSP.</u> None of the individuals in Samples R.1, R.2, and R.4 with AAC systems had these systems integrated throughout their ISPs through the provision of direct therapy services, formal skill acquisition programs, and/or strategies to reinforce their use in a variety of environments throughout their daily schedules. <u>AAC devices are portable and functional in a variety of settings.</u> None of the individuals in Samples R.1, R.2 and R.4 (0%) had PNMPs or daily schedules that provided staff strategies for the use of their AAC devices in multiple environments, such as during mealtime, community outings, or leisure time, or at the work, in the activity center, or at home. <u>AAC devices are individualized and meaningful to the individual.</u> As stated above, individuals with AAC systems did not have these systems integrated into their ISPs to provide a foundation for consistent implementation of their devices, and to ensure the devices were functional and meaningful to the individual. <u>Staff are trained in the use of the AAC device.</u> Five of the seven individuals in Sample R.2 (71%) had staff performance check-offs in their records for some of their AAC devices. The following positive observations were made: ▪ The competency check-off for radio use provided sequential steps for staff to set	Noncompliance

#	Provision	Evaluation of Status	Compliance
		up and assist an individual with his radio, and required staff performance. ▪ AAC Communication Book Competencies check-off incorporated staff demonstration of the communication book and interacting with the individual. However, the following concerns were noted in relation to staff instructions, training and competencies: ▪ Individual PNMPs did not provide staff strategies to engage individuals with their AAC systems. ▪ Individuals' staff had not received competency-based training and performance check-offs for individual-specific and/or generic AAC systems. ▪ Staff instructions were not sufficiently discrete to provide staff with adequate information to engage an individual with a communication device. ▪ AAC/AT Competencies form did not require staff to demonstrate engaging individuals with individual-specific AAC systems. The Facility should continue to develop and implement individual-specific AAC competency check-offs that require staff to demonstrate performance with AAC devices and individual engagement. LBSSLC was not in compliance with this provision of the Settlement Agreement, and no progress had been made. Individuals reviewed who would benefit from the use of an AAC system(s) or had an AAC system did not receive adequate SL support. Moreover, skill acquisition programs for formal learning opportunities and/or multiple informal opportunities had not been integrated into their daily schedules to support utilization of functional communication systems.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily	<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> As stated in the previous report, no Facility AAC monitoring policy and/or procedures existed for the implementation of the AAC Individual Equipment Monitoring Form. The Presentation Book for Section R presented monthly analyses of monitoring data for Section R. These analyses identified the following problems: individual AAC devices were not being utilized as recommended during communication opportunities; generic communication equipment was not being used by direct support professionals; communication strategies were not being used or implemented; communication strategies were not integrated into the ISP; ISPs did not contain information about how the individual communicates; generic communication devices were not re-installed after a move; ISPs did not reflect information which described individual communication strategies, and/or why individuals might benefit from an AAC system; action plans did	Noncompliance

#	Provision	Evaluation of Status	Compliance
	available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	not reflect communication objectives; staff indicated they had been trained on how to use the AAC devices, but they continued to be under utilized and sometimes could not be readily located; and communication home devices were not very portable. For none of the individuals within Sample R.2 (0%) was evidence found of a system that effectively monitored all AAC communication systems. Monthly SL equipment monitoring had occurred. However, the following strengths and concerns were noted: ▪ Some monitoring forms had been modified to include numbering of individual equipment. This was an improvement, because it allowed the auditor to provide monitoring findings for a specific piece of equipment. Previously the AAC monitoring form had one field for multiple pieces of equipment. The monitor would have to document which pieces were not present, clean, and in use. ▪ Communication/Hearing Equipment listed in the SL evaluation and the PNMP were not consistently reflected on the monitoring forms. The SL equipment monitoring form should monitor all communication equipment. ▪ Communication equipment was not monitored in a variety of environments. The form should be modified to document monitoring in multiple environments. ▪ Staff had not monitored individuals with multiple AAC systems. ▪ Monitoring was not completed on a consistent basis. The Monitoring Team requested six months of communication equipment monitoring, but documentation provided reflected inconsistent monitoring. As recommended in the previous report, the Facility Speech Language monitoring policy should incorporate the following: ▪ Definition of monitoring process to ensure all communication equipment is available, functioning, and effective for the individual; ▪ Monitoring forms should include instructions for individual monitoring indicators to support consistency and provide a platform to test 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; and ▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies. <u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.</u> As stated above, the monitoring policy should define how monitoring will occur in a	

#	Provision	Evaluation of Status	Compliance
		variety of environments (e.g., home, activity center, work sites, leisure activities, mealtimes, etc.). Validation checks are built into the monitoring process and conducted by the plan's author. None of the individuals at LBSSLC participated in direct SL therapy. LBSSLC was not in compliance with this provision of the Settlement Agreement, and minimal progress had been made.	

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

1. The Facility should continue to recruit SLPs. (Section R.1)
2. SL evaluations should incorporate the following information:
    a. Evaluation data should be analyzed to identify an individual's strengths, abilities, and potentials for learning and skill acquisition. The analysis of evaluation findings should provide a rationale for functional outcomes and recommendations. The analysis should discuss possibilities for the development of formal programs, as well as informal activities that would support the achievement of functional outcomes and recommendations.
    b. Recommendations should include criteria that would enable the team to assess and monitor implementation to ensure efficacy of formal program(s).
    c. Recommendations should be based on an individual's preferences, goals, strengths, and needs. The recommendations should support learning within the home, work and leisure environments, including the community.
    d. Evaluations should discuss risk action plans and/or risk factors that might impact functional communication. (Section R.1)
3. The Facility should develop and implement a policy to address therapists' responsibilities for completion of an SL evaluation. Such a policy should include evaluation instructions, definition of direct therapy procedures, and guidance regarding integration of AAC systems into ISPs. (Section R.2)
4. Therapists' roles and responsibilities in working with psychologists on the development of PBSPs and skill acquisition programs should be formalized in policy and/or procedures. (Section R.2)
5. Functional communication recommendations should be integrated formally through skill acquisition programs/action plan objectives, and informally reinforced through integration into daily activities. (Section R.2 and Section R.3)
6. Competency-based training and performance check-offs should to be implemented to ensure staff have the core competencies to use generic devices, as well as the competencies to implement individual-specific AAC system(s). (Section R.3)
7. The Facility SL monitoring policy should incorporate the following as recommended in the previous report:
    a. Definition of monitoring process to ensure all 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; and
    f. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies.

(Section R.4)

8. The Facility should focus on identification of a relevant sample, and development of adequate instructions and criteria for the audit tools. In addition, procedures should be developed and implemented to ensure inter-rater reliability. (Facility Self-Assessment)

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 Section S Presentation Book; o LBSSLC Plan of Improvement/Self Assessment, dated 9/19/11; o LBSSLC – IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring, revised 6/28/11; o Personal Focus Assessment (PFA) rubric, revised 9/7/11; o State Support Living Centers Procedure – Personal Focus Assessment, dated 9/7/11; o PFA Webinar – Revised PFA/PFA Instructions and Follow-up Questions email, dated 9/8/11; o In-service Training for Personal Focus Assessment – QMRP, dated 9/1/11; o Active Treatment NEO/OJT Training, including Skill Acquisition Program (SAP) process – power point training materials; o LBSSLC Plan of Improvement; o Habilitation, Training, Education, and Skill Acquisition Programs – power point training materials, including In-service Training Documentation for SAP Pilot Process, dated 3/9/11; o Revised SAP Training - power point training materials, including In-Service Training Documentation, dated 5/16/11; o Summary of SAP Trainings for: PST on pilot homes, department heads, OJT staff, and staff on pilot homes, including related attendance rosters; o Example of revised Skill Acquisition Program Strategy Sheet, revised 8/3/11; o Example of revised SAP Progress Note, dated August 2011; o PST Consultant PSP Process/Skill Acquisition Training, including SAP training notes, dated 8/25/11; o LBSSLC Active Treatment Monitoring/Coaching Tool, undated; o Active Treatment Monitoring/Coaching Tool Summary data – across residential programs and questions, from May through August 2011; o Corrective Action Plan targeting engagement, undated; o For Section S.1, Skill Acquisition Programs, as well as associated collected or summary data, as available, for: Individual #151, Individual #1, Individual #284, Individual #290, Individual #266, Individual #19, Individual #202, and Individual #131; o For Section S.2, Functional Skills Assessments (FSA), Personal Focus Assessments, Positive Assessment of Living Skills (PALS), Personal Support Plans, Personal Support Plan Addendums, 30-Day Active Record Review and PSP Quarterly Reviews, as available, for: Individual #151, Individual #7, Individual #293, Individual #15, Individual #203, Individual #175, Individual #108, Individual #322, Individual #321, Individual #131, Individual #265, Individual #302, and Individual #201;

	○ For Section S.2, Vocational Assessments for: Individual #94, Individual #131, Individual #291, and Individual #312; ○ State Supported Living Centers Procedures – Vocational Assessments, undated; ○ QMRP Coordinators/Active Treatment Coordinators Conference Call - Engagement Tool Discussion meeting minutes, dated 8/10/11); ○ For Section S.3.a, 30-Day Active Record Review (Integrated Progress Notes) and PSP Quarterly Reviews, as available, for: Individual #151, Individual #7, Individual #293, Individual #15, Individual #203, Individual #175, Individual #108, Individual #322, Individual #321, Individual #131, Individual #265, Individual #302, and Individual #201; ○ For Section S.3.b., Skill Acquisition Programs, as provided, for: Individual #70, Individual #250, Individual #210, Individual #233, Individual #132, Individual #95, Individual #235, Individual #61, Individual #25, Individual #255, Individual #4, Individual #51, and Individual #273; ○ Summary Community Integration Data, for September 2010 through August 2011; ○ Sample Trip Data Sheets, for June through August 2011; ○ Corrective Action Plan targeting Engagement for Residential Programs, including 504, 517, 518, 526, and 525 Cedar; ○ NEO Training Documentation and Power Point Slides: Introduction to Active Treatment, Promoting Activities, and Principles to Providing Active Treatment; and ○ Active Treatment Staff Training documentation, including the Skilled Acquisition Training, Progress Note/Check Competency Session form, SAPs Test, example Skill Acquisition Program Strategy Sheet, example Progress Monthly Note form, and Active Treatment OJT Training true/false exam. ▪ **Interviews with**: ○ Jim Forbes, Director of Behavioral Services, and Sally Schultz, State Office Consultant on 10/3/11; ○ Lola Walker, QDDP Coordinator; Marisol Gonzales, ISP Coordinator; Rodshadi Moore, Active Treatment Supervisor; Christina Sosa, Psychologist; Tracey Snow Murphy, Director of Residential Services; Sandra Kennedy, Unit Director and QDDP Educator; Jim Forbes, Director of Behavioral Services; and Deborah Burgett, DADS, on 10/4/11; ○ Rodshadi Moore, Active Treatment Supervisor; Adrian Richardson, Active Treatment Coordinator; and Erika Flores, Active Treatment Coordinator, on 10/4/11; ○ At Risk Meeting for Individual #33, on 10/5/11; ○ Tracey Snow Murphy, Director of Residential Services, on 10/5/11; ○ Libby Allen, Facility Director; Robin Seale, Assistant Director of Programs; and Donna Jessee, DADS SSLC Director of Operations, on 10/5/11; ○ Psychologists including Carolyn Milton, Philip Kite, Christina Sosa, Krista Leubner, Joanna Molleca, and Beckie Crawford, as well as Psychology Assistants including Anna Shackelford, Amber Flores, Blake Perez, and R. Jamie Trevino, on 10/5/11; ○ Jim Forbes, Director of Behavioral Services, and Robert Robbins, on 10/6/11; ○ Lola Walker, QDDP Coordinator; Tracey Snow Murphy, Director of Residential Services; and Marilynn Foster, QA/QI, on 10/6/11;

	○ Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 10/6/11; ○ Sandra Kennedy, Unit Director, on 10/7/11; ○ Sandra Edge, on 10/7/11; and ○ Mary Ortiz, Director of Competency Training and Development, on 10/7/11; ▪ **Observations of**: ○ Brief campus tour with the President of the Self Advocacy Group, Individual # 237; ○ PICA Reduction Committee Meeting, on 10/4/11; ○ Behavior Support Committee Peer Review Meeting, on 10/6/11; ○ 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 QDDPs were conducted throughout the day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Workshop (536), on 10/3/11; ▪ Canna (521), on 10/3/11; ▪ Violet (523), on 10/3/11 and 10/4/11; ▪ Aspen (513), on 10/3/11; ▪ Birch (514), on 10/3/11 and 10/6/11; ▪ Elm (515), on 10/3/11 and 10/6/11; ▪ Fir (516), on 10/3/11 and 10/6/11; ▪ Iris (527), on 10/4/11; ▪ Tulip (526), on 10/4/11; ▪ Rose (525), on 10/4/11; ▪ Willow (520), on 10/4/11, 10/5/11, and 10/6/11; ▪ Oak (518), on 10/5/11 and 10/6/11; ▪ Maple (517), on 10/5/11 and 5/6/11; ▪ Educational Building (511), on 10/7/11; and ▪ Pine (519), on 10/7/11.
	Facility Self-Assessment: The Facility had developed a Plan of Improvement and Self Assessment with regard to Section S of the Settlement Agreement. The POI/Self Assessment contained sections of each settlement agreement provision with the current Facility determination of noncompliance or substantial compliance, as well as corresponding descriptions of ongoing status. 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. As reported in the Monitoring Team's previous reports, the Facility had developed a self-assessment tool based on the Monitoring Teams' Section S rubric. Reports indicated that the QDDP Coordinator, Program Compliance Monitor (PCM), as well as other Active Treatment staff conducted reviews using the self-assessment tool. According to verbal reports, each month, a total of 14 individual PSPs were randomly selected for review and, of these, four of these were selected for inter-rater agreement. Reported data

	indicated that compliance scores from May, June, and July were 69%, 72%, and 62% (average of 68%) for the PCM, and 72%, 79%, and 68% (average of 73%) for the QDDP Coordinator, respectively. In addition, inter-rater agreement between the PCM and QDDP Coordinator for May, June and July were 70.5%, 75.5%, and 65%, respectively. No data was reported for August or September. Verbal reports indicated that the QDDP Coordinator and PCM met monthly since May to review and discuss the completed assessment tools, ensure completion of all sampled PSPs, improved accuracy and inter-rater agreement over time, and the strengths and weaknesses of the reviews. Although it was positive that reviews were being conducted, the POI provided only overall scores. It is unclear how the Facility calculated these, because the indicators within the tools were not weighted. In addition, in order for the data to be useful to the Facility in identifying areas in which strengths or needs exist, data should be reviewed per indicator. This will allow the Facility to identify and broaden best practices, and identify and address specific areas requiring correction. As the Facility expands it POI, it will be important for the POI to reflect the analysis completed, and the decisions made regarding areas requiring additional attention. In addition, the POI/Self Assessment included 21 action steps across two selected sections (S.1 and S.2) of the Settlement Agreement with corresponding descriptions of required evidence, the persons responsible, start dates, projected completion dates, and the completion status. According to provided documentation, out of 21 total action steps, the Facility reported that 16 had been completed, four were in progress, and one had not been started.
	Summary of Monitor's Assessment: Initial progress had been noted in the area of habilitation services in the development of improved skill acquisition programs (SAPs). This included the identification of a new SAP format, including progress monitoring, and initial progress in developing plans that adhered to this format. Evidence had yet to be provided to demonstrate use of the new SAP progress monitoring format. Although improvement was noted, concerns regarding the adequacy of the SAPs remained. Estimates of engagement reflected less than desirable levels of engagement during brief on site observations. These observations also evidenced, at times, low staff-to-individual ratios at some sites. Continued changes within the ISP process included the recent revision and inclusion of several assessments, including the Personal Focus Assessment, Functional Skills Assessment, and Vocational Assessment. Although progress in completing improved vocational assessments was evident, concerns regarding their adequacy were noted. Efforts were also observed in the provision of competency-based training of direct support professionals in implementing active treatment, including SAPs. However, it appeared that training curriculum and on-going monitoring required additional specification and support. The provision of formal skill programming in the vocational and community-based settings remained a concern. This included the lack of improvement in opportunities for individuals in off-campus vocational

	settings.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Since the Monitoring Team's last visit, initial progress had been noted in the area of habilitation services in the development of improved skill acquisition programs. That is, a new format was implemented, and new SAPs that adhered to this new format were slowly being developed. As the Monitoring Team noted in its last report, very limited progress had been observed. That is, at that time, there were no newly completed SAPs available for review. However, four residential programs (i.e., 518, 523, 521, and 520) had been identified for inclusion in a second pilot program that was designed to develop SAPs utilizing a revised format, as well as monitoring documentation (i.e., Strategy Sheet, Performance Documentation sheet, and the Skill Acquisition Plan Data Graph). Documentation also evidenced the development and training of a new curriculum targeting habilitation, training, education, and skill acquisition programs. Since the Monitoring Team's last review, progress had been made in the refinement of the SAP format and the development of improved skill acquisition programs. Documentation evidenced efforts to train staff in Active Treatment, including an in-depth overview of skill acquisition plans (i.e., review of the SAP strategy sheet), including description of the necessary elements, and review of how to document progress using progress notes. It should be noted that the training materials (i.e., the Skill Acquisition Program Strategy Sheet) inaccurately described forward and backward chaining. In addition, examples of SAPs (i.e., currently utilized in training materials) were not written in the most current format. The Facility should closely examine the training materials to ensure that they are accurate, and reflect the most current formats of SAPs and related data collection methodology. Consideration should be given to supplementing or expanding the training provided to those writing the SAPs as they, although much improved, continued to be inadequate in some ways as discussed below. In addition, it remained unclear how progress on SAP would be regularly summarized and reviewed, because the new format has appeared to replace the previous "Performance Documentation" and "Skill Acquisition Plan Data Graph" forms. According to verbal reports and documentation provided, the changes described above had not yet been integrated formally into LBSSLC policy. According to documentation provided, 31 individuals had SAPs completed since 7/31/11 using the new SAP format. Of these, eight individuals (26%) were randomly selected, and their most recently developed SAPs were reviewed to ensure that they included the components necessary for learning and skill development. The full list of individuals for	Noncompliance

#	Provision	Assessment of Status	Compliance
		whom documentation was requested is included in the documents reviewed section. Although SAPs were provided as requested for all of the individuals sampled, only two of the selected individuals had SAPs written using the most current SAP format (i.e., Individual #151 and Individual #284). Indeed, several SAPs were completed utilizing the format that was in place over a year ago (i.e., Individual #131, Individual #1, and Individual #290), and several used the improved, although just recently outdated SAP format that was initially developed earlier this year (i.e., Individual #266, Individual #19, and Individual #202). Overall, the SAPs following the most recently revised format appeared to be improved compared to previous programs, because they were more likely to contain the identified sections and related content necessary to support effective skill acquisition. However, consistent with the findings included in the Monitoring Team's previous reports, some of the currently sampled SAPs continued to evidence inadequacy in one or more areas, including: 1) an objective, measureable, operational definition of the skill being targeted for acquisition or maintenance; 2) specific detailed teaching instructions (typically across multiple steps) based on a task analysis; 3) detailed instructions on the use of differential reinforcement, including more individualized reinforcers and when (or not) to deliver the reinforcer; 4) detailed instructions on how to introduce and fade necessary prompts; 5) comprehensive and/or perhaps more standardized instructions for error correction, including correction trials and the withholding of reinforcement; 6) use of discriminative stimuli, such as an initial instruction or other relevant stimuli, perhaps integrated within the objective as well; 7) programming for planned maintenance and/or generalization; and/or 8) sufficient trials per day or week to promote acquisition and maintenance. Specific examples of related concerns, based on the current sample, included: ▪ In some cases, measureable objectives should have been more detailed to ensure accurate training and measurement. For example, some terms used in the tooth brushing SAP for Individual #19, including "independently brush teeth," and "special attention to gum line" did not appear adequate. ▪ In some cases, the differences between steps of the SAP were primarily based on prompt levels. For example, in a SAP targeting use of an augmentative communication device for Individual #151, the steps appeared to be differentiated by the use of less restrictive prompt levels. Typical practice following incorrect responding would involve the use of one or more intrusive prompts (following the prompt hierarchy), if necessary, to ensure accurate responding. Therefore, a more general direction of using "least to most prompting" to ensure a correct response following an incorrect trial would likely facilitate accurate responding, while limiting the use of unnecessary, potentially more intrusive prompts. ▪ If the steps identified within a plan differ by intrusiveness of prompt level, the mastery criteria should not reference a prompt level or an independent level of	

#	Provision	Assessment of Status	Compliance
		responding for the "mastery" of a completed a step. Rather, mastery of a step would include consecutive accurate completion of responses at the specified prompt level (e.g., the alternative augmentative communication device SAP for Individual # 151). ▪ Removing the discriminative stimulus (i.e., "cue") from individual steps, for example, the verbal cue from step 1 for Individual #151, in SAPs will reduce the likelihood that individuals will become prompt dependent. Overall, it should be the intent to have typical stimuli in the natural environment (i.e., that might not be verbal cues) set the occasion for the targeted response. ▪ It was unclear from some SAPs that the identified method of training was really the method of training desired. For example, in the tooth brushing SAP for Individual #151, "total task" was identified as the training method, but the steps were set up to be meet individual criterions (i.e., they were not likely working on all the steps each time the SAP was conducted). In addition, "backward chaining" was identified as the method of training. However it appeared that staff were encouraging and completing data collection for each identified step. In addition, "discrete trial" was selected for a campus walking SAP for Individual #19. This appeared to indicate that the writer did not quite understand the format of discrete trial training. ▪ In several SAPs, only one step of the task analysis was identified. When this was observed, it questioned the need for a formalized skill acquisition program or, at the very least, the inclusion of additional steps including more specification across steps. For example, it would appear that Individual #151 had already acquired the skill identified in the self-administration of medication (SAMS) SAP. Therefore, the salient issue appeared to be performance (motivation) problem and not a skill problem. Consequently, a skill acquisition program was not needed. ▪ It was unclear how many of the reviewed SAPs would generalize training into the community consistent with prescribed staff instructions (i.e., outlined in the "Generalization" section). For example, the instructions outlined in the SAP targeted the use of a snack box for Individual #284 in the community. This appeared inappropriate and perhaps unrealistic. In addition, generalization criteria for Individual #19 did not actually address generalization of the skill. ▪ Consideration should be given to achieving mastery at a specific prompt level prior to moving onto another prompt level. This has implications for how the individual learns the skill (i.e., becomes more independent over time), how stimuli and supports are faded, how staff collect data, and importantly, how prompt dependency is avoided. Currently, staff appeared to be providing reinforcement regardless of what prompt level was necessary for the individual to complete the step. Differential reinforcement occurs when an individual completes a step using the assigned prompt level (or less). If a mistake is made	

#	Provision	Assessment of Status	Compliance
		or a more intrusive prompt level is utilized, the identified reinforcer is usually not presented for that trial. ▪ Some SAPs did not utilize the full spectrum of prompt levels. This could limit how quickly prompt levels could be faded. The SAP for cleaning of dinner items for Individual #266, for example, only prescribed verbal and physical prompts. ▪ Overall, it would be helpful if there were an original implementation date and any revised dates conspicuously recorded on the SAPs. Consistent with findings of the Monitoring Team's previous reviews, the collection and summary of skill acquisition data continued to be inadequate. This was not necessarily surprising, because the new SAP data collection methodology was just implemented. Currently, data was still not summarized or displayed in any format (i.e., table or graph) that would facilitate efficient analysis of individual performance. Indeed, the newly proposed data collection format was not used for any SAP reviewed. In addition, as previously observed, the adequacy and consistency of data collection continued to appear insufficient. More specifically, skill acquisition data was often missing (e.g., SAMs data sheet for Individual #284, tooth brushing data sheet for Individual #19, and cleaning utensils SAP for Individual #266). In addition, data sheets for Individual #266, for example, only evidenced data collection across seven trials, even though the program had been in place for three months with the expectation that the SAP be conducted daily. Similarly, Individual #284 was expected to utilize his snack box six times a day, and yet less than six trials per day were documented. 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. It is anticipated, however, that with some modifications, once the new SAP format is implemented adequately across all residential programs, improvement in the development of more rigorous and fundamentally sound skill acquisition programs and monitoring will occur. As similar to 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 (i.e., number of individuals engaged to total number of individuals) in relation to staff-to-individual ratios across program sites.	

#	Provision	Assessment of Status	Compliance
		Engagement and Staffing Ratio Observations ***Location*** / ***Engaged*** / ***Staff-to-individual ratio*** Violet 0:6 1:6 Aspen ---- 1:7 Birch 1:2 2:1 Birch 1:2 0:2 Elm 3:3 1:3 Elm 4:4 1:4 Fir 3:3 0:3 Fir 4:4 2:3 Iris 0:3 0:3 Tulip 4:9 4:9 Rose ---- 2:11 Rose 1:3 0:3 Willow 3:3 2:3 Willow 4:4 1:4 Oak 4:4 2:4 Maple 3:3 3:5 Maple ---- 2:7 According to collected data, during brief residential visits overall engagement was 70%. An engagement level of at least 75% would be a typical target for a facility like LBSSLC. However, as noted during the Monitoring Team's previous visits, this percentage might be an overestimate as at least one television was on in every setting where observations occurred. That is, often individuals were judged to be "engaged," if they were facing the television, which in many observations was the case. Consistent with observations during the Monitoring Team's previous visits, the staff-to-individual ratios observed in some settings were concerning. Observations from the Monitoring Team's previous visit noted examples (i.e., at Elm, Maple, and Oak) of seemingly inadequate ratios to support active engagement or participation in more structured opportunities for skill acquisition. These concerns were similarly noted again during recent onsite observations at Maple, Aspen and Rose. As noted in the Monitoring Team's previous reports, engagement had been assessed utilizing the Active Treatment Monitoring/Coaching Tool. This tool was conducted by Active Treatment staff to ensure staff competence regarding maintaining acceptable levels of engagement in all settings, including residences, worksites, and day programs.	

#	Provision	Assessment of Status	Compliance
		Verbal reports indicated that since the Monitoring Team's last visit, Active Treatment staff revised this tool. This included changing the language on some of the items, as well as shortening the observation duration. In the past, this tool had assisted Active Treatment staff in identifying sites where levels of engagement had not been acceptable. According to verbal reports and documentation, a corrective action plan was implemented this past summer to address low levels of engagement at five programs (i.e., 504, 517, 518, 526, and 525). However, it was unclear if the specific action steps were completed, because completion status was not recorded on the document provided. In general, these tools were currently completed at residences each month, and data were tracked (by residence and item) over time. Summary data from May, June, July, and August 2011 indicated monthly average scores of 98%, 79%, 89%, and 86%, respectively. Although verbal reports indicated that four probes (i.e., two probes on each of the 6 a.m. to 2 p.m. and 2 p.m. to 10 p.m. shifts) were conducted each month in each residence, summary data did not include the number of completed engagement probes conducted per residence each month. In addition, engagement data for worksites or day programs was not included. Verbal reports indicated that this tool was likely to be revised again in an attempt to standardize engagement measures across all of the SSLCs. Summary data was also available on the number of planned on-campus activities, as well as the number of individuals that participated in each activity. According to this data, 20 events had been held between 4/4/11 and 10/4/11, with an average of 26 individuals (range of 15 to 121) in attendance at each event. As noted during the Monitoring Team's previous review, the use of any new monitoring tools and/or procedures should be outlined in current Active Treatment policy (i.e., LBSSLC IDT Program Development: Active Treatment Program Development, Implementation, and Monitoring, dated 6/28/11). Although this policy was recently updated, it was unclear to the Monitoring Team what specific changes had occurred. The current policy outlined the use of Program Observation Drills that it did not appear the Facility was currently using. In addition, other assessments (e.g., "Skilled Acquisition Program Training") utilized in training and monitoring of staff's active treatment competencies were not integrated into this revised policy. Additional specificity within the policy describing the nature of competency-based training and monitoring would assist staff to more fully understand how to effectively implement new procedures. Lastly, verbal reports from the Director of Vocational and Day Programs, as well as the Coordinator of Supportive Employment indicated that no substantial changes had occurred with regard to the vocational and employment opportunities both on and off	

#	Provision	Assessment of Status	Compliance
		the LBSSLC campus. As presented in the Monitoring Team's previous reports, individuals participated in a variety of work activities both onsite (i.e., workshops) and off-site (i.e., supported enclaves in the community and competitive employment), as well as within the Enterprise program and the Client Worker program. Review of documentation indicated that since the Monitoring Team's last visit, the number of individuals in supported employment, enclave work, or competitive employment had not changed significantly. However, it appeared that one additional individual was participating in each of the Enterprise and Client Worker program. Indeed, over the past year, the only program that had increased the number of workers was the Client Worker program. According to verbal reports from the Director of Vocational and Day Programs as well as the Coordinator of Supportive Employment, one remaining barrier to improving the number of individuals working within supported, enclave, or competitive employment positions was the continued effect of the poor economy. Indeed, this appeared to be a rather intractable variable that had negatively impacted potential opportunities for individuals residing at LBSSLC. As previously noted, the Facility should continue to strive to identify community-based opportunities, including vendors and others within the systems the Facility utilizes, to trial and ultimately place individuals in supported or competitive employment positions. Successful community-based employment will continue to be an increasing need to ensure that more individuals are placed 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.	Minimal progress was noted in the area of conducting annual assessment of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities. More specifically, progress was noted in the development of new and revised assessments (i.e., Personal Focus Assessment and Vocational Assessment). However, their use had just been initiated. One consistent finding across the Monitoring Team's previous visits included the continual revision of the ISP process. This included changes in assessments used as initial measures to identify areas for further discussion and potential evaluation prior to the ISP meeting. As noted in the Monitoring Team's previous reports, the Personal Focus Assessment replaced the Personal Focus Worksheet: Individualized Assessment Screening Tool. According to email documentation, on 9/8/11, the final revision of the PFA was just recently implemented, and on 9/7/11, a new policy was developed to provide detailed instructions for its use. The PFA was implemented to facilitate the identification of individual goals and preferences, as well as the necessary subsequent assessments and developed supports. Other noted revisions in the ISP process included the more recent replacement of the Positive Assessment Of Living Skills with the Functional Skills Assessment. This change was reported to have occurred in mid-July. Both of these assessments were central to the ISP assessment process, as they offered the	Noncompliance

#	Provision	Assessment of Status	Compliance
		potential to facilitate the examination of a substantial number of skill areas, as well as provide additional information on an individual's preferences, strengths, needs, and barriers to community integration that could be utilized to inform the development of objectives and goals, including targeted skill acquisition programs. In an attempt to estimate the current status of the recently revised ISP assessment process, a sample of individuals who had PSP meetings within the last few months was identified. Verbal reports indicated that all of the most recent changes would be reflected in ISPs completed during or after August. Consequently, the current sample of 13 individuals was randomly selected from those who had an ISP meeting during or after August 2011 and assessments provided, as requested, were reviewed. That is, of the documents available, completed PALS, PFAs, and/or PSPs were examined. Of the 13 individuals currently sampled, (i.e., those listed in the documents reviewed section) documentation showed completion of PFAs for only nine (69%) individuals. PFAs were unavailable for Individual #15, Individual #131, Individual #201, and Individual #7. Although PFAs were available for the majority of individuals sampled, the assessments for two of the nine appeared to be incomplete (i.e., Individual #293 and Individual #203). In addition, two PFAs did not include identification or summary of individual preferences (e.g., Individual #203 and Individual #321). Overall, PFAs appeared either not completed or incomplete for 46% of the sample. In addition, it was not always apparent that the PFA was completed prior to the IDT meeting (e.g., Individual #322, Individual #321, and Individual #15). Based on the estimate from the Monitoring Team's previous visit (i.e., where 50% of those sampled appeared to have missing or incomplete PFAs), the current performance did not reflect any improvement. It also should be noted that all of the PFAs examined were completed prior to the implementation of the newly revised PFA format, dated 9/7/11. As noted during the Monitoring Team's previous visit, the completion of the PALs appeared somewhat inadequate. More specifically, of those sampled during the last review, only 75% appeared to have adequate PALs assessments completed. Currently, given that the ISP process was in transition, both the PALs and FSAs were found within the sampled documentation. Of the 13 individuals sampled, 10 (77%) appeared to have a PAL or FSA completed within the last year. Of these, provided documentation evidenced that only two IDTs had started utilizing the new PFA format (for Individual #15 and Individual #131). Based on verbal reports regarding the progression of the revised IDT process, the Monitoring Team expected more of the IDTs to be utilizing the new PFA format. The status of the use of the PFA, therefore, should be more evident at the time of the next review. For the remaining individuals within the sample, the PALs were either outdated (i.e., Individual #108 and Individual #203) or not available (i.e., Individual #7).	

#	Provision	Assessment of Status	Compliance
		One consistent theme noted throughout the review of available PALs and PFAs was the lack of comprehensive summary of the results for some of the assessments. That is, select sections in the assessments were completed as recommended by the ISTs but, in many cases, the results were not summarized or conspicuously utilized to inform programming. This appeared evident for a number of individuals (e.g., Individual #151, Individual #203, Individual #321, and Individual #201). Indeed, in some cases, it appeared that the previous goals were simply integrated within the current assessment without any indication of how the current results might have impacted past or current programming (e.g., Individual #108, Individual #293, and Individual #175). The Facility should consider ensuring that all staff completing the required assessments as part of the ISP have been adequately trained in completing the assessments as designed. As reported in the Monitoring Team's previous report, a revised vocational assessment had been developed and, upon review, it appeared more comprehensive and included an open-ended format designed to elicit responses central to an individual's v vocational and/or employment vision and other related issues. At that time, examination of available vocational assessments revealed several concerns, including: 1) lack of integration within the ISP; 2) decisions based on limited amounts of data; 3) inconsistent and inadequate completion of vocational assessments; 4) outdated review (reports not revised annually); 5) inadequate individualization; and, 6) insufficient direction regarding potential employment or vocational settings. At the current time, documentation indicated that the most recent revision of the vocational assessment, completed with assistance of State Office, had been initiated recently in August 2011. At that time, new procedures had been developed that included a statement of purpose, general procedures, and instructions for staff how to complete the revised assessment, including directions on how to obtain the most comprehensive information, including situational vocational exploration, including both on and off campus. In addition, administration guidelines indicated that the each individual would be required to have a vocational assessment and that these would be completed every three years. Guidelines prescribed that annual updates would be completed for "individuals who are actively involved with the vocational department," and as needed for individuals the IDTs referred, or for those who have experienced a life-changing event. It was unclear why only these individuals were identified. For example, it was not evident that someone who historically refused to attend work and perhaps was not currently "actively involved within the vocational department" would be targeted by these guidelines. These might be the exact individuals that would benefit from a comprehensive and perhaps ongoing vocational assessment. In addition, it was unclear at the time of the Monitoring Team's current visit when these procedures would be integrated formally within LBSSLC policies.	

#	Provision	Assessment of Status	Compliance
		According to summary documentation, 66 vocational assessments were completed between March and September. However, only 19 of these were recently completed (during August and September) using the newly revised format. Of these, four (20%) were selected for review. They are listed in the documents reviewed section. In general, the sampled vocational assessments utilized the new format, including items in the areas of communication, physical characteristics, identified strengths and barriers, vocational characteristics, safety, preferences, work history, and vocational exploration. Once these items were completed, a summary of the vocational/employment vision, work preferences, education/work history, related strengths, barriers and necessary supports, ideas for the future, and recommendations were recorded. Overall, the assessment appeared much more comprehensive and provided an opportunity for direct assessment (using the situational assessment). The four sampled assessments included responses across all of these areas. However, the current vocational assessments also were noted to be inadequate in several ways. For example: ▪ In some assessments, the vocational/employment vision was not identified or described. For example, instead of identifying a potential vocational vision, only demographic data was provided for Individual #291 and Individual #94. In addition, it was unclear how the IDT determined the specific work preferences of "the small workshop" and "disassembling of paper and shredding" for Individual #291 when every assessment item under "work preferences" was scored "no response." ▪ According to the assessment, Individual #312 voiced a desire to work at WalMart or the mall as a greeter, but that health concerns limited that opportunity. It was unclear from the assessment what specific supports were in place to support his health, or how the IDT would determine when he was sufficiently healthy enough to pursue his vision in the community. It also was unclear why he could not greet shoppers at WalMart or the mall, if he was healthy enough to greet diners on campus. In addition, the recommendations did not appear to address needed skills (e.g., staying healthy by washing hands) or supports (e.g., assisting with arrangements for transportation) that would facilitate progress toward his ultimate vision. ▪ For some individuals, the established and typical onsite vocational options continued to drive how assessors (and perhaps IDTs) approached answers to questions related to vocational placement. This appeared to be the case for Individual #291 and Individual #131. For example, Individual #131 expressed an interest in working in a restaurant and washing dishes, but the vocational exploration section only targeted other options (i.e., picnic packs, sealing, hearts and hands) available only on campus. ▪ Answers to some questions did not appear to provide sufficient detail and seemed contradictory. For example, when identifying barriers to achieving the stated vision, the assessors only recorded response was "attendance" and when	

#	Provision	Assessment of Status	Compliance
		identifying needed supports to overcome this barrier, the assessor recorded "attendance" and "job coaches" when completing the vocational assessment for Individual #131. ▪ Overall, based on limited sample of vocational assessments, the assessors did not appear to integrate the information gained through the completion of the many items when developing recommendations to support meaningful progress (i.e., building the necessary prerequisite skills) toward the attainment of the identified vocational vision. ▪ Lastly, none of the individuals sampled appeared to complete situational assessments (i.e., vocational exploration) in settings other than those available on campus. Although the current sample was small, the restricted nature of the situational assessments was notable. The Facility is strongly encouraged to provide vocational exploration across more diverse jobs in settings beyond those already established onsite. Indeed, for many of the individuals served, it might be difficult to imagine and identify an interest in a particular job and/or workplace setting when the options are unknown.	
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 of the Settlement Agreement, and as consistent with findings from the previous review, it was unlikely that the majority of skill acquisition programs were currently promoting significant growth, development, and independence across most individuals served at LBSSLC. Similarly, as previously reported, the current method in which SAP data was collected and summarized, as a whole, continued to be inadequate. However, at the current time, initial progress in developing more rigorous and fundamentally sound SAPs, as well as systems to monitor related performance was evident. The Monitoring Team looks forward to reviewing these changes and the Facility's progress during the next visit. According to documentation and verbal reports, substantial efforts had been initiated to ensure that staff had the knowledge and competencies to implement active treatment programming, including SAPs, with integrity. As noted within previous Monitoring reports as well as in the current report with regard to Section K.12, revisions in the New Employee Orientation curriculum, as well changes in the nature on-the-job training (OJT)	Noncompliance

#	Provision	Assessment of Status	Compliance
		were made to facilitate improvements in staff knowledge and skills. In addition, the Active Treatment Department had worked to ensure that new and current staff had these competencies through the completion of indirect measures (e.g., paper and pencil tests, such as the Skilled Acquisition Program Training Active Treatment/OJT Training, and SAPs Test forms), as well as direct measures (observations during Progress Note and Check Competency Sessions). Indeed, a substantial amount of raw data was provided to demonstrate the effort exhibited to conduct these assessments since the Monitoring Team's previous visit. However, it was unclear if this data was summarized, reviewed and analyzed as well as if there were any implications related to training, monitoring, and/or measuring performance of staff. If not already in place, the Facility should determine an effective method of tracking this data and identify a review process that facilitates improved NEO and OJT and, ultimately, staff competencies. Recent changes in the ISP process might have implications for how progress on SAPs are summarized and reviewed. Starting this past August, QDDPs were now completing 30-day Active Record Reviews in the Integrated Progress Notes in addition to the ISP Quarterly Reviews reports that already were being completed. The available 30-Day Active Record Reviews and Quarterly Reports for the current sample of 13 individuals (randomly selected from those who had an ISP meeting during or after August 2011) were reviewed. Although no documentation was provided for two of the selected individuals (i.e., Individual #7 and Individual #131), one or more 30-day and/or Quarterly reports were available for the remaining sample. It appeared that, in most cases, QDDPs briefly listed the SAPs in place and described their progress as "maintenance," "regression," progression," or some other descriptor (e.g., "no data," "program change," etc.). Or, in some cases, no discussion of the status of skill programs was included in Quarterly Reviews (i.e., Individual #108, Individual #322, and Individual #201). There was no actual data presented in any of the documentation reviewed, and no clear discussion of data based decision-making in any of the 30-day or Quarterly reports that were reviewed, with one exception. The IDT for Individual #293 indicated that the team had "…closely reviewed all programs" and "…[no] need for change of any sort as the programs continue to adequately support and meet identified needs." The Facility is strongly encouraged to consider integrating data (graphs) into 30-Day Active Record Reviews and Quarterly Reports (perhaps as an attachment) to assist IDT members to monitor ongoing performance on a regular basis, facilitate more meaningful interpretation of current status (compared to baseline or longitudinal data), and, ultimately, make more informed, data-based decisions.	
	(b) Include to the degree practicable training opportunities in community	Findings reported within the Monitoring Team's previous reports indicated that the Facility was offering opportunities for skill programming in community setting. Of those sampled during the Monitoring Team's previous visit, four (33%) individuals had skill	Noncompliance

#	Provision	Assessment of Status	Compliance
	settings.	acquisition plans that targeted implementation within a community setting. These included money management programs, or healthy food choice/eating programs. However, at that time, formal data collection and summary of the nature of their implementation was inadequate. Consequently, the Monitoring Team's previous report recommended that the Facility collect and summarize this data (i.e., number of opportunities, number of programs reflecting success, etc.). As described with regard to Section S.1 of the Settlement Agreement, skill acquisition programs were reviewed for a sample of eight (26%) individuals randomly selected from those identified as having newly developed SAPs that adhered to the revised format. Of theses, 0 (0%) appeared to specifically target completion in a community setting. However, three (38%) of the SAPs indicated conducting generalization trials (once per week) in a different setting, including a community setting. However, it was unclear how individuals would complete SAMs (i.e., Individual #151) or tooth brushing (i.e., Individual #19) SAPs in the community. A larger sample drawn from provided examples of new SAPs (i.e., found within the Section S Presentation Book) evidenced a similar finding of integrating skill programming within community settings during generalization trials. More specifically, out of a sample of 13 individuals, all (100%) had at least one or more SAPs that prescribed conducting generalization trials (once per week) in a different setting, including a community setting. The Monitoring Team's previous report found that 50% of those sampled had SPOs targeted for completion within a vocational setting in one of the work centers. This was noted as an improvement over the previous review, when it was estimated that only 16% of those sampled had SPOs that targeted completion within a work setting. Of those within the current sample, four (50%) had skill programming targeted for completion in a work center (i.e., Individual #1, Individual #290, Individual #202, and Individual #131). Overall, the current review was very challenging given the fact that the selected sample contained a diversity of SAP formats (i.e., even though all had been identified as having been developed using the new SAP format), as well as individuals who might not have had a recent ISP and, consequently, whose available documentation lacked correspondence with the new ISP process and related document formats. Verbal reports during the current visit indicated that, going forward, all developed (or revised) SAPs would be completed concurrent with the annual ISP cycle. The Monitoring Team looks forward to future reviews for which ISP documentation, including SAPs, will be more likely to reflect the most up-to-date formats and processes and be more consistent across individuals at LBSSLC.	

#	Provision	Assessment of Status	Compliance
		As previously reported, summary data of community outings reflected a surprising decreasing trend from December through February. More recently provided data, however, indicated an increase in outings in March, and a relatively stable trend in frequency of outings across programs since then through the end of August. Data from September reflected a significant increase in outings for programs in Unit 1 (primarily at Quail, Sparrow, and Iris). A substantial of number of Trip Sheets, dated March through August 2011, were provided for review. Unfortunately, the majority of these data sheets were not completed fully and appeared to target only a very limited number of individuals. Currently, was no efficient way to identify the number of individuals who had skill acquisition programs intended for completion in the community, or any system to monitor their ongoing performance on these programs while in the community. The current trip sheets were not necessarily designed to facilitate the collection of the data necessary to adequately examine performance on SAPs. That is, the trip sheets primarily allowed identification of the individual, the skills trained/reinforced, and the individual's response (five-point Likert scale). In addition, it was not clear if the data from these trip sheets were summarized and reviewed in a systematic way. The Facility should examine the current data collection system to ensure that it will effectively and efficiently capture performance on SAPs while in the community. This should include monitoring performance of all skill acquisition programs supported by both residential and vocational services staff. Lastly, as evidenced across the Monitoring Team's previous visits, only a very small number of individuals worked in supported employment, enclave, or competitive work settings within the community. The number of individuals reportedly working in these settings has not changed significantly over the last three Monitoring reviews. 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 development of revised skill acquisition plans (SAPs) for each individual concurrent with their ISP cycle. (Section S.1)
2. The Facility should closely review and revise the training materials related to SAP development to reflect improved accuracy and the formats currently in place. (Section S.1)
3. The Facility should ensure that developed SAPs include the following necessary components:
    a. An objective, measureable, operational definition of the skill being targeted for acquisition or maintenance;
    b. Specific detailed teaching instructions (typically across multiple steps) based on a task analysis;
    c. Detailed instructions on the use differential reinforcement, including more individualized reinforcers and when (or not) to deliver the reinforcer;

d. Detailed instructions on how to introduce and fade necessary prompts;
e. Comprehensive and/or perhaps more standardized instructions for error correction, including correction trials and the withholding of reinforcement;
f. Use of discriminative stimuli, such as an initial instruction or other relevant stimuli, perhaps integrated within the objective as well;
g. Programming for planned maintenance and/or generalization;
h. Sufficient trials per day or week to promote acquisition and maintenance. (Section S.1)

4. More specification should be added to Facility policies regarding the new SAP process and formats, including how these will be regularly reviewed and monitored. (Section S.1)
5. Monitoring of engagement should continue and should be extended to vocational and day programming as well. The Facility is encouraged to add more specification to collected data, including how many probes were completed at each residence per month. (Section S.1)
6. The Facility should strive to expand available community-based vocational opportunities to identify and place individuals in supported or competitive employment positions. (Section S.1)
7. As previously recommended, 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 (e.g., vocational exploration), whether successful or not, might help to more accurately reflect the ongoing support to individuals at the Facility. (Section S.1)
8. As previously recommended, as LBSSLC proceeds with implementation of the new ISP process, including the new SAP format, 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. (Section S.1)
9. As previously recommended, policies and procedures related to competency-based training for skill acquisition programming and the assessment of competency should be developed and/or revised to reflect current practice. 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. (Section S.1)
10. The Facility should ensure adequate completion of the PFA and FSA prior to the ISP. (Section S.2)
11. The Facility should continue to implement the new Vocational Assessment, including an emphasis on completing more direct evaluation through vocational exploration (situational assessments) targeting new employment positions as well as community-based settings. (Section S.2)
12. If not already completed, current procedures related to completion of the Vocational Assessment should be integrated with current LBSSLC policies. (Section S.2)
13. The Facility is strongly encouraged to consider integrating data (graphs) into 30-Day Active Record Reviews and Quarterly Reports (perhaps as an attachment) to assist IDT members to monitor ongoing performance on a regular basis, facilitate more meaningful interpretation of current status (compared to baseline or longitudinal data), and, ultimately, make more informed, data-based decisions. (Section S.3.a)
14. If not already in place, the Facility should determine an effective method of collecting and summarizing the data collected by Active Treatment staff (i.e., engagement, competency, and/or integrity data), as well as identifying a review and dissemination process that facilitates improved NEO and OJT and, ultimately, staff competencies. (Section S.3.a)
15. Efforts should be made significantly increase the integration and completion of SAPs in day program, vocational settings, or community based settings. It appeared that the majority of current skill acquisition programs were completed in residential programs, and individuals should be offered the option of completing them in the community. (Section S.3.b)
16. The Facility should examine how data will be collected when individuals complete skill acquisition programs in the community. This should include monitoring performance of all skill acquisition programs supported by both residential and vocational services staff. (Section S.3.b)

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, updated 8/30/11; o List of individuals referred for placement, dated 9/7/11; o List of individuals who have requested community placement, but have not been referred, dated 9/7/11; o List of individuals not referred due to Legally Authorized Representative (LAR) preference, dated 9/7/11; o Since the last onsite review, a list of individuals who have had a community living discharge plan developed, undated; o Community Placements since 4/1/11; o Since the last review, a list of individuals who have returned from a community placement: "There have been no community placement returns since the last on-site review;" o Since the last review, a list of all deaths, if any, that occurred following transition to the community: "Since the last review, there have been no deaths of individual transitioned from this Facility, nor have there been any deaths for individuals for whom the Facility provides post-move monitoring;" o Since the last onsite review, a list of individuals discharged pursuant to an alternate discharge, undated; o Since the last review, a list of all individuals who have transferred to other SSLCs, including name, and date of transfer, undated; o A current list of alleged offenders committed to the Facility following court-ordered evaluations, undated; o In response to request for analysis of obstacles, the statement that: "Information is currently unavailable and should be available by the time of the on-site review;" o Community Placement Report, from 3/1/11 through 8/31/11; 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 training materials and sign-in sheets; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; o LBSSLC – Continuity of Services: Most Integrated Setting, dated 4/27/11; o LBSSLC – IDT Process Program Development: Personal Support Plan Process – Supporting Visions, dated 4/14/11; o LBSSLC – IDT Process – Program Development: Personal Support Plan – At Risk

	Individuals Process, revised 8/24/11; o LBSSLC – IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs, revised 6/28/11; o Community Living Discharge Plan, related assessments, and sign-in sheet for: Individual #134; o Draft Community Living Discharge Plan (CLDP), related assessments, and sign-in sheets as available for: Individual #48, Individual #166, Individual #173, and Individual #290; o Since the last onsite review, a list of all post-move monitoring visits completed, undated; o Individual Support Plans, related assessments, and monthly/quarterly reviews for: Individual #210, Individual #8, Individual #7, Individual #58, Individual #151, Individual #267, Individual #238, Individual #197, Individual #1, and Individual #213; o Pre-Move and Post-Move Monitoring Checklists for: Individual #206, Individual #159, and Individual #134; o Special Review Team documentation for Individual #266; and o Presentation Book for Section T, including updates provided on site. ▪ **Interviews with**: o Carla Prell, Admissions/Placement Coordinator; o Annette Webster, Post-Move Monitor and Guardianship Coordinator; o Marisol Gonazales, ISP Coordinator; and o Lola Walker, QMRP Coordinator. ▪ **Observations of**: o ISP meetings for the following: Individual #269, and Individual #170;
	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. The three sub-sections that the Facility indicated it was in compliance with were T.1.c.2 (identifying in CLDPs the staff responsible and timeframes for completion), T.1.c.3 (reviewing the CLDP with the individual and/or LAR), and T.1.h (submitting the Community Placement Report to the Monitor and DOJ). The Monitoring Team found the Facility in compliance with these provisions, as well as Sections T.2 (post-move monitoring) and T.4 (alternate discharges). With regard to its findings of compliance as well as noncompliance, it was not always clear that the conclusions drawn were based on objective data. Throughout the section, the POI included helpful narrative information. In some cases, the Facility also had used data appropriately. For example, with regard to Section T.1.c.3, the Facility cited the number of CLDP meetings that had been held, and how many had been involved the participation of the individual and/or guardian. For most of the sub-sections of Section T, no data was provided, or an overall score was provided for the monitoring that the programmatic staff and QA Department had completed. Given that the tools were not designed to provide and overall score, this information was not helpful in substantiating compliance determinations and/or assisting the Facility to identify areas of strength and/or weakness. In addition, although the Facility provided inter-rater reliability scores, as is discussed elsewhere in this report, an adequate system for establishing inter-rater reliability was not in place.

	The Facility also included a number of action plans in the POI related to Section T. These action plans were in various stages of implementation, but all were worthwhile endeavors to assist the Facility in complying with Section T.
	Summary of Monitor's Assessment: Individuals' ISPs 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 ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. ISPs had begun to identify obstacles to individuals moving to the most integrated setting appropriate to meet their needs. Since the last review, teams had begun to discuss services or supports that either were unavailable or the teams believed did not exist in the community. Often these discussions revealed misconceptions about what was or was not available in the community. Training recently had been done with teams on the State Office list of obstacles. However, in the plans reviewed, teams had not yet used this list, and as a result, had not clearly summarized their conclusions related to obstacles. Given that teams were at this stage in the process, obstacles had not yet been analyzed, which will be an essential component of developing plans to overcome them on a more systemic level. The State Office directive that each SSLC team member include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need generally had not occurred in the plans reviewed. Occasionally, an assessment included this information. However, team discussions, as documented in a sample of recent ISPs, did not reflect that the staff had made an independent recommendation for discussion with the individual and his/her guardian. However, during some of the ISP meetings that members of the Monitoring Team observed during the onsite review, this process was beginning to occur. Since the last review, only two individuals had transitioned from the Facility to the community. The revised Community Living Discharge Plan process was resulting in better documentation of many of the planning efforts. The CLDPs reviewed included essential and non-essential supports. However, 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 the small sample of 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, and for one individual for whom it was required, adequate follow-up was conducted to address the concerns that were identified.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	As reported in previous reports, on 3/31/10, DADS issued a revised policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding for community transition of individuals from LBSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and 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, very few of the assessments prepared for annual PSP meetings had begun to include the assessor's recommendation regarding transition to the community (e.g., speech and language evaluations). In addition, individuals' ISPs generally did not include a summary or conclusion with regard to the professional team members' determination with regard to whether or not community placement was appropriate. Based on a review of 10 ISPs (including those for Individual #210, Individual #8, Individual #7, Individual #58, Individual #151, Individual #267, Individual #238, Individual #197, Individual #1, and Individual #213), for one of the 10 PSPs reviewed (10%) (i.e., Individual #197), the team had documented a determination of the professionals regarding whether or not transition to the community was recommended. However, this team had not used the process that the State had set forth in which each assessor would make a recommendation, and provide a list of supports the individual would need if he/she transitioned to the community. Rather, this team concluded that	Noncompliance

#	Provision	Assessment of Status	Compliance
		the individual's desire to live in the community was not appropriate. Adequate justification for this decision was not documented in the ISP. The remaining team made joint recommendations based largely on the guardians' stated preferences. As was discussed at the parties' meeting in June, in addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the ISP. The professionals' recommendation 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. Since the last review, only two individuals had transitioned to the community. LBSSLC recognized the need to increase referrals to the community. A plan had been developed, and implemented, 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. At the time of the review, five additional individuals had been referred for transition to the community.	
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:	Since the previous review, the Facility had approved a policy entitled: LBSSLC – Continuity of Services: Most Integrated Setting, dated 4/27/11. It had been modified to reflect the most recent draft State policy. However, it was anticipated that the State Office was going to issue a final version of the updated policy related to Most Integrated Setting in the near future, which likely would require modifications to be made to Facility policies. The three Monitoring Teams submitted comments on the DADS draft policy for the State's consideration. The Facility remained out of compliance with the implementation of the policy. This is discussed below with regard to each of the subsections of provision T.1.b of the Settlement Agreement. As a result, an overall finding of noncompliance has been made for Section T.1.b.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the	As noted above with regard to Section F of the Settlement Agreement, LBSSLC had continued to make efforts to improve ISPs. The ISP format included a section entitled the "Optimistic Living Vision for…" This section included discussion regarding the individual's and his/her LAR's awareness of community options, their preferences for a specific living option, obstacles that the IDT identified, and the supports and services the individual needed in various areas. A review was conducted of a sample of 10 PSPs. The findings related to this review are discussed below with regard to the two requirements	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	included in this provision, including: 1) the identification in the ISP of the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles. <u>Identification in ISPs of Needed Protections, Services, and Supports</u> As was discussed with regard to Section F of the Settlement Agreement, individuals' ISPs 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. Some of these issues were due to the fact that thorough and adequate assessments were not being completed (e.g., nursing, psychiatry, physical and nutritional management, and communication), services and supports were not being adequately integrated with one another (e.g., psychology and psychiatry, and psychology and dental/medical), and/or adequate plans were not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychiatry, psychology and habilitation, physical and nutritional supports, and communication). As has been reiterated since the baseline review, it is essential, as teams plan for individuals to move to community settings, that ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. This is important for three 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 perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals the Facility serves, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move, and non-essential supports are provided in a timely and complete manner. When all of the necessary protections, supports, and services are not outlined in the ISP, it is much more difficult to ensure the individual's safe transition. Based on a review of 10 ISPs, none of the plans reviewed (0%) included a comprehensive list of the protections, supports, and services needed to support the individual. Often this appeared to be due to staff's assumptions that supports were being provided at the SSLC, and that they did not need to be spelled out in detail. In other instances, the continuing deficits in assessments from various disciplines appeared to stymie the teams' ability to	

#	Provision	Assessment of Status	Compliance
		create a comprehensive list. In other instances, the lack of integration across disciplines and lack of incorporation of the various plans (e.g. PBSPs, PNMTs, health care plans, psychiatric treatment plans, communication plans, etc.) continued to result in incomplete ISPs. Previous reports have provided detailed examples of concerns related to PSPs. The Facility is encouraged to review the Monitoring Team's previous reports in relation to Sections F and T of the Settlement Agreement, as well as to critically analyze recent transitions to the community, and identify supports that were missing from ISPs and CLDPs. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u> As noted above, the ISP format included a section on obstacles that the IDT identified. In addition, the State Office had standardized a list of obstacles/barriers to community transition to assist in the analysis of information collected from IDTs throughout the SSLC system. The State Office had issued the list in April 2011. However, according to the Admissions Placement Coordinator, IDTs did not incorporate its use. A data entry form was developed, and shortly before the Monitoring Team's visit, the Admissions Placement Coordinator had provided re-training to IDTs on obstacles, and their identification in ISPs, as well as related action plans. The State Office Continuity Services Coordinator also had met with team members and provided training as well. Based on documentation provided, teams had been instructed to begin using the standardized list on 9/1/11. As a result, as illustrated in the findings below, at the time of the review, ISPs did not yet reflect this new system. In reviewing the sample of 10 ISPs, teams had discussed some obstacles. Of the 10 ISPs reviewed, all should have had obstacles defined, because none of the individuals had been referred to the community. Of the 10 plans, none (0%) included an adequate list of obstacles. The problems associated with the obstacles in the plans included the following: ▪ None conformed with the State Office's standardized list; ▪ Many were not adequately justified (e.g., an individual with psychiatric issues who required medication compliance monitoring, and individuals with physical and nutritional support needs that required accommodations and specialized equipment, etc.); ▪ Some identified the individuals' needs as obstacles, as opposed to supports or services not being available in the community to support such needs (e.g., Individual #197's behavioral and psychological needs); and ▪ When guardians or individuals objected, adequate inquiry did not occur with regard to specifically what their concerns were. Moreover, action plans to overcome the obstacles identified were not present. Of the 10 ISPs, none (0%) included an action plan to overcome obstacles identified.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team has provided numerous examples in previous reports regarding the concerns related to the identification of obstacles, and the lack of plans to overcome them. The Facility is encouraged to review the previous reports. LBSSLC remained at the beginning stages of identifying obstacles to community transition, and developing plans to overcome such obstacles. This deficiency, in addition to ISPs 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. The Facility had added some new activities to the ones it had been consistently completing. The new activities included: ▪ An article was submitted and published in a "New… News by Dominick." The article addressed community exposure tours. ▪ In May 2011, the Admissions Placement Coordinator had been an invited speaker at the Self-Advocacy meeting. During the meeting, she discussed community exposure tours and community transitions. ▪ In conjunction with the Human Rights Officer, the Admissions Placement Coordinator worked with the self-advocacy group to develop a poster contest to promote community living options. This was a creative idea that resulted in much excitement, and participation. It culminated in the posters being displayed at the diner in early September, and voting continued for approximately a week. At the time of the Monitoring Team's visit, the winning posters were on display in the Administration Building. ▪ Since the last review, the Facility had increased its community exposure tours from once to twice a month. Based on interview, efforts were underway to work with the local Mental Retardation Authority (MRA) to increase them to once a week. ▪ The Admissions Placement Coordinator also was working with the MRA to collect information about community providers, including brochures and DVDs. ▪ The Facility had added a second provider fair. An additional one was held on September 18, 2011 in conjunction with the Family Association meeting. Eight providers participated. Individuals and staff were provided with a template of questions to prompt some additional discussion. Due to the low participation of families and guardians, the Facility was considering conducting one of the fairs on a weekend day. Some of the activities that LBSSLC had previously completed, and continued to complete	Noncompliance

#	Provision	Assessment of Status	Compliance
		included: ▪ On October 28, 2011, the Mental Retardation Authorities were scheduled to provide training on services and supports available in the community. Families, individuals, and staff were invited. ▪ Individuals and their guardians also were provided information through the Mental Retardation Authority Community Living Options Information Plan (CLOIP) process. This was occurring regularly as part of the individual planning process. As discussed in previous reports, 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. The Optimistic Living Vision section of the 10 PSPs was reviewed. For one of these individuals (i.e., Individual #197), the team identified in the narrative discussion portion of the ISP the need for additional education, particularly with regard to foster care. However, in none of the applicable plans (i.e., for Individual #197) (0%) was an adequate written action plan included. Generally, the problems included: ▪ Obstacles listed included the individual and/or guardian resistance. However, the reasons for this were not explored, and, as a result, no actions were developed to individualize information provided to attempt to specifically address guardian concerns. ▪ Even when specific concerns related to an individual or guardian's resistance were noted, and no action plans were developed to provide further individualized education or support. 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, the poster contest was a creative approach to increasing awareness and fostering discussion about community alternatives, and the Facility is commended for this effort. As has been recommended previously, 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.	
	3. Within eighteen months of	The Monitoring Team requested for the last 12 months, a list of individuals who had been	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	assessed for placement. In response to this request, LBSSLC submitted a list of individuals with their most recent ISP date, and an indication of whether or not the IDT had made a referral. As is discussed above with regard to Section T.1.a of the Settlement Agreement, the individuals' ISPs reviewed did not document an independent assessment or determination by the professionals on the team of the individuals' appropriateness for transition to the most integrated setting appropriate to meet their needs. Based on meetings observed during the week of the onsite review, it appeared that the Facility had just begun to implement the State Office's plan to have each professional member of the IDT document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual PSP meetings. These assessments also were to identify supports that the individual would need in a community setting. As noted earlier, a very few of the assessments for some of the ISPs reviewed included recommendations related to community transition. As was discussed at the parties' meeting in June, in addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the ISP. It was early in the implementation of this new process, and, as would be expected, the ISPs reviewed did not yet include such documentation.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	At the time of the previous review, LBSSLC was in the initial stages of implementing the new Community Living Discharge Plan process. Since then, the Facility had continued to use the new format. Although progress had been made, particularly with regard to documentation related to the selection of appropriate community providers, the CLDPs continued to need significant improvement. In the previous compliance report, the Monitoring Team made a number of recommendations regarding the revised CLDP format. Based on discussions with Facility and State Office staff, it appeared that the State Office, working in conjunction with the SSLCs, was in the process of making additional changes to the format. The recommendations previously made will not be repeated here, but can be referenced in the last report. Since the last review, only two individuals had transitioned to the community. For one individual, the Monitoring Team reviewed her CLDP as part of the last review. As a result, only one complete CLDP was reviewed (i.e., Individual #134). Although this represented 100% of the relevant CLDPs, it was an extremely small sample from which to make findings. However, the Monitoring Team is presenting these findings in an effort to continue to improve the process. In addition, the Monitoring Team reviewed the draft CLDPs for four additional individuals (i.e., Individual #48, Individual #166, Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
		#173, and Individual #290). These were in the very initial stages of development. With regard to the timeliness of the Community Living Discharge Plans, the one plan was developed beginning a month prior to the individual's transition. This was a short timeframe, but the individual's guardian was adamant that the transition occurred within 30 days. It was clear from the narrative that the team had met a number of times within these 30 days to discuss components of the plan. As noted previously, noting the various dates on which the team revises a CLDP either on the first page or in the footer of the document would be beneficial. Documentation, either in the CLDPs or in PSPAs, also should be maintained to show the details of the ongoing development of the CLDPs between the time of referral and the individual's transition. It was noted in reviewing the four draft plans that the teams had done minimal work in listing essential and non-essential supports. One of the benefits of a lengthier CLDP development process should be to better define these supports on an ongoing basis. However, the action plan sections for all four individuals were blank. As is discussed in greater detail below, the essential and non-essential supports continued to be inadequate. The Facility should begin using the pre-transition time to more effectively define these supports. With regard to the timeliness of the development of CLDPs, the Facility had made significant progress. However, as is detailed in further detail below, the Facility was not yet in compliance with developing and implementing adequate CLDPs.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The Community Living Discharge Plan reviewed included a number of action steps related to the transition of the individual to the community. However, none of the one plan reviewed (0%) clearly identified a comprehensive set of specific and measurable steps that Facility staff would take to ensure a smooth and safe transition, and when such steps were identified, they often were not sufficiently detailed or measurable. Some examples of the general concerns noted included: ▪ The plan identified the need for training for community provider staff. However, it did not define which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or what level of mastery of the information was required (e.g., classroom training, demonstration of competence, etc.). ▪ The plan also did not specify the method of training, for example, if it would be necessary for community provider staff to shadow LBSSLC staff, and/or show competency in actually implementing a plan, such as a PBSP, nursing care plans, etc. For some individuals, specific components of their PSPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., an essential support), or, at a minimum, evidence should be	Noncompliance

#	Provision	Assessment of Status	Compliance
		provided that the community provider staff have the competencies necessary to safely support the individual. ▪ Missing from the plan was any requirement that collaboration occur between the Facility clinicians currently working with the individual and the community clinicians who would assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, psychiatrists, etc.). For many individuals, this would be necessary to ensure ongoing coordination of care. ▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff. ▪ The plan did not describe LBSSLC's staff's involvement in evaluating potential sites at which individual would be served. Examples of this depending on the needs of the individual would include Habilitation Therapies staff ensuring adequate accessibility and/or equipment, Behavioral Services Department staff determining if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment. ▪ The plan did not address any role that LBSSLC staff or community provider staff might play in assisting the individual to make the transition. For example, it was unclear if consideration had been given to the need for LBSSLC staff to follow the individual into the community for any period of time (e.g., the first day or longer), or to check in by telephone or in-person on occasion. Likewise, action steps might need to be included in the CLDPs for community provider staff to visit the individual at LBSSLC. Different individuals have different reactions to transitions. However, teams should be cognizant of the stress that transition can cause, and should build mechanisms into CLDPs to reduce this to the extent possible. As is described in further detail in the section of this report that addresses Section T.1.e of the Settlement Agreement, the CLDPs also did not consistently identify the essential supports required by the individuals. The Facility remained out of compliance with this provision.	
	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 one out of one of the plans reviewed (100%). This was a consistent finding with the previous review.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-	From the sign-in sheet provided with the CLDP that was reviewed, it appeared that the teams reviewed the CLDP with the guardian prior to the individual's transition. For one of the one plans reviewed (100%), sign-in sheets were provided that confirmed the presence of the individual and his/her guardian. This was consistent with the finding	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	making regarding the supports and services to be provided at the new setting.	from the previous review. As discussed above, the new CLDP format requires that teams meet multiple times to complete various portions of the transition process. This is a positive development. To ensure continued compliance with this provision, it is recommended that the Facility maintain with the CLDP document sign-in sheets that show the attendance at the various meetings held.	
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.	This requirement of the Settlement Agreement includes two components, including the timeliness of assessments (i.e., within 45 days of the individual leaving the Facility), and the comprehensive nature of the assessment. Although the Facility had made progress with regard to obtaining timely assessments, the quality (i.e., comprehensiveness) of the assessments was significantly lacking. As noted in the previous report, it appeared that a process had been put in place to improve compliance with the timeliness of assessments. Brief updates often were included to supplement full assessments or evaluations that had been completed as part of an earlier ISP 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 the one individual's CLDP reviewed, it appeared that a number of assessments had been updated within the 45-day timeframe. However, no nursing assessment was provided. This was particularly concerning given the level of medical issues the individual had experienced since his admission. One was listed as having been provided, but it was not attached, and not discussed in the team's deliberations. The quality of these assessments was lacking. None of the one CLDPs reviewed (0%) was based on adequate assessments. In particular: ▪ Most of the assessment formats were not designed to provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility. ▪ In addition, assessments frequently were inadequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. They did not describe or recommend the protections, treatments, and supports that needed to be provided (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), and/or the specific clinical supports required (i.e., qualifications of clinical staff,	Noncompliance

#	Provision	Assessment of Status	Compliance
		the frequency and level of their involvement, etc.). ▪ Moreover, assessments did not identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. For example, nursing assessments for individuals who had nursing care/health management plans at the Facility should include recommendations about their continuation and/or any modifications that needed to be made to accommodate community settings that might not have nurses available at all times. Similarly, psychology/behavioral assessments should identify differences (e.g., environmental, staffing, training of staff on protective holds, etc.) that could impact the implementation of the PBSP in place at the Facility, and/or make recommendations about needed modifications. ▪ In addition to specific issues related to transition, as is discussed in other sections of this report, the underlying assessments were not of adequate quality. ▪ Finally, as has been recommended in previous reports, a process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). Some, but not all of these were listed in the summary for Individual #134. This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information. The Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessments is necessary.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a	The CLDP reviewed included essential and non-essential supports. Since the baseline review, progress definitely was being made, but the Facility continued to struggle with this process. On a positive note, efforts were underway to improve ISPs to more effectively describe individuals' needs for supports, and define how such supports were to be provided at the Facility. If done correctly, this should greatly assist teams when it is time to plan for an individual's transition to the community. Given the current inadequacies of ISPs, teams had to identify these supports after the individual was referred for transition, which made it more difficult due to the generally short timeframes from referral to transition. At the time of the current review, teams still were not consistently identifying all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the	Noncompliance

#	Provision	Assessment of Status	Compliance
	plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	success of the transition. This made it difficult to ensure individuals' successful transitions, and for thorough and meaningful monitoring to occur prior to and after the individual's transition to the community. Likewise, teams did not consistently identify non-essential supports or do so in measurable ways. In none of the one plan reviewed (0%) was a comprehensive set of essential and non-essential supports identified in measurable terms. The Monitoring Team has provided many examples of concerns in previous reports. The following summarizes the general concerns noted: ▪ Generally, teams had not visualized the individual with no supports at all, and then identified each and every support that was needed to assist the individual to be successful in a particular community environment(s). Due to the current inadequacies of the ISPs, teams needed to start at the beginning, and describe the full array of supports the individual needed and wanted. Once these were listed, the CLDP needed to identify how they would be provided in the community, by whom, when, with what frequency, and for how long. This could only be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they did for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built. ▪ Although some clinical services (e.g., psychology/behavior, psychiatry, dietary, etc.) were now referenced in the sample CLDP, the intensity of the supports was not identified, nor were the qualifications or the roles of clinicians clearly defined. Supports defined as "psychological consultation," or "establish services with a dietician" were inadequate. Teams were not clearly identifying what these supports entailed for the individual at LBSSLC, and then defining in the CLDP how functionally equivalent supports could be provided in the community. ▪ In addition, clinical supports that LBSSLC was providing, based on assessment information, were not included in the sample CLDP, and no justification was provided for not identifying a functionally equivalent support. For example, nursing care/health management plans often were not referenced in the sample CLDP. ▪ In removing any support that the individual utilized at the Facility from the array of supports that would be provided in the community, teams should justify why the support is not needed in the community. If the individual had health care plans to monitor, for example, weight, or a behavior support plan, these should not be left out of the CLDP without adequate justification. ▪ It was positive that the CLDP required that community staff be trained on existing plans. As noted above, concerns existed with regard to the lack of expectations for the quality or outcomes of this training. ▪ The CLDP did not identify as an essential or nonessential support for treatment	

#	Provision	Assessment of Status	Compliance
		plans to be implemented (e.g., PBSP, nursing care plans, health management plans, diets, exercise programs, etc.). ▪ Although it appeared that the individual reviewed had specific health care indicators that needed to be monitored and reported (e.g., input/output, meal refusals, psychiatric symptoms, etc.), the only one the CLDP addressed was weekly weights. Few, if any supports were included in the CLDPs to ensure that specific staff were responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff. ▪ The CLDP did not identify a crisis intervention plan, and/or how the current methods for dealing with crises at the Facility needed to be modified in a community setting. Although for this individual, behaviors had changed in recent months, it would have been prudent for proactive planning to occur to ensure any crisis in the community was handled appropriately. ▪ Direct support staffing ratios and requirements were not specified. What was specified did not provide specific guidance regarding the individual's staffing requirements. For example, "24-hour awake staff" was not helpful in ensuring the individual who was the subject of the transition plan received adequate staffing supports. Depending on the ratio and other staff responsibilities, "24-hour awake" staffing in no way guarantees that the individual will remain safe, and be adequately supervised. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). ▪ In reviewing assessments, albeit incomplete, many recommendations were not specifically addressed in CLDPs (e.g., SPL, and OT/PT therapy recommendations, adherence to weight reduction programs, etc.). ▪ Generally, day and vocational supports were not well defined. ▪ Supports that needed to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) were not included as part of the day/vocational component. ▪ Issues continued to be noted with regard to the measurability of supports identified. Many of the supports listed were not measurable. Since the last review, minimal improvement was noted with regard to the comprehensiveness of essential and non-essential supports. As previously reported, with regard to Monitoring by the MRA or other means to ensure	

#	Provision	Assessment of Status	Compliance
		essential supports were in place prior to an individual's transition, the MRA's review appeared to be a general safety assessment as opposed to an individualized assessment based on the essential supports identified by the team. The only assurances that the MRA staff completing the "Pre-Move Site Review Instrument for the Community Living Discharge Plan" had that the essential supports were in place appeared based on a "meeting with the site administrator/manager." The form included two related questions, including: 1) "Did the site administrator/manager have a copy of the consumer's draft Community Living Discharge Plan and know the outcomes important to the consumer or legally authorized representative"; and 2) "Did the site administrator/manager verify services and supports could be provided that are necessary to assist the consumer in achieving the outcomes?" (Emphasis added.) Responses to these questions did not represent adequate proof that the essential services required by the CLDPs were in place. However, the Facility had begun to implement the process of having the Post Move Monitor conduct a pre-move site visit designed specifically to determine if the essential supports were in place. A review was conducted of one individual's pre-move site visit documentation (i.e., Individual #134), because it was the only one completed during this review period. It appeared thorough, and included each essential support listed in the individual's CLDP. It identified the evidence that had been reviewed to determine that the essential support was in place. It appeared to have been completed in a timely manner, specifically three days prior to the individual's transition. It should be noted that the process will become more complicated as more essential supports are appropriately identified in individuals' CLDPs. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Although progress was noted with regard to the pre-move confirmation of essential supports, substantial work was still needed in adequately delineating the essential and non-essential supports in individuals' CLDPs.	
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.	Progress had been made and/or sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that CLDPs are developed and the Facility implements the portions of Section T of the Settlement Agreement for which it is responsible. Positive developments included: ▪ At the time of the last review, the Facility begun using the monitoring tools that had been modified based on the Monitoring Teams' audit tools. At the time of this most recent review, the Facility continued to conduct audits using these tools. The QA Department, as well as the Admissions Placement Coordinator conducted reviews of the Living Options Discussion, CLDPs, and the Post Move Monitoring Process.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Areas in which continued efforts needed to be made included: ▪ As noted above, minimal amounts of the data was being incorporated into the Facility's self-assessment/POI. ▪ Inter-rater reliability had not yet been established, nor had the accuracy of the monitoring data. The Facility had recognized this need based on the varied results of the auditing that had been completed thus far. As is discussed with regard to Section E, the procedures being used to establish inter-rater reliability needed modification. It was positive, however, that the QA Department had a plan to meet monthly with the Department staff with one goal being to attempt to resolve discrepancies in monitoring. A standard inter-rater reliability methodology should be used statewide, and focus should be placed on ensuring that not only were the results of the monitoring similar, but that also they were accurate. In other words, if both auditors were incorrect in their assessment of an indicator, high inter-rater reliability would be present, but the data still would not be valid. ▪ As detailed in the Monitoring Team's report on Austin SSLC, dated 7/7/11, the Monitoring Team continues to have concerns about the adequacy of the guidelines provided to reviewers. Efforts to improve these are necessary to ensure accuracy in monitoring as well. ▪ As a result of inadequate instructions or criteria for auditing, many of the completed review tools that the Facility submitted for review did not appear to have captured relevant issues, particularly with CLDPs. Many of them found compliance with close to 100 percent of the indicators, which was inconsistent with the Monitoring Team's findings related to CLDPs it reviewed. It is important to note that now that more clear criteria had been established for the obstacle categories that teams could consider, more critical review was seen in this section of the Living Option reviews. ▪ Based on documentation provided, the Facility had implemented a corrective action plan to address: 1) improvement in the Living Options discussions to ensure they reflected adequate individualized protections, supports and services; 2) development of plans to address obstacles identified; and 3) development of a Facility policy on most integrated setting. The Facility submitted documentation stating that all three of these had been completed. No specific outcome measures were included for these plans. However, based on the Monitoring Team's review, the only one that had been successfully completed was the one addressing the development of a Facility policy. Significant issues continued to exist in the other two areas. Although progress had been made in this area, the Facility was continuing to develop and implement quality assurance processes necessary to assess its implementation of Section T. The Facility should continue to expand its monitoring activities in this area, including	

#	Provision	Assessment of Status	Compliance
		modifying, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability. In addition, as corrective action plans are developed, it will be important to set forth adequate and appropriate measures to ensure that the implementation of such plans results in the desired improvements.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	Although some progress was being made in this area, the State and Facility were still in the beginning stages of implementing this provision of the Settlement Agreement. The Facility had not yet generated an annual report to State Office. LBSSLC did not submit any data to the Monitoring Team. Progress that had been made included: ▪ The State had developed a list of standard obstacles that teams would be asked to utilize. On 5/16/11, the Monitoring Panel provided the State Office with comments on the draft revised Most Integrated Setting policy, including the list of obstacles. In general, though, this list should assist in standardizing the data collected, which in turn should provide the State Office with better information about protections, supports, and services that should be enhanced in the community, as well as concerns that individuals and LARs have regarding transition to the community. ▪ LBSSLC had drafted an action plan to address Section T.1.g. It appeared to set forth a reasonable plan for complying with this provision, and the Facility had begun to implement it. For example, the Facility provided documentation of training on the new obstacles categories that the Admissions Placement Coordinator had provided to PST members. Data entry staff also had been trained on entering information gained through ISP and ISPA meetings. Although LBSSLC remained out of compliance with this provision, activities were underway to achieve compliance. It will be essential for PSTs to be provided ongoing technical assistance on the proper identification of obstacles in order for these efforts to be successful.	Noncompliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall	In response to a document request, the Facility submitted to the Monitoring Team a Community Living Placement Report, for the period between 3/1/11 and 8/31/11. The report listed: ▪ Current Referrals: This included individuals who had been referred by their	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	teams for community placement and had an open referral, including the individual's name, the date of referral, and the status of the referral. Six individuals were included on this list. However, since the list had been generated one of these individuals recently had transitioned 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 one individual. As noted above, a second 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 these categories, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the name of 10 individuals 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 six individuals, including the date of the meeting and a brief description of the reason for the referral not being made. For four individuals, the reason was noted as "Behavior/Psychiatric," and for the remaining two individuals, the reason stated: "Exploring Community Options." ▪ LAR Prefers Community, Not Referred: One individual was listed in this category, and the reason give was that the designated MRA was not present. 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**		

#	Provision	Assessment of Status	Compliance
	Moved From the Facility to More Integrated Settings Appropriate to Their Needs		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for three individuals (i.e., Individual #206, Individual #159, and Individual #134). For these individuals during the time period reviewed, the LBSSLC Post-Move Monitor should have conducted four reviews. Of the four required visits, four (100%) had been documented as having been completed on time. The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that this was clearly documented in the reports. For all of the four reports reviewed (100%), the Post Move Monitor had visited the individual at his/her home, as well as day/vocational site. <u>Content of Checklists</u> With regard to the content of the checklists, since the previous review, LBSSLC had begun to use the new format that the State Office had developed for post-move monitoring activities, which had been modified a second time in May 2011. Only one report (i.e., for Individual #134) used the newest format. Each of the items on the checklists reviewed had been addressed. Efforts clearly were being made to add additional information regarding the interviews conducted, the documents reviewed, and the observations made. The checklists reviewed were completed thoroughly. It should be noted that the newest version included a column to identify specifically whether or not the essential or nonessential support had been provided adequately. This was an improvement over the previous revised version of the form. <u>Use of Facility's Best Efforts to Ensure Supports Are Implemented</u> The primary reasons for conducting post-move monitoring are to identify if any protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: ▪ Of the three individuals reviewed, one of them (33%) had needs identified for follow-up to be conducted to ensure supports were implemented. The individual who required follow-up activity was Individual #206. ▪ Of the one individual for whom follow-up was indicated, documentation was present to show that for one individual (100%), adequate follow up had	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		occurred (i.e., Individual #206). It should be noted for this one individual, the need for follow-up had not been identified at her seven-day visit, or 45-day review. However, during the 90-day review, significant follow-up needs were noted. This prompted an IDT meeting with the new provider, and additional visits beyond the 90 days. Based on the notes provided, Facility staff appeared to take the issues to a higher level within the community provider structure, and follow-up until resolution occurred. Based on the Monitoring Team's review of a very limited number of post-move monitoring reports, a finding of substantial compliance is being made for this provision. However, it is important to note that because CLDPs continue to include minimal requirements, the Post Move Monitor's job is expected to grow exponentially as the CLDPs begin to include more of the necessary essential and nonessential supports. As a result, to sustain compliance in this area, considerable effort will be necessary to confirm the existence of these protections, supports, and services, and to take action to correct deficiencies identified.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the review, the only post-move monitoring visit scheduled was a four-hour round trip. Due to the Monitoring Team's other commitments during the onsite review week, it was not possible to attend the visit. As a result, this provision of the Settlement Agreement has not been rated.	Not Rated
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)		

#	Provision	Assessment of Status	Compliance
	for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (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.	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. Since the previous review, one individual had had an alternate discharge. The discharge package for Individual #131 was included in the Facility's Presentation Book for Section T, and reviewed. Each of the requirements of the CMS-required discharge planning process is discussed below: ▪ If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause: Based on the information provided, Individual #131 was placed at LBSSLC temporarily on an emergency placement, and the discharge was pursuant to this placement ending. ▪ The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies): It appeared that the individual and family were aware of the upcoming discharge, and plans had been made with the individual's previous community provider for his return. ▪ At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: The final summary included each of these components. Fairly specific and extensive information was provided for each. ▪ With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies: Based on the documentation provided, this is unknown. However, it appeared that the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		receiving community provider was involved throughout the process. ▪ The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narrative provided in the Transfer Discharge Reassignment Summary, the IDT at LBSSLC identified what they believed were the key supports that Individual #131 would need in a community setting. This was presented in a narrative, as opposed to action plan format, but appeared to be sufficient to meet the minimal standards included in the CMS guidelines. As appeared to be the intent of this sub-section of the Settlement Agreement, the same standards for an adequate plan in other sub-sections of Section T were not applied here. As a result, the Facility was found in substantial compliance with this provision.	

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. With regard to policy:
    a. State policy should be modified to reflect the changes that have occurred regarding transition procedures so that expectations regarding practice are clearly delineated.
    b. In addition, as appropriate, the Facility should include in its local policies any Facility-specific details that are relevant to full implementation of the State policy. (Section T.1.b)
3. 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. (Section T.1.b.1)
4. 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. The Facility and the State should collect and analyze such information. (Section T.1.b.1)
5. As teams begin to better define obstacles to movement, and begin to talk in greater depth about the options available in community settings to meet individuals' specific needs in comparison with services and supports available at the Facility, this discussion should be memorialized in the ISP to document that individuals and their families are making informed decisions with regard to an individual's living options. (Section T.1.b.1)

6. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based. (Section T.1.b.1)
7. LBSSLC should expand the creative and individualized educational activities to meet the needs of various individuals and families/guardians. The action plan developed should be revised, as needed, to provide an adequate scope of educational activities. (Section T.1.b.2)
8. Particular focus should be placed on improving the action plans in individuals' ISPs to ensure that they are individualized to meet individuals' and guardians' specific needs for education related to community options. The Admissions Placement Coordinator, as well as the Post-Move Monitor, who have knowledge about community programs and successful transitions, should play a key role in working with teams to individualize these action plans. (Section T.1.b.2)
9. 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. (Section T.1.c)
    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. (Section T.1.c.3)
10. Essential and non-essential supports should be better defined in Community Living Discharge Plans. More specifically:
    a. The role of the Facility and community provider staff in the transition and discharge process should be defined better. This should include, but not be limited to defining:
        i. Which community provider staff need to complete which training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or what level of mastery of the information was required (e.g., demonstration of competence);
        ii. The method of training, for example, if it would be necessary for community provider staff to shadow LBSSLC staff, and/or show competency in actually implementing a plan, such as a PBSP, PNMP, etc. For some individuals, specific components of their PSPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., an essential support), or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual;
        iii. Collaboration between the Facility clinicians currently working with the individual and the community clinicians who will assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.);
        iv. Coordination between current and future residential or day/vocational staff;
        v. LBSSLC's staff's involvement in evaluating potential sites at which individuals would be served (e.g., Habilitation Therapies staff to ensure adequate accessibility and/or equipment, Behavioral Services Department staff to determine if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment); and
        vi. The role LBSSLC staff or community provider staff might play in assisting the individual to make the transition;
    b. Due to the current inadequacies of the ISPs, teams should start at the beginning, and describe the full array of supports the individual needs and prefers. Once these are listed, the CLDPs should identify how the necessary supports will be provided in the community, by whom, when, with what frequency, and for how long. This can be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they do for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built;
    c. With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians;
    d. Clinical supports that LBSSLC is providing should be included in the CLDPs, or adequate justification for not identifying a functionally equivalent support should be documented in the CLDP;
    e. In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community,

teams should justify why the support is not needed in the community;

f. Teams should factor in modifications that need to be made to current programs or plans, and writing such modifications into the essential or nonessential supports;
g. As appropriate, teams should identify as an essential or nonessential support the implementation of current plans (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications might need to be made to the methodology for providing these supports, with the end result being the individual's need for the support being met;
h. For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), team should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff;
i. As appropriate, crisis intervention plans should be developed, and/or essential and non-essential supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting;
j. Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.);
k. Recommendations in assessments should be addressed specifically in CLDPs (e.g., SPL, and OT/PT therapy recommendations, adherence to weight reduction programs, etc.), and justification provided for any recommendation not included as an essential or non-essential support;
l. As recommended previously, 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;
m. 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. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component; and
n. Focused effort should be placed on ensuring each of the supports identified is measurable. (Sections T.1.c.1 and T.1.e)

11. In addition to addressing recommendations related to assessments in other sections of this report to improve the overall quality of assessments used in developing CLDPs, modifications should be made to assessments to:
    a. Provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility;
    b. Assist teams in developing a comprehensive list of protections, supports, and services in a community setting. Assessments should describe or recommend the protections, treatments, and supports that an individual requires (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), as well as the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.); and
    c. Identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. (Section T.1.d)
12. A process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not

been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would facilitate the transition of this information to community medical care providers. (Section T.1.d)

13. With regard to monitoring activities related to the Facility's performance with this section of the Settlement Agreement, the Facility should:
    a. Modify, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors;
    b. Provide staff responsible for conducting audits with competency-based training;
    c. Ensure the reviews accurately evaluate quality as well as the presence or absence of items;
    d. Establish inter-rater reliability; and
    e. 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 T.1.f)
14. As the Facility expands its self-assessment activities, the POI should include the results of data analysis to substantiate the Facility's findings of noncompliance or substantial compliance. The POI also should indicate how the Facility has used this data to identify problematic trends, and develop corresponding corrective actions. (Facility Self-Assessment)

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 4/4/11; o LBSSLC Final prioritized list of those persons needing guardians based on information obtained from the QMRPs, revised 8/25/11; o Statement in response to record request number TX-LB-1009-XVII.2; o LBSSLC Rights Assessment form, revised July 2007; 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 3/1/11; o Contact Log regarding guardianship from 3/5/10 through 9/8/11; o Presentation Book for Section U; o POI for Section U, dated 9/19/11; o Email from Annette Webster regarding Guardianship Status with 10/3/11 version of Prioritized List of Those in Need of an LAR attached, dated 10/5/11; o For each home on campus, documentation of team reviews of individuals' need for guardianship resources, including discussion of factors related to their level of need, various dates; o Meeting agenda for Mustang Aktion Club, dated 10/6/11; o Meeting agenda for Self Advocacy Group, dated 10/6/11; and o Self Advocacy Meeting Minutes from 3/29/11 through 9/8/11; 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 Annette Webster, Post-Move Monitor and Guardianship Coordinator; o Shelia Powell, Human Rights Officer; and

	o Debbie Burgett, DADS State Office.
	Facility Self-Assessment: The Facility self-assessment showed that it continued to be in noncompliance with the provisions included in Section U of the Settlement Agreement. This was consistent with the findings of the Monitoring Team. The POI included narrative descriptions of steps being taken to attain compliance. The Facility had used some summary data from reviews or self-audits it had completed, but it was unclear specifically what had been measured. The scores appeared to be overall compliance scores, but the tools had not been designed for this purpose. 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, whether individuals' needs for guardians are being prioritized appropriately, and whether or not adequate efforts are being made to identify needed supports. In addition to providing statistics and narrative descriptions of activities, the POI should include analyses of the audit results. The Facility included two action plans in the POI, including one related to the maintenance of a prioritized list of individuals needing guardians, and the other related to identifying guardians for individuals who needed them. A number of the steps in the second action plan had been implemented, and some limited success in facilitating the appointment of guardians. As noted at the exit interview, some of the ideas that Facility staff discussed with State Office staff regarding potentially expanding the pool of guardians appeared worth pursuing.
	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 no instrument or process was available to determine functional capacity. It was anticipated that the State Office policy would provide guidance with regard to this issue. In the absence of any formal instruments or processes to prioritize the needs of individuals for guardians, the LBSSLC Guardianship Coordinator had met with each of the IDTs on campus, and reviewed the teams' impressions of each individual's decision-making capacity, and using the criteria in a draft State Office policy, discussed the individual's priority level for guardianship. This was a substantial undertaking, and a good effort at further defining the priority list that LBSSLC had been maintaining. The updated prioritized list included names of 102 individuals served by LBSSLC. At the time of the review, Lubbock supported 225 individuals, of whom approximately 45% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, this was a good initial step. Based on the list, 51 individuals had a Priority I need for guardianship, 43 individuals were in the Priority II category, and eight were in the Priority III category. 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. In addition to continuing to work with families and primary

	correspondents of individuals, the Guardianship Coordinator had reached out to other SSLCs in an attempt to identify other potential resources. Although this had not resulted in any leads, it was a good attempt to network with other SSLCs. During the Monitoring Team's onsite visit, a consultant with the State Office offered to work with Facility staff in trying to identify local social service agencies that might be willing to solicit grant money to start a nonprofit guardianship resource. Given the numbers of individuals potentially needing guardians, this would seem to be a worthwhile idea to pursue. Despite the limited guardianship resources, the Facility had had some success in identifying family members, friends, and former staff members to petition the court for guardianship. Since the previous review, guardians had been obtained for four individuals, and guardianships were pending for an additional six individuals. The persistence of staff in identifying and pursuing guardianship resources on an individual basis, and then working with interested people was the reason for the Facility's success in this area.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	At the time of the review, DADS State Office was in the final stages of finalizing Draft Policy #019: Guardianship/Advocate. The Facilities had been asked to review the draft policy and offer final comments. A second policy on consent reportedly was in development. Since the last review, because LBSSLC was awaiting further guidance through State Office policy, some limited progress had been made with regard to consent and guardianship. The State is encouraged to finalize these policies, because they should assist the Facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. As noted in the last report, the Facility had developed a policy entitled LBSSLC - Rights: Guardianship Process, revised 4/4/11. 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 IDTs' role in identifying the need for a guardian in general terms, but did not define a specific screening or assessment process. QDDPs 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 Facility staff noted during the on-site review, implementation of the policies the State Office was developing was expected to require significant effort and changes to a number of practices at the Facility, including more intense involvement of individuals' IDTs in assessing individuals' "functional capacity to render a decision" and provide informed consent. At the time of the review, this process was still not being completed using an	Noncompliance

#	Provision	Assessment of Status	Compliance
		adequate standardized process, but it was anticipated that the State Office policy on consent would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area. This likely will require LBSSLC to modify its policies and procedures to ensure thorough implementation of the State 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. Since the last review, the Facility had further defined the process it was using. Using language taken directly from the Settlement Agreement, the draft policy from the State Office listed the factors that needed to be considered in prioritizing individuals' need for guardianship. In the months preceding the Monitoring Team's review, the Guardianship Coordinator had met with each of the IDTs on campus, and reviewed the teams' impressions of each individual's decision-making capacity, and using the criteria in the draft State Office policy, discussed the individual's priority level for guardianship. Each of these team discussions was documented, including clear descriptions of the teams' opinions about the need for guardianship, the frequency with which consent was obtained for the individual, the restrictions that the individuals had in place that might impact their priority level, as well as the resources that each had for potential guardians. Using this information, a score was then calculated, and used to determine the individual's priority level. This was a substantial undertaking, and a good effort at further defining the priority list that LBSSLC had been maintaining. The updated prioritized list included names of 102 individuals served by LBSSLC. At the time of the review, Lubbock supported 225 individuals, of whom approximately 45% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, this was a good initial step. Based on the list, 51 individuals had a Priority I need for guardianship, 43 individuals were in the Priority II category, and eight were in the Priority III category. It is important to note that the teams' discussions were not informed through the completion of a valid screening or assessment process to assist them in identifying individuals' capacity to make decisions, including different types of decisions, and/or to think through some of the supports that might increase individuals' decision-making capacity. As a result, teams identified individuals who were described as "able to express wants and needs" or "able to give consent regarding his/her health or welfare" as needing guardians (e.g., Individual #314, and Individual #108). No discussion was documented of whether or not the team would recommend limited guardianship, or if other supports could be provided to the individuals to assist them in maintaining some of all of their ability to make decisions for themselves.	

#	Provision	Assessment of Status	Compliance
		As discussed during the onsite review, in addition to continuing these efforts, efforts also should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures (e.g., similar to what the State Office was beginning to develop with regard to psychotropic medication); expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). The Facility remained out of compliance with this provision of the Settlement Agreement. However, LBSSLC continued to make progress in prioritizing the list of individuals whose teams at least initially believed required the supports of a guardian. This proactive approach of beginning to have teams think about individuals' decision-making capacity, as well as using the Settlement Agreement requirements to review each individual and prioritize the list should assist the Facility in more quickly implementing the State policy once it is finalized.	
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	According to documentation and interview with staff, since the previous monitoring visit, four individuals had guardians appointed. This included the appointment of family members, as well as a former staff member as guardians. The persistence of staff in identifying and pursuing guardianship resources on an individual basis, and then working with interested people was the reason for the Facility's limited success in this area. At the time of the review, potential guardians were in some stage of the process of petitioning the court for guardianship for an additional six individuals. As noted above, the list provided by the Facility showed that a total of 102 individuals of the 225 individuals served by the Facility (45%) had been identified as needing guardians. 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. In addition to continuing to work with families and primary correspondents of individuals, the Guardianship Coordinator had reached out to other SSLCs in an attempt to identify other potential resources. Although this had not resulted in any leads, it was a good attempt to network with other SSLCs. The Monitoring Team's previous reports illustrated many of the	Noncompliance

#	Provision	Assessment of Status	Compliance
	persons with disabilities.	Facility's ongoing efforts to work with families, as well as local groups to identify additional resources for guardianship, as well as legal resources at reduced rates should potential guardians be identified. Based on the log sheet provided, the Facility continued these activities on a regular basis. One concern noted with regard to the Facility's efforts related to a letter the Facility sent to families and primary correspondents on June 6, 2011. Although the letter included a substantial amount of accurate information about guardianship and the related requirements of the Settlement Agreement, one paragraph in the letter raised concerns. In describing the Settlement Agreements requirements regarding guardianship, it stated: "Due to these new requirements, the facility will no longer be able to support or allow family and correspondents who are not LARs to make decisions regarding where your family members lives. Also, non-LAR families and correspondents will have no decision making ability regarding but not limited to the following issues: medical treatments/care, restrictive/intrusive practices, end of life decisions, and monetary expenditures." This characterized the ability of a family member or primary correspondent who were an active member of an IDT as having "no decision making ability," which was inaccurate. As long as a family member is a member of the IDT, they have the ability to participate in many of the decision-making processes, particularly for individuals who had not yet been appointed guardians. A statement later in the letter appeared to be more accurate. In describing the Facility's need to seek out other guardianship resources for individuals who need them should the family not be interested in pursuing guardianship, it stated: "We will continue to value the opinions of the family or correspondent, but the guardian will have the final decision making authority." Although the Monitoring Team agrees that families and primary correspondents should understand the implications of teams identifying individuals' need for guardianship or other decision-making supports, it is essential that families and primary correspondents be provided accurate and balanced information regarding the process, and their roles as members of IDTs. During the Monitoring Team's onsite visit, a consultant with the State Office offered to work with Facility staff in trying to identify local social service agencies that might be willing to solicit grant money to start a nonprofit guardianship resource. Given the numbers of individuals potentially needing guardians, this would seem to be a worthwhile idea to pursue. As discussed in previous reports, 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,	

#	Provision	Assessment of Status	Compliance
		and/or investigators may be appointed to assist the court in evaluating the need for guardianship as well as the type of guardianship needed. In addition, it appeared that it was possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings included family members, as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs and preferences, teams could potentially provide valuable information both in terms of written reports as well as verbal information regarding individuals who become the subject of guardianship proceedings. As the State finalizes its policy on consent and guardianship, it should define the potential roles of SSLC staff in the process.	

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

1. The State should finalize the state policy on guardianship and consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies alternatives to guardianship, including potential supports or resources that would either allow an individual to make informed decisions or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.);
    c. A standard tool/process for identifying priority with regard to the need for guardianship; and
    d. Definition of the role of State and Facility staff in the guardianship process, including potentially completing assessments for use in guardianship proceedings, participating in guardianship proceedings, and assisting in the identification of potential guardians for consideration by the Court. (Section U.1)
2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation. (Section U.1)
3. Once the State policy is finalized, LBSSLC should modify its policy on guardianship to reflect the State policy. (Section U.1)
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. (Section U.1)
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. (Section U.1)
6. Efforts should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures (e.g., similar to what the State Office was beginning to develop with regard to psychotropic medication); expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign

interpreters, someone to read and explain information in a user-friendly manner, etc.). (Section U.1)

7. As the Facility provides information to families and others about guardianship and the related Settlement Agreement requirements, it is essential that families and primary correspondents be provided accurate and balanced information regarding the process, and their roles as members of IDTs. (Section U.2)
8. 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 State Office staff, and staff from other SSLCs to identify and implement potential initiatives and resources for identifying guardians. (Section U.2)
9. 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 U.2)
10. As the processes for assessing individuals' capacities to make decisions are implemented, it will be important for the Facility to conduct audits to ensure that teams are correctly identifying individuals who might need guardians or other assistance in making decisions, that individuals are appropriately prioritized on the list, and that adequate efforts are being made to identify needed supports. In addition to providing statistics and narrative descriptions of activities, the POI should include analyses of the audit results. (Facility Self-Assessment)

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 LBSSLC Communication Process: Individual Notebooks, revised 2/24/11; o LBSSLC Communication Processes: Active Record Check Out/Check In Process, dated 6/10/11; o LBSSLC Communication Process: Process for Submission and Timely Filing of Information in the Active Record, dated 8/11/11; o List of Persons Responsible for Record Maintenance; o Table of Contents (TOC) for Active Record, revised 5/13/11; o Master Record Index, undated; o Individual Notebook TOC and Guidelines, revised 5/13/11; o Quality Assurance checklists for last 10 records reviewed, with Unified Records Coordinator audit for five of 10 records reviewed, various dates; o Plan of correction resulting from record audits, and documentation of follow-up, various dates; 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 QA/QI Data Section V, for June, July, and August 2011; and o Various individuals' records. ▪ **Interviews with**: o Javier Vasquez, 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. In addition, for this section of the POI, on a limited basis, the Facility had begun to effectively use some of the monitoring data it was collecting. More specifically, the Facility had specifically cited monitoring data, and the analysis of the data, which revealed an area requiring improvement. This data related to monitoring conducted to determine if staff were adhering to the procedure on the Active Record Check Out/Check In Process. The POI further provided relevant information about steps the Facility took to rectify concerns noted through the monitoring process. This was a good use of data both to illustrate the

	Facility's compliance with the Settlement Agreement, as well as its ability to identify its own problems, and take appropriate corrective action to address them. Although only limited reviews of records were conducted of records due to the hiring of a new Unified Records Coordinator, the Facility had not yet incorporated the data from record reviews into the POI. As the Facility expands its self-assessment activities, the record audit data should be used in similar ways to identify and address strengths as well as concerns, and to address problematic areas. The POI included action plans for each of the sub-sections of Section V. These plans appeared to address priority areas.
	Summary of Monitor's Assessment: Since the last review, the Facility had updated the active records across campus to be consistent with a revised Active Record Table of Contents. This was a significant project, and showed continued teamwork on the part of the Records Department. In its previous reports, 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. During this most recent review, a significant improvement was seen. Since the previous review, the Facility had finalized and implemented a policy entitled: LBSSLC Communication Process: Process for Submission and Timely Filing of Information in the Active Record, dated 8/11/11. The impact of this policy's implementation appeared to have been significant. Based on documentation provided, 52 procedures that were developed or revised since the previous compliance review. The OPM Committee had reviewed an additional 16 that were undergoing final edits. An additional 14 were pending review and approval. Review and revision of this number of policies was a significant accomplishment, and had required the OPM Committee to meet twice monthly. Although there was evidence that new policies were being disseminated, a system was not yet in place to track the training provided. As a result, it could not be determined whether or not adequate efforts were made to ensure staff had the necessary knowledge and skills to implement the policies. Although a brief lapse occurred while the Facility hired and trained a new staff member, at the time of the review, as required by the Settlement Agreement, at least five audits were being completed of records each month. These audits were identifying numerous problems with the records. The Facility was at the beginning stages of aggregating and analyzing this information. However, since the last review, as noted above, a workgroup had developed creative solutions to addressing issues related to timely submission and filing of documents, and a process had been developed to address problems identified with knowing the whereabouts of records. Once the new procedure was in place related checking records in and out, the Facility also had developed its own tool to determine compliance with the procedure. This was a positive initiative, and it directly related to the security requirements included in Appendix D of the Settlement Agreement. When this data showed that over several weeks, multiple residences were not complying with the new procedures, a plan was put in place to

	re-train staff. This plan was followed through to completion, including the tracking of training rosters, and multiple reminders being sent. The Unified Records Coordinator continued to monitor compliance, with results showing marked improvement in the months following the training effort. This was a good example of the use of monitoring results to identify an area needing improvement, as well as implementation of actions designed to correct the deficiency, and monitoring of the outcomes to ensure the actions were effective. 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.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	As noted in previous reports, 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. Progress had been made and/or sustained with regard to the establishment and maintenance of a unified record consistent with the guidelines in Appendix D of the Settlement Agreement. Positive developments included: ▪ Since the Monitoring Team's last review, a new Unified Records Coordinator had been hired. One Unified Records Coordinator, a Lead File Clerk, four File Clerks, and a Medical Records Clerk were assigned to the Quality Assurance Department. Their primary responsibilities related to the maintenance of records. At the time of the review, the only vacancy was for the Medical Records Clerk. The Medical Director had given permission for one of the Medical Department's staff to assist with filing, and the other File Clerks also were helping to ensure these duties were covered. ▪ At the time of the review, staff reported that each individual had an Active Record, a 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. Since the last review, the Facility had updated the active records across campus to be consistent with a revised Active Record Table of Contents. This was a significant project, and showed continued teamwork on the part of the Records Department. The Master Record contained legal documents, original documents, and correspondence. ▪ In its previous reports, 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. During this most recent review, a significant improvement was	Noncompliance

#	Provision	Assessment of Status	Compliance
		seen. Except for a few documents, documents generally appeared to be in the records. Since the previous review, the Facility had finalized and implemented a policy entitled: LBSSLC Communication Process: Process for Submission and Timely Filing of Information in the Active Record, dated 8/11/11. It clearly identified responsibilities for the clinical and programmatic departments, as well as the records management staff. In implementing the policy, the Quality Assurance Director had met with each department to ensure clear delineation of staff responsible for logging in and delivering documents for filing. Formal training also was provided to key staff. The impact of this policy and the related efforts appeared to have been significant. ▪ Similarly, a new procedure defined the process for signing records in and out of the residences. The policy was entitled: Active Record Check Out/Check In Process, dated 6/10/11. As is discussed in further detail with regard to Section V.3, when initial implementation of this policy did not result in records being properly signed out and back in, corrective action was identified and taken. Areas in which improvements should be made in order to achieve compliance, included: ▪ As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. This is discussed in further detail with regard to Section V.3. However, some of the issues that staff verbally identified included legibility, gaps in records, and the inclusion of the most current information in the record. Now that a new Unified Records Coordinator had finished the initial orientation phase, it was anticipated that further work would be done to correct such issues. ▪ As has been discussed in previous reports, accuracy of data maintained in records was an ongoing concern. The Facility was taking some specific steps to address issues related to behavioral and skill acquisition data. 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. As is discussed with regard to Section K.4, a new system had been introduced involving the use of index cards for the collection of behavioral data. The intent was to improve the accuracy and timeliness of data collection. However, at the time of the Monitoring Team's review, this process was in the early stages of implementation, and the results were not yet evident. The Facility also was in the process of modifying the way in which skill acquisition data was collected.	

#	Provision	Assessment of Status	Compliance
		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. As noted in the previous report, 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." 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. Although changes were being made, it remained to be seen if LBSSLC's methodologies would address fully the requirements of the Settlement Agreement. The State Office should provide additional guidance on this issue. While the Facility had continued to make progress with regard to the quality of the active records, it was not yet in compliance with this provision of the Settlement Agreement. In addition to finalizing a process(es) to address the intent of the requirement for Individual Notebooks, LBSSLC should continue to address issues related to the quality of the records.	
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. Progress had been made and/or sustained with regard to the development, review and/or revision, as appropriate, and implementation, of all policies, protocols, and procedures as necessary to implement Part II of the Settlement Agreement. Positive developments included: ▪ As previously reported, the Operating Procedures Manual (OPM) Committee was meeting to review and approve policies and procedures. As appropriate, the group made recommendations to the policies' authors, and approval for policies was provided when all recommendations had been addressed. ▪ Based on documentation provided, 52 procedures that were developed or revised since the previous compliance review. The OPM Committee had reviewed an additional 16 that were undergoing final edits. An additional 14 were pending review and approval. Comments on a number of these policies are	Noncompliance

#	Provision	Assessment of Status	Compliance
		included in other sections of this report. Review and revision of this number of policies was a significant accomplishment, and had required the OPM Committee to meet twice monthly. Areas in which efforts are needed in order to achieve compliance, included: ▪ 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. ▪ As noted in the previous 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. ▪ 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." 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). However, as discussed with the Quality Assurance Director, this is a challenging undertaking given the number of Facility policies, and the number of staff who need to be trained on them. It is recommended that the Facility define in policy or procedure the process that will be used to ensure this occurs. It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided. In addition, for each policy approved, consideration should be given to having the OPM Committee define who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency	

#	Provision	Assessment of Status	Compliance
		Training Department, but often others would have responsibility. Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP training). Based on documentation provided, it appeared a system was available to track which staff had completed which training, and to run exception reports showing who still required training. Incorporation into this system of the training on policies would appear necessary and appropriate. 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.	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ At the time of the review, the Lead File Clerk was responsible for completing 10 record audits per month. The Unified Records Coordinator subsequently completed a review of a sample of five of these 10 records. Due to the need to hire a new Unified Records Coordinator and to provide training to the new staff member once the position was filled, during this review period, a couple of months went by when record reviews were conducted according to this schedule. This was understandable, and since July 2011, the Lead File Clerk and Unified Records Coordinator were again completing full audits. ▪ As previously reported, 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 addition, starting in June 2011, one individual's team was selected for completion of the State Office's interview tool designed to solicit information specifically about Section V.4, which requires the Facility to routinely utilize individuals' records in making care, medical treatment and training decisions. ▪ The Facility also had developed its own tool to determine compliance with the new procedure related checking records in and out. This was a positive initiative, and it directly related to the security requirements included in Appendix D of the Settlement Agreement. When this data showed that over several weeks, multiple residences were not complying with the new procedures, a plan was put in place to re-train staff. This plan was followed through to completion, including the tracking of training rosters, and multiple	Noncompliance

#	Provision	Assessment of Status	Compliance
		reminders being sent. The Unified Records Coordinator continued to monitor compliance, with results showing marked improvement in the months following the training effort. This was a good example of the use of monitoring results to identify an area needing improvement, as well as implementation of actions designed to correct the deficiency, and monitoring of the outcomes to ensure the actions were effective. Based on a review of the 10 most recent record reviews conducted, for most of these reviews, numerous issues were identified, for which detailed comments were provided regarding issues identified. The data collected through the implementation of the Settlement Agreement monitoring tool appeared to have been aggregated. QA/ QI Data Section V reports also were submitted for the months of June through August 2011. None of these documents showed a full analysis of the information. As noted above, with regard to Section V.1 of the Settlement Agreement, staff were able to verbally discuss some issues they believed were systemic in nature. Some of the issues LBSSLC staff had identified informally involved legibility of the records, accuracy of information included in the records, and gaps in documentation. Although progress continued to be made with regard to this provision of the Settlement Agreement, LBSSLC 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.	Progress had been made and/or sustained with regard to the Facility's use of such records in making care, medical treatment, and training decisions. Positive developments included: ▪ As discussed above, to address issues related to the timely filing of information needed to make decisions, a specific procedure entitled: Process for Submission and Timely Filing of Information in the Active Record, dated 8/11/11, had been implemented. This policy clearly identified roles and responsibilities, and set timelines for completion of specific activities. Although its implementation was in the early stages, both internal monitoring audits, as well as the Monitoring Team's experience with the records during the onsite review indicated that improvements had been made with regard to the availability of needed documents. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		to staff's use of information in the records to make care, medical treatment, and training decisions. ▪ 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 just beginning to be developed and implemented to ensure data reliability. ▪ As discussed during the QA/QI Committee meeting while the Monitoring Team was on site, the records were not consistently available for appointments, particularly dental appointments. Due to the extent and the ongoing nature of the issue, the Committee agreed that a corrective action plan should be developed. The Facility had begun to implement the State Office tool for monitoring this component of the Settlement Agreement. Although this was a positive development, additional monitoring methodologies will be necessary to substantiate compliance with this provision. It will require a number of different methodologies, including, for example, observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, PSP meetings, etc.), reviewing Integrated Progress Notes and other 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 the Facility with additional guidance with regard to Individual Notebooks. Once this guidance is provided, the Facility should move forward to quickly implement the decided upon procedures. (Section V.1)
2. As recommended in the previous report, if not already completed, 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. (Section V.1)
3. 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. (Section V.2)
4. 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. To accomplish this, the Facility should define in policy or procedure the process that will be used to ensure this occurs. In developing such a policy, the following should be considered:
    a. It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided.
    b. In addition, for each policy approved, consideration should be given to having the OPM Committee define who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom

training, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility.

c. Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training).

d. Based on documentation provided, it appeared a system was available to track which staff had completed which training, and to run exception reports showing who still required training. Incorporation into this system of the training on policies would appear necessary and appropriate. (Section V.2)

5. Monitoring efforts for Section V.4 should be expanded to include a number of different methodologies, including, for example, 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 Coordinators, but might be distributed in other monitoring tools. (Sections V.3 and V.4)
6. As is recommended elsewhere in this report, revisions to the processes the Facility was using to establish inter-rater reliability should be made. Development of adequate instructions for the audit tools also would facilitate validity and reliability of the data collected. (Section V.3 and Facility Self-Assessment)
7. As is specified in other sections of this report, improvements should be made with regard to the quality of the data and other information that is entered into individuals' records. (Section V.4)
8. As the Facility's self-assessment processes continue to evolve, the POI should include more information related to the analyses of data collected through the internal audit processes. (Facility Self-Assessment and Section V.3)

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. (Section V.2)

List of Acronyms

Acronym/ Symbol	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ADA	American Dental Association
ADL	Adaptive Living Skill
ADR	Adverse Drug Reaction
AED	Anti-epileptic Drugs
AED	Automatic External Defibrillation
ALS	Amyotrophic lateral sclerosis
AAMD	American Association on Intellectual and Developmental Disabilities
A/N/E	Abuse/Neglect/Exploitation
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 (Order)
DOJ	United States Department of Justice
DPN	Dental Progress Note
DSM	Diagnostic and Statistical Manual
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EF	Enteral Feeding
EGDs	Esophagogastroduodenoscopy
EIRS	Estacado Industries Residential Services
EIWS	Estacado Industries Workshop
EKG	Electrocardiogram
EMS	Emergency Medical Staff
ENT	Ear, Nose and Throat
ER	Emergency Room
FAST	Functional Analysis Screening Tool
FDA	Federal Drug Administration
FSA	Functional Skills Assessment
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
ISPA	Individual Support Plan Addendum
IV	Intravenous
J-tube	Jejunostomy Tube
LAR	Legally Authorized Representative
LBSSLC	Lubbock State Supported Living Center
LOS	Level of Supervision
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
MH/MR	Mental Health/Mental Retardation
MIC	Mealtime Improvement Committee
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
MSSC	Medication Safety and Systems Committee
MT	Mealtime
MTC	Mealtime Coordinator

n	Number that was audited
N	Total population being reviewed
N/A	Not Applicable
Na	Sodium
NCC MERP	National Coordinating Council for Medication Error Reporting and Prevention
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
OJT	On-the-Job Training
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
PNMPC	Physical and Nutritional Management Plan Coordinators
PO	By mouth
POI	Plan of Improvement
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
QA/QI	Quality Assurance/Quality Improvement
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
Sd	Discriminative Stimulus
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
SLPA	Speech Language Assistant
SO	State Office
SOAP	Subjective, Objective, Assessment, and Plan
s/p	Status Post
SPCI	Safety Plans for Crisis Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
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
URI	Upper Respiratory Infection

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